# 'It's really quite a delicate issue':[1] GPs talk about domestic violence

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This paper evolved from an ongoing concern with the health effects of domestic violence for women. As researchers and service users it seems important to focus attention on healthcare delivery rather than continuing the practice of research *on* women who have been abused as if they were *'the problem'*. While it remains necessary to identify health effects experienced by women, the ongoing problems women encounter when seeking healthcare need to be addressed. Current research suggests that non-detection of domestic violence by healthcare professionals, and the identification of symptoms such as chronic pain, injuries and substance abuse without attention to the underlying cause of those symptoms – violence within intimate relationships – is problematic. Although healthcare professionals are in a particularly good position to render assistance, the relationship between them and their patients who experience the effects of domestic violence may be such that the experience of violence remains unspoken.

Although healthcare delivery problems are relevant to all medical health professionals, general practitioners (GPs) are privileged in this paper. GPs are likely to know women across time and are likely to regard the general health of their patients as the domain of their practice. Therefore, they are more likely to be able to detect subtle changes in their patients' general health, attribute these changes to an effect of lifestyle (i.e. exercise and diet; socioeconomic, psychological and emotional factors) and to prioritise detection of 'lifestyle effects' as an integral part of their approach to, and treatment of, their patients. This paper reports part of a study that addresses some problematic aspects of GPs' understandings of domestic violence and their response to issues of detection and prevention.

## Domestic violence and medical health professionals

Health service providers are likely to be among the few whose professional relationships with women will be ongoing (Heise *et al.,* 1994; Pahl, 1995). As such, health professionals are in a unique

position to recognise, diagnose and treat the effects of domestic violence against women (Fischbach & Herbert, 1997). They are of particular importance considering that the isolation imposed on women by abusive male partners may estrange them from other support services which could render assistance (Stevens & Richards, 1998).

Although it is estimated that of all women patients who seek medical care from emergency departments between 22 per cent and 35 per cent are women who have been battered (Smith & Gittelman, 1994), all women who are abused by their partners will also have general medical issues, and will therefore seek non-trauma medical care at some point (Stark and Flitcraft, 1991). The healthcare system is often the first and most likely place for women who have been abused to seek help (Pahl, 1995; Smith & Gittelman, 1994). However, domestic violence histories go routinely undetected by medical health professionals (Campbell, Harris, *et al.,* 1995; Harris & Dewdney, 1994; Yam, 1995). More recently, research has shown that health professionals believe domestic violence is a significant healthcare issue but they do not agree with routine screening until there is evidence that it is beneficial (Richardson, Feder, Eldridge, Chung, Coid & Moorey, 2001).

In addition, research reports that women rate health professionals as the least helpful service providers (Campbell, Harris, *et al.,* 1995; Easteal & Easteal, 1992; Randell, 1990; Stark, Flitcraft, & Frazier, 1982). This is of concern because women who are abused are more likely to seek help from non-emergency primary care sites, such as general practitioners, than emergency departments (Stark & Flitcraft, 1991).

The failure of health professionals to detect abuse means that the immediate health issues of the woman presenting are treated, but the underlying cause of those health issues remain unaddressed (Kingston & Penhale, 1995; Yam, 1995). One reason for this may be that women are infrequently asked about abuse (Campbell, Harris *et al.,* 1995; Fischbach & Herbert, 1997). Cultural myths and stereotypes, such as the belief that women provoke men which results in violence, that 'fighting' is a normal part of an intimate relationship, that domestic violence against women is not a medical matter, and that women who are abused by their male partner cannot be helped, often deter practitioners from asking about abuse (Yam,

1995). It is likely that the same attitudes that have kept domestic violence a private matter inform the belief that the violence of men against their female partners is neither prevalent nor severe (Browne, 1993). Several sources suggest that women are reluctant to disclose or volunteer abuse histories due to shame and self-blame though they may be willing to disclose if asked (Bewley & Gibbs, 1991; Heise *et al.,* 1994; Campbell & Lewandowski, 1997). Reluctance to disclose or volunteer information appears to indicate the need for greater awareness of abuse and the possibility of domestic violence histories on the part of health professionals, based on the consistent finding that most women who have been abused and sought treatment wish that someone had questioned them about abuse in a direct manner (Bewley & Gibbs, 1991; Campbell, Harris *et al.*, 1995; Fischbach & Herbert, 1997). Recent research has shown that women welcome being asked about their experience but are rarely asked by their doctors (Bradley, Smith, Long & O'Dowd, 2002; Jewkes, 2002; Richardson, Coid, Petruckevitch, Wai, Moorey & Feder, 2002).

