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"Figuring it out on our own": Exploring family medicine residents' sexual assault and domestic violence training

« On se débrouille comme on peut » : la formation des résidents en médecine familiale en matière d'agression sexuelle et de violence familiale

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Résumé de l'article

Contexte : Les médecins de famille sont particulièrement bien placés pour fournir des soins complets et longitudinaux aux personnes victimes d'agression sexuelle et de violence familiale (ASVF). À ce jour, nous savons peu de choses sur la façon dont les résidents en médecine familiale (MF) au Canada se familiarisent avec l'ASVF. Cette étude explore la formation sur le sujet dans le cadre de la résidence en MF, du point de vue des résidents eux-mêmes.

Méthodes : Cette étude qualitative s'est déroulée dans le cadre du programme de résidence en FM de l'Université Western. Nous avons mené des entretiens semi-structurés avec des résidents en première et deuxième année de médecine familiale (n=8). Les données ont fait l'objet d'une analyse thématique.

Résultats : Nous avons relevé trois thèmes interdépendants : (1) Formation inégale en matière d'ASVF, (2) Attitudes envers l'ASVF et (3) Hésitation de la part des apprenants. La qualité et la quantité des occasions d'apprentissage sur le sujet de l'ASVF n'étaient pas uniformes parmi les apprenants, alimentant des sentiments d'incompétence et un manque de confiance dans la prestation de soins liés à l'ASVF. En conséquence, les apprenants sont hésitants lorsqu'ils rencontrent des situations liées à l'ASVF en clinique.

Conclusions : Il est essentiel de comprendre les expériences et les idées des résidents en MF concernant la formation sur le sujet de l'ASVF afin de former des médecins qui seront outillés pour s'occuper d'une population vulnérable. Nos travaux mettent en évidence la relation entre les expériences, les attitudes et les comportements des apprenants et des enseignants. On peut améliorer l'apprentissage en matière d'ASVF en ciblant ce cycle comportemental.

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Canadian Medical Education Journal

Brief Reports

"Figuring it out on our own": exploring family medicine residents' sexual assault and domestic violence training

« On se débrouille comme on peut » : la formation des résidents en médecine familiale en matière d'agression sexuelle et de violence familiale

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Abstract

Background: Family physicians are uniquely able to provide comprehensive and longitudinal care to those experiencing sexual assault and domestic violence (SADV). To date, we know little about how Canadian family medicine (FM) residents learn about SADV. This study explored SADV teaching in residency from the perspectives of FM residents.

Methods: This qualitative study took place in the Western University FM residency program. We conducted semi-structured interviews with first- and second-year FM residents (*n* = 8). We analyzed data using thematic analysis.

Results: We identified three inter-related themes: (1) Inconsistent training for SADV, (2) Attitudes towards SADV and (3) Learner hesitancy. Quality and quantity of SADV learning opportunities were inconsistent across learners, fuelling feelings of incompetence and lack of confidence around providing SADV care. This led to hesitant behaviours by learners when encountering SADV clinically.

Conclusions: Understanding FM residents' experiences and ideas regarding SADV education is critical in order to graduate physicians equipped to care for this vulnerable population. This research highlights the relationship among learners' and teachers' experiences, attitudes and behaviours; targeting this behavioural cycle may improve SADV learning.

Résumé

Contexte : Les médecins de famille sont particulièrement bien placés pour fournir des soins complets et longitudinaux aux personnes victimes d'agression sexuelle et de violence familiale (ASVF). À ce jour, nous savons peu de choses sur la façon dont les résidents en médecine familiale (MF) au Canada se familiarisent avec l'ASVF. Cette étude explore la formation sur le sujet dans le cadre de la résidence en MF, du point de vue des résidents eux-mêmes.

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Résultats : Nous avons relevé trois thèmes interdépendants : (1) Formation inégale en matière d'ASVF, (2) Attitudes envers l'ASVF et (3) Hésitation de la part des apprenants. La qualité et la quantité des occasions d'apprentissage sur le sujet de l'ASVF n'étaient pas uniformes parmi les apprenants, alimentant des sentiments d'incompétence et un manque de confiance dans la prestation de soins liés à l'ASVF. En conséquence, les apprenants sont hésitants lorsqu'ils rencontrent des situations liées à l'ASVF en clinique.

Conclusions : Il est essentiel de comprendre les expériences et les idées des résidents en MF concernant la formation sur le sujet de l'ASVF afin de former des médecins qui seront outillés pour s'occuper d'une population vulnérable. Nos travaux mettent en évidence la relation entre les expériences, les attitudes et les comportements des apprenants et des enseignants. On peut améliorer l'apprentissage en matière d'ASVF en ciblant ce cycle comportemental.

