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Using a Delphi Method to Develop Competencies: The Case of Domestic Violence

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Abstract

Background: The past decades have occasioned an explosion of research on Domestic Violence and the health care response. It has become clear that abused women are frequently seen in emergency departments, yet despite the research, the prevalence of the issue among patients, its serious health consequences, and the need for training acknowledged by numerous medical organizations, there is no standardized curriculum for training health care providers, nor an articulated set of competencies to guide curricular development.

Objectives: To develop evidence-based competencies on Domestic Violence relevant to health care providers, particularly those in emergency department settings.

Methods: Following a modified Delphi process, we completed a literature review for the years 2001-2006 to determine evidence-based practices. Next, an expert panel extracted relevant competencies from the reviewed literature. The competencies were confirmed through consultation with 66 stakeholders across the province of Ontario.

Results: Forty-four respondents provided concrete feedback on the competencies, confirming their importance and validity.

Conclusion: This paper describes a comprehensive methodological approach to the challenge of developing competencies in DV relevant to health care providers practicing in emergency department settings. The development of competencies is an important first step in the development of a common, standardized, evidence-based medical curriculum.

Keywords: Domestic Violence; Intimate Partner Violence; Evidence-based competencies; Medical education

Introduction

Over the last decade there has been an emphasis on competency development as a focus for medical education as in for example, Can MEDS 2005 Physician Competency Framework: Better Standards, Better Physicians, Better Care [1] and the Medical Leadership Competency Framework [2]. A recent study published in 2011 noted "the need to continue to develop new educational methods such as competency based approaches", [3] suggesting competency based curricula will likely remain important in medical education for some time. These documents provide a framework for understanding the multiple roles of the competent physician and the steps required to achieve that competency; as such they have been important in setting the standards of practice. However, until recently there has been no clear definition of what competency based medical education actually meant. In 2010 a systematic review on the topic was completed and yielded ten relevant themes as fundamental to the concept. These included: progression of skills, learner-centeredness, alignment to patient needs, curriculum flexibility, transparency, greater engagement of learners, and allowing learners to progress at their own pace [1]. The findings contributed to a "21st century definition" that reads: Competency-based education (CBE) is an approach to prepare physicians for practice that is fundamentally oriented to graduate outcome abilities and organized around competencies derived from an analysis of societal and patient needs (p. 636).

Despite the clear interest in competencies as a framework for education and skill development, the process by which "societal and patient needs" are identified and turned into specific skills or behaviors remains unclear. In this paper we describe a systematic and collaborative process to identify competencies on Domestic Violence (DV) for health care providers, in particular those working in hospital emergency departments where women who have been abused are frequently first seen [4]. Identifying the requisite competencies was the first step in a larger project focused on developing a practice relevant curriculum on DV for those working in hospital emergency departments.

Since the early 1980s there has been an explosion of research on DV and the health care response. By the mid-nineties, the numerous and serious medical sequelae of DV, also known as intimate partner violence (IPV), had finally been recognized as was the extent to which the issue was overlooked by health care providers across a range of settings but particularly in hospital Emergency Departments (ED) [5-13].

Yet, despite this significant body of research, the prevalence of the issue among patient populations, its serious health consequences, and the acknowledged need for training by numerous medical organizations

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(including the American Medical Association, American Academy of Pediatrics, the Family Violence Prevention Fund, the Canadian Public Health Association, Canadian Psychiatric Association, Canadian Nurses Association, the Society of Obstetricians and Gynecologists of Canada) little headway has been made in developing a core curriculum for health care providers and physicians, particularly those in ED settings [14-15]. The need to educate health care professionals on identification and management of domestic violence is compelling.

Earlier efforts to promote a core curriculum on DV had led to the publication of essential topic areas to be covered in medical education in 1997 [16] but no identified competencies. In 1999 a Position Statement was issued by the American Association of Colleges of Nursing recognizing the need for education on DV for nurses. Although the Position Statement did include a set of competencies for nurses there was no explanation of whether or not these were evidence based or other information provided on the process followed in their development (T *Position Statement on Violence as a Public Health Problem, Competencies Necessary for Nurses to Provide High-Quality Care to Victims of Domestic Violence)* [17].

Method

We followed a modified Delphi method based on a review of existing evidence at the time of the study to determine competencies related to DV for physicians practicing in hospital ED settings. The first step was the completion of a literature search using PubMed and limited to the years 2001 -2006 with the keywords: *domestic violence, intimate partner violence, woman abuse, spouse abuse*; plus *education, training, evaluation*; plus *emergency department.* The initial search generated more than 4,000 articles. Refining and limiting the search to *English language empirical* or *evaluation* studies or *English language guidelines* reduced that number to 516. Excluding articles which did not address hospital emergency department settings, training or education, and were not specific to violence against adult intimates further reduced the number of articles to 33. The project research assistant, a PhD candidate with research experience in DV, read these abstracts and further excluded those that were not research based (including systematic reviews, evaluations, and qualitative studies). Twenty-two articles remained.