**Medical Health Professionals Responses When Abuse Is Detected**

Historically, research has shown that abused women do seek healthcare, especially when seriously injured and regardless of their utilisation of or reporting to other services such as the police (Stark, Flitcraft, & Frazier, 1982). However, medical response is often less than satisfactory to the purpose of helping and treating women who are abused by their male partners, whether this abuse has been detected or disclosed, or not. In early studies, women consistently reported that their disclosure of abuse by their intimate partner was not accepted by doctors (Stark, Flitcraft & Frazier, 1982), medical health professionals did not implement protocols designed to assist abused women, they often blame women for 'being victims', and they were unsympathetic to women's experiences of abuse (Yam, 1995). Heise *et al.,* (1994) state that little training is given to medical professionals regarding the nature, incidence, or *sequelae* of abuse. Research on training programmes for healthcare professionals suggest that screening rates for domestic violence remain low due to professionals reporting they are inadequately trained to provide care for abused women. Davidson, Grisso, Garcia-Mareno, Garcia, King and Marchant (2001) argue that there has been inadequate evaluation of recent training programmes for healthcare providers.

In addition to being unsatisfactory, the medical response to women who are identified as having been abused by their partners is often inappropriate, if not damaging and destructive. Archival and observational research reports that women who are abused by male partners are more likely than non-abused women to be referred to psychiatric services, institutionalised or denigrated by attendant service providers. They are also more likely to be prescribed tranquillisers, antidepressants and pain medication (Stark & Flitcraft, 1991). It appears to be a mundane finding that health professionals respond to women who have been abused by their partners by treating medical problems only, whilst the cause of these problems, the abuse, remains unaddressed or simply ignored (Randell, 1990; Yam, 1995). This means that the ongoing risk to the women is never assessed (Browne, 1993). Moreover, mistreatment may occur when interventions related to secondary problems, such as substance abuse, exacerbate the women's vulnerability to 'victimisation' (Stark & Flitcraft, 1991). Bewley and Gibbs (1991) found that there is often poor liaison and communication between helping agencies so that even sympathetic responses to women abused by their male partners may not result in adequate assistance being received.

As well as the dissatisfaction women who have been abused express at the response of medical health professionals, doctors too have expressed their discomfort regarding the problem of domestic violence and their professional response to it. In a review of empirical research on doctors' attitudes and responses to domestic violence against women, Richardson and Feder (1996) identified doctors' fears and worries regarding the detection of abuse in the lives of their women patients. Doctors had fears about the amount of time needed to deal with domestic violence, and that lack of time might prevent identification of the problem; fears that detecting domestic violence might 'open a Pandora's box' or lead to threats against the doctor by the perpetrator; close identifications with women from similar backgrounds to the doctor; worry about offending the woman or putting the doctor–patient relationships at risk; feeling powerless to 'fix' the problem and without control over the success of interventions; lacking medical training about domestic violence against women and also lacking knowledge about appropriate community services.

Researchers concerned with the medical health effects of women's abuse by male partners make various calls for changes in

the attitudes and protocols of medical health professionals, in their training and in their awareness of the prevalence and significance of women's experiences of abuse. Research concerned with the care of abused women and the desire to better assist them was easily found, particularly in the nursing and midwifery literature. Campbell, Poland *et al.* (1992) call for a greater degree of alertness, and the provision of extra nursing and follow-ups for women abused during pregnancy. Taggart and Mattson (1996) advocate greater awareness of the more subtle signs of abuse, namely psychosomatic complaints and other indicators of abuse such as explanations of injuries which are incongruous with them, missing appointments, and vigilant partner presence. Saunder, Hamberger and Hovey (1993) caution physicians to be aware of domestic violence histories when treating divorced and single women because of the long-term health effects of abuse and the possibility of ongoing abuse even after women separate from violent partners. Stevens and Richards (1998) state that nurses are in a prime position to assist women through healthcare delivery, commitment to higher education and research, and their position in policy development. Therefore, calls for changes to be made by medical health professionals in terms of what they should do to address these problems is supported in the literature, yet there is little empirical research which addresses the problems some medical health professionals have regarding the issue of domestic violence against women.

This research is therefore particularly concerned with the experiences of GPs as primary non-emergency service providers for women who have been abused by male partners. It is concerned with the question – how do GPs' experiences support the detection and intervention of domestic violence (DV) as problematic? What are the implications for women?

## Method

Since the focus of the research question was on GPs' experiences we used a semi-structured interview technique to speak with doctors directly about their experiences. All participants were asked the same questions; even so, each interview was substantially different from any other. The aim of the interviews was to enable doctors to speak openly and in confidence about their experiences. They were encouraged to direct the course of the conversation with the interviewer, who

followed tangents that they introduced and picked up on issues that they raised, as well as asking questions in a different order (or not at all) depending on the direction chosen by the interviewee.

