



Assessing Medical Student Attitudes Toward Intimate Partner Violence and Sexual Assault Following Protocol Training in a Student-Run Clinic Network

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Abstract

Background: Intimate Partner Violence (IPV) and Sexual Assault (SA) represent critical challenges in clinical settings, impacting patient safety and well-being. IPV and SA can be prevalent among vulnerable unhoused populations like the patients that are served at the Tulane Student Run Clinics. This study assesses how implementing IPV/SA protocols in the student clinic will impact student-reported comfort and knowledge about IPV/SA.

Methods: A protocol was developed to guide clinic leaders on how to interact with victims of IPV/SA. Training was conducted for clinic leaders to learn how to follow the protocol. Leaders completed a survey before the one-hour training and again immediately after the training evaluating the training's impact on their comfort in assessing and treating patients experiencing IPV, as well as their knowledge of IPV. Pre and post-training responses were compared using paired t-tests, and the threshold for statistical significance was $p < .05$. Data was analyzed using R 4.3.3 (2024, R Foundation, Vienna, Austria).

Results: The study included a sample size of 24 participants. The results show that students felt significantly more comfortable ($p < 0.001$), knowledgeable ($p < 0.001$), and confident ($p < 0.001$) about the topic of IPV/SA after the training. Students were also more prepared and willing ($p < 0.001$) to discuss subjects such as sexual health and sexual assault with patients. The study found no significant difference in students perceived necessity ($p = 0.50$) of a standardized protocol after the training.

Conclusions: Protocol-based IPV/SA training was associated with significant improvements in participant comfort, knowledge, confidence, and preparedness. These findings suggest that utilizing structured IPV/SA training may strengthen student-run clinic leaders' ability to identify and support patients experiencing IPV/SA.

Introduction

Intimate Partner Violence (IPV) and Sexual Assault (SA) are pervasive issues that affect individuals across all demographics but are particularly prevalent among vulnerable populations such as the unhoused and socioeconomically disadvantaged groups. Around 30% of women in the United States have or are currently experiencing IPV.³ 85% of IPV victims are women, with a majority being between the ages of 18 and 24.¹ In Louisiana specifically, there is a disproportionate number of women and vulnerable populations facing IPV.² In 2023 alone, 1 in 25 Louisiana women reported experiencing a form of IPV.² Vulnerable populations, including those who are disabled, experiencing homelessness, or incarcerated, are on average four times more likely to face IPV than those who are not.²

Physicians are often in a position to serve as a confidential point of contact for those facing IPV.³ Existing research highlights the benefits and the necessity of quality IPV training programs for medical professionals.⁴ IPV training for medical students is limited and inconsistently implemented.^{5,6}

There is limited evidence guiding the development and evaluation of effective intimate partner violence (IPV) education in medical training. A scoping review by Ghaith et al. identified the inability to measure curriculum effectiveness as a major barrier to providing medical students with training on working with patients who survived IPV.⁶ One study that evaluated the effectiveness of an IPV education program for students found no significant improvements in student attitudes or knowledge after an IPV education program.⁷ This current study aims to address the barrier by including surveys to evaluate program effectiveness and significantly improve students' attitudes and knowledge of IPV. Additionally, this study is conducted within the context of student-run clinics, a setting where there have been no studies exploring IPV training in this context.

Student-run free clinics (SRFC) across the country operate with the primary objective of helping disadvantaged individuals gain access to reduced-cost, holistic primary and preventative care.⁸ Tulane University School of Medicine's Student-Run Clinics (TUSOM SRC) serve a diverse patient population, with 30 clinics across 13 clinical sites around the city. SRFCs are some of the few sites in New Orleans offering free healthcare.⁸ TUSOM SRC has many clinical sites within shelters that do not house individuals long-term, so shelters may also not be aware of the domestic or personal situations of specific patients that students see. Student-run clinics are crucial to addressing health disparities in disadvantaged communities, including recognizing signs of IPV. Thus, student leaders at TUSOM SRC received training in which they were given the proper screening tools and knowledge to address IPV.

This study aims to evaluate the efficacy of the IPV/SA protocol implemented in TUSOM SRCs to clinic leaders, focusing on the impact that training clinic leaders with this protocol will have on their understanding of IPV and how to assist survivors.

Methods

The Intimate Partner Violence Protocol was created in collaboration with the Louisiana Foundation Against Sexual Assault (LAFASA). This protocol outlines a step-by-step approach to caring for a patient demonstrating signs of or needing resources/treatment for IPV/SA. Patient and student safety was emphasized first, then risk assessment, standardized questions, and examples of proper communication tools to aid students in utilizing the appropriate language were also given.⁹⁻¹² Resources for patients were listed at the end, specifically for those in Louisiana.¹³ The protocol can be accessed in the Appendix.

