

BARRIERS TO SCREENING AND POSSIBILITIES FOR ACTIVE DETECTION OF FAMILY MEDICINE ATTENDEES EXPOSED TO INTIMATE PARTNER VIOLENCE

OVIRE ZA PRESEJANJE ZA NASILJE IN MOŽNOSTI DEJAVNEGA ODKRIVANJA OSEB Z IZKUŠNJO NASILJA V PARTNERSKIH ODNOSIH V DRUŽINSKI MEDICINI

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Received: Apr 23, 2015
Accepted: Aug 04, 2015

Original scientific article

ABSTRACT

Keywords:

domestic violence, qualitative research, mass screening, early diagnosis/early detection

Introduction. In 1996 the World Health Organization declared intimate partner violence (IPV) the most important public health problem. Meta-analyses in 2013 showed every third female globally had been a victim of violence. Experts find screening controversial; family medicine is the preferred environment for identifying victims of violence, but barriers on both sides prevent patients from discussing it with doctors.

Methods. In July 2014, a qualitative study was performed through semi-structured interviews with ten family doctors of different ages and gender, working in rural or urban environments. Sound recordings of the interviews were transcribed, and the record verified. The data were interpreted using content analysis. A coding scheme was developed and later verified and analysed by two independent researchers. The text of the interviews was analysed according to the coding scheme.

Results. Two coding schemes were developed: one for screening, and the other for the active detection of IPV. The main themes emerging as barriers to screening were lack of time, staff turnover, inadequate finance, ignorance of a clear definition, poor commitment to screening, obligatory follow-up, risk of deterioration of the doctor-patient relationship, and insincerity on the part of the patient. Additionally, cultural aspects of violence, uncertainty/helplessness, fear, lack of competence and qualifications, autonomy/negative experience, and passive role/stigma/ fear on the part of the patients were barriers to active detection.

Conclusion. All the participating doctors had had previous experience with active detection of IPV and were aware of its importance. Due to several barriers to screening for violence they preferred active detection.

IZVLEČEK

Ključne besede:

nasilje v partnerskih odnosih, kvalitativna analiza, presejanje, dejavno odkrivanje

Uvod. Nasilje v družini je bilo leta 1996 z resolucijo Svetovne zdravstvene organizacije prepoznano kot najpomembnejši javnozdravstveni problem. Metaanaliza leta 2013 je pokazala, da je vsaka tretja ženska na svetu žrtev nasilja. Nasilje v partnerskih odnosih v lastnem domu za ženske predstavlja večjo grožnjo kot v kateremkoli drugem okolju. Za identifikacijo žrtev nasilja naj bi bila najprimernejša družinska medicina. Mnenja o presejanju so v strokovnih krogih različna. Ovire pri pacientih in pri zdravnikih družinske medicine preprečujejo prepoznavanje in obravnavo žrtev nasilja.

Metode. V okviru kvalitativne raziskave smo julija 2014 intervjuvali deset zdravnikov družinske medicine. Razlikovali so se po spolu, starosti, letih delovnih izkušenj in po delovnem okolju. Semistrukturiran intervju je bil usmerjen v iskanje ovir pri presejanju in v možnosti dejavnega odkrivanja nasilja v ambulantni družinske medicine. Zvočni posnetki intervjujev so bili natančno prepisani, skladnost zapisov je preverjena. Na podlagi literature in začetne analize sta bili oblikovani po ena kodirna shema za presejanje in za odkrivanje nasilja v partnerskih odnosih. Nadaljnje besedilo sta dva neodvisna raziskovalca analizirala po metodi analize vsebine glede na kodirno shemo.