To recruit participants, letters were sent to ninety GPs in a central North Island province (including rural areas)[2] inviting them to take part in the study. Three general practitioners out of ninety responded to this mailing. Due to the low response rate, twenty days after the first mailing, the original letters plus a note saying 'Just in case you didn't receive this the first time' were sent again. Five doctors responded to this mailing and agreed to participate. Two doctors were recruited through personal contact. Therefore, of ninety GPs in the region, ten agreed to participate in the study.

The difficulty in finding participants may be attributed to several factors. Response rates to single unsolicited requests by mail are only around 20 per cent (Bourque & Fielder, 1995). Additionally, people are less likely to volunteer to participate in studies they perceive to be on sensitive or threatening issues (Bradburn, 1983). However, another possible reason for the low response rate was the belief of some doctors that they do not see women patients who are suffering the effects of domestic violence. Evidence for this was revealed by the responses of some doctors declining participation, and by some who were interviewed.

Three GPs' receptionists/secretaries telephoned to decline the request to participate. One told us 'We don't see that type of people here'. Another told us that as the doctor she worked for was elderly he was not likely to see women experiencing domestic violence. Two doctors telephoned to decline, one of whom said he 'didn't see that type of person' in his practice. He was asked if he would still be willing to take part in an interview; he was not.

Six doctors declined by letter. Two doctors referred to 'not seeing' domestic violence as their rationale for not wanting to participate, and their responses are as follows: 'I hardly ever see any direct consequence of domestic violence, probably only 1 in the last 5 years'; 'I haven't completed your research survey as I am a Specialist in Obstetrics and Gynaecology rather than a General Practitioner. I therefore have little personal involvement in cases of domestic violence and don't feel I would be able to contribute much to your study. I do wish you well with your ongoing research'. Although this study was concerned with GPs this was still a particularly telling

response. In a study of violence against women before and during pregnancy, Irion, Boulvain, Straccia and Bonnet (2000) found that prevalence rates were high for this group of women but severely underestimated by their healthcare providers.

Two general practitioners wrote letters after the second mailing, saying they were willing to be interviewed but had felt they would not have much to offer to the research. One stated that 'I work part time, and have a large proportion of older patients in my practice, and therefore do not see many cases of domestic violence. I did not reply to your original letter, as I felt my contribution would probably not be very helpful to you.' The other expressed similar feelings, saying that 'I didn't think I could be of much use to you – only in a negative way as I seldom recognise this problem'. After assuring both participants that their experience would be valuable to the research interview times were made and interviews later took place.[3]

Interviews with the ten GPs were conducted and transcribed by the first author (Amy) as per the ethical requirements of the Massey University Human Ethics Committee. Her goal was that the experience of being interviewed would not be a negative one for the participants. The participants stated that they wanted to know how to better help their patients and to know how to take positive action, hence their involvement in the research. All participants were offered a copy of the transcripts for comment and change prior to analysis.

The concept of narrative is appropriate to the analysis in this project because the interview questions took the form of requests for the GPs to tell stories. The GPs who participated in this study did account for their past actions, individually, and each transcript offers an understanding of their past in relation to the issue of domestic violence, it's bearing on their present experiences, and makes sense of their interest in the issue, their concern for solutions to problems of detection, and their willingness to contribute to the research (Freeman, 1993). Storytelling so dominated the interviews that the GPs did not always answer questions when these were not connected to a particular story they wanted to tell and subsequently did tell. They employed topic-centred narratives, which are characterised by the relating of past events that are linked thematically (Riessman, 1993). Thematic linking and the organisation of events into storylines enable narratives to be analysed to identify commonalities and to 'build up' an aggregate story which represents these commonalities. Reissman (1993) calls

the result of this kind of narrative analysis 'metastories'.

In analysing the doctors' texts, we attended to sequence both within and across stories (Riessman, 1993). We also attended to thematics. Through analysing sequence and thematics we were able to build up metastories around particular issues and events that the doctors commonly experienced. The metastory we present in this paper concerns how GPs *feel* about women's experiences of violence by intimate partners and how they respond to it in their practice.

### A metastory of doctors' feelings and responses to women suffering the effects of abuse by their violent partners

In this study the GPs' feelings and responses to domestic violence are informed by a number of concerns, both personal and professional. All but one of the GPs interviewed had experience of a female patient with a history of violence. The GPs were worried about failure to detect such histories. In part, this worry stemmed from a belief that women do not disclose to their doctor. The GPs were also concerned that they had not been trained in the effects of DV or in its detection and were therefore not sure what to look for or how to help. They also commented on the lack of response from GPs to take part in the research and suggested that the lack of knowledge/training about DV may be a source of embarrassment for doctors and therefore might be felt by them to be a 'weakness'. They suggested that DV was not a comfortable issue to talk about, particularly if they too have a history of abuse or of being abusive. They did, however, suggest that it was important to deal with the effects of DV despite the difficulties of facing the issues. They suggested that the only possible explanation for not addressing the issues was through ignoring them. The fragments below illustrate the desire of the participants in this study to be able to respond responsibly and appropriately to women who present with the effects of abuse.

