REVIEW ARTICLE

ROLE OF HEALTH CARE PROVIDER IN INTIMATE PARTNER VIOLENCE: A LITERATURE SYNTHESIS

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ABSTRACT

INTRODUCTION: Intimate Partner Violence (IPV) has significant societal impact, including high financial costs and serious health consequences for women and children. Women exposed to IPV suffer significant acute and chronic physical and mental health outcomes, including death, injury, chronic pain, poor gynecologic and general health outcomes. Women who experience violence use more health care services. The IPV victims are at risk for marginalization in the health care system due to the complexity of their physical and mental health needs. Intimate Partner Violence (IPV) has been an important issue for researchers, practitioners, and policymakers. This literature focuses on challenges and role of health care professional in Intimate Partner Violence.

KEYWORDS: Intimate Partner Violence, Health Care Provider

INTRODUCTION

Intimate partner violence (IPV) is defined as a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, used by adults or adolescents against their intimate partners[1]. The term "intimate partner" is used to describe several types of couples: current or former; dating, cohabiting, or marital; heterosexual, gay, or lesbian[2].

The IPV has been an important issue for researchers, health care professionals, and policymakers[3]. It is also a major challenge and a serious public health problem. The costs associated with intimate partner violence exceed $5.8 billion each year, $4.1 billion of which is for direct medical and mental health care services. Domestic violence accounts for 27% of all incidents of violence in the workplace and costs employers $3 billion to $5 billion annually in the form of increased health care costs, increased absenteeism, decreased productivity, and increased security[4]. Although the health care system is an important site for identification and intervention, there have been challenges in determining how health care professionals can best address this issue in practice.

At present no recent systematic review related to IPV exists, the common themes that emerge from these and other studies include: gaps in health care provider knowledge and lack of adequate preparation in educating the health care professional in regards to IPV. The gap includes lack of screening, effective interventions; knowledge related to available resources for IPV victims andperceived system support by health care providers. Poor interviewing or communication skills; resources and providers' fears about legal involvement; and provider age and years in practice are the major concerns. In the face of this most often an overwhelming problem, the health care facilities have a key role in identifying and responding to abused victims[5].

The health care providers (HCPs) across the spectrum of disciplines are increasingly encouraged to ask about exposure to violence as part of their routine care of women, especially when clinical indicators of abuse are present[6]. Tilley (1999)[7] reinforced," if women are asked directly about violence in their intimate relationships, they are four times more likely to offer information about abuse than if they are asked to respond in writing or aren't asked at all". The health sector, however, has been criticized for providing less than optimal care to women exposed to IPV. As Alpert (2007)[8] states "the ability of most health professionals to effectively identify, assess, and respond to domestic violence has lagged far behind societal awareness and community responses".

Since the 1970s, IPV has been an important issue for researchers, practitioners, and policymakers[3]. This problem has significant societal impact, including high financial costs and serious health consequences for women and children. Women exposed to IPV suffer significant acute and chronic physical and mental health outcomes, including death, injury, chronic pain, poor gynecologic and general health outcomes[9]. Women who experience violenceuse more health care services[10]. The IPV victims are at risk for marginalization in the health care system due to the complexity of their physical and mental health needs[11]. In health care settings, the best approach to identifying women exposed to violence

remains unclear, with several systematic reviews finding insufficient evidence regarding the effectiveness of universal IPV screening in improving outcomes for women, primarily due to lack of evaluation of the interventions to which women are referred[10]. In the absence of evidence regarding universal screening, one approach to the identification of woman abuse in health care settings, is routine inquiry when signs or symptoms of abuse are present. This "diagnostic" or "case finding" approach requires awareness by the clinician of factors associated with abuse, including physical injuries, mental health symptoms, and relationship issues shown to be related to recent or current abuse[12]. IPV has been identified as a major public health problem[13]. According to the Bureau of Justice Statistics, 42% of women victimized by an intimate partner sustained injuries, with females comprising 58% of murder victims[14]. There is an urgent need of well-conducted evaluative research to assess the impact of IPV education on clinical knowledge, skills and practices which at present remains a pressing gap[15].