Introduction

Rates of sexual assault and domestic violence (SADV) are rising; 13-61% of women experience physical violence and 6-59% of women report sexual violence at home.[1] Domestic violence, defined by the World Health Organization, is "any act of physical, sexual, or emotional abuse by a current or former partner, whether cohabiting or not."[1] SADV is associated with long-term emotional, psychosocial and physical effects on victims and their families.[2,3] Outcomes in women who experience SADV span endocrine, gynecologic, musculoskeletal, neurologic, pulmonary, reproductive and psychiatric spheres of health.[4] Nevertheless, only 7-25% of patients affected by SADV are identified in clinical practice.[2,5]

Family physicians are uniquely positioned to provide comprehensive care to victims of SADV. Studies show women are supportive of routine screening for SADV in primary care.[6-10] Identifying and caring for women experiencing SADV is a competency for Canadian graduating family physicians.[11] However, survey data shows reduced emphasis on this topic.[12] To our knowledge, Canadian Family Medicine (FM) residents' experiences learning about SADV have not been explored.

This study examined how FM residents experience SADV learning, and how their experiences influence their perceptions, beliefs, and behaviours. Our research questions were (1) What SADV teaching have FM residents experienced? (2) How do FM residents' experiences affect their perceptions, beliefs and behaviours with respect to SADV care?

Methods

We conducted a qualitative study, drawing on social constructivist principles; this involved exploring the topic through the lens that participants' views and experiences are shaped by time, culture, and personal history.[13] This study was approved by the Western University Health Sciences Research Ethics Board.

Setting and participants

The Schulich School of Medicine & Dentistry FM residency program has Canadian and international medical school graduates, distributed across urban and rural training centres in Southwestern Ontario. Study participants were residents in this two-year program. All current FM residents were invited to participate, and all residents who responded to the recruitment letter were interviewed (Table 1). Participants did not receive any reimbursement.

Data collection

We developed a semi-structured interview, drawing on experience of the research team. We piloted the interview with a team member and refined it (Appendix A). DK conducted the interviews. Interviews lasted 20.5 to 53 minutes, with a mean of 38 minutes. Audio recordings were de-identified and transcribed verbatim by Transcript Heroes.™

Data analysis

Employing Braun and Clarke's reflexive thematic analysis,[14] all research team members read interview transcripts. DK coded the data using NVivo (QSR International Pty Ltd.) and developed themes by identifying broader patterns of significance.[14] Themes were discussed and iteratively revised over several research team meetings. Interviews were conducted until the data sufficiently answered the research questions without subsequent interviews providing new themes.[15]

Research team & reflexive statement

At the time of this study, DK was a master's trained FM resident, with qualitative research experience. MK is a family physician and medical education researcher. SM is a physician responsible for teaching FM residents on SADV. AW was a postgraduate academic program coordinator.

Results

Eight participants were interviewed over 18 months. Participant details are presented in Table 1. In examining participants' responses through a social constructivist lens, we sought to understand how the social context within which our participants' were training influenced their experiences, perspectives and behaviours.

Table 1. Participant characteristics

Variable	*N* (%)
Recruitment	
Residents invited to participate	156
Recruitment responses	8 (5.1)
Total residents interviewed	8 (5.1)
Sex	
Male	3 (37.5)
Female	5 (62.5)
Site of residency	
Urban	5 (62.5)
Rural	3 (37.5)
Site of Medical School training	
London, ON	3 (37.5)
Toronto, ON	2 (25)
International medical graduate	3 (37.5)
Time in Residency	
First six months of training	5 (62.5)
Last six months of training	3 (37.5)

We identified three overarching themes: (1) Training for SADV, (2) Attitudes towards SADV, and (3) Hesitant approaches to SADV. Each theme influenced the subsequent one; student training in SADV informed their attitudes to learning and this shaped their approaches to further learning and skill acquisition in SADV.

Training

Participants learned SADV through classroom, clinical, and personal experiences. In medical school, participants learned indirectly about SADV: *"Where you learn doing pap smears and pelvic exams, you learn focused and trauma informed care and how to do a pelvic exam in [the least] retraumatizing way possible."* (P6) But this was insufficient preparation for residency, where SADV was encountered during emergency department and psychiatry rotations. *"I was in a situation where somebody came to Emerg. and had just experienced an assault and I don't think I ever was taught how to process that with someone."* (P6) Formal learning was ad hoc, *"scattered here and there.*" (P7) Participants drew on experiences outside their medical training. One participant stated "*most of what I know is from personal experiences of friends I've supported through events, rather than actual educational content."* (P6) When discussing knowledge regarding the forensic aspect of SADV care, another participant stated *"just what I've seen on TV."* (P3) Others, were more motivated: *"I've gone out of my way to try and read and learn about this sort of thing."* (P5)

