Primary Care Physicians' Response to Domestic Violence

Opening Pandora's Box

Nancy Kathleen Sugg, MD, MPH, Thomas Inui, MD, ScM

Objective.—To explore primary care physicians' experiences with domestic violence victims to determine the barriers to problem recognition and intervention in the primary care setting.

Design.—Ethnography, a qualitative research method involving the use of open-ended, semistructured interviews.

Setting.—An urban health maintenance organization serving a predominantly white, middle-income population.

Participants.—Thirty-eight physicians, predominantly family practitioners (89%), were interviewed.

Results.—Analysis of the interviews revealed that physicians found exploring domestic violence in the clinical setting analogous to "opening Pandora's box." Their issues include lack of comfort, fear of offending, powerlessness, loss of control, and time constraints.

Conclusion.—This study revealed several barriers that physicians perceived as preventing them from comfortably intervening with domestic violence victims. These issues need to be addressed in training programs. Further studies should be done to assess generalizability of these findings to other groups of physicians.

(*JAMA.* 1992;267:3157-3160)

THE IMPACT of repetitive violence on an individual's health often brings domestic violence into the medical setting. Since it is believed that the majority of medical visits related to domestic violence are not in the form of overt trauma, but present as multiple somatic complaints or stress-related illnesses, primary care physicians are in a key position to offer referral for intervention.[1] Although the term *domestic violence* is used to describe the use of violence against a variety of household members, this study focuses on primary care physicians' response to violence between intimate partners or spouses.

The landmark prevalence study for the general population was conducted in 1975.[2] In a nationwide random sample of couples, 28% were found to have experienced violence at some point in their history. Furthermore, 3.8% of women living in couples had experienced severe violence in the year of the study. When extrapolated to the general population, this represents 1.8 million women per year being battered; if divorced or separated women are included, this estimate is 3 to 4 million women per year.[3]

In the medical literature, most of the prevalence data are from emergency department studies. One survey[4] of emergency department patients found that 22% of both men and women had experienced at least one episode of domestic violence. McLeer and Anwar[5] found that when an appropriate trauma history was obtained, 30% of female trauma cases were a result of domestic violence.

Recently, concern about physician responsiveness to domestic violence has been expressed.[6] Several studies have shown that even with knowledge of the underlying cause of the trauma, many physicians fail to respond to the battering. One study[7] found that in 40% of the cases where physicians interacted with battered women in an emergency department setting, physicians made no response to the abuse. In another emergency department that had a protocol for domestic violence, in 92% of the domestic violence cases, physicians failed to give any referral or follow-up for abuse.[8]

Little information is available on the prevalence of domestic violence in the primary care setting or on the primary care physicians' response to domestic violence. This study explores primary care physicians' experiences with and attitudes about domestic violence to determine the barriers to effective intervention in a primary care setting.

METHODS

The goal of this study was to uncover the barriers to domestic violence intervention from within the physician's frame of reference, as opposed to verifying the investigators' a priori hypotheses about the barriers. For this reason, ethnography was the chosen research method. Ethnography is a qualitative research method that seeks to generate hypotheses through analysis of narrative data obtained by in-depth interviews. One of us (N.K.S.) conducted all the interviews after studying ethnographic techniques and training with a medical anthropologist.

The study consisted of semistructured, open-ended interviews with 38 primary care physicians between August 1990 and February 1991. The study was approved by the Human Subjects Review Committee at the University of Washington, Seattle, and informed consent was obtained from all participants. Physicians were asked to describe domestic violence cases they had managed. Probe questions were asked concerning the physicians' role in identifying and intervening in domestic violence cases and also the physicians' own personal experiences of violence or abuse. The interviews lasted approximately 1 hour and were audiotaped. Demographic information was obtained at the end of the interviews. Brief field notes were made after the interviews, and the tapes transcribed.

From the Division of General Internal Medicine, University of Washington, Seattle. Dr Sugg was a fellow in the Robert Wood Johnson Clinical Scholars Program, Seattle, when this work was completed.

The views expressed in this article do not necessarily reflect the views of the Robert Wood Johnson Foundation.

Reprint requests to Harborview Medical Center, 325 Ninth Ave, Seattle, WA 98104 (Dr Sugg).