HEALTH CARE PROFESSIONAL CHALLENGES

There are many challenges like lack of education and training that affect the HCP confidence in her/his ability to screen and intervene with adequate support and resources for IPV victims. A number of studies have examined the knowledge, attitudes, and beliefs of physicians, nurses and other health care provider's identification of IPV[16]. Although the health care system is an important site for identification and intervention, there have been challenges in determining how health care professionals can best address this issue in practice. Gutmanis, Beynon, Tutty, Wathen, and MacMillan (2007)[13], surveyed nurses and physicians regarding their attitudes and behavior with respect to IPV including whether they routinely inquire about IPV, as well as potentially relevant barriers, facilitators, experiential, and practice-related factors. Approximately 1000 nurses and 1000 physicians via mail were surveyed and were randomly selected from professional directories and represented practice areas including family practice, obstetrics and gynecology, emergency care, maternal/newborn care, and public health. The survey instrument had a case-based scenario followed by 43 questions asking about behaviors and resources specific to woman abuse. In total, 931 questionnaires were returned; 597 by nurses (59.7% response rate) and 328 by physicians (32.8% response rate). Overall, 32% of nurses and 42% of physicians reported routinely initiating the topic of IPV in practice. The 8 identified constructs were: preparedness, self-confidence, professional supports, abuse inquiry, practitioner consequences of asking, comfort following disclosure, practitioner lack of control, and practice pressures. Preparedness emerged as a key construct related to whether respondents routinely initiated the topic of IPV.

This study provides new insight into the factors that facilitate and impede clinicians' decisions to address the issue of IPV with their patients. Inadequate preparation, both educational and experiential, emerged as a key barrier to routine inquiry, as did the importance of the "real world" pressures associated with the daily context of primary care practice. This study showed a gap in provider knowledge and lack of education regarding IPV. Hence the current research does suggest an association between IPV training and clinical behavior[17].

INADEQUATE EDUCATIONAL PREPARATION

The other challenge HCP does not know how to recognize, ask about and respond to IPV (Hamberger, 2007)[15]. Tilly (1999)[7], mentioned that the “research shows that an effective way to screen patients at risk of domestic violence is simply to ask if they are being abused” (p. 24jj). The other factors that are challenging for HCP'S includes lack of time to deal with a complex social issue; a fear of offending patients or retribution from the abuser; personal experiences with family violence, and feeling helpless when clients disclose/experience violence.

In the research study by Sheryl, Douglas, Debra, Dahlia, and Tammie (Are these first names or last names of the authors? (2010)[18], where 41fourth year medical students participated in the standardized patient (SP) exercise during three separate evaluation periods. The authors (or researchers) used 360-degree evaluations within an Observed Structured Clinical Examination (OSCE) to assess medical student comfort level and communication skills withIPV patients. A cohort of fourth year medical students' performance used an IPV SP encounter in an OSCE. Blinded pre- and post-tests determined the students' knowledge and comfort level with core IPV assessment. Students, SPs and investigators completed a 360-degree evaluation that focused on each student's communication and competency skills. Results noted insignificant increase in students' comfort level. Although 88% of students screened for IPV and 98% asked about the injury, only 39% asked about verbal abuse, 17% asked if the patient had a safety plan, and 13% communicated to the patient that IPV is illegal.Likert scoring on the competency was used. The correlations between trainee comfort level and the specific competencies of patient care, communication skill and professionalism were positive and significant ($p<0.05$). Students felt comfortable caring for patients with IPV. The OSCEs with SPs can be used to assess student competencies in caring for patients with IPV.

This research study does support that there is an increase demand and commitment on the academic community to improve IPV education in the United States . To prepare and better equip ourhealth care providers, this intervention should be integrated in their curriculum. The Liaison Committee on Medical Education

accreditation standards state that it is important that curriculum prepare students of health care discipline for their role in addressing the medical consequences of common societal problems, for example by providing instruction in the diagnosis, prevention, appropriate reporting and treatment of violence and abuse[19]. Recently the Institute of Medicine (IOM) compiled a comprehensive review of the current state of family violence education in the IOM's (2001) report. It reinforced the education and training of HCP on Family Violence. In addition, the IOM made specific recommendations for family violence curricular development. As noted in the IOM report, basic competency skills for health providers, as recommended by the American Association of Colleges of Nursing (AACN), can serve as template for describing competency skills for all healthcare professionals[20].