Rezultati. Vključenih je bilo sedem zdravnic in trije zdravniki družinske medicine, starih od 29 do 65 let, povprečna starost je bila 45,9 leta. Po specialnosti so bili trije specialisti splošne, štirje specialisti družinske in trije specializanti družinske medicine. Pet zdravnikov je prihajalo iz ambulante v mestnem, eden iz ambulante v primestnem in štirje iz ambulant v ruralnem okolju. Glede presejanja je bilo odkritih osem glavnih tem oziroma ovir: pomanjkanje časa, menjavanje zdravnikov, neurejeno financiranje, nepoznavanje jasne opredelitve, dolžnost ukrepanja, nizka zavzetost za presejanje, tveganje za poslabšanje odnosa z bolnikom in neodkritost bolnikov. Kot spodbudi za presejanje za nasilje sta bili prepoznani dve temi: način izvedbe z možnostjo timske obravnave in zavedanje pomembnosti presejanja za nasilje. Za odkrivanje nasilja so bile odkrite naslednje teme: pomanjkanje časa/kompleksnost, organizacija in financiranje, kulturološki vidik nasilja, negotovost/nemoč/strah, pomanjkljiva kompetentnost in usposobljenost, vpliv odkrivanja na odnos z bolnikom, pri bolnikih pa še avtonomija/negativne izkušnje ter pasivnost/toleranca/stigma/strah. Kot spodbude za dejavno odkrivanje nasilja so bile prepoznane štiri teme: zavedanje položaja zdravnika družinske medicine, zavedanje pomembnosti odkrivanja nasilja, pozitivni vplivi odkrivanja nasilja in bolnikova potreba po zaupanju.

Zaključek. Vsi sodelujoči zdravniki so imeli predhodne izkušnje z obravnavo nasilja v partnerskih odnosih. Zavedali so se pomembnosti dejavnega odkrivanja žrtev in bili zaradi številnih ovir manj naklonjeni presejanju za nasilje.

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1 INTRODUCTION

A resolution of the World Health Organization (WHO) in 1996 recognized violence as a major threat to global health (1). In 2002 the WHO published the analysed data of 28 population-based studies; 10-69% of the participants were discovered to be victims of intimate partner violence (2). In 2005 there were between 15 and 71% such victims (3). A meta-analysis of 155 studies from 81 countries, published in 2013, found that every third woman admitted to having been exposed to family violence (4).

Domestic violence is mostly hidden from the public eye and takes place in the home environment (5, 6, 7), where an individual can become a victim of physical, sexual or psychological abuse, including economic violence and neglect (5, 6, 7). The victims of domestic violence are mostly women (8, 9). In 2005, on the basis of the results of a large-scale multi-centre survey, the WHO proposed (10) that the term domestic violence (also family violence) be replaced by the expression intimate partner violence (IPV), so as to recognise the predominance of intimate partner violence compared to other forms of domestic violence, and the impact of intimate partner violence on all the relationships within the family. This expression also includes intergenerational violence, i.e. violence of parents towards children and violence of children towards grandparents (elderly abuse) (10).

In accordance with international recommendations, the detection of IPV should take place at the primary health care level in general/family medicine practice settings (6, 11, 12). Due to the frequency and long-term consequences of violence, there is a growing interest in the identification of cases of IPV (13-18). Screening for violence is defined as the posing of standardized questions on violence to all individuals, even those without symptoms, which should vary as little as possible in different environments (19). In addition to universal screening, other methods of detection of IPV include selective screening (questions posed to certain high-risk groups, such as all pregnant women, or all women seeking abortion); routine inquiry (all the respondents are women, but the method/question would depend on the clinical background or situation, for example, asking all injured women in a certain age group); and active detection of violence (when risk factors are present) (20).

The different effects on the incidence of violence and the resulting variability require specific evaluation of the level of violence in each country. Due to differences in tradition, religion, cultural norms, social conditions and research methodology, the proportion of female victims of lifelong IPV vary more than ten-fold across the European continent: from 4% in Serbia, to 53% in the Netherlands (21-24). Screening is justified for the first assessment of the prevalence of IPV in a particular environment, but not for routine treatment of individuals (1, 6, 11). Results

of research, guidelines, and expert opinions regarding systematic screening for violence still differ greatly (20, 22 -24). The WHO clinical guidelines do not recommend screening, particularly in environments in low or middle-income countries (23).

Despite recommendations from professional organizations to actively detect violence, only about 10% of physicians routinely investigate their patients in relation to violence (25).

