Screening and Intervention for Intimate Partner Abuse

Practices and Attitudes of Primary Care Physicians

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Context Although practice guidelines encouraging the screening of patients for intimate partner abuse have been available for several years, it is unclear how well and in which circumstances physicians adhere to them.

Objective To describe the practices and perceptions of primary care physicians regarding intimate partner abuse screening and interventions.

Design, Setting, and Participants Cross-sectional survey of a stratified probability sample of 900 physicians practicing family medicine, general internal medicine, and obstetrics/gynecology in California. After meeting exclusion criteria, 582 were eligible for participation in the study.

Main Outcome Measure Reported abuse screening practices in a variety of clinic settings, based on a 24-item questionnaire, with responses compared by physician sex, practice setting, and intimate partner abuse training.

Results Surveys were completed by 400 (69%) of the 582 eligible physicians, including 149 family physicians, 115 internists, and 136 obstetrician/gynecologists. Data were weighted to estimate the practices of primary care physicians in California. An estimated majority (79%; 95% confidence interval [CI], 75%-83%) of these primary care physicians routinely screen injured patients for intimate partner abuse. However, estimated routine screening was less common for new patient visits (10%; 95% CI, 7%-13%), periodic checkups (9%; 95% CI, 6%-12%), and prenatal care (11%; 95% CI, 7%-15%). Neither physician sex nor recent intimate partner abuse training had significant effects on reported new patient screening practices. Obstetrician/gynecologists (17%) and physicians practicing in public clinic settings (37%) were more likely to screen new patients. Internists (6%) and physicians practicing in health maintenance organizations (1%) were least likely to screen new patients. Commonly reported routine interventions included relaying concern for safety (91%), referral to shelters (79%) and counseling (88%), and documentation in the medical chart (89%). Commonly cited barriers to identification and referral included the patients' fear of retaliation (82%) and police involvement (55%), lack of patient disclosure (78%) and follow-up (52%), and cultural differences (56%).

Conclusions These findings suggest that primary care physicians are missing opportunities to screen patients for intimate partner abuse in a variety of clinical situations. Further studies are needed to identify effective intervention strategies and improve adherence to intimate partner abuse practice guidelines.

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PHYSICAL VIOLENCE IS ESTIMATED to occur in 4 to 6 million intimate relationships each year in the United States.[1,2] The term *intimate partner abuse* refers to the physical, sexual, and/or psychological abuse to an individual perpetrated by a current or former intimate partner. While this term is gender-neutral, women are more likely to experience physical injuries and incur psychological consequences of intimate partner abuse.[3]

In addition to injuries, abused women often experience somatic and stress-related illnesses, chronic pain syndromes, depression, posttraumatic stress disorder, and substance abuse disorders.[4,5] Furthermore, compared with women with no history of abuse, abused women have higher levels of health care use.[6] In fact, 31% to 54% of female patients seeking emergency services,[7,8] 21% to 66% of those seeking general medical care,[5,9-11] and up to 20% of those seeking prenatal care report experiencing intimate partner abuse.[12,13]

Despite the high prevalence of intimate partner abuse, less than 15% of female patients report being asked about abuse by health care professionals or disclosing abuse to them.[9,14-16] Yet, in 2 studies, the majority of female patients favored physician inquiry and reported that they would reveal abuse histories if asked directly.[14,16] Prior studies examining physician practices suggest that only a small fraction of physicians and other health

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care professionals commonly inquire about intimate partner abuse.[14,17,18] Unfortunately, these findings are limited by small sample sizes, low response rates, and/or the use of convenience samples. Patient attitudes, lack of institutional support, and other environmental factors may hinder efforts to address intimate partner abuse in clinical settings.[19,20] In addition, physicians' feelings of discomfort and powerlessness may also contribute to this low level of inquiry.[21-23]

Early identification of abuse has been a priority in efforts to improve the health care response to intimate partner abuse.[24] Because of the prevalence and associated health care costs of intimate partner abuse, national public health organizations have endorsed the use of interventions such as protocols in clinical settings for the identification of patients experiencing abuse.[25-27] Several national medical organizations have developed practice guidelines for intimate partner abuse that encourage routine screening and interventions.[28-30] Although many of these guidelines have been available for several years, it is unclear how often and in which clinical circumstances health care professionals actually adhere to them.