IMPORTANCE OF SCREENING FOR IPV

Due to inadequate preparation of health care professionals on screening patients with physical trauma for possible IPV, there is a major challenge in the emergency room and family practice clinics. The trauma associated with IPV with majority of injuries sustained by IPV victims are classified as contusion, abrasions, and lacerations. An estimated 73,000 hospitalizations and 1,500 deaths among women are attributed to IPV annually[21]. Many studies support that the IPV victims are at risk for physical and psychological problems, which can be long lasting[23]. Roughly half of female IPV victims suffer injuries, which are typically minor (e.g., scratches, bruises), but may involve more serious injuries such as lacerations, broken bones, and head trauma (Tjaden & Thoennes, 2000)[22]. Campbell et al. (2002)[23] found that abused women are more likely to have a host of medical problems than are non-abused women regardless of differences in health care access. Overall, men are much less likely to report injuries than women. However, when injured, males and females are about equally likely to seek medical care. Tjaden and Thoennes (2000) reported that 28.1% of female victims who were injured sought medical care, compared to 21.5% of males. Hence it becomes very important for health care professionals (could put HCP)to look for the common trend of location and severity of injury among IPV victims.

A study by Stavrianos, Zouloumis, Dietrich, Papadopoulos, Diamantopoulou and Moumtsakis could put et al. because there are 6 authors(2011)[24] studied IPV cases with severe injuries referred to their department of oral and maxillofacial surgery. Data collection was completed through direct observation of the participants. This case study's main aim was to describe the nature of those who were studied called a "case report". The most common injuries were the head, neck and facial injuries in cases of IPV. Nasal and zygomatic arch fractures as well as blow out traumas and periorbital injuries were the most frequent types of injuries after IPV, whereas mandible fractures were mostly related to assaults by an unknown. This study also recommended that health care professionals (could put HCP) need to recognize injury and document them appropriately. This study also reinforced that the health care professionals need to screen patients specially with potential IPV by closely looking for most common sites of injuries related to IPV. This study supports that there is nott only physical violence but also psychological, economical, (should this be emotional?) and sexual abuse of the partner.

ROLE OF HEALTH CARE PROVIDER IN SCREENING

The individual practitioner's commitment to routine screening for IPV is the greatest predictor that the victim will be screened and referred for services.It is vital that screeners are dedicated, knowledgeable, and confident in their ability to recognize and assist victims of violence. HCPs often express feelings of inadequacy and discomfort at the thought of screening patients for intimate partner violence[25]. Nevertheless, clinicians and health care organizations are being encouraged

??? Numerous professional societies recommend routine IPV evaluation, assessment, and/or screening as a part of standard patient care[26], The standards of the Joint Commission (TJC) require that hospitals have objective criteria for identifying and assessing possible victims of abuse and neglect (TJC, 1996). These policies and recommendations persist despite the lack of evidence regarding effective interventions for IPV. The educational opportunities and training sessions for health care providers about intimate partner violence screening and intervention is the key to the screening of IPV [34].

The evidenced- based practice related to universal screening and case findings have shown that rates of routine inquiry about IPV by HCPs)are generally low in the range of 5–10% in primary care settings[6]. The IPV screen was used in approximately 25% in emergency care settings[8]. Sybil (2010)[27] in her study found that 44% of victims of domestic violence talked to someone about the abuse; 37% of those talked to their health care provider. Additionally, in four different studies of survivors of abuse, 70% to 81% of patients studied reported that they would like their health care provider to ask them privately about IVP (Family Violence Prevention Fund, 2008).

The IPV screening and intervention practice needs to be patient-centered and needs to advance the competency of health care professionals (could put HCP) in conducting the screening, increasing the comfort of both the health care provider and the patient, and to increasing the safety of the patient.There is a need for on- the- job training periodically to be offered to the health care professionals (could put HCP).