Next, a second search of the grey literature (non academic publications) was conducted using Google search engine and combinations of the same search terms plus *manuals, guidelines, curricula, recommendations*. Results of this search were reviewed by the project leads for credibility of source (for example, those produced by professional bodies, colleges, or national organizations), application to Canadian health care practice and hospital emergency department settings, and date of publication. This yielded 11 guidelines and 6 curricula.

We assembled an interdisciplinary expert panel to develop the final competencies. The 15 panel members represented different disciplines as well as a range of values and philosophical perspectives. The panel was comprised of: 5 physicians, 4 with emergency department experience and one Ear Nose and Throat surgeon who developed and taught a course on DV at one of the province's medical schools; 5 nurses, all of whom had worked in ED settings and 3 of whom were sexual assault nurse examiners; and 3 social workers including the Director of social work for a large urban trauma centre. The panel was co-led by the authors [a psychologist (RM) and an emergency physician (BS)] who had collaborated on other initiatives focused on DV research and education. Before the first meeting, two of the physicians withdrew from the panel but they did contribute written feedback during the process.

To supplement the literature reviews, panel members were invited to contribute additional materials they had found helpful. No additional material was provided. In total, 11 guidelines, 6 curricula, and 22 articles were reviewed by the research assistant and project leads.

The study method, the key issue(s) and finding(s) from each study was identified and incorporated into a chart which was later shared with the expert panel members during a day-long meeting in the early days of 2006. Panel members were asked to consider the study method, the nature of the research evidence, the key findings, and to compare these with their own experience in practice. They were also asked to consider the practicality, feasibility and implications of each study's findings for incorporation into a list of competencies in ED practice, for example: if non-judgmental communication is an evidence-based competency, is it feasible and practical to teach practitioners and to implement this practice in a busy ED; is it feasible and practical to set up an environment for disclosure in an ED. A note taker documented and regularly summarized the discussion. By the end of the day a rough draft of the competencies was completed.

Over the next six weeks the competencies were refined through an ongoing email dialogue with panel members. As well, the competencies were ordered into *attitudes, knowledge* and *skill* subsets and then from *basic* to *advanced* skills. All changes were approved by panel members.

External stakeholders from across the province, including women with experience of DV, physicians and nurses from hospital and community settings, as well as allied health professionals, were solicited via email to provide critical feedback on the specific competencies, the language used, and whether the order (from basic level to advanced skills) was appropriate. The stakeholders were drawn from a list of medical and nursing managers in ED department across the province, as well as health care providers working in the province's network of designated sexual assault/domestic violence centers, and shelters/volunteer organizations. They represented a spectrum of locations, rural/urban settings and consumers and providers of health care services.

Results

By March 2006 substantial feedback on the competencies had been received. Of the 62 stakeholders who received the draft for review, 44 responses were received with several collective submissions. For example, an 8 page group response was submitted by a group of urban hospitals. Another response from the medical director of a single hospital included the results of consultations held with all staff from that hospital's ED. In total 79 separate comments were received, some of which incorporated concrete suggestions, for example: "I really liked how 2.5 was so specific …but felt "Perform" was not the right word". General comments were also received, for example: "Personally I found the competency list to be appropriate, relevant and comprehensive…" and "I think most of these are reasonable core competencies for docs, however many ER docs I'm sure, don't do them well, or don't have much of the background knowledge or training to do them well…" Some questioned the choice of language ("Why are you using *Domestic Violence* instead of *Violence against Women?*") and the selection and composition of the expert panel ("How were panel members selected?" "Can I become a member of the panel?"). A few commented that some issues had been overlooked, for example abuse of men by their female partners.

Feedback was generally provided on the order of the competencies or the specific language used. Feedback was incorporated whenever possible except when it conflicted with the published literature, another stakeholder, or the funded mandate of the project (focus on women's rather than men's experiences of violence). In the few instances where there were disagreements that could not resolved by published evidence, a consensus decision was reached, facilitated by the panel co-chairs. The exception to this protocol related to maintaining the term, Domestic Violence, rather than intimate partner violence, IPV, or "violence against women" or "woman abuse" as suggested by some stakeholders. The rationales for maintaining the term Domestic Violence over the other choices included a) pilot testing of the language revealed most of the physicians recognized and were more familiar with DV than with the other terms; and, b) the funder, the Province of Ontario, was using the term Domestic Violence in their training materials and public education campaigns. Regarding the inclusion of the abuse of men, the panel decided to maintain the focus on women as the primary victims of abuse but agreed to acknowledge the occasional abuse of men within the curriculum text itself. Questions about panel selection were individually answered and no additional members were recruited. Once all feedback had been received the co-chairs re-categorized the competencies into two sections: a) Identification and, b) Assessment and Intervention (Table 1: List of Competencies).