A commonality across interviews was that the GPs felt concerned about and wanted to help their patients. However, they articulated feelings of powerlessness, and explained how this can lead to a feeling of despair for them. Part of their despair arose from understanding the situation as one that cannot be fixed, or even approached in the same manner as a discrete medical problem. In this way, they questioned their medical training as not necessarily able to address the effects of violence, raising the question of training. The GPs interviewed stated

that they understood the problem of domestic violence against women to be deeply complex, and an impossible problem for them to solve, leaving them feeling inept and incompetent to deal with it.[4]

> I'm trying to help as much as possible
>
> (Dr G, 267)

> you have this great feeling of despair I guess not only for the person but the fact that you can't really fix it. You see GPs like to fix things and when you can't fix things, that's a bit depressing for us I think. ... And it's very frustrating, very frustrating too ... 'Cause it's a very hard thing to fix, isn't it. ... If you had a broken leg it would be easy, put it in plaster ... if you had a broken leg people could see your broken leg too, and they'd think 'Oh, how bad,' you can't fix domestic violence and you can't see it either ... it's a very difficult, I find it a very difficult condition.
>
> (Dr J, 286–99)

> I mean, there's very little, you, you end up feeling absolutely impotent as to what you can do to help. ... so (.) you know, we (.) i-, it's a very difficult area for us to get into.
>
> (Dr A, 93–110)

> [It is hard] to know quite how to deal with it, what to do for the best.
>
> (Dr A, 212–21

The above extracts illustrate some of the problems that emerged through the GPs' stories, such not being able to 'fix' domestic violence as if it was a broken leg. As a consequence, the participants considered their attempts to resolve the problem through urging the women to take action to help themselves, which often was understood as not happening. This ultimately left the doctors feeling that there is not much they can do, and they conclude that the woman must help herself as she is the only one who can.

> And to (indecipherable) counselling, very seldom have I been able to make any dent. ... Even when I've appealed to the victim ... to seek legal redress, they often don't.
>
> (Dr L, 22–27)

> I try and point out to them that, that no one in this society has to live in fear of physical violence. And that nothing can be done about this until they do something about it.
>
> (Dr B, 51–53)

In this study, when attempts at intervention did not have the desired outcome, the GPs sought to explain the problem by attributing it to personal characteristics of the women. In this study women in violent relationships were understood as extremely difficult to help. This was attributed to the woman's trouble accepting help, either because of the ongoing abuse, or the possibility of gender issues – one GP felt that being male may make it less easy for women to disclose to him.

> I mean, I can't tell them what to do, and often I suspect it doesn't matter what you tell them anyway, (2) and I'm, I'm always worried that a lot of them are going to go back and get abused again and I point out to them (.) that there is a risk that they could be killed.
>
> (Dr J, 73–76)

> And ah, she had many incidents with really serious injuries and I was really quite concerned ... that the [injuring things] kept happening basically and police intervention and the guy (2) sort of (2) not, (.) didn't change and so she [left him].
>
> (Dr N, 73–77)

> And they are difficult people too, 'cause you can say 'Now look, I'm worried about you and I'd like you to come back in the next week 'cause we've got so much to talk about,' but you never see them sometimes, they are not very good at um (2) not very good at coming back and accepting help, whether they don't like men and I'm a male I, I don't know but they're hard people to try and help sometimes. ... Um (.) I think they find it hard to accept help from anyone, they are a rather special sort of difficult, not on purpose, just difficult people to help, I think.
>
> (Dr J, 305–12)

Having identified abused women as being difficult to help, the GPs in this study also encountered difficulties when they attempted to get help from government agencies for women. One doctor talked about frustration with welfare and justice systems, specifically Children, Young Persons and their Families Service and Family Court.

> I sit there and I think about (3) I don't report to CYPS, if CYPS come to me it works brilliantly, (2) if you go to CYPS and get through their intake process, that's something I've never managed to wade through.
>
> (Dr K, 178–80)

So while the GPs were able to identify concerns about the women's access to adequate care, they also described losing sympathy for

women when they presented with the same problems repeatedly – not changing herself or her life sufficiently to prevent her own 'victimisation'.[5] The woman's behaviour was commonly explained in terms of emotional dysfunction linked to a cycle of violence where there was a familial history of abuse.