In Slovenian family medicine, a study in 2012 confirmed previous findings and the evaluation of the frequency of violence; in 2572 patients, a total of 17.9% of participants reported IPV (psychological, physical, or both (26)). In Slovenia, screening for violence is not performed as a part of routine medical treatment. Moreover, the treatment of patients who are potential victims of sexual or physical violence, or of those who were proved to having participated in any acts of violence was identified to be one of the most severe ethical challenges for family doctors (27), aside for the abandoned and the patients without means of livelihood.

The aim of this qualitative study was to obtain a deeper insight into the attitudes of physicians towards screening for domestic violence. We wanted to identify the barriers to screening for violence of family doctors in their respective populations, and to learn about their experiences and obstacles in the active detection of violence.

2 METHODS

In order to obtain an insight into the barriers to physicians screening for domestic violence, a qualitative study using semi-structured interviews was performed in July 2014 (28). This was a phenomenological study on the experience of detecting violence and on the barriers to it, in the light of the nature and importance of screening for violence. A purposive sample of doctors was recruited, from whom we could obtain more information regarding the objectives. They were most relevant for such a survey as they were appropriately knowledgeable about the topic, as allowed in qualitative research (28).

2.1 Participants

The study included ten family doctors of both genders who came from different health centres and worked in different regions, were of different ages and had different years of experience in family medicine. The age of the seven female and three male doctors varied from 29 to 62 years, the mean age was 45.9 years. Three of the participating doctors were specialists in general medicine, four specialists in family medicine and three

were trainees in family medicine. Five doctors worked in urban environment, one came from a suburban clinic in and four from clinics in rural areas. Their working experience varied from two to 45 years, and all had already had experience with the detection of IPV. With this sample we were looking for a wide variety of viewpoints towards screening for violence and experience in detecting violence (28).

2.2 Procedure and Measures

A semi-structured interview with pre-prepared questions was used, although free replies were also encouraged. The sub-questions were only implemented when trying to deepen or direct the content and themes relevant to the survey (29). All the interviews were conducted during July 2014.

Before commencing the interview, the participants were informed about the purpose and methods of the research, and were offered the possibility to withdraw from the study at any time. They all agreed to participate. The interviews were conducted in a private room, and lasted between 12 and 19 minutes. The interviewing phase was concluded when the data were saturated, i.e. until new codes within the given category were no longer emerging, which was achieved with the 10th interview. In order to respect the privacy of the participating physicians their names are not disclosed in the text.

The following issues were discussed: (1) According to you, how important a health problem is IPV? (2) What has been your experience in dealing with IPV in your patients? (3) What do you think about screening as a method of detecting domestic violence? (4) What are the barriers to screening? (5) How well qualified do you feel for the detection of domestic violence?

All the audio recordings of interviews were accurately transcribed. After completion, the transcription was rechecked for accuracy. The transcripts were analysed by two independent researchers; in cases of discrepancies in the analysis, the issues were discussed until agreement was achieved.

2.3 Data Analysis

The transcripts of the interviews were analysed by qualitative content analysis and by deductive analysis, which is used when data are tested against known basic features in the new context. The categories and concepts were tested in the following steps (28):

1. Construction/forming of a matrix, which consists of several categories (the categorisation matrix);
2. Definition of the units of analysis (word, phrase, and theme);

3. Testing of the analytical matrix (by encoding the initial interviews);
4. Modification of the categorisation matrix;
5. Analysis/encoding data in the categorisation matrix;
6. Interpretation of the results.

This type of analysis is typified by a rapid reduction of the data. The categorisation matrix was formed according to data from the literature (28-37), and completed according to the results of our own original analysis. The subsequent text was analysed within the categorisation matrix.

3 RESULTS

3.1 Demographics of Participants

The sample consisted of seven female and three male family doctors, aged between 29 and 65 years; the mean age was 45.9 years. Three of the participating physicians were specialists in general medicine, four were specialists in family medicine, and there were three residents/trainees in family medicine. Five doctors came from urban clinics, one from a suburban clinic and four from clinics in rural areas.

3.2 Results of the Analysis

Data are shown separately for the results of the analysis of screening and of the active detection of IPV, according to the definition of each mode of identification of victims (19, 20).