Discussion

Competence has been defined and conceptualized in diverse ways. In general, it is understood to describe one's ability to carry out a specific task with individuals falling somewhere along a continuum of ability. In medicine competence is understood to encompass more than the specific abilities required and includes the conditions under which the ability should be manifest, as well as the standard at or above which that ability should be maintained [18]. Beginning in 1999 with the Accreditation Council for Graduate Medical Education Outcome Project, articulation and evaluation of specific competencies has played a large role in undergraduate and post graduate medical school curricula and specialty practices. For example, in 2006 in the U.S., The Core Competencies in Hospital Medicine: A Framework for Curriculum Development by the Society of Hospital Medicine [19] was published to begin standardizing medical curricula across different domains (e.g. medical school, post-graduate and continuing medical education programs). In each of the document's 51 chapters the introduction is followed by a set of learning objectives that are broken down into three subcategories: knowledge, skills or attitudes. Similar efforts to standardize medical education have unfolded in the U.K. where postgraduate medical education has been revised through the Modernizing Medical Careers initiative [20]. The fourth objective of this initiative, (just after fair, equitable and transparent recruitment

1. UIDENTIFICATION
1.1 *Define* violence against women within the context of an intimate relationship
1.2 *Describe* the prevalence of intimate partner abuse in women presenting to Emergency Departments
1.3 *Identify* health effects of intimate partner abuse
1.4 *Describe:* cycle of violence, barriers women face in leaving, characteristics of abusive men
1.5 *List* presentations of abused women in the Emergency Department *(includes injury pattern, behaviours, medical presentations, vague complaints and emotional affect)*
1.6 *Discuss* the effects of culture, geography, home environment, disability and sexual orientation on presentations
1.7 *Identify* those patients that may be at high risk of abuse (*include pregnancy, partner's behaviour, etc*)
1.8 *Identify* patient-related barriers to disclosure (include concerns about privacy, confidentiality, cultural/ethnic/religious beliefs, resource availability etc)
1.9 *Acknowledge* pre-existing values, attitudes, beliefs and experiences related to abuse among Health Care professionals and how these impact on the interaction with the patient
1.10a. *Explain* issues that contribute to a lack of safety in identifying abused women in the ED environment
b. *Identify* factors that contribute to a safe environment in identifying abused women
c. *Describe* how to set up a safe environment enabling women to disclose abuse
1.11 *Communicate* with patients in a supportive, nonjudgmental manner
1.12 *Demonstrate* appropriate ways of asking about, or screening women for, intimate partner abuse or violence
2. UASSESSMENT AND INTERVENTIONU
2.1 *Communicate* appropriate responses to disclosure, nondisclosure, and indicators of abuse despite nondisclosure
2.2 *Acknowledge* the patient's response in a non-judgmental, supportive manner
2.3 a. *Describe* legal obligations upon disclosure of abuse
b. *Describe* reporting obligations regarding children
c. *Communicate* with the patient regarding reporting issues (woman and her children) in a clear and supportive manner
2.4 *Discuss* repercussions of disclosure for the women and her children
2.5 a. *Identify* available local hospital, community, regional and provincial resources and how to access them
b. *Review* with patient available options
c. *Value* and respect a woman's rights to make her own decisions
d. *Communicate* information to the woman that supports her decision making
e. *Offer* appropriate referrals
2.6 *Identify* high risk situations for:
continued abuse
medical morbidity/mortality including suicide
homicide
2.7 a. *Perform* a focused assessment of immediate risk/safety
b. *Distinguish* among hospital and/or community resources to be called upon in the event of immediate risk to her safety
2.8 *Perform* appropriate documentation of patient's history, physical findings, working assessment/diagnoses, follow up arrangements

Table 1: Crere Competencies on IPV for Health Care Providers.

and, two references to specialty training) is, "educational progression for individuals should be assessed by an annual review of the documented acquisition of competencies and clinical and professional competency" [20].