The Study Site

A large, urban health maintenance organization (HMO) was chosen as the site of the study. The HMO had several attributes that made it an optimal study site, including a large primary care physician staff, an orientation toward disease and injury prevention, and a research group interested in the prevalence of domestic violence. There was no protocol in place for dealing with intimate-partner violence at the time of this study. The HMO served an enrollee population that was predominantly white and middle-income, with the majority of enrollees having received some education beyond high school.

The Participants

Primary care physicians serving in six of seven satellite clinics associated with the urban hospital were selected for the study. One clinic was excluded from the study because of the familiarity of the clinic staff with the investigator. At the onset of the study, the intent was to interview 35 to 40 subjects. The physicians were sent letters describing the study and requesting participation. Of the 58 physicians who received the letter, 41 (71%) agreed to participant, eight (14%) refused to participate, and nine (14%) could not be reached after multiple telephone attempts. Three physicians who agreed to participate were not interviewed because of schedule conflicts. Of the 38 physicians who were interviewed, 63% were men and 37% were women, which was representative of the male-to-female primary care provider ratio at the institution. The age range was from 33 to 58 years old, with a mean of 41 years. The study group was 89% white, 8% Asian, and 3% black. Eighty-two percent of the physicians were married, and 87% had children. The group consisted of 34 family practitioners and four internists. Time since graduation from medical school ranged from 4 to 29 years, with a mean and median of 15 years.

Analysis

Multiple readings of the transcripts were performed to identify major ideas or themes revealed in the physicians' words, phrases, metaphors, and examples. Important and frequently expressed ideas or themes were then studied for patterns of connection and grouped into broader categories, for example, issues of power, issues of privacy, and issues of time constraints. The dominant ideas and patterns of connection were compared between various subgroups of physicians, such as men and women, abused and nonabused.

Validity

Method of analysis and review of results were critiqued by two independent medical anthropologists. Peer review of hypothesis formation and data analysis was formally accomplished in work-in-progress sessions with nine physicians who were not study participants and not staff members of the HMO study site. Member group review was accomplished by distributing the final results to all physicians who participated in the study and asking for their critiques. Of the five participants who responded with critiques, none expressed concern regarding the accuracy of the findings.

RESULTS

Repeatedly, the image of opening Pandora's box[1] was used by physicians to describe their reaction to exploring domestic violence with patients. Eighteen percent of physicians used the phrase, "Pandora's box." (According to Greek mythology, Pandora was the first woman. Her creation was part of Zeus' revenge against Prometheus for providing mankind with fire. She single-handedly opened a box and unleashed the spites of aging, labor, sickness, insanity, passion, and vice into the world.[9]) Eight percent used analogous phrases such as "opening a can of worms."

I think that some physicians, and I do the same thing, if you are very busy and have lots of patients waiting, you just don't ask a question that you know is going to open a Pandora's box. Even if it crosses your mind, you don't ask.

This metaphor suggests the fear of unleashing a myriad of evils. By examining the comments of the respondents, these "evils" begin to take the shape of "too close for comfort," "fear of offending," "powerlessness," "loss of control," and "tyranny of the time."

Too Close for Comfort

The close identification that physicians have with their patients may preclude them from considering the possibility of domestic violence in their differential diagnosis. Close identification was a major theme for 39% of physicians in this study. Physicians who came from white, middle-class backgrounds, with no experience of domestic violence, often assumed that their patients with similar characteristics would likewise not be at risk for violence.

Maybe you're dealing with, presuming you're a woman with a husband and two kids, a professional, you're so similar to me, we probably both drive Suburbans, both go skiing, we all don't abuse the children.... And then maybe you get a young black woman in with two little kids, unemployed, having a headache or God knows what, you might bring it up because it is chaos, social chaos. Although, I guess both women could be abused.

Although most physicians intellectually acknowledged that domestic violence cuts across all races, classes, and ethnic groups, the socioeconomic status of the patient was clearly used as a marker for determining whether abuse was likely.

Now the kind of patients that I take care of are probably somewhat less at risk for that ... while, primarily these are, at least in this clinic, white, middle-class folks. And obviously there is domestic violence in white middle-class folks, but it's not rampant. And I see it very seldom.

Many physicians also admitted that they were more likely to ask patients of lower socioeconomic status about abuse.

We have a unique population here in that it's poorer, inner-city population, fairly substantial Afro-American population. So I think we see the majority of domestic violence in that group. I think we are looking for it more there too. We're more tuned in to it.

Among women physicians, the close identification with patients created another problem. Uncovering domestic violence among patients similar to them would expose some of these physicians to their own fear of vulnerability and lack of control.