The study by Chapin, Coleman, and Varner (2011)[28] included training to health care providers by a domestic violence center on how to screen for domestic violence. There were 320 nurses and medical students participated in training provided by a domestic violence center. This study supported self-efficacy linked with successful outcomes. It mainly focused on self-efficacy, the perceived usefulness of screening the accessibility of victim services, understanding of obstacles faced by victims, and knowledge-level regarding local IPV services. Participants self-reported their gender, age, race, and position with the hospital system. Nurses and medical interns exhibit a wide range of self-efficacy regarding their ability to screen victims of IVPIPV training yielded participants who were better informed about IPV services and the obstacles faced by victims. In the absence of uniform screening guidelines, hospitals, systems, and individual practitioners must be vigilant in screening procedures. Partnerships with women's centers may provide valuable resources and training that may ultimately improve patient care. The knowledge of services available to victims of IPV and obstacles faced by victims were both related to self-efficacy. Partnerships between hospitals or medical schools and women's centers provide cost-effective cross-training, as well as provide potentially life-saving services to victims. While clinicians are being encouraged to implement routine screening, subsequent actions including referrals are often left to the clinicians' discretion. It is important to understand the potential risks and benefits of screening for IPV in health care settings.

Once the screening programs are implemented for IPV victims, it is very important to evaluate the effectiveness of screening program by getting feedback from the clients. One of the major research study conducted by MacMillan, Waton, Jamieson, Boyle, Shannon, Gilboe, Worster, Lent, Coben, Campbell, and McNutt (could use et al because more than 6 authors)[29] (2009) examined the effectiveness of IPV screening and communication of a positive screening result to clinicians in health care settings, compared with no screening, in reducing subsequent violence and improving quality of life. The authors also examined secondary health outcomes for abused women. This study included 6743 English-speaking female patients aged 18 to 64 years who presented between July 2005 and December 2006, can be seen individually, and were well enough to participate in this study. This study focused on effectiveness of IPV screening and communication of positive results to clinicians through randomized controlled in 11 ED, 12 FP and 3 O OB/GYN clinics. Women in the screened group (n=3271) self-completed the Woman Abuse Screening Tool (WAST).If screened positive, this information was given to her clinician before the health care visit. The non-screened group (n=3472) self-completed the Woman Abuse Screening Tool (WAST) and other measures after their visit. Participant loss to follow-up was high: 43% (148/347) of screened women and 41% (148/360) of non-screened women. At 18 months (n=411) observed recurrence of IPV among screened vs non-screened women was 46% vs 53%. Screened women showed statistically significant improvements in quality-of-life and depression scores compared with those in the non-screened group. Screened women reported no harms of screening. This study supported that evaluation of services for women after identification of IPV remains a priority. This study also included women disclosing past-year IPV interview at baseline and every 6 months until 18 months regarding IPV re-exposure and quality of life as well as several health outcomes and potential harms of screening. Although this study had several methodological limitations, including loss of 42% sample to follow up and about 30% immediately after the index visit. Hence, further research is essential to determine whether these findings are replicated in other settings and samples. It is also important to determine whether screening and follow up are acceptable or feasible for women reporting exposure to more severe IPV in the previous year. Based on the results and implication of this study, it shows that there is a huge gap related to educational and training offering for HCP as well as evaluation of the screening tools used by HCP on IPV victims in terms of their safety and reoccurrence of IPV abuse.

CURRENT KNOWLEDGE

In summary, the present study adds to our understanding of the barriers and facilitators identified by health care providers to appropriately identifying patients who may be exposed to violence. This synthesis of literature highlights the significant impact that IPV-specific training and professional experience has on clinicians' self-reported attitudes and practices regarding inquiry about IPV. Finding a better match between these expectations and clinicians' realities will provide the best context for an appropriate health care response for abused victims. Educational efforts that integrate established and emerging evidence about how best to recognize, ask about, and respond to IPV in health care settings are an urgent priority.

RESEARCH GAPS

There is a lack of research studies related to the educational preparation of health care teams and strong foundation of health care professional curriculum on IPV and related resources needed. Current research and literature are primarily in the social science journals rather than nursing. Additional research could be carried out in the area of health care professionals IPV screening skills and knowledge and availability of resources to guide the IPV victims. In the case of victims who experience IPV, research could identify areas in which health care providers need to focus and make adequate resources available for victim of IPV. Evaluating the frequency and effectiveness of screening in a variety of healthcare settings can be studied to provide information for healthcare

providers to access appropriate resources for IPV victims. A number of studies did not evaluate all aspects of IPV, focusing on one or more of the four types of violence: physical, psychological, sexual abuse and stalking. A larger study that could be generalized across the population and collect data on the four types of violence would be beneficial to provide information to IPV victims and healthcare providers about the real problem of IPV. Due to the limited research into the preparation and training of HCP, it is an important area in which new research needs to generate.