> I think you'll find that health professionals, when you see a person coming back, having reinserted themselves into the same set of circumstances again and again and again, um, with different spouses, different de facto's, um, that you tend to lose your, lose your sympathy, and realise that they are emotional victims of themselves and that, probably that they [inaudible] sort of person who abused or has a parent of (3) ...
>
> (Dr B, 24–30)

This loss of sympathy was also experienced by the GPs in this study as frustration at what they saw as the wilful continuation of the behaviour that keeps a woman in an abusive relationship. They felt that this is because the woman denies to herself the potential seriousness of her situation. It was commonly speculated that repeated violence is attributed to the woman being overpowered by her violent partner, which reduces her emotional strength and her ability to leave. They spoke of the possibility that the violent relationship is in a way co-dependent, which functions to keep the woman emotionally tied to her violent partner. It was also commonly understood that their healthy and normal women patients would not tolerate any violence from their partner, and they contrasted them to women who have been abused, who do as illustrated in the excerpt below:

> (8) Um, one of the most frustrating things I've found is the denial of the abused person (2) who (.) listens when you say 'Look, this is a very potentially serious thing,' um, (.) I've always found it very difficult to understand why a woman comes along and then three months later comes along again (2), it's something that obviously is a power thing and almost a co-dependency state sometimes but it never ceases to amaze me how they keep coming back (laughs) um, and I know in the Women's Refuge twenty-five percent come back to the refuge so I can't understand that, but I can, and it seems very odd. ... it makes me feel so sad for the lady, and you think, you know, now why does she do it? Now I think I know why she does it, 'cause she's so overpowered and so terrified that she does come back (.) um but you think, you almost feel like grabbing her and saying 'Look, go away.' ['What are you doing?'] Yeah, 'What are you doing?' My, some of my healthy clients would say 'Well if he even

> laid a finger on me, I'd plant him or I'd leave him,' but these people get so overpowered by it, obviously they can't, they haven't got the strength to leave, now, I find that so frustrating, I'm sure everyone does, so it's the denial that's the hardest thing to understand.
>
> (Dr J, 228–47)

The GPs in this study had strong personal responses to abuse. They experienced distress when treating a woman requiring care for the effects of a severe violent attack from her partner. While they commonly speculated on the emotional effects of detecting abuse in the context of previous experience of violence, the following fragments explicitly link practice with personal experience suggesting that GPs might also be required to understand their own histories.

> Yeah – and it can, can be to a young um, GP I think a real, a severe abuse can be quite frightening, um and brings up your own, of course, issues, and how um, how you handle abuse yourself, or if you've ever been abused or whatever, but there's a lot of emotions involved
>
> (Dr J, 183–86)

> I personally have never liked violence much and I think it's a matter of whether you are used to violence and if you handle it right.
>
> (Dr J, 200–201)

It was apparent that despite their experiences (their frustrations) of not being able to 'fix' the problem, the GPs commonly experienced a great deal of worry about the consequences for a woman who remained in a relationship with her violent male partner, and for her children.

> Mm, so it is so frustrating ... and you worry about them you know, you think 'Oh, God, what's going to happen to your kids and what's going to happen to you?'
>
> (Dr J, 254–57)

Building on the thematic that the GPs worried about continued violence for their women patients, they talked about their personal involvement with some cases of continued violence against a woman patient. This personal involvement increased the impact of the patient's situation on the GP, especially knowing that the abuse continued, or ended in death.

> I know that when, when I left South Africa, the couple concerned came to me and they gave me a gift, and they said 'You know,' um 'You understand us.' ... They actually went out of their way to do that ... Which I

> found really quite touching ... but it didn't help – 'You were still beating her up regularly'!
>
> (Dr L, 45–54)

> Um, (2) and um, also I had a person (2) who was a patient that I knew very well who was in a violent relationship that kept, you know like (2) um (.) she had a terrible time ... (4) I can remember her pretty clearly, in fact it's probably the one that I remember most, um, so it's kind of really this thing that kept happening to her and it kept happening despite all of the intervention and a lot of support, it kept happening. Um, although eventually she did move out [inaudible, spoken very quietly and quickly], so that was another part of all that and, and then she, um, she had a dramatic death ... so, I, kind of feel like I'm linked to that story, really, it was a pretty amazing story.
>
> (Dr N, 61–71)

Alongside the experiences of distress and frustration, the GPs in this study commonly experienced fear as a strong personal response to abuse. Common across narratives were fears about possible threats to them from the perpetrator of the violence. The GPs did not necessarily have to have come into contact with the perpetrator to experience this fear: the experiences of the abused woman were sufficient to instil it. However, it was also commonly reported that they had also been personally assaulted within their practices. Their fear of the threat to their own physical safety is therefore realistic and well-founded.

