

**PANDORA'S MANY
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CULTURE AND
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TO INTIMATE PARTNER
VIOLENCE AGAINST
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CULTURE AND DIFFERENCE IN FAMILY
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Abstract

In a culturally diverse Australia, women abused by their intimate partners often attend their family doctor (GP) and so do their children and partners. However, GPs have not been trained or supported to respond effectively to the multiplicity of women, to their abusive partners or to children. Nor are always they mindful of the subjectivities they themselves bring into the consultation. This paper explores the many consequences for women's safety and quality of care and draws out the implication for GP training.

Introduction and rationale

In the overall community, the Australian Bureau of Statistics found one in four or five Australian women report physical or sexual abuse from a male partner over their lifetime, and three in every hundred women report abuse in the previous twelve months (Australian Bureau of Statistics, 1996). In contrast, in 1998, Hegarty found that just under twenty in a hundred Australian women presenting to GPs reported abuse in the past twelve months. Within this figure, about one in ten experienced multi-dimensional abuse, that is physical, sexual, or emotional abuse and harassment, while five percent experienced physical abuse only and a further five percent only emotional abuse or harassment. She concluded that urban family doctors would be likely to see at least one woman a week experiencing some form of partner abuse

(Hegarty, 1998). Only one small American study has investigated the self-reported levels of physical violence against intimate partners among male GP patients and found that 13.5% of male patients reported using abusive behaviours, while 4.2% reported using severe violence (Oriel et al., 1998). These studies tell us a little more about the complexity of violence against women by their intimate partners, why general practice is an important site for potential beneficial care for women and their children, but not enough about the differences and meanings of the interactions between the diversity of doctors and patients in a multicultural Australia. I will argue in this paper that we need to take more account of the complexities of the interactions of family doctors as diverse in their genders, ethnicity, religious beliefs and professional enculturation as their patients are diverse in their gender, class, ethnicity, religious beliefs and the violence they endure or perpetrate.

I will illustrate how this diversity of factors converges in the lenses through which partner abuse and who are its legitimate victims and perpetrators is constructed. These perceptions then influence GPs' decisions about when and with whom to intervene and how to manage the problem. I will suggest that if we wish to ensure the quality of care provided by GPs to all family members, but first and foremost the safety of women and children, we should be paying attention to the quality and content of medical education at all levels and to any mechanisms informing the wider infrastructures that should support GP management of partner abuse.

The overall design of this study was a comparative case study evaluation of two GP domestic violence Continuing Medical Education (CME) now referred to as Continuing Professional development (CPD) projects, one in a rural, the other in an inner city and culturally diverse area (Taft, 2000). The largely ethnographic methods were appropriate for the developmental nature of the projects and the largely narrative practice of medical consultations, particularly with psycho-social issues. The major data consisted of 130 interviews. Within the projects, I interviewed 28 (15 urban and 12 rural) GPs before and after their training. The majority – 15, were female. Seven of these doctors (four women and three men) then described their work with partner abuse patients in depth every eight weeks on average from four to seven times. From the consecutive interviews, I extracted and constructed over fifty doctor/patient case narratives. Other interviews were conducted with project staff, policy-makers, specialist workers and educators. I observed 13 training

sessions and conducted four focus groups, two with bilingual workers and two around men who abuse. Last I designed, analysed and reported pre and post-training surveys. The study uses a feminist framework, but the analysis also drew on Bourdieu's theory of 'habitus', which I discuss later (Bourdieu, 1990).

Medical anthropologist Byron Good wrote that: 'The person is a cultural construct. A complex and culturally shaped way of experiencing self and other... which combines culture and ideology, interpersonal relationships and development. Cultural 'work' is required to reconstitute the person who is the object of medical attention' (Good, 1994). This concept is a critical one in understanding how GPs make sense of their patients' life worlds. GP consultations rely on dialogue in which the doctor's communication skills elicit the patients' narratives in which they, in turn, construct culturally bound stories of their illness and its context. The doctor interprets what s/he hears through the filters of a professional lens sufficient to make a diagnosis and decide on a course of management. There are 20,000 GPs in Australia and the great majority have very little or no professional education or expertise in partner abuse management. Without a specific professional lens available, doctors may draw on other aspects of their selves.

Perception and diagnosis

Without such expertise, I found a great diversity in how the doctors perceived partner abuse itself, their victimised female patients, patients who presented in couples and male patients who spoke about their own abuse of women. The GP narratives of patient abuse described a continuum of perceptions from brutal oppression of women and children to couples throwing things at each other. Unsurprisingly, doctors diverged in their knowledge and understanding of what partner abuse consists. The problems here lie in the paradox that if they considered abuse could only be physical and looked only for bruises, then they don't see much of it and consequently may not seek more expertise in it. This Indian doctor with a very diverse patient population describes the number of victims he perceives:

In a year, [I see] about three or four... There might be a lot more, but it was difficult, at least with the Sri Lankans and South Americans and the Vietnamese people, you can see their body, but with the Turkish and Arabic people you can't see their body.