Lawmakers have attempted to respond to intimate partner abuse by passing legislation, such as mandatory reporting laws, to help improve the health care response. Our previous work addressed physicians' perspectives on mandatory reporting of intimate partner violence to police in California.[31] We previously reported on conflicting attitudes among California primary care and emergency physicians toward mandatory reporting. An estimated 64% of primary care physicians and 25% of emergency medicine physicians might not report abuse if patients object. While almost all states have laws that require reporting certain injuries, 5 states have reporting laws that specifically address reporting intimate partner violence. California's law, which passed in 1994, requires that health care professionals report cases in which they provide medical care for female or male patients whom they suspect are suffering from an intimate partner violence-related injury to the police with or without the patient's consent.

The objectives of the current study included (1) estimating intimate partner abuse screening and intervention practices of primary care physicians in California, (2) exploring how physician specialty, sex, and training might influence screening and intervention practices, and (3) examining primary care physicians' perceived barriers to identification and intervention.

METHODS

Sample

We selected a stratified probability sample of 900 physicians from the California Medical Association database, which includes licensed California physicians (members and nonmembers) and incorporates information from the Medical Board of California and the American Medical Association. Equal proportions were drawn from each of 3 specialties: family practice, internal medicine, and obstetrics/gynecology. In this report, these specialties are collectively referred to as primary care physicians because they provide primary medical care for the majority of female patients. To increase our ability to assess the influence of physician sex, female physicians were oversampled. Because women represent nearly one quarter of physicians in these 3 specialties, they were sampled at 1.5 times their proportion in each specialty. Physicians were excluded if they were retired, in training, practicing outside the state, or working primarily in nonclinical areas. Physicians without a valid California telephone number or address, as verified by local telephone companies and the Medical Board of California, were also excluded.

Recruitment involved 3 mailings of the questionnaire starting in July 1995. Physicians who had not responded after 3 mailings were contacted by telephone and sent an additional survey if requested. A letter that accompanied the questionnaire provided information about the study purpose, procedure, confidentiality, and contact data for further information. Informed consent was implied when a respondent returned the completed questionnaire. This study was approved by the University of California, San Francisco, Committee on Human Research.

Survey Instrument

A 24-item questionnaire was developed based on published research[21,23,32] and discussions with domestic violence advocates. Pilot testing was performed with 30 physicians, both male and female, from all 3 primary care specialties. Based on the feedback from the pilot study, all references to intimate partner abuse were made gender-neutral to enhance acceptability to respondents. Screening practices were assessed in 4 different clinical situations: evidence of injury, new patient visit, periodic checkup, and first prenatal visit. The frequency of screening was assessed by asking, "How frequently do you ask direct, specific questions about domestic violence to patients?" For each clinical situation, respondents were given choices on a 4-point Likert scale of never, sometimes, often, or always. Respondents' use of 7 selected intervention practices was assessed using the same 4-point scale. Perceived barriers to identification and intervention were assessed by providing a list of potential barriers and asking respondents to identify each as a major barrier, minor barrier, or not a barrier.

The survey also included questions about demographics (age, sex, ethnicity), US vs non-US medical training, practice setting, knowledge of relevant legislation, and personal experience with intimate partner abuse. In addition, respondents were asked whether they had "taken a class or continuing medical education course on domestic violence in the last 3 years." To assess childhood exposure to intimate partner abuse, respondents were asked, "When you were growing up, did one of your parents ever threaten, hit, slap, kick or otherwise physically hurt the other?" To assess personal experience with intimate partner abuse, respondents were asked, "Have you ever feared for your safety or been

hit, slapped, kicked, or otherwise physically hurt by an intimate or previously intimate partner?"

Statistical Analysis

Routine screening and intervention practice was defined as a response of "often" or "always" to the different clinical situations and interventions. These variables were dichotomized (never/sometimes vs often/always) for statistical comparison. Similarly, responses to barriers were dichotomized (not/minor vs major) for statistical comparison. The data were analyzed using SPSS statistical software.[33] Analysis of variance was used for statistical comparison of means. For cross-tabulations of proportions with greater than 2 rows or columns, statistical significance was determined using Pearson χ^2. For 2×2 cross-tabulations, Yates corrected χ^2 was used. Statistical significance was defined as $P<.05$.