> … they're crying and upset and there's some big hairy monster in the background who's probably gonna knock your block off if you ever came within [inaudible] there's a threat to your own physical (.) safety sometimes.
>
> (Dr J, 188–90)[6]

> I either ask them or they tell me that physically, sexually, if they've been abused at home. Occasionally you find out because you interview the partner, and he physically abuses you, which is always an exciting experience!! ... Whereupon you get to do those great expressions of 'what is that like to live with?' while you are trying to get the ringing out of your ears and they are kind of shouting at you (laughs).
>
> (Dr K, 62–68)

The fear of personal safety was not the only fear the GPs in this study talked about. The GPs also held had fears related to professional practice, one of which was the fear of harming or killing a patient due

to lack of knowledge of specific physiological medical conditions – a fear of failure. They stated that expectations of medical students are incredibly high, and the emphasis is on the possibility of a fatality if a doctor has insufficient medical knowledge. This fear also seems reasonable in the light of findings that healthcare professionals do have the opportunity to intervene prior to the murder of some women by their partners, yet that opportunity appears to have been neglected (Sharps, Korziol-McLain, Campbell, McFarlaine, Saches, & Xu, 2001). The extracts below follow one narrative that problematises lack of knowledge.

> [medical students] live in this very, very sort of boxed world, incredible expectations, if you don't know about these Japanese vascular diseases, one day you'll kill somebody, it will be your personal fault that that person dies a slow and agonising death because you failed, the public says you failed, if it is not a good outcome it is because the doctor failed.
>
> (Dr K, 364–68)

Lack of knowledge and/or a patient's death will be perceived to be the doctor's personal fault and will result in public and professional condemnation. In this extract the GP refers to professional discipline for failing to correctly make a life-saving diagnosis, as a necessary requirement of practice. However, the fear of failure is more associated with those health problems that are concrete.

> … it's just the fact that you are in this pressure cooker learning environment where if you don't know how to save the person's life with the heart problem, or the lung problem, or the whatever problem, you will be negligent, they will hang you. ... So you are so busy worrying about the concrete.
>
> (Dr K, 371–75)

Within this framework, empirical and practical medical knowledge is favoured over learning about social problems with health consequences. In this instance, it is commonly understood that GPs are not so likely to be professionally censured for inadequate treatment of health problems related to social issues.

> And someone comes along and says 'My husband hit me' and if it's not fractured (indecipherable), then what do I do? [Professional body] doesn't tend to strike people off because I mean if you get it wrong then they just hang you up for the bad outcome, no one gets hung for stuffing up emotional abuse.
>
> (Dr K, 384–87)

Another common theme that emerged was the possibility of being set up by a patient, and having to go through litigation. While the GPs felt that they can be caught between two sets of agents who have the power to damage them both personally and professionally, it seems likely that the power of litigation, rather than adequate intervention, informs practice.

> You have to actually be, ah, you know, how would, it, it, it's really quite a delicate issue. [So you feel that this delicacy is something that prevents doctors from approaching patients?] Yes. ... Especially in this litiginous age. ... You know? I mean look at what happened (indecipherable) I don't condone what I read about the goings on in Hawke's Bay, um (3) but (2) where it is possible that you could be set up by a woman who might see this as an opportunity to take you to the cleaners, and maybe, you know, so in the end you say well, well my notes look fine ah, you know, I've done everything according to the plan that says subjective, objective assessment plan, medical counsel can't (2) hammer me, I've done everything correct here, if she didn't bring up that issue, it's not my department.
>
> (Dr L, 250–65)

In this context of personal liability, the participating GPs greatly feared making mistakes in the course of medical practice. Thus, they focus on making sure they have done everything formally required of them. They are aware that public expectation of GPs is high. They are also continually alert to the surveillance of medical authorities, whilst also noticing that one group of doctors who should be dealt with by the authority are never formally disciplined and continue to practice – apparently with the support of the 'powers that be'. For most GPs, however, censure is severe; affecting the doctor professionally and personally, and therefore the possibility of it must be taken seriously. This concentration on following the rules, and the importance of doing so, deflects these practitioners away from pursuing abuse issues where they suspect a patient has them.

> you do spend your life trying to cover your arse and making sure you've done everything right and it's been properly documented. ... So you spend most of your life being afraid ... So yeah, so there is one group who are incredibly arrogant, and incredibly hide-like-leather and don't give a damn about their patients, and so all sorts of awful things, often with really bad medicine and certainly atrocious psychological medicine, and the system seems to make sure that they practice, and practice forever, and

> the rest sit there largely with a great deal of fear because they re so afraid of being caught out … and um, discovering some retrospective piece of legislation from the health benefits [indecipherable] that they didn't know about and didn't discover until two months after they committed the offence. ... And they will be personally held liable for that.
>
> (Dr K, 478–97)

Another professional practice fear was the censure of the medical community (their peers) for attempting to intervene on behalf of and help their female patients experiencing violence. They fear this censure would take the form of ostracism and unpleasant representations of them.