Lack of SADV teaching was attributed to clinical service pressures, where *"we had a lot going on"* (P3) and it is often *"onto the next, you have patients waiting."* (P6) Some participants felt preceptors sheltered them from SADV-related clinical presentations: *"it's such a sensitive topic that oftentimes the supervisors just take it over.*" (P3) This was thought to be due to the potential for patient harm when involving a learner. Participants' overall sentiment was that learning opportunities were insufficient: *"It's a bummer that [SADV] happens to so many people, yet we're all here trying to figure it out on our own."* (P6)

Attitudes

The ad-hoc nature of SADV teaching fostered a lack of confidence providing SADV care, with participants describing themselves as "amateur" (P3). When recalling a clinical situation of caring for a patient who experienced SADV, one participant stated "*I felt pretty unprepared for that situation actually. It's upsetting to me, because it's something obviously you should be ready for."* (P6)

One participant suggested his gendered learning experiences influenced his attitudes toward SADV care provision, stating *"being male, I automatically know that if it's a female patient who has been a victim of sexual abuse…it's quite possible that they'll be uncomfortable with my presence, so seeking that opportunity is something I'm more apprehensive about."* (P10) This highlights how participants' personal history—as well as the current social context of SADV being less commonly experienced by cisgendered men—influenced their approaches to learning about SADV care.

Hesitancy

Lack of confidence meant participants approached SADV care hesitantly, anxious they might *"make the interview not go well" (*P3) or *"say the wrong thing.*" (P3) As a result of *"not wanting to go in there and just guess"* (P3), participants refrained from involving themselves in SADV cases if a staff physician was already involved.

Participants perceived the transient nature of patient-trainee relationships a barrier: *"you're just getting to know the patient, and that might be a barrier for them having that conversation with you.*" (P4)

Synthesis

We developed a schematic summarizing the relationships among themes (Training, Attitudes, and Hesitancy) (Figure 1). Viewing our results through the theoretical framework of social constructivism, we highlight how learners' attitudes and behaviours are shaped by not only their individual past experiences, but also the context within which they are training. This is understood by examining the cyclical relationship among themes (Figure 1). The manner by which each theme influences another is rooted in the current culture of SADV care provision and teaching. Social constructivism also considers how participants' experiences, views and behaviours are influenced by time; in examining our results within this paradigm, it is evident that the interconnectedness of our depicted themes has the potential to impact generations of family physicians, as learners become teachers.

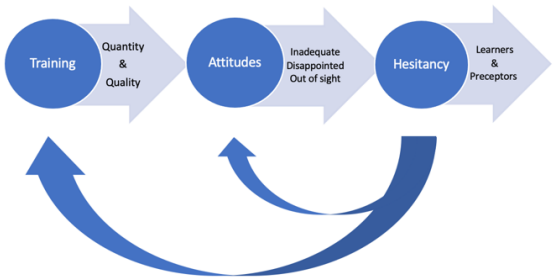

Figure 1. A model for the relationship among learners' training, attitudes, and hesitant behaviour with regards to SADV healthcare. Arrows denote the cyclical nature of these themes as experienced by learners who then become preceptors and accordingly influence new learners.

Discussion

Participants felt inadequately taught and unprepared to care for patients experiencing SADV. Survey-based research in the USA and Canada has demonstrated family physicians often do not feel they possess the strategies needed to help SADV victims, and endorse anxiety and discomfort regarding providing SADV-related care.[16-18] This is worrisome, particularly as patients are advocating for proactive assessment for SADV during primary care visits.[6-10]

Our results can be interpreted using the Capability, Opportunity, Motivation, Behaviour (COM-B) conceptual framework for behavioural change.[19] This framework views a behaviour system as relying on the interconnection among individuals' capability, opportunity, and motivation.[18] Capability is defined as an individuals' psychological and physical capacity to engage in a behaviour, and motivation refers to the internal processes that direct behaviour.[19] Using this model, we can view participants' training as a factor influencing their motivations. Lack of training impacts motivation, resulting in residents hesitating to engage in care for this patient group. This framework highlights the cyclical and inter-dependent nature of our research themes. Future efforts to improve SADV learning could be targeted towards intervening at any stage of this behaviour cycle.