To generate population estimates, weighted overall proportions were calculated using the inverse of the sampling fraction for each of the 6 sex/specialty strata. Based on data from the 1995 California Medical Association database, practicing California physicians included 5968 family physicians, 9020 internal medicine physicians, and 3831 obstetrician/gynecologists. With the exception of the sample descriptions, all proportions and bivariate statistical analyses make use of weighted estimates. The 95% confidence intervals (CIs) for weighted proportions were calculated by multiplying the SE of proportion by 1.96.

We used logistic regression analysis to estimate adjusted odds ratios (ORs) and 95% CIs for the factors associated with reported screening practices. Four variables were included as predictors in the multivariate models. Three of these variables (specialty, practice setting, and intimate partner abuse training) were included because each was significantly associated with screening practices in at least 1 of the 4 clinical settings using univariate logistic regression models. Although sex was not predictive of screening practices in any clinical setting, it was retained in the models because it was of particular interest. Other potential predictors were not significant in the bivariate analyses. The final models were reviewed for goodness-of-fit and validated using the Hosmer-Lemeshow statistic. Because multivariate models included both specialty and sex, data were not weighted.

RESULTS

Respondents

Of the 900 physicians sampled, 582 were ultimately determined to be eligible for the study and 400 (69%) completed the survey. Of the 400 respondents, 149 (37%) practiced family medicine, 115 (29%) practiced internal medicine, and 136 (34%) practiced obstetrics/gynecology. Response rates for the different specialties did not vary significantly; however, female physicians had a higher response rate compared with male physicians (78% vs 63%; $P = .001$).

The characteristics of the study group are presented in TABLE 1. The mean age was 46 years. Compared with male, female physicians were younger (mean age, 42.0 vs 48.9 years; $P<.001$). The sample was predominantly white and the majority of physicians practiced in private clinic settings.

An estimated 22% (95% CI, 18%-26%) of California primary care physicians had taken a class or continuing medical education course on intimate partner abuse in the past 3 years. This proportion did not differ significantly by physician specialty, sex, age, or practice setting. Overall, the majority of physicians (80%; 95% CI, 76%-84%) had identified intimate partner abuse at some time in their career. However, reported identification varied significantly by specialty: 90% of family physicians, 80% of obstetrician/gynecologists, and 74% of internal medicine physicians ($P = .001$). Identification of a patient who had experienced intimate partner abuse did not differ significantly by physician sex or having taken recent training course on intimate partner abuse.

An estimated 15% (95% CI, 12%-19%) of California primary care physicians had witnessed intimate partner abuse between their parents at some time during their childhood. This exposure did not significantly differ by physician specialty or sex. Overall, 12% (95% CI, 9%-15%) of physicians reported experiencing physical abuse from an intimate partner or feared for their safety as an adult. This experience did not differ by physician specialty. However, compared with male physicians, twice as many female physicians reported having experienced intimate partner abuse (20% vs 10%, $P = .01$).

Table 1. Characteristics of the Physician Respondents According to Specialty*

Characteristic	Family Medicine (n = 149)	Internal Medicine (n = 115)	Obstetrics/ Gynecology (n = 136)	Total (N = 400)
Age, mean (SD), y†	45.3 (10.1)	44.4 (10.8)	48.2 (10.1)	46.0 (10.4)
Women	40	41	44	42
Ethnicity				
White	72	70	73	72
Asian/Pacific Islander	16	23	17	18
Latino	6	3	2	4
Black	3	4	6	4
Practice setting‡				
Private office	60	52	70	61
Health maintenance organization	16	23	17	18
Public clinic	15	6	5	9
Other§	10	19	8	12
Non-US training	24	12	22	20

*Values are expressed as percentages unless otherwise indicated.
†Analysis of variance comparison of means, $P = .008$.
‡Pearson χ^2, $P = .02$.
§Other practice settings include academic, in-patient, military, and unspecified clinics.

Screening Practices

Although screening for intimate partner abuse was common among injured patients, screening was less common for routine medical encounters (TABLE 2). In circumstances that involved physical injuries, an estimated 79% of California primary care physicians often or always ask patients direct questions about intimate partner abuse. An estimated 10% of physicians routinely screen for intimate partner abuse during new patient visits and 9% screen during periodic checkups. Of physicians who provide prenatal care, an estimated 11% routinely screen for intimate partner abuse during the first prenatal visit. Obstetrician/gynecologists reported the highest level of new patient screening (17%), followed by family physicians (10%), and internal medicine physicians (6%). Routine screening in the different clinical situations was not significantly associated with physician age, ethnicity, international medical training, personal experience with intimate partner abuse, or knowledge of the California domestic violence injury mandatory reporting legislation.