CONCLUSION

Intimate partner violence is a global epidemic that has devastating effects on victims and their children. The ealth care setting is an optimal arena for IPV identification through screening and provision of adequate resources and support through referrals as indicated (World Health Organization, 2002). It is important to have universal screening to be performed in health care settings (Campbell, 2002[23]; Gunter, 2007[30]; Larkin, Rolniak, Hyman, MacLeod, & Savage, 2000[31]). Domestic violence and IPV need to be added in the health care professionals training curriculum and should be followed by educational sessions. These steps will equip health care professionals, including physicians and nurses, in terms of their knowledge and skills in IPV screening and intervention. Research findings from different studies and current literature review does support the need for universal screening, ongoing training and education for HCP, and an organized program with accompanying policies and procedures (Larkin et al., 2000[31]; Olive, 2007; Shattuck, 2002[32]). These training program for health care providers in intimate partner violence screening and intervention can result in increased skill and comfort with this screening and intervention (Larkin et al., 2000[31];Shattuck, 2002[32]).

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Citation	Sample	Variables (DV/IV)	Methodology	Findings	Conclusion	Role of HCP on IPV
Gutmanis, I., Beynon, C., Tutty, L., Wathen, N.C and MacMillan, L.H. (2007). Factors influencing identification of and response to intimate partner violence: a survey of physicians and nurses. *BMC Public Health*, **7:**12 doi:10.1186/1471-2458-7-12	Approximately 1000 nurses and 1000 physicians by mail in Ontario, Canada. Respondents were randomly selected from professional directories and represented practice areas pre-identified from the literature as those most likely to care for women at the point of initial IPV disclosure: family practice, obstetrics and gynecology, emergency care, maternal/newborn care, and public health.	Attitudes and behaviors with respect to IPV, including whether they routinely inquire about IPV. It also included potentially relevant barriers, facilitators, experiential, and practice-related factors.	Descriptive cross sectional study using modified Dillman Tailored Design approach was used. Respondents were randomly selected from professional directories and represented practice areas pre-identified from the literature. The survey instrument had a case-based scenario followed by 43 questions asking about behaviors and resources specific to woman abuse.	In total, 931 questionnaires were returned; 597 by nurses (59.7% response rate) and 328 by physicians (32.8% response rate). Overall, 32% of nurses and 42% of physicians reported routinely initiating the topic of IPV in practice.	The 8 identified constructs were: preparedness, self-confidence, professional supports, abuse inquiry, practitioner consequences of asking, comfort following disclosure, practitioner lack of control, and practice pressures. Preparedness emerged as a key construct related to whether respondents routinely initiated the topic of IPV	This study provides new insight into the factors that facilitate and impede clinicians' decisions to address the issue of IPV with their patients. Inadequate preparation, both educational and experiential, emerged as a key barrier to routine inquiry, as did the importance of the "real world" pressures associated with the daily context of primary care Practice.

Citation	Sample	Variables (DV/IV)	Methodology	Findings	Conclusions	Role of HCP in IPV
Gilboe, F.M., Worster, A., Lent, B., Coben, H.J., Campbell, C.J and McNutt, A.L. (2009). Screening for Intimate Partner Violence in Health Care Settings: A Randomized Trial. JAMA, *302*(5):493-501.	Among 6743 English-speaking female patients aged 18 to 64 years who presented between July 2005 and December 2006, could be seen individually, and were well enough to participate. The non-screened group (n=3472) self-completed the WAST and other measures after their visit.	It focused on effectiveness of IPV screening and communicatio n of positive results to clinicians.	Randomized controlled conducted in 11 ED, 12 FP and 3 Obs/gyn clinics. Women in the screened group (n=3271) self-completed the Woman Abuse Screening Tool (WAST); if screened positive, this information was given to her clinician before the health care visit. Subsequent discussions and/or referrals were at the discretion of the treating clinician. The non-screened group (n=3472) self- completed WAST and other measures after their visit.	Participant loss to follow-up was high: 43% (148/347) of screened women and 41% (148/360) of non-screened women. At 18 months (n=411 observed recurrence of IPV among screened vs. non-screened women was 46% vs. 53%. Screened vs. nonscreened women had greater improvement in quality-of-life scores. Screened women reported no harms of screening.	Although sample attrition urges cautious interpretation , the results of this trial do not provide sufficient evidence to support IPV screening in health care settings. Evaluation of services for women after identification of IPV remains a priority.	Women disclosing past-year IPV were interviewed at baseline and every 6 months until 18 months regarding IPV re-exposure and quality of life (primary Outcomes), as well as several health outcomes and potential harms of screening.