This study is limited as it was conducted in a single FM residency program, with a small group of participants. Though our interviewee pool was a convenience sample of volunteers, we recruited participants iteratively until we achieved data sufficiency.[15]

This study has important practical implications for clinician teachers. Our findings provide insights regarding how the behaviours and attitudes FM preceptors model may influence the behavioural cycle of SADV learning and practice. Locally, this research will inform curricular change regarding how SADV teaching is delivered to FM residents. To our knowledge, current training routes for those interested in providing SADV care in Canada are institution-specific and varied; they include optional didactic and practical training sessions, provincial sexual assault examiner's courses, and participating in United States-based certification courses.

Future research may ask similar questions at other Canadian institutions to gauge the extent to which our findings are mirrored elsewhere. It also would be interesting to seek experienced family physicians' perspectives regarding what training would have prepared them better for providing SADV care in practice.

Conclusions

This study provides a foundational understanding regarding FM residents' SADV learning experiences, and how these experiences shape attitudes and behaviours. We highlight a behavioural cycle wherein the opportunities provided to students colour their attitudes, and contribute to hesitancy seeking further learning and SADV care. In understanding this pattern, we can target interventions to improve SADV teaching in Family Medicine and, in turn, the quality of care family physicians provide to affected patients.

Conflicts of Interest: None of the authors of this manuscript has any conflicts of interest.

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Appendix A – Interview Instrument

Definitions

Domestic violence is defined as any act of physical, sexual, or emotional abuse by a current or former partner, whether cohabiting or not.

Sexual assault is defined as is an act in which a person intentionally sexually touches another person without that person's consent, or coerces or physically forces a person to engage in a sexual act against their will.

Semi-structured interview questions

1. Can you share with me your experiences in your education to date around caring for people who have been victims of sexual assault or domestic violence?

Probe: where in their education? What were they taught? Who taught it?

2. In your experience as a medical student, have you cared for individuals who experienced sexual assault and domestic violence? Can you tell me about this experience?
3. When would you consider sexual assault or domestic violence when you are seeing patients? In what instances would you think of it most often?
4. How comfortable do you feel with managing a patient who discloses to you an experience with sexual assault and domestic violence?

Probe: what aspects of care do you have comfort with or discomfort with? Ex. History taking, physical exam, medical management, resources, forensic aspect

5. How do you anticipate being exposed to sexual assault and domestic violence in your career as a family physician?
6. Do you feel that education about sexual assault and domestic violence should be a part of family medicine training?

Probe: ask regarding sexual assault or domestic violence if they only spoke of one of them.

7. Do you feel that you have had adequate training and teaching to date to effectively manage sexual assault and domestic violence to the extent that you may encounter it in your career? Please elaborate.
8. In learning about sexual assault and domestic violence, what do you think would be the most helpful teaching methods? (Prompting if needed: case-based learning, didactic lectures, simulation…)
9. Do you feel that there are any barriers to learning about this topic for family medicine residents? If so, what do you feel some of those barriers are?

Prompting if needed: curriculum not provided, lack of patient experience in clinical setting…

The following few questions focus more on the forensic and detailed clinical aspects of managing patients with sexual assault and domestic violence:

10. What are your thoughts regarding the forensic options available to victims of sexual assault or domestic violence in Ontario?
11. What training have you had with regards to the forensic examination involved?

Probe: What are your thoughts with respect to what you may offer in terms of management to a patient who discloses an experience of assault?

12. How comfortable are you with where to seek specialized help for patients who have been recent victims of sexual assault or domestic violence? What about patients who have a remote history of sexual assault or domestic violence?
13. How comfortable do you feel with managing long-term consequences of intimate-partner violence or sexual assault and domestic violence? (Prompting if needed: psychological aspect of domestic violence, for example)

Last thoughts

14. *(If second-year resident)* Now that you are graduating from residency in a few months, when you look back at your residency training, what are your thoughts about the teaching you had with respect to sexual assault and domestic violence?
    a. What, if anything, do you wish had been offered or done differently?
15. What career plans do you have for after graduation? How do you anticipate encountering sexual assault and domestic violence issues in your work?
16. Can you tell me a bit about how prepared you would feel if a patient presented to you with experiences of sexual assault or domestic violence in your work as a staff physician?
    a. Prompts: Would you feel comfortable with what to do or uncomfortable? Confident or needing support? Elaborate.
17. Can you share with me what barriers you think a FM program might experience in developing a formal program related to the care of patients of sexual assault and domestic violence?
18. The FM program here at Western offers training in sexual assault as part of the Wednesday afternoon seminars.There is a plan to develop a full day of training in sexual assault and domestic violence for all residents. Could you offer any thoughts, ideas or suggestions as the program moves forward in this direction?
19. Do you have any other thoughts that have not come up in this interview yet that you would like to share with respect to sexual assault and domestic violence training in family medicine?