3.2.1 Barriers to Screening for IPV

Based on the expected categories and on the initial coding, the barriers to screening for IPV were classified into three main categories, namely: barriers related to the organization of work within the health care system; barriers associated with physicians; and barriers arising from the patients. The interviewees also stated certain incentives in each of the categories. The results of the qualitative analysis of barriers to screening are shown in Table 1.

The survey identified seven themes as barriers to screening associated with physicians: three originating from the health care system, four pertaining to the doctors themselves, and a single barrier attributed to the patients by the participating doctors. The incentives for screening were presented in two themes.

Table 1. Barriers to screening for intimate partner violence.

	Barriers	Incentives
Healthcare system/ organisation of work	<ul style="list-style-type: none"> • lack of time • staff turnover • inadequate financing 	<ul style="list-style-type: none"> • method of implementation and possibilities of a team approach
Doctor	<ul style="list-style-type: none"> • ignorance of a clear definition • poor commitment to screening • obligation to follow up • risk of deterioration of the doctor-patient relationship 	<ul style="list-style-type: none"> • awareness of the importance of detecting violence
Patient	<ul style="list-style-type: none"> • insincerity 	

Some actual statements of the participating doctors are presented by quoting the gender of the respective doctor (M= male, F=female) and the age of the participant in the parenthesis.

Barriers to screening: The health care system and organization of work - Lack of time: “Yeah, with a proper introduction, the screening would be too long, therefore. And the question arises, how many times it should be repeated. Now, even if you do not ask (=the patient about violence) for one year, two years, one (=the patient) is at risk every day. Time to ask him every time (= about violence), I would not have. Should be continuously monitored (=for violence), it varies from today to tomorrow.”(F, 34)

Barriers to screening: The health care system and organization of work - Staff turnover: “If you are a ‘new’ doctor, you don’t know the patients and therefore all is wrong. Where is the just trust ...”(M, 29)

Barriers to screening: The health care system and organization of work - Inadequate financing: “The logistical barrier to dealing with violence is not compatible with the calculations of the health insurance: it is not possible to do(= deal with violence) in a regular clinic.” (M, 55)

Barriers to screening: Doctor - Ignorance of a clear definition of IPV: “The starting point of screening for violence should be a good definition of the threshold of violence, which is sometimes subjective. The definition should be in terms of action. It is clear what physical violence is, but with psychological-verbal (=violence) things are more scalable.”(M, 55)

Barriers to screening: Doctor - Poor commitment to screening: “I have never considered to ask about it on a regular basis. I think one should ask about it.” (F, 45)

Barriers to screening: Doctor - Obligation to follow up: “To just uncover something, without trying to act, is pointless, just like diagnostics without treatment.” (M, 55)

Barriers to screening: Doctor - Risk for deterioration of doctor-patient relationship: “This issue (= single screening question for violence) can hurt both, those who are involved and those who are not. Those who do not have contact with this (= violence), could feel threatened, why ask about it now. They would think, why we ask, has there been perhaps some information or what is wrong now.”(F, 34)

Barriers to screening: The patient - Insincerity: “The main obstacle to the screening question is the reliability of the data. Patients would see the screening as more negative than positive. In particular, the question is, if those exposed would even tell about the violence.”(M, 55)

Incentives: The health system / organization of work - Method of implementation and possibilities in team approach: “We are overburdened, perhaps the screening could be included into the program of the model practices. Practice nurse has more time to create the climate, to obtain the data, which the doctor during his assembly-line-style work cannot.”(M, 55).

Incentives: Doctor - Awareness of the importance: “Many things are important: the heart attack to survive, this (= violence) is also important. Violence affects the quality of life and is part of the treatment, which we need.”(M, 65)

3.2.2 Barriers to Active Detection of IPV Cases

After completing the analysis of the interviews, we classified the barriers to active detection of IPV, as seen by doctors, into three main categories: barriers in the healthcare system, i.e. the organization of work; barriers associated with physicians; and barriers arising from the patient. In each of the categories, the interviewees also stated individual incentives. The results of the qualitative analysis of barriers to detection are shown in Table 2.