I think it's that I tend to identify with these people too much. If they are getting beaten up and don't have control over the situation, maybe that could happen to me.... And if it is some lady who doesn't speak much English because she came from Ethiopia, well, that's one of those people. But if it's a PhD who teaches ... which is what I used to do before I went to medical school, that gets pretty close.

The diagnosis of abuse may also be hindered when physicians too closely identify with abused patients due to their own past experience of abuse or violence. When asked about a previous history of child abuse or physical violence with an intimate partner, 14% of male physicians and 31% of female physicians acknowledged their own experience. As a group, abused physicians could not be distinguished from nonabused physicians in their major themes or patterns of responses.

Fear of Offending

Fear of offending the patients was one of the strongest fears expressed by physicians. Over half (55%) revealed concern regarding offending the patient. This fear often originated in the physician's discomfort with areas that are culturally defined as private.

The second factor is the fear of offending the patient. I don't ask a married woman if she has

lesbian thoughts. It just doesn't occur to me even though I might ask sexual preference of other patients. Again, out of context, where I'm not really thinking of domestic violence, it's sort of a sensitive private area that I might not explore unless I really need to.

The uncertainty of whether patients would consider domestic violence a legitimate area to probe was distressing to physicians.

It's the same kind of hesitance that I have or feeling of comfort I have in dealing with people's sexual preference. I'm not wanting to touch on something that they are uncomfortable dealing with too. It has to do with both of us, our levels of comfort. And also I don't want to be nosing into somebody's business if they don't want me nearby.

Physicians felt that by even broaching the subject of violence, the patient would take offense at the implications of the question. However, many male physicians voiced an even stronger fear that if they were to inquire about violence, it would be viewed as a betrayal of trust by the patient and endanger the physician-patient relationship.

I guess it is because you are asking about behavior that the great majority of people would find abhorrent. Tough questions about sexual preference or anything else, some people get the worrisome thought that by asking the question, the patient is going to think that you think that he does that. He is going to think, "I'm not like that, Doc. What must you think of me?" That, you worry, does violence to your relationship.

It is of interest that even though female physicians expressed concern about offending the patient, none suggested that inquiring would jeopardize the physician-patient relationship.

The fear of offending the alleged batterer may underlie some physicians expressing the need to judge the truth of the situation and the discomfort they felt if the truth was not clear.

With children I have an automatic sense of vulnerability. With domestic violence I have enough of a sense of uncertainty about the vulnerability and the dynamics between the two.... Whenever I thought it was clear-cut and began to explore it with the partner, it quickly became more complex and not as clear-cut, and so I would, I guess, with even the little experience I have had with it, have been left in doubt about the clarity of who is vulnerable and who isn't.

A patient responding positively to a physician's question concerning whether abuse had occurred did not establish the diagnosis of abuse for some physicians. These physicians felt they needed to get unbiased information and go to persons other than the patient to get the truth. The language used to express the concern of truth took on a legal tone for some physicians.

Well, one thing is the credibility of the witness. Some people will say things that I may not tend to believe, I may not have reason to believe them. And in that setting I may well contact some other family member or something to see if I have some confirmation of the problem, with the permission of the patient if I can get it.... Because for some people there may be secondary gain in trying to say something.

It appears that to suggest the diagnosis of domestic violence is to "accuse" the partner of being a batterer. When this weight of judgment is placed on the diagnosis, full "truth" is required by some physicians. For some physicians, blame needed to be assigned, and a "true victim" and "true perpetrator" needed to be identified. Anything less clear-cut was unsettling.

Powerlessness

Many of the physicians (50%) voiced frustration and feelings of inadequacy when discussing what would constitute appropriate interventions.

Well, it doesn't seem to make any difference to me if you have a skull fracture because a tree fell on you or a baseball bat fell on you. It is still a skull fracture. It needs to be dealt with. And you try to prevent another occurrence. If it is a baseball bat that a spouse used, then that seems to be a legitimate cause for concern. But the problem is, what the hell do you do about it?

Many pointed to the complexity of the problem and the fact that they had no "tools" to help.

I think we tend to look more on the technical side of medicine, things we can help, like appendicitis. Domestic violence is a big morass which we will never escape. I get a headache thinking about it. And that attitude translates into the type of care we give those patients.