> There are individuals who have a passion for it, and there are other professionals up in [location] (.) most of us don't mention it. ... we are afraid of stereotyping (indecipherable) with impressions, being labelled, being rejected (2).
>
> (Dr K, 247–51)

Many of the GPs in the study talked about their medical training as inadequate for addressing domestic violence as a health issue. They understood this as a problem of the reductionist model of medicine. In the excerpt below, one GP articulated this problem as related to the specialisations in medical training: they are trained divide the body into parts, and each specialist area deals with a particular part.

> A separate world, you are in that separate world, you are taught only by hospital doctors, about hospital medicine from hospital perspectives – nobody does integrative medicine, you know, it's all 'the lung man will tell you about lung diseases' and then you finish the lung course and go on to the heart course, and then a skin course and then a kidney course and if you say 'Is there a link between skin and kidney?', they decide which side of the white line you are on and if it's a skin question ask it and if it's a kidney question tell you to go and talk to the kidney man and that's how the specialist process works. If you go in with a cough – you'll be seen by the lung man who will tell you that it may be a (indecipherable) lung, if yes, he'll fix it, if no. ... Heart man says, yes, no, if no, he sends you to the tummy man, if no for the tummy you are out the door, because it is not lung, not heart, not tummy – but she's still got the cough. [Go home?] Well it's not go home, but it's just not my problem, it's my problem if it's a tummy problem, and it's not a tummy problem.
>
> (Dr K, 346–62)

Health problems linked to social problems, such as intimate violence and alcoholism, were specifically excluded as medical problems in these GPs' training, resulting in their feeling that they lack a way of understanding health problems that arise from social problems.

> I remember seeing (2) alcoholic cases and, you know, told it was a social disease you know, we didn't have to get involved in it, and that meant I wouldn't see the patients.
>
> (Dr L, 176–78)

> It's a social problem, if her lungs were fine, her heart was fine, her kidneys were fine, it's not really our chair.
>
> (Dr K, 393–94)

Despite their own training, it was commonly understood that there has been a change of awareness in the medical profession regarding the issue of domestic violence against women. As illustrated below, there was a belief that there is better awareness of its prevalence and perniciousness, in contrast to the past when little was published in medical literature on the issue and it was not talked about among themselves.

> Like people were not aware of how prevalent it was and how serious it was and how dangerous it was, and, and so on, you got me? And I think (.) over the years all of that has shifted. ... I think. Both in me, and doctors, and society, I think, basically. And sometimes with the public campaigns ... have helped, I think in that um, but, I don't know, it, it, subtle change occurs you know, like when you read articles about it in our journals, we discuss it at meetings and you know what I mean. I, it it's okay to talk about and so on, whereas before it was sort of like, oh yeah, you know? kind of thing. About twenty years ago.
>
> (Dr N, 20–30)

So, although there is a fear of (peer) censure when talking about being concerned with domestic violence, the GPs in this study were able to attribute these changes to public campaigns, and changes in social attitudes as well personal change based on experience working alongside other concerned service providers.

> There's doctors that are fairly (2) unliberated and conservative in general, yeah I'm sure there are. ... Although I think that, I think that it's less and less acceptable ... um (6) yes it's interesting, I don't really know. Um (4) I

> mean it's kind of like a guess at their social attitudes, and um (2), I 'spose I'm [inaudible]. No, I think it's shifted, I don't think a doctor could defend this any more, (.) except in his own head or in his own family. ... But he couldn't, no one would buy it, in any discussion group he'd be jumped on by everyone else.
>
> (Dr N, 335–43)

> Oh, no. No, in my, I and remember, in my um, I can't remember whether it was paediatrics or what it was we were, [I was given] work with a social worker and um, that was my very first evidence of anything untoward happening in a family. ... and, um, it just blew me away, at that stage, I didn't believe that anyone – everybody wasn't a happy family, ... um, but no, and had I not been (.) allocated to that (.) um, social worker I guess I might have continued thinking that nothing ever happened to people.
>
> (Dr A, 71–84)

Although the GPs in this study felt that it was indefensible that their peers could ignore the effects of violence, one doctor felt that medicine as a profession still does not pay sufficient attention to issues with health effects which cannot be empirically tested or defined.

> (Sighs) As a profession I think it does lip service to most issues it can't measure with a stethoscope.
>
> (Dr K, 241–43)

Another doctor felt that an improvement in the ability of GPs to assist people in terms of psychological issues has risen commensurate with the rise in the quality of general practice in general, although this depends on the measurable quality of the psychological problem.