Citation	Sample	Variables (DV/IV)	Methodology	Findings	Conclusions	Role of HCP in IPV
Stavrianos.C. Zouloumis, L., Dietrich, M.E., Papadopoulos., Diamantopoulos, P., and Moumtsakis, S. (2011). Intimate Partner Violence (IPV): Both a social and a Medical phenomenon: Part 11. *Research Journal of Medical Sciences, 5*(1), 14-19.	Case reports from the consults of physical injuries referred to department of oral and maxillofacial surgery department of General hospital	Prevalence of IPV injuries commonly in percept of social and Medical phenomenon	Ethnography research strategy is used and studied cases referred to the department of oral and maxillofacial surgery of General hospital Data collection is done through participant observation. Its aim is to describe the nature of those who are studied called a "case report"	The most common injuries are the head, neck and facial injuries are the most prominent types of injury in cases of IPV. Nasal and zygomatic arch fractures as well as blow out traumas and periorbital injuries are the most frequent types of injuries after IPV whereas mandible fractures are mostly related to assaults by an unknown.	It is high importance to recognize injury for it is documented that head, neck and facial injuries are the most prominent types of injury in cases of IPV	There is a lot of controversy regarding the description of IP. It becomes more evident the term and related discussion should include not only physical violence but also psychologica l, economical and sexual abuse of the partner. Each IPV whether it is emotional abuse, physical assault or forced inter-course, aims at controlling partner's behavior.
Sheryl, H., Douglas, A S., Debra, H., Dahlia, H.M. and Tammie, Q. (2010). Standardized Patients to Teaching Medical Students about Intimate Partner Violence. *Western Journal of Emergency Medicine*, 11(5), 500-507.	Forty-one 4th year medical students participated in the SP exercise during three separate evaluation periods.	Used 360-degree evaluations within an Observed Structured Clinical Examination (OSCE) to assess medical student comfort level and communicatio n skills with intimate partner Violence (IPV) patients.	A cohort of fourth year medical students' performance using an IPV Standardized patient (SP) encounter in an OSCE. Blinded pre- and post-tests determined the students' knowledge and comfort level with core IPV assessment. Students, SPs and investigators completed a 360-degree evaluation that focused on each student's communication and competency skills.	Results noted insignificant increase in students' comfort level. Although 88% of students screened for IPV and 98% asked about the injury, only 39% asked about verbal abuse, 17% asked if the patient had a safety plan, and 13% communicated to the patient that IPV is illegal.	Using Likert scoring on the competency. The correlations between trainee comfort level and the specific competencies of patient care, communicati on skill and professionali sm were positive and significant ($p<0.05$).	Students felt Comfortable caring for patients with IPV. The OSCEs with SPs can be used to assess student competencies in caring for patients with IPV.

Citation	Sample	Variables (DV/IV)	Methodology	Findings	Conclusions	Role of HCP in IPV
Chapin, A. J., Coleman, G., and Varner. (2011). Yes we can! Improving medical screening for intimate partner violence through self-efficacy. *Journal of Internal Violence Research, 3(*1), 19-23.	320 nurses and medical students participated in training provided by a domestic violence center.	self-efficacy, the perceived usefulness of screening the accessibility of victim services, understanding of obstacles faced by victims, and knowledge-level regarding local IPV services. Participants self-reported their gender, age, race, and position with the hospital system.	Posttest survey	Nurses and medical interns exhibit a wide range of self-efficacy regarding their ability to screen victims of intimate partner violence. Intimate partner violence (IPV) training yielded participants who were better informed about IPV services and the obstacles faced by victims.	In the absence of uniform screening guidelines, hospitals, systems, and individual practitioners must be vigilant in screening procedures. Partnerships with women's centers may provide valuable resources and training that may ultimately improve patient care.	The knowledge of services available to victims of IPV and obstacles faced by victims were both related to self-efficacy. Partnerships between hospital or medical schools and women's centers provide cost-effective cross-training, as well as provide potentially life-saving services to victims.

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