The survey uncovered twelve main themes, which were developed using the results of the initial analysis. The doctors stated more barriers from their own viewpoint than those which they attributed to their patients, and also found more of their own incentives.

Table 2. Results of qualitative analysis: barriers to active detection of violence.

	Barriers	Incentives
Healthcare system/organisation of work	<ul style="list-style-type: none"> • lack of time/complexity • organisation and finances 	<ul style="list-style-type: none"> • awareness of the position/role of the family practitioner
Doctor	<ul style="list-style-type: none"> • cultural aspects of violence • uncertainty/helplessness/fear • lack of competence and qualifications • impact of the disclosure on the patient-doctor relationship 	<ul style="list-style-type: none"> • awareness of the importance of active detection of cases • positive effects of the disclosure of violence
Patient	<ul style="list-style-type: none"> • patient autonomy, negative - experience • passive role, tolerance, stigma, fear 	<ul style="list-style-type: none"> • the need to trust

Some of the topics in the active detection of IPV overlapped with the themes found in barriers to screening for violence. In this category, just as in the screening category, participants cited lack of time, inadequate finance, and the risk of deterioration in the relationship with the patient as important barriers.

Other topics were given a different emphasis in screening, which is a process, as against active detection, where they were discussed in the light of further action which could be taken, triggered by the disclosure of IPV.

Barriers to active detection of IPV cases: Healthcare system/organisation of work - Lack of time/complexity: *"...sometimes, with this conveyor-belt style practice, I simply lack the time and the energy to tackle the subject of violence (M, 55 years)."*

Barriers to active detection of IPV cases: Healthcare system/organisation of work - Organization and finances: *"Physicians should be informed, not only familiar, precisely, about what could be expected within each of the services (=which helps victims of domestic violence). We are obliged by law, but we are not connected, we do not get the feedback."(F, 55)*

Barriers to active detection of IPV cases: Doctors - Cultural aspect of violence: *"I ask patients whether it's alright for them. I would like to make sure that you are OK, that you are happy. For other cultures and habits I*

do not know, but I just want to make sure the patient believes this situation is okay and he/she does not suffer."(F, 45)

Barriers to active detection of IPV cases: Doctors - Uncertainty / helplessness / fear: *"The victim may be subjective, I would like to hear both sides of the story. It always takes two to quarrel, a dispute can also be provoked."(F, 55)*

Barriers to active detection of IPV cases: Doctors - Lack of competence and qualifications: *"Unimaginably, this woman has been to see me several times, and I know nothing about it (=violence). I told her directly: your problems are not caused by diseases. When I asked her about violence, it all erupted from her. Before that, I perceived this patient as -I will not say- as a hypochondriac."(F, 45)*

Barriers to active detection of IPV cases: Patient - Patient autonomy, negative experiences: *"The patient's will is different than the law. Procedures are problematic because patients have their own will. I have good experience with the services dealing with domestic violence, but only when the victim accepted the assistance."(F, 55)*

Barriers to active detection of IPV cases: Patient - Passive role, tolerance, stigma, shame: *"They are afraid they will not be able to escape, that the situation cannot be resolved, that nothing can be done. No one can help, they are powerless and trapped in it. These people probably do not have an alternative: if they could, they would probably put things in order and leave."(F, 45)*

Incentives: Doctor - Awareness of the position/role of the family practitioner: *"(She) must know that she can turn to me whenever needed. The door has to be left open, but she should not be pushed through the door. I will not say that we can solve everything, but the main thing is for them (=victims) to know where to turn."(F, 45)*

Incentives: Doctor - Awareness of the importance of active detection of the cases: *"We (= family doctors) are the necessary starting point in the early detection of domestic violence." (F, 55)*

Incentives: Doctor - The positive effects of disclosure of violence: *"Now it is easier for her to trust me, and that makes me feel positive. Now she can come anytime, the door is always open."(F, 34 years old)*

Incentives: The patient - The need to trust: *"If one can trust the doctor, it (=the secret) will remain there and will not go anywhere. You (the victim) must have someone whom you can tell and know it will remain intimate. It helped her that I know now. We talked about the possibilities, what she could do."(F, 45)*

4 DISCUSSION

In this qualitative study the aim was to obtain a deeper insight into attitudes towards IPV detection in family physicians. The results for screening and for the active detection of IPV demonstrate some overlapping themes: lack of time, inadequate finance, endangering the doctor-patient relationship and awareness of the importance of IPV.