There was a strong sense of powerlessness when physicians described their inability to "fix it." Many pointed to their lack of training on this issue, with 61% revealing that they had no training on intimate-partner violence in medical school, residency, or continuing medical education courses, as opposed to 8% who expressed that they had received good training in this area.

Loss of Control

Forty-two percent of physicians expressed the frustration that although they would intervene with advice or referral to resources, ultimately the control of the outcome was in the hands of the patient. Until the patient was motivated to change, these physicians felt their attempts at intervention were useless.

I try to refer to resources. But that is part of my sense of impotence. I can't give this woman a job. I can't hold her hand. I can't do it for her.

Many physicians were frustrated by their inability to control the patient's behavior, and the patients' inability to control the circumstances of their lives. This need to gain control and expediently solve the problem was one of the major obstacles to physicians' willingness to address domestic violence.

And the fact is I am not sure I'd have any effect anyway. I certainly find that most of my advice on smoking and alcohol and other self-destructive behaviors has no effect on people and it gets very frustrating. And to see this as rarely as I do, I get the feeling that it would be another one of those frustrating situations where I get involved and invest myself and yet have nothing come of it.

This issue of control was most prominent when physicians described their frustration with the repetitive nature of domestic violence. This reaction was most marked among female physicians.

I get to the point where I feel discouraged because I feel like, with someone that's in... an abusive situation, until that person's ready to take care of it, I'm banging my head against the wall. I'm doing it over and over and over again, and it's like my own abuse in a sense.... At what point do I just say "We'll take up your hypertension today, and I'm sorry your family life isn't going so well"?

The Tyranny of the Time Schedule

The majority of physicians (71%) identified the time constraints of a busy primary care practice as the major deterrent for asking about violence in the home. Their greatest fear was that this is one more issue that will consume more of their scarce time.

You don't open a Pandora's box for the same reason you don't generally ask people, "Do you have sexual problems?" Not because it is not important, but because you don't have time to do that. You literally don't have time to deal with all this.

The majority of the physicians interviewed felt that domestic violence was of such low prevalence in their patient population that pursuing it was not a good investment of time.

Well, I think in part because you still see it rarely. You know, it's not the major medical issue that you see in your practice. It might be there much more than you realize, but it is not a confrontation in your practice. There are so many topics that this one is low on my list of how yielding, I mean, how much yield do you get to spend 5 minutes, 3 minutes on this.

Several physicians voiced frustration with the overwhelming role physicians were being asked to play.

In the case of being a primary care provider and being expected to deal with the total person and the total body and you have 30 minutes, you can't ask all the questions.

Outliers

There were two physicians who stood out from the rest because of their level of comfort in dealing with domestic violence. They differed from their colleagues in several ways. They identified domestic violence cases often in their practice. They had a comfortable, neutral, business-as-usual approach to asking questions about violence. They perceived their role as validating a patient's feelings, discussing safety issues, and referring patients to appropriate resources. They also saw the time frame for change as a prolonged course and were not concerned with the idea of a quick fix. One physician had encountered several abused patients early in his clinical career and had experienced positive outcomes when the issue was addressed in the medical setting. A sense of personal competence developed through subsequent reading on abuse and experience with abused patients. The other physician had a previous history of abuse for which he had received counseling. His own recovery was his evidence that intervention had a significant effect.

COMMENT

The issues raised by the physicians in this study have broad implications. The close identification of physicians with patients of their own socioeconomic background can generate a denial that leads to two dangerous consequences. First, abused patients from higher socioeconomic groups will not be identified because they will not be asked. Second, the misconception that domestic violence is predominantly a product of poverty will be perpetuated through selective questioning of lower socio-economic groups.

If physicians have a personal experience of violence, the impact of that experience is likely to influence their ability to broach the issue with patients. As was revealed in this small group, violence with intimate partners and child abuse are experiences that are not unknown to physicians. It is interesting to note that no clear difference in the pattern of response was found between abused and nonabused physicians. Further research is necessary to understand how a previous history of abuse influences a physician's ability to diagnose and intervene with domestic violence.

The fear of offending the patient is embedded in the cultural construct of what is private. Not wanting to overstep the bounds of what is private, yet acknowledging that domestic violence has medical consequences, leaves the physician wary of how to approach the issue. It is the same tension that had to be overcome in addressing such issues as cigarette smoking, alcohol and drug use, and sexual preference.