We used logistic regression to further clarify the relationship between physician characteristics and reported screening practices in new patient encounters (TABLE 3). After controlling for the effects of physician sex, practice setting, and training, the higher level of screening among obstetrician/gynecologists remained significant compared with internal medicine physicians. Although more female physicians reported routinely screening new patients, these sex differences were not statistically significant. Physicians working in public clinics reported the highest level of new patient screening (37%); routine screening was less frequent for physicians in private offices (9%), health maintenance organizations (1%), and other practice settings (12%) ($P<.001$). These differences remained significant after controlling for physician specialty, sex, and training. More physicians with recent intimate partner abuse training reported routine screening, but the effect was not statistically significant.

Similar analytic approaches were used to determine the associations between physician characteristics and reported screening practices in the other clinical situations. In contrast to new patient screening, routine screening during the first prenatal visit did not differ significantly by specialty or practice setting. However, compared with physicians without recent training in intimate partner abuse, a greater proportion of those with training reported routine screening of prenatal patients (24% vs 8%; $P = .007$). Although reported screening during periodic checkups was not significantly associated with physician specialty, sex, or training, physicians working in public clinics reported the highest level of screening (26%) compared with physicians in health maintenance organizations (5%), private clinics (9%), and other practice settings (10%) ($P = .02$). This difference remained significant after controlling for the effects of physician specialty, sex, and training. Screening practices for injuries did not differ significantly by specialty, sex, practice setting, or recent training in intimate partner abuse.

Interventions

The most commonly reported interventions included discussing physician's concern for safety with the patient (91%; 95% CI, 88%-94%), recording battering in the patient's chart (89%; 95% CI, 86%-93%), making referrals to counseling (88%; 95% CI, 85%-92%), and giving information about shelters and services (79%; 95% CI, 74%-83%). Asking about guns in the home (46%; 95% CI, 40%-51%) and reporting to police (44%;

Table 2. Percentage of Respondents Who Routinely Screen for Intimate Partner Abuse in Different Clinical Situations*

Clinical Situation	Family Medicine (n = 149)	Internal Medicine (n = 115)	Obstetrics/ Gynecology (n = 136)	Weighted Overall (N = 400)
Evidence of injury	80 (74-86)	76 (68-84)	84 (78-90)	79 (75-83)
New patient†	10 (5-15)	6 (2-10)	17 (11-23)	10 (7-13)
Routine checkup	14 (8-20)	7 (2-12)	10 (5-15)	9 (6-12)
First prenatal visit	12 (6-18)‡	NA§	14 (8-20)	11 (7-15)

*Values are expressed as percentage (95% confidence interval). Values for each specialty are weighted for sex and are weighted overall for specialty and sex.
†$P = .01$ for internal medicine and obstetrics/gynecology.
‡Only 64% (96/149) of family physicians who provide prenatal care responded to this item.
§NA indicates data are not available because only 22% (25/115) of internists who provide prenatal care responded to this item.

Table 3. Physician Characteristics Associated With Reported Routine Intimate Partner Abuse Screening of New Patients*

Characteristic	Weighted % (95% CI)	OR (95% CI)	Adjusted OR (95% CI)
Medical specialty			
Internal medicine	6 (1-10)	1.0	1.0
Family medicine	10 (5-15)	1.75 (0.75-4.12)	1.60 (0.58-4.42)
Obstetrics/gynecology	17 (11-24)	3.24 (1.38-7.63)	3.61 (1.36-9.55)
Physician sex			
Male	9 (6-12)	1.0	1.0
Female	12 (5-18)	1.42 (0.66-3.05)	1.15 (0.59-2.25)
Practice setting			
Health maintenance organization	1 (0-4)	1.0	1.0
Private office	9 (5-13)	5.69 (0.93-34.94)	4.42 (1.00-19.60)
Public clinic	37 (19-55)	31.73 (4.61-218.23)	20.30 (4.05-101.8)
Other setting†	12 (2-22)	7.43 (1.00-55.24)	5.29 (0.95-29.34)
Intimate partner abuse training			
No recent training	8 (5.3-12)	1.0	1.0
Recent training	14 (6.8-22)	1.73 (0.82-3.64)	1.58 (0.75-3.33)

*OR indicates odds ratio; CI, confidence interval.
†Other practice settings include academic, in-patient, military, and unspecified clinics.