All participating doctors openly talked about the issue of screening and the active detection for IPV, and enabled a rich set of data. In the original analysis, there were more than 300 codes. All participating physicians, regardless of the amount of experience in family medicine, had a history of contact with this issue and also had formed a standpoint on it. Their opinions on the five previously mentioned items discussed in the interviews were well harmonized, regardless of the differences in gender, mode and amount of training, location of their practice, age and years of experience.

4.1 Family Doctors' Attitudes towards Screening for IPV

The current organization of work in family medicine clinics tends to reduce the potential for screening, due to limited time for each consultation and understaffing in this specialty (38, 39). The responses expose the fast pace of consultations (like a "conveyor belt") and lack of time to deal with patients, while still carrying a large responsibility for them (Table 1). A cross-sectional study (40) which measured workload in the clinic, carried out among 50 family doctors in Slovenia, showed that the physicians have an average of only 6.93 minutes for each patient (39). This is due to the lack of family doctors in Slovenia compared with the European average, and consequently to an excessive number of patients per doctor (41).

It therefore seems reasonable that doctors are reluctant to take on screening as an additional burden, as they are aware that it is not a common topic in a typical consultation, and stressed that such conversations demand extra time (Table 1). This standpoint was shared by all participating doctors, regardless of their demographic data, mode of training (general medicine or family medicine), years of experience and their working environment. Lo Fo Wong notes that even 10-15 minutes, which is double the average time of consultation in Slovenia, is insufficient for screening and the consequent identification of potential victims of violence, where there are no known risk factors (42). Some studies have shown the inquiry should be repeated several times for the same individuals (13, 43, 44). Such a treatment plan, to detect IPV in multiple consecutive short conversations with prior preparation, taking account of the current limitations of consultation time in Slovenia, was also proposed by one

of the interviewees. In a foreign qualitative research study (42), the desire for progressive detection was also expressed from the point of view of the victims; they expected more consecutive direct questioning, in order to prepare themselves for the disclosure.

Doctors have expressed difficulties in connection with the organizational peculiarities of work in family medicine (Table 1). The lack of doctors means a high turnover, and this reduces one of the most important competencies in family medicine - continuity. Doctors in family medicine have normally known and followed up their patients and their families over a long period of time (45). Because of their position, the 'new' doctors usually feel a lower confidence level than required in order to discuss violence (46). On the other hand, experienced physicians in this research recognized that their profession was the right place to detect IPV.

One of the participating physicians expressed the fear that dealing with violence meant an expansion of the health services program in the family medicine clinic (Table 1). In their research, Zink and colleagues encountered a similar barrier in family doctors considering family violence; they thought that in their work "there is no need to look for new problems" (43). Lack of resources was also one of the major barriers to screening identified in a study by Lapidus (47). The participants in our interviews expected a clear definition of violence in order to carry out screening (Table 1). While they did not have any doubts or concerns about physical violence, they found the boundaries between certain specific behaviours and psychological violence less clearly defined. Psychological violence is more common than physical violence and has serious consequences, but its definition in different environments and cultures is problematic, as researchers have found, even in large studies (4, 48-50). In the context of the detection of violence, doctors presented a somewhat more flexible stance on its definition, taking into account the ethnic and cultural background, and, in particular, the position of the victim in the family (Table 2). If certain behaviour was perceived by victims as expected, acceptable and harmless, the doctors in the study did not consider it as violence.