> Um, what I'm trying to say is that I think the quality of general practice in, in, has improved substantially and that I've, because, and because it's in ways that are easier to measure, I think it's probably fair to assume that we've improved in those which are more difficult to measure, like the psychological issues.
>
> (Dr G, 300–303)

**Conclusions**

The participants in this study expressed concern that they do not always detect histories of abuse, and had received no training regarding domestic violence or the detection of it during the course of their medical schooling. They were aware, however, of the forms violence can take, and that the effects of violence extend beyond physical injury. They expressed several views regarding the cause of violence, most

commonly accounting for it as an effect of social problems. Detection was a problem for the interviewed GPs, as was asking patients about their experiences. They felt that trust and knowing the patient reduces the difficulty of this situation. They were deeply concerned about the problem of abuse, and tried to support women to leave violent male partners. When women do not leave, the GPs may experience worry, frustration, or a loss of sympathy.

While these GPs understood abused women as damaged by the effects of the abuse, and as suffering a loss, lack or impairment of their ability to make decisions or take action, they also understood recovery as *her* responsibility and that *she* has to leave her partner to make that possible. According to the GPs understandings, women often choose to return to unsafe and damaging relationships. They account for their frustration, lack of comprehension or sympathy, and their sense of powerlessness to help, by attributing responsibility to the abused women: if she chooses to return, then the violence is her responsibility.

The analysis suggested that the GPs in this study were able to locate the act of violence as a problem of an individual man – one who exercises control over the woman and who is capable of posing a real threat of physical harm to the doctors themselves. They also construed violence as a social problem, implicating social conditions and strains in the aetiology of the violent act. However, they did not introduce a notion of social responsibility for ending the violence or preventing its damaging effects. Furthermore, they stated that social problems are often not regarded as part of their professional domain, and as such they may avoid dealing with them so as to not place themselves at risk professionally.

As a medical practitioner, a GP is an 'expert' in general health and wellbeing, and makes decisions based on the standards of and ideal for 'normal' physical wellbeing. As a consequence, they are able to distinguish the decisions and actions of a 'normal' woman from those of an 'abnormal' woman. In this study, they spoke of the possibility that the violent relationship is in a way co-dependent, which functions to keep the woman emotionally tied to her violent partner. It was a common theme among these GPs that their healthy and normal women patients would not tolerate any violence from their partner; this distinction risks promoting a view of male violence as a form of pathology within the woman.

Despite their expertise, the medical model through which the GPs understand health and wellbeing does not enable to doctors to speak directly of abuse as underlying a medical condition. Psychological abuse is particularly problematic for GPs because it leaves no observable, medical 'trace'. Where the effects are not visibly located 'within' the body, its 'discovery' does not rely on the usual techniques of diagnosis through interpreting signs and symptoms, but on the woman's disclosure of the relationship in which she being abused. If a woman is unwilling or unable to disclose abuse, she may well be understood as 'difficult' or 'powerless'. The GPs who participated in this research were acutely aware of the lack or inadequacy of their training in domestic violence, and their inability to offer appropriate support. They were also aware that other doctors did not share their concern, and were even less well equipped to provide support for their distressed patients.

The GPs' narratives account for all but two of the empirically identified attitudes and responses of doctors to domestic violence against women by Richardson and Feder (1996). Doctors in this study did not speak of close identification with women who had experienced abuse by their male partners or lack of knowledge of community services. In our study, they tell of fears and worries, feelings of inadequacy and powerlessness, frustration and distress.

How the GPs understand the abuse of women by their intimate partners contributes to avoiding, denying or deferring responsibility in the face of powerful negative emotions such as fear and powerlessness. It may be the case that improved training could provide a more sympathetic understanding of the psycho-social effects of the experiences of abuse and increase doctors' opportunities for supportive intervention. However, future evaluations of training programmes need to include assessments of how well the programmes address GPs' emotional responses to violence against women.

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## Notes

[1] *Dr L, 250–265.*

[2] There were 90 GPs listed for the region at the time of the study.

[3] These two participants were included in the 5 GPs who responded to the second mail-out.

[4] **(.)** – a pause of less than one second; **(3)** – a pause in speech, and the length of pause, in this case a pause of three seconds; **I was cross** – underlined words indicate speech was emphasised; **...** indicates that material has been omitted from the transcript; **[text]** – this is not the participant's speech. Text within these brackets are either the interviewer's speech or an explanatory note; **(23–78)** – numbers within a bracket indicate the lines from which excerpts from GPs' transcripts are taken. The letter representing a particular GP bears no resemblance to the actual name of the participant.

[5] While the terms 'victim' or 'victimisation' are problematic in feminist literature, medical discourse has a tendency to reduce the effects of abuse to the patient.

[6] This doctor showed me (Amy) that the chair provided to the patient was chained to the floor. He explained that a male patient had picked it up and tried to hit him in the head with it. It was not related to a domestic violence situation that he knew of.