Table 4. Major Barriers to Physician Identification of Intimate Partner Abuse and Referral of Patients

Major Barriers	Weighted Overall % (95% CI)*
Patient-related barriers	
Fear of retaliation	82 (78-86)
Lack of disclosure	78 (74-82)
Fear of police involvement	55 (50-60)
Lack of follow-up	52 (47-57)
Mutual barriers	
Cultural differences	56 (51-61)
Lack of privacy	48 (43-52)
Language differences	39 (34-43)
Provider-related barriers	
Lack of training	39 (34-44)
Lack of time	37 (32-42)
Lack of resources/referrals	30 (25-35)
Sense of inefficacy	18 (15-22)

*CI indicates confidence interval.

95% CI 38%-49%) were less common. Reported interventions were not consistently associated with physician specialty or sex.

Compared with physicians with no recent training in intimate partner abuse, physicians who had received training in the last 3 years were more likely to report routinely using information about shelters (89% vs 76%; $P = .02$), reporting to police (65% vs 37%; $P < .001$), and asking about guns in the home (58% vs 42%; $P = .02$).

Perceived Barriers

Patient-related factors were most frequently identified as major barriers to identifying and referring patients experiencing intimate partner abuse (TABLE 4). The most commonly cited major barriers included the patient's fear of retaliation by the partner (82%) and the lack of disclosure of battering during history taking (78%). In addition, a majority of physicians agreed that the patient's fear of police involvement, lack of follow-up on referrals, and cultural differences between patients and physicians are major barriers. Less than half of physicians identified lack of training, lack of time, lack of information about local community agencies, or the belief that physicians cannot make a difference in intimate partner abuse as major barriers.

Compared with physicians without recent training in intimate partner abuse, physicians who had received training in the last 3 years were less likely to report the lack of information about local community agencies as a major barrier (17% vs 33%; $P = .005$). Perceived barriers were not consistently associated with physician specialty, sex, or reported screening practices in the different clinical situations.

COMMENT

This study documents significant differences for routine screening for intimate partner abuse, depending on the clinical situation. An estimated majority of primary care physicians (79%) routinely screen patients with injuries. However, for patients seeking care in other clinical situations, screening for intimate partner abuse was less common (9%-11%). The higher level of reported screening of patients with injuries is likely to reflect physician's awareness that intimate partner abuse is an important cause of injury in women. In contrast, the lower level of routine screening of patients in other clinical situations suggests that primary care physicians are missing important opportunities to detect intimate partner abuse and intervene on behalf of those experiencing abuse.

Our findings, which are consistent with previous physician surveys,[14,17] suggest that most physicians do not adhere to current practice guidelines for intimate partner abuse screening. Interventions that focus on administrative changes, such as protocols, may improve adherence. Recently, researchers have begun to examine the sensitivity and specificity of a variety of screening protocols[34-36] and the effect of incorporating screening questions into self-administered history forms.[37] Preliminary results are encouraging. Most of these protocols are concise, easy to use, and effective at identifying intimate partner abuse. However, there are unanswered questions regarding the efficacy of universal screening. While identification of the problem is essential, the utility of screening ultimately depends on the yet unproven benefits of intervention.

In our study, recent education in intimate partner abuse was associated with higher levels of screening of prenatal patients, the routine use of information about shelters and protective services, reporting to police, and inquiring about guns in the home. In contrast, recent training had little effect on reported screening practices in other clinical situations. Previous cross-sectional surveys have found that professional training positively influenced reported intimate partner abuse screening practices[17,32]; however, studies that directly examined the effects of training have produced conflicting results depending on the type of training and length of follow-up.[38-40] Professional training has the potential to increase knowledge, comfort, and skills for effective inquiry and intervention. However, without structural changes, regular in-service education, and institutional policies, physician training is unlikely to be sufficient to change clinical practice.[38,40-42] Controlled studies are needed to determine the effectiveness of interventions for improving physician behavior regarding intimate partner abuse. In light of the evidence that US medical schools require an average of only 2 hours of training in adult domestic violence[43] and less than half of family practice residencies have required education about intimate partner abuse,[44] effective training programs should be identified and expanded. In addition, information about local shelters and community resources should be widely disseminated to health care professionals.