When physicians encounter instances of domestic violence, they may feel ineffective in their ability to intervene. Some physicians felt they had no power because their tools were limited to medications or surgeries, and these were clearly inappropriate approaches to "fixing" of domestic violence. Other physicians felt they did have tools in the form of emotional support and/or appropriate referrals, but were frustrated by their inability to control whether a patient accepted what they offered. This is an area where the deficit in training is most evident. Physicians need to be educated in appropriate intervention strategies and need to become knowledgeable about the expected time course of change so that issues of power and control become less problematic.

The time element was the most pervasive and driving fear. It magnified the other fears mentioned by the physicians. Problems that could be offensive or have no easy answers may not be delved into because of time pressure. Higher priority will likely be given to the organic causes of disease that can be expediently dealt with in the time frame that has emerged for medical practice. Given the number of illnesses that do not fall neatly into 20 minutes, it may be necessary to re-examine the clinical time schedule that has evolved.

The data generated by ethnography provide information on the dilemmas confronting physicians, from within the physicians' frame of reference and in the physicians' language. This type of information is crucial in designing educational programs. It is clear from this study that educating physicians to intervene more effectively in domestic violence is not simply a matter of providing facts. As with all health issues that encompass elements of both medicine and social work, education on domestic violence must include examining and reshaping the internal barriers that may hinder physicians' clinical skills. Describing the actual educational approach to these issues is beyond the scope of this paper but is an area in great need of further research and development.

Several limitations to this study should be cited, since most medical researchers will not be familiar with ethnographic research. First, the nature of qualitative research is to explore what is present, as opposed to counting how often something is present. The percentages given in this study cannot be used to determine the prevalence of a belief, but only to give the frequency of expression of the dominate themes. The statement that 71% of physicians identified time as an issue does not mean that 39% did not think time is an issue but that the comments of 39% did not reveal time to be a dominant theme.

Next, "reliability" and "validity" are not concepts that can be directly taken from quantitative research and applied to qualitative research. These concepts, it has been suggested, are represented in the qualitative research domain by concerns about "trustworthiness."[10] Would another investigator examine our data and discover the same themes? Probably, but not certainly. This issue was dealt with explicitly by peer review, the process by which dominant themes were reviewed and confirmed by physicians not involved in this study. Do the results accurately reflect the beliefs of the physicians studied? We believe they do. The group member review, where the results were reviewed by all the study participants, supports this belief.

Finally, would all physicians produce the same themes if given the opportunity? We do not know. Qualitative research results are not assuredly generalizable. The in-depth nature of the study method does not lend itself to large sample sizes, nor are the participants chosen randomly. The information obtained is true to the locale studied. Further study by survey or widely dispersed focus groups would be needed to produce generalizable information. The subject matter is serious enough to merit such an effort since the course of domestic violence tends to be repetitive and to escalate in severity, making early diagnosis and intervention necessary to prevent severe injury or death. The issues raised in this study need to be addressed for physicians to develop a nonthreatening approach to domestic violence that will no longer raise the specter of Pandora's box.

References

1. Stark E, Flitcraft A, Zuckerman D, Gray A, Robison J, Frazier W. *Wife Abuse in the Medical Setting: An Introduction for Health Care Personnel.* Washington, DC: Office of Domestic Violence; 1981. Monograph 7.
2. Straus M, Gelles R, Steinmetz SK. *Behind Closed Doors: A Survey of Family Violence in America.* New York, NY: Doubleday; 1980.
3. Stark E, Flitcraft A, Frazier W. Medicine and patriarchal violence: the social construct of a 'private' event. *Int J Health Serv.* 1979;9:461-493.
4. Goldberg CA, Tomlanovich MC. Domestic violence victims in the emergency department. *JAMA.* 1984;251:3259-3264.
5. McLeer SV, Anwar R. A study of battered women presenting in an emergency department. *Am J Public Health.* 1989;79:65-66.
6. Randall T. Domestic violence intervention calls for more than treating injuries. *JAMA.* 1990;264:939-944.
7. Kurz D. Emergency department responses to battered women: resistance to medicalization. *Soc Probl.* 1987;34:69-81.
8. Warshaw C. Limitations of the medical model in the care of battered women. *Gender Soc.* 1989;3:506-517.
9. Graves R. *The Greek Myths.* Mt Kisco, NY: Moyer Bell Limited; 1986.
10. Lincoln Y, Guba E. *Naturalistic Inquiry.* Beverly Hills, Calif: Sage Publications; 1985.