Domestic Violence Screening in Pregnancy: Comparing Prevalence and Detection Rates with OB-GYN Practices and Perceptions of Screening in a Hospital-Based Clinic and the Private Community

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Introduction: Routine and universal screening for domestic violence (DV) is a recommended component of prenatal care by the American College of Obstetrics and Gynecology. However, even in primary care settings, only 10 percent of physicians routinely screen for DV. Domestic violence affects as many as three hundred twenty-four thousand pregnant women each year, with conservative prevalence estimates at 7-8 percent. Violence in pregnancy is associated with multiple maternal and infant health problems, including delayed prenatal care, preterm labor and low birth weight, as well as with increased health care costs. Pregnancy has been described as a unique time when women tend to take greater interest in and responsibility for their own health and that of their children. Taking into account the intimate nature of prenatal care encompassing monthly and weekly prenatal visits, the prenatal course may provide the greatest opportunity to screen for DV. Despite ACOG recommendations that pregnant women be screened in every trimester, it is unclear if such screening actually occurs and how obstetricians view screening for DV in this community.

Objectives: The goals of the study are to (1) compare the prevalence of prenatal screening and detection rates for domestic violence in a hospital-based clinic setting vs. private obstetric practices in Honolulu and (2) explore provider perspectives on screening.

Materials and Methods: We reviewed prenatal charts of all Queen Emma Clinic (QEC) patients who presented for prenatal care and delivered at Queenâ€™s Medical Center (QMC) during a twelve-month window, October 2003 through October 2004 (105). We also reviewed a randomized sampling of prenatal charts of patients of private obstetricians in the community during the same time period who delivered at QMC, representing approximately 10 percent of all QMC deliveries (189). Eighty-five clinic charts and one hundred eighty-five private charts met inclusion criteria.

In addition, we surveyed all private obstetricians who deliver regularly at QMC (33) and all current OB-GYN residents (25) regarding DV screening practices.

Main Outcome Measure: Prevalence of DV screening and detection based on prenatal records; cost-excess projection based on assessment of acknowledged risk factors for DV victimization; analysis of provider self-assessment of DV screening practices based on a 6-item questionnaire, with responses compared by physician sex, practice setting, and domestic violence training.

Results: Ninety-eight percent (83) of the QEC patients were not screened for DV during pregnancy, compared to 70 percent (129) of private patients. However, 80 percent (45) of private patients indicated as "screened" had a "global negative" screen: no positive responses to a comprehensive list of medical problems, including "trauma and violence." A sole case of DV was identified, postpartum, among the QEC population, while no cases of DV were identified among the private patients.

Patients who were screened were more likely to have had prenatal care by a female practitioner (42) than a male practitioner (14) (p=0.0001).

QEC patients were more likely to have multiple risk factors associated with victimization (age <24 years, late prenatal care, public insurance, and single marital status) than patients of private providers.

Provider survey: Though most (76%) were aware that ACOG recommends DV screening in pregnancy, the majority of private practitioners and residents (69%) "never or rarely" screened their patients. The data suggested that female practitioners were more likely to screen than male practitioners and that younger physicians (<age 50) were more likely to screen than older physicians (>age 50). Recent domestic violence training made no difference in likelihood of screening.

Ninety-two percent of physicians perceived barriers to screening. The most frequently perceived barriers identified were lack of time, lack of privacy (partner in room), and inadequate training. Perceived barriers were not consistently associated with physician gender, age or clinical setting.

Conclusions: Despite professional recommendations and awareness of those recommendations, during 2003-2004, routine prenatal screening for DV was notoriously lacking for patients delivering at Queenâ€™s Medical Center. The Queen Emma Clinic in particular, despite having a patient population that is at high risk for domestic abuse, was deficient in its screening practices. The detection rates in both private and clinic-based settings were not consistent with national prevalence data, which may indicate a lack of coordinated screening efforts. Both private obstetricians and residents are missing opportunities to screen for domestic violence in pregnancy, with important clinical and fiscal implications.

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