Obstetrician/gynecologists reported the highest level of new patient screening, followed by family physicians and internal medicine physicians. These differences should be viewed with caution given our finding that specialty had only a modest effect on reported screening practices in other clinical situations, including prenatal visits. These variations may be related to differences in patient demographics, types of medical problems encountered, clinical procedures, or advocacy and awareness within the field. In particular,

obstetrician/gynecologists are more likely to provide care for young female patients, who are at the highest risk for intimate partner abuse. A better understanding of these differences will require further investigation.

Physicians working in public clinics reported the highest level of screening in clinic situations involving new patients and routine checkups. Routine screening was markedly less frequent for physicians practicing in health maintenance organizations. These differences may be related to differences in the patient population, clinic procedures, or institutional policies and support. Different clinic settings may also have other health care professionals or staff who provide routine screening procedures. Further research is necessary to explain these compelling results.

Contrary to our expectations, we found no significant associations between physician sex and reported screening practices. Prior research that examined the effects of physician sex on screening for intimate partner abuse has produced conflicting results. Some studies have found that a significantly higher proportion of female physicians reported such screening[17] or had better skills in detecting intimate partner abuse.[39] However, other related research found no effect of physician sex.[40] Although physician sex has been found to significantly affect both patient-physician communication[45] and the delivery of women's preventive care,[46] further work is needed to determine the effects of physician sex on the delivery of care for intimate partner abuse.

Routine interventions reported by a majority of physicians in each specialty included relaying concern for safety to the patient, referral to shelters and counseling, and documentation in the medical chart. These interventions are among the most accepted and recommended.[28-30] Reporting to the police without patient consent is more controversial because of potential risks to patient safety and violations of medical ethics.[47,48] The California law contains recommendations for physicians to refer patients to local intimate partner abuse services and provides protection for these persons from civil or criminal liability.

We estimated that less than half (46%) of California primary care physicians routinely inquire about guns in the home. Given the increased risk of injury and death with firearms, determining the accessibility of guns is an essential part of a safety assessment. Research has demonstrated that the presence of a firearm in the home is a key contributor to the escalation of intimate partner abuse to homicide.[49,50] In 1 study, firearm-associated intimate assaults were 12 times more likely to result in death compared with assaults not involving firearms.[51] Knowledge of the availability of a firearm determines the type and urgency of interventions when physicians discuss gun safety issues.

A greater proportion of respondents identified patient-related barriers to identification and intervention (fear of retaliation, fear of police involvement, lack of disclosure, and lack of follow-up) compared with physician-related barriers (lack of time, lack of training, lack or resources and referrals, and sense of inefficacy). Similar barriers have been identified in previous studies of physicians[21-23] and abused patients.[15,52,53] Knowledge of the specific barriers encountered by different types of physicians helps to shape future training and tools for identification and intervention. Based on the results of our study, future training should provide strategies to deal with patients' fears and reluctance to disclose abuse and address cultural differences. Furthermore, training should be customized to address the unique barriers faced within the different specialties or practice settings.

This study had several limitations. California's mandatory reporting law (adopted January 1994) may have prompted specific policy development within medical organizations that increased awareness of intimate partner abuse among physicians. As a result, physician inquiry in California, particularly in cases of injury, may be more frequent than in states with different reporting requirements.[31] In addition, the potential bias of overreporting socially desirable behavior may have overestimated actual screening practices. Because the definition of intimate partner abuse and other survey language were gender-neutral, we are unable to determine how patient sex affects reported screening practices. Finally, this study did not survey other health care professionals (eg, nurses, physician assistants, social workers, and psychologists) who often play key roles in patient assessment and management, particularly in relation to psychosocial issues.

This study provided insight into the practices and attitudes of a representative sample of California primary care physicians regarding intimate partner abuse. As the discussion regarding the appropriate role of health care professionals in addressing intimate partner abuse evolves, these data will inform our understanding of the patterns, justifications, and barriers to physician inquiry. The rationale for universal screening is based on the high prevalence, the high association with an array of health problems, the low level of suspicion and inquiry on the part of physicians, abused women's general unwillingness to volunteer information, and the high level of patient acceptance of direct physician inquiry. Furthermore, screening incurs minimal costs and risks to patients, while offering significant potential benefits.[54] Because of the newness of intimate partner abuse as a health issue, studies examining the impact of routine health care screening and interventions on health or the prevention of future abuse is unknown. Although recommendations for screening cannot yet be based on evidence of proven efficacy, the magnitude and severity of the problem, coupled with the feasibility of screening and the potential for meaningful intervention, make intimate partner abuse an important issue in primary care practice.

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