The concern of the participating physicians with regard to screening as an effective and reliable instrument for the detection of IPV (Table 1) is consistent with previous findings, which could not confirm evidence-based support for the benefits of screening, and which may show that screening does not meet the criteria for secondary prevention (i.e. screening must, by definition, be an intervention which improves prognosis) (51). A recently published meta-analysis of several studies showed that more victims of violence are detected by screening, but that this proportion is still low compared to the frequency of violence; likewise, no improved outcomes for the victims

following the screening could be demonstrated (22). The opinion of other researchers is that screening is justified because it detects violence as a risk factor responsible for a wide range of mental and physical problems (52). However, screening for violence, unfortunately, is not a simple diagnostic test with clear interpretation (42), as in the case of most chronic diseases. The sensitivity of the screening is also questionable in terms of false-negative results, as it may occur during the period of denial, when the victim is not willing to disclose (53). In this regard, doctors were aware of their own limitations during consultation, as has been observed in several other publications (54-60).

The concern of doctors for their own safety in relation to retaliation by the perpetrator of violence was also mentioned while investigating IPV (Table 2). Doctors minding their own safety is understandable; a recent survey on violence against doctors in Slovenia showed considerable exposure on the one hand, and relatively rare or completely lacking mechanisms for protection on the other (61). This phenomenon is not specific to the Slovenian environment, as it has also been reported elsewhere (62).

Doctors highly value and protect the confidential doctor-patient relationship, as well as the privacy of their patients (Table 1, 2). While discussing violence, they have a sense of intrusion into the privacy of patients and are, therefore, reluctant to do it. They fear that, by asking about violence, they may hurt the patients' feelings, arouse their suspicions or reduce their confidence (Table 1, 2). With these concerns, physicians demonstrate a highly ethical stance, particularly in protecting confidentiality and upholding the principle of do-no-harm to the patient (63). Similar dilemmas and obstacles to screening have also been reported by other authors (64-66). However, any harmful effects of screening have not been scientifically proven (22, 64). Doctors should have sufficient knowledge and skills for the screening, and be properly trained to respond professionally in the event of disclosure of violence (11, 67). Even the subjects in this qualitative research expressed fears within the meaning of the 'Pandora's Box' phenomenon: merely asking about violence is not enough - there needs to be further action. Two recent studies, however, have found the importance of the disclosure of violence and subsequent participation in support programs: even the mere disclosure and subsequent clarification of the concept of violence helped victims to enter the 5-stage model of change (43, 44).

Although the participants of the study were not in favour of screening, they did suggest some urgent organizational conditions under which screening would be potentially feasible (Table 1).

Screening for only the most serious forms of physical violence was mentioned. It is known that different types

of violence are interlinked, and therefore the victims of physical IPV are highly likely to be also exposed to mental and sexual violence (5). Screening with a single question about severe physical violence could perhaps identify high-risk victims, but the comprehensive treatment of victims would be neglected and the more frequent victims of psychological violence could be overlooked (5). The option proposed by two of the subjects in this study, of screening in the Slovenian model practices, has not been foreseen in the project program (68).

Notwithstanding the prevailing negative attitude towards screening, all the participants recognized the importance of adequate treatment of violence in a family medicine environment (Table 1, 2). They had all already been exposed to specific situations associated with IPV with their patients, had had experience of it, and been aware of the significance and frequency of domestic violence. The reluctance towards screening of the participating doctors is consistent with the results of research: screening should be implemented only to determine the frequency of violence in individual countries (1, 6, 11). It is primarily the environment of family medicine, as compared to all other environments, that allows the identification of the majority of the victims of IPV; research in family medicine practices (13, 21, 22, 64) in Australia, Ireland and the United Kingdom detected a higher incidence of IPV (between 37% and 40%) compared to studies in the general population in the same environment (an average of 30%) (4, 10, 12, 69, 70).