Upon completing the protocol in May 2024, a training session on its content was established for students in July 2024. Pre- and post-surveys were created for students to take before and after the training (Table 1). The questions in the survey were developed by the study investigators, principal investigator and representatives from the Louisiana Foundation Against Sexual Assault (LAFASA), who have expertise in IPV/SA education and advocacy. Study participants included the medical student leaders of each clinical site who attended the monthly student-run clinic meetings and the Student Clinic Council executive board. IRB approval was not required as this study was conducted as a quality improvement project.

The comparative survey method was used to gauge the knowledge students could gain from the training on the protocol. While protocols can be given to clinic leaders to use as needed, the protocol may not be accessible at an appropriate time when students are faced with an immediate situation in which knowledge of the protocol is necessary. Therefore, a training and survey approach was utilized so all students were introduced to the topic and could ask questions to clarify any confusion on their role in handling IPV in a clinical setting.

Students were then given the pre-survey before the training. The training was provided by a third-year Tulane student and a member of LAFASA in July 2024. The training began with important terminology and the prevalence of IPV in Louisiana. Then, all protocol aspects were reviewed with resources and time for questions. The training was interactive, and students were given clinical scenarios and were asked about the next steps in helping a patient. Scenarios were tailored to what stu-

Table 1. Survey questions and corresponding labels used in data analysis

Survey Question (On a Scale of 1-10)	Label
How comfortable do you feel discussing intimate partner violence (IPV) and sexual assault (SA) with patients?	Comfort
How knowledgeable do you feel about recognizing the signs and symptoms of IPV/SA?	Knowledge
How confident do you feel in conducting a risk assessment for IPV/SA?	Confidence
How comfortable are you in discussing sensitive topics such as sexual health and substance use with patients?	Discussion
How necessary do you think a structured protocol is for managing IPV/SA cases in a clinical setting?	Necessity
How prepared do you feel to provide patients with resources and referrals for IPV/SA?	Preparation

Table 2. Pre- and post-training survey means and difference in mean response score (N=24)

Survey Question	Mean		Difference	p-value
	Pre-training	Post-training		
Comfort	5.4	7.4	2	<.001
Knowledge	4.8	7.3	2.5	<.001
Confidence	3.8	6.5	2.7	<.001
Discussion	6.3	7.3	1	<.001
Necessity	9.2	9.4	0.2	0.5
Preparation	2.4	7.1	4.7	<.001

Survey responses were rated from 1-10. A paired t-test was conducted with $p < .05$ as significant.

dents would typically see in a clinical setting at one of the various clinic sites. The training lasted approximately one hour and was followed by a post-survey for students to complete. Both surveys were done through an online surveying platform and were administered anonymously with responses paired using non-identifiable codes. As a quality improvement initiative, no patient data were used. The training was mandatory for all student clinic leaders.

Survey responses were rated on a 1 to 10 scale, with higher scores indicating more positive attitudes. Pre- and post-training responses were compared using paired t-tests, with significance set at $p < .05$. Statistical data was analyzed using R (version 4.3.3, R Foundation, Vienna, Austria).

Results

Fifty-four participants filled out surveys. However, out of the 54 participants, 30 only completed the pre-training survey, so they were not included in the data analysis. The final total was 24 participants whose data was analyzed using R.

Table 2 shows the pre- and post-training means and the differences in means. Survey responses ranged from 1 to 10. The average level of preparation to provide patients with resources and referrals was 2.4 before training and increased to 7.1 after training, representing the lowest baseline and greatest improvement. Confidence in conducting a risk assessment, knowledge in recognizing signs and symptoms of IPV and SA, comfort in discussing sensitive topics such as sexual health and substance use, and comfort in discussing topics of IPV and SA all had an increase in mean after the training intervention. The belief in the necessity of a structured protocol was high at baseline prior to training at 9.2, and remained high at 9.4, which demonstrated the smallest change.

Pre-training and post-training survey results were examined using a paired t-test. Mean survey values for comfort in discussing IPV/SA ($p < 0.001$), knowledge about recognizing the signs and symp-

toms of IPV/SA ($p < 0.001$), confidence in conducting a risk assessment for IPV/SA ($p < 0.001$), comfort with discussing sensitive topics such as sexual health and substance use with patients ($p < .0001$), and preparation in providing patients with resources and referrals for IPV/SA ($p < 0.001$) all significantly increased from before the training to after the training. The only survey question that did not differ substantially between pre- and post-training scores was how necessary participants thought a structured protocol would be for managing IPV/SA cases in a clinical setting ($p = 0.50$).

Discussion

After the training session, the results suggest that students may have felt more comfortable, knowledgeable, and confident handling IPV/SA in a clinical situation. Students may feel more prepared and willing to discuss topics such as sexual health. Students gained knowledge in recognizing the signs and symptoms of IPV/SA due to the detailed discussion highlighting both physical and emotional signs of IPV/SA. The increase in comfort and confidence in discussing IPV and SA with patients after the training may be due to the emphasis on the initial screening of a patient for IPV/SA and how to incorporate that into standardized history taking. In typical standardized history taking, students often ask limited questions about sexual health and history, mainly due to preconceived stigma and varying levels of comfort.^{14,15} The perceived necessity of a standardized IPV/SA protocol did not significantly change after participants did the training, likely because they already recognized its importance prior to training, resulting in a high baseline score and limited opportunity for further improvement.