Identifying the desired competencies is a necessary first step in curriculum development. To our knowledge this was the first comprehensive methodological effort to establish relevant, evidence based competencies in DV relevant to health care providers, particularly those who work in hospital ED settings. Some of the competencies were readily identified and articulated, for example, *that health care providers are able to recognize the various forms of DV including physical, sexual, psychological and financial abuse*. Others were more challenging due to divergent findings reported in the research literature, sometimes the result of differing methodologies (for example qualitative versus quantitative studies; process versus outcome studies), as well as conflicts among the research and grey literatures. Differing values, beliefs and paradigms were represented in the different literatures resulting in findings and recommendations that sometimes conflicted with each other. Similarly, those who participated in this process also brought to the table their different epistemological and philosophical beliefs and values. These crucial and passionately held beliefs could not be predicted on the basis of discipline, gender, or profession. For example early in the meeting one physician argued for the hierarchy of evidence with the randomized control trial (RCT) representing the highest level of evidence while another physician argued that qualitative research capturing the preferences of abused women should be more strongly weighted than RCTs. While both types of research may be valid and complementary, few studies in emergency department settings qualify as either. Some members argued that the term "domestic violence" masked the gendered nature of the abuse and we should instead refer to "woman abuse" thereby educating emergency department personnel to the term, while others felt that we should use the language most familiar to ED physicians and nurses, "Domestic Violence", so as not to alienate anyone before we even began.

Not surprisingly, the question of whether or not to include screening for DV as a core competency was one of the most challenging issues the panel confronted. Two systematic literature reviews had reported there was insufficient evidence to recommend routine screening [4,21]; yet other studies [22-24] considered routine screening an important component of care. In addition, studies showed that routine screening increased rates of disclosure [25] while the qualitative literature reported that most women support routine screening under most conditions, except when screening questions were asked in abrasive or judgmental tones of voice [26-27]. There are also some suggestions that paper and pencil self reports may be more effective in some health care settings [28-29] and legal settings [30] but these data were not available at the time of this project suggesting that a regular review and potential revision of the competencies is required.

The panel unanimously decided to emphasize asking about abuse and supporting disclosure over screening. The final related competencies appear as: "Identify patient-related barriers to disclosure (include concerns about privacy, confidentiality, cultural/ethnic/religious beliefs, resource availability etc)" and, "Demonstrate appropriate ways of asking about, or 'screening' women for, intimate partner abuse", thus allowing learner/providers in the absence of definitive evidence to choose their own practice strategy while insisting they at minimum have a strategy. Although few topics generated this level of discussion, each competency was subjected to the same process.

Limitations of our methodology include a general dearth of scientific evidence from which to base recommendations (as pointed out by one of the respondents); and potential values-laden and biased opinions of stakeholders, in spite of recognized expertise (given the reported prevalence of domestic violence it is likely that some of the health care respondents are victims or perpetrators of DV). However attempts were made to reconcile differences of opinion with available evidence and an inclusive process facilitated by the authors. From this mix of evidence, recommendations and expert opinion, the panel identified the core issues as: a) health care providers must recognize indicators of abuse; b) must be able to speak to patients in non-judgmental ways; and c) understand why women might be reluctant to disclose abuse.

Although some years have passed since we first developed the competencies on DV for health care professionals, and while a number of studies have addressed DV in a variety of health care settings (for example, Kapur & Windish [31] MacMillan et al. [15], D'Avolio [32], and Clements, et al. [33]), there have been only modest gains made in applying competency based education to this topic in the ED environment. An American organization dedicated to promoting health professional education and research, the Academy on Violence and Abuse (AVA), has recently published (2011) Competencies Needed by Health Professionals for Addressing Exposure to Violence and Abuse in Patient Care.

We found that developing competencies relevant to Domestic Violence for emergency department health care providers was not without its challenges. As we and other panel members considered the research literature, our own experiences and expertise, and the implications of these for the developing competencies, personal, philosophical, epistemological and discipline based differences became apparent. Reaching consensus required respectful negotiation, compromise and flexibility. It helped that we had a common goal: to improve the emergency department encounter for women who experience abuse. And, to reach that goal other lesser goals were sometimes sacrificed as when the panel decided to maintain the term, Domestic Violence, instead of Violence against Women, the preferred language of advocates and grassroots workers. Validating the competencies through the external stakeholder consultations invited even more complexity into the process but also helped offset any bias that might have entered the process, reassured us that the competencies were reasonable and practical, and increased the number of individuals and organizations connected to the project.

Conclusion

By adopting the framework and language prevalent in medical education, and using a literature review combined with stakeholder feedback and expert opinion, we were able to situate the issue of DV within the medical paradigm and to outline in concrete terms the evidence based competencies and standards for practice. This method may be usefully applied to other contentious topics and issues.

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