4.2 Family Doctors' Attitudes towards the Detection of IPV Cases

In our study, the physicians identified several obstacles to the active detection of IPV from the point of view of the patients: the powerlessness of victims of violence; their fear; a sense of stigma or shame; tolerance of violence; and even passivity and negative experiences with the healthcare system (Table 2). These findings are confirmed by patient-oriented research: the bullying of the victim by the perpetrator or the victim's fear of reprisal undoubtedly reduce the possibility of the victim reporting IPV (67-71). Similarly to our study, the fear of stigma and shame, which appear due to self-accusation of the victims, and sometimes the attitude of the environment (e.g.: "He's your own choice.") were confirmed by other researchers (13, 29, 32). Observation of the helplessness of the victims and their bad experiences with services and institutions that deal with the treatment of violence, e.g. the police and social services in our study (Table 2), are consistent with the findings of other studies, in which the victims cited pressure from family and/or community, and the hope that the violence would cease, as important barriers to disclosure (17, 37, 70).

In connection with the discovery of IPV, the family doctors in the study mentioned relief, a deepening of the relationship with the patient, a better understanding of patients and their problems, solutions to unspecified health problems and an open field of sincere communication following the disclosure by the victim of violence (Table 2); so disclosure of violence brings many positive outcomes for both doctor and patient, not just the latter. Similar positive experiences of physicians are reported by other researchers (42, 55, 56).

Notwithstanding the negative attitude towards screening, which is consistent with current guidelines (36), all the participants expressed great interest in the identification of victims of violence in those with the recognized risk factors. Motivation for the active detection of violence was also recorded in their statements on the importance of awareness of IPV and its consequences (Table 2).

4.3 Required Resources for Dealing with Patients at Risk of IPV in Family Medicine

In the interviews with the doctors, a great desire and need was expressed for specific skills for communicating with patients on this subject, both in terms of screening and in active detection of violence (Table 1, 2). In their view, IPV screening requires different skills from those needed for treating chronic diseases and other risk factors. A desire and readiness to upgrade their skills in both verbal and non-verbal communication was stressed by all participants. Published research confirms that a lack of specific skills is a common reason for non-recognition of victims of violence (16, 54). The experience of the patients shows that an empathic manner when communicating with them reduces discomfort and increases the potential of disclosure of violence, irrespective of the gender of the doctor (55, 56).

In the context of educational activities, some authors do not address the views and attitudes of doctors towards violence (19, 42). In addition, the lack of knowledge of IPV can have negative consequences on the outcomes of screening, not only for patients, but also for doctors (42, 57). The concept of "creating an appropriate atmosphere to talk about violence" appears in the literature, which reports the viewpoint of female victims to screening; as in this Slovenian survey, the participating victims in the literature confirmed that an appropriate atmosphere helped them in overcoming denial, in addition to the doctor listening to them without prejudice or value judgments, showing empathy and allowing them time for decision-making (58-60). The participants in this study spontaneously listed most of these factors (Table 1, 2). They appreciated the trust of the patients while leaving them time and space to decide what to do, and the participating doctors emphasised their impartiality.

Further research in this field would be useful, in particular into the performance of different strategies for the early detection of IPV.

4.4 Limitations to the Study

The main limitation of the research is that it was carried out with only ten participating doctors, but saturation of data occurred even in this number of interviewees. Views on the barriers met by the patients could be better obtained not only indirectly from the observations of doctors, but also directly from some of the patients.

However, it was the first qualitative IPV-related study in family medicine in Slovenia, identifying the obstacles as well as the enhancing factors in the detection of IPV cases. Our findings provided a sufficiently thorough insight into the complexity of this threatening phenomenon, and could be used as basic knowledge for professionals preparing guidelines for family medicine practitioners dealing with patients exposed to IPV.

5 CONCLUSIONS

Slovenian family doctors prefer active detection of violence to systematic screening, which is concordant with the results of other studies and international recommendations.

Considering the importance of IPV as a public health issue, it would be reasonable to try to overcome the identified system/organizational barriers, and to provide necessary resources, organizational and staffing opportunities, and appropriate education, for which the interviewees expressed a lot of interest.

CONFLICTS OF INTEREST

The authors declare that no conflicts of interest exist.

FUNDING

The study was partly supported by the Slovenian Research Agency, Research Programme Code P3-0339.

ETHICAL APPROVAL

The study was approved by the Medical Ethics Committee, consensus number 111/0409, dated 28.05.2009.

The family doctors did not receive any compensation or bonuses for their participation in the study, and were informed of this beforehand.

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