The training offered a step-by-step approach to asking necessary yet “uncomfortable” questions to provide proper and holistic patient care. Also, students were allowed to participate in a hypothetical situation that would help them apply the standardized protocol in a realistic scenario. They received training in conducting a proper risk assessment for intimate partner violence. Empathetic verbiage, phrases of support, and examples of insensitive communication were also given in the training and protocol to further aid students in clinical interactions. Students may feel more prepared to provide patients with resources for IPV/SA due to the list of local and national resources for IPV/SA provided in training and the protocol. The training also emphasized the importance of post-interaction care and gave students examples of how to personalize patient care after clinical visits. This aspect of the training also may have helped students with unanswered questions on dealing with the confidential information discussed during patient interactions.

There is limited research on the effectiveness of IPV/SA training in healthcare settings, with even less attention given to student-run clinics and the importance of screening and education for those working with vulnerable populations. A scoping review of 65 studies on IPV training programs for healthcare professionals found that 55% demonstrated positive program effectiveness.¹⁶ However, these programs varied widely in their delivery methods and participant demographics, with none specifically evaluating medical students. A 2012 study explored the relationship between training frequency and IPV-related knowledge in medical students, showing a statistically significant correlation between interactive versus didactic activities in enhancing IPV-related knowledge.¹⁷ Although the training was primarily didactic, incorporating interactive elements likely improved students' knowledge and confidence in managing IPV/SA, as their active participation may have enhanced learning outcomes. Increasing student interaction and discussion may be a future direction to improve the effectiveness of the training.

Another study evaluating an IPV training program for pediatric residents found that after the training, 91% of residents could identify appropriate IPV screening questions, and 79% were aware of referral sources, compared to 53% and 30%, respectively, before the training. Additionally, 85% of participants recognized the relationship between child abuse and IPV, up from 35% pre-training. The study also identified key barriers to IPV screening, including time constraints and discomfort when discussing IPV with patients.¹⁸ This current study's survey enlists medical students, who are building

a foundation on IPV screening/education, and receiving a head-start in handling IPV/SA scenarios in their future careers. Also, the other study's acknowledgement of barriers to IPV screening could be an avenue for future improvements to administering IPV screening in the clinical context.¹⁸

A strength of this study is its emphasis on the importance of IPV/SA training for medical students, particularly those working with high-risk, vulnerable populations. The participants in this study predominantly work with low-income populations and on a volunteer basis, making this study unique compared to previous studies. Another positive attribute of this research is that the study participants received the same standardized training to become clinic leaders for their respective clinical sites. Thus, there is an element of homogeneity among this study's participants.

A limitation in this study is that the training is primarily for one institution. This study does not measure the effect of this program on multiple student-run free clinics working with similar patient populations. Thus, the effectiveness of the training may vary for clinic leaders at other schools with SRFCs who have received other training or work with different demographics of patients. Additionally, participant demographic data were not collected to reduce survey burden and preserve respondent anonymity, which may limit the generalizability of the findings. Another limitation is that the study measured student attitudes towards the training instead of objective measures like a test of knowledge gained from the training or a standardized patient encounter that assesses student ability to provide care for patients who have experienced IPV. Assessing students using the methods mentioned above could more objectively determine the effectiveness of an IPV training program. The study was also limited by a small sample size. Lastly, the study was limited by the use of non-validated survey questions, which may introduce measurement bias.

The findings in this study can serve as a foundation to establish standardized IPV/SA training within other student-run clinics at other institutions. To support the sustainability of this initiative at TUSOM, the training is planned to be implemented annually, with the recruitment of student leaders who have prior IPV-related experience to serve as peer trainers, and long-term goals include integration of the program into the broader medical school curriculum. Future research could further quantify the effects of this training at TUSOM by recording how student clinic leaders utilize the protocol/training in their respective clinics. The current training, protocol, and future research on IPV in SRCs will be used to investigate interventions to assist patients who experience IPV.

Findings from this study support the recommendation that medical schools should implement a similar IPV/SA training for their students. Also, practitioners/medical students should willingly participate in IPV/SA trainings to further aid the detection and treatment of IPV/SA in their patients. An increase in the availability of IPV/SA trainings to medical students and practitioners could both change preconceived attitudes held by participants about IPV/SA and improve detection, counseling, and treatment for at-risk populations.

Conclusion

The results show that students felt significantly more comfortable, knowledgeable, and confident about the topic of IPV/SA, and prepared and willing to discuss subjects such as sexual health and sexual assault with patients. The study did not find a significant difference in students' perceived necessity of a standardized protocol after the training. Although further research is warranted regarding the long-term effectiveness of the protocol outlined in this study, mandatory IPV/SA training within other student-run clinics could help improve detection, counseling, and treatment for these patient populations.

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