This concerned Muslim doctor, as others did, perceived that culture prevented him asking about private issues, much as the police did before acquiring more professional training and expertise. The education the projects provided persuaded most GPs that it was their professional responsibility to inquire directly and overcome cultural barriers, but the time available for CPD is really inadequate to effectively upskill GPs to manage disclosures, as this educator perceptively outlines:

With one of those groups we had an Indian male doctor. We had three very powerful potential cultures sitting in the room, and we don't even know exactly which culture of Indian-ness, which culture of maleness, which culture of doctor-ness until we begin to unpack it a bit... The problem is that it's a very short time frame to skill somebody up. That's a fact of life. I've trained people in two days extensive training where by the end of that they've really got it, but, two hours, you know, whatever it is, it is a big ask.

Constructing 'victims' and 'perpetrators'

I'd like to turn to the problems occurring when GPs attempt to distinguish victims and perpetrators among their patient populations. McWhinney discussed the communicative distance, which can exist between cultures, but that gender, class and medicine are also cultures, which can distance and therefore require communicative sensitivity (McWhinney, 1989). This problem can emerge particularly when GPs work with couples.

Dr Threadgold, a male, middle-aged, Anglo-Australian and stated pro-feminist GP, works in a private group practice in a disadvantaged working class area. He describes the problems managing couples:

The difficulties of managing both husband and wife, I think it does present a real dilemma for people. Because I find myself often siding on one side, and tending to therefore counsel from one person's perspective over the other. And I frequently as you probably gathered, take the woman's side.

He could not achieve his desired change with a working class couple, in which the wife had spoken about the beatings she experienced. Andrea

stayed at home, while Jack, ' a frightening bloke' drove trucks when he had work. Here, he describes them... Andrea was:

Not terribly insightful...got a motor mouth, which was thrown into gear before you open the mouth... she just reacts... When Jack was not on drugs or booze he's a very clever man to talk to and ...has a bit more insight into things when he's got time to relax and think about it.

Dr Threadgold described Jack's violence as losing his temper, but he said he was not sure who was more responsible as:

Once it turns violent, they're both into it...She's physically violent to him because he hasn't done a great deal...she's admitted it, she's said, yeah, sometimes I'm a real bitch...and I've actually said, I don't think that's really fair because he's got a few problems to put up with.

Dr Threadgold was frustrated with his inability to persuade Andrea (rather than Jack) to change. He alternately blamed her for coming at the 'wrong' times, manipulating the clinic by seeing different doctors and fighting back. Andrea's anger needed medication. Dr Threadgold maintained her for a long time on tranquillisers. He observed: *I think the quieter Andrea gets, the better the system runs. When she's under control, everything else seems to fit in and go under control.* Thus Andrea's anger was the focus for 'control'.

He was frustrated by his lack of success in persuading them to attend marriage counselling. He said in frustration:

I've often thought there's a group who do not understand intellectually these problems, and they can't do that sort of process. I've often thought that's why they're blue-collar workers, that they're not thinkers they're doers, they just use their hands.

In spite of his gendered self-perception, in this couple, rather than support the victim, he had blamed her, medicated her and colluded with Jack, attributing the lack of progress to their class. In this further example, an ethnic minority male GP again implicitly colludes with the male partner from his own community, and is frustrated with his female patient who is afraid to leave, as he has suggested and is regularly physically and sexually abused by her unrepentant male partner. He says, empathising with the husband:

I wouldn't like to live with her, as she is provocative...and then when she is hit, she starts stammering and crying. I'm not saying that she

deserves to be hit, what I'm saying is that there is some provocation, and some people can't take that.

Male patients could either be empathised with or were experienced as 'other' because they could be alternately thought to be genetically predisposed to violence, were culturally constructed through their class or ethnicity to be violent or were quite frightening, they were, as another male GP said – '*all bastards and on a dark night I'd run over them*'. Otherwise as a female doctor commented, they had difficulty reframing their charming patient as an abuser.

I think it's hard to think of some of the men as perpetrators if you've been caring for them in other ways and really had no suspicion. I also think there's a tendency to minimise the violence and reassure yourself and the woman that, oh you know, it's just bad temper or something like that.

Implications of diversity for patient management

Partner abuse is a gendered issue. Doctors in this study believed that gender played a role in their practice with partner abuse patients, although they varied in their views and consciousness of ways in which it did so. Some male doctors expressed the view that men would be more likely to disclose to them and women less likely, because they were male. Others differed and believed that smaller numbers of women and men would disclose to them, as both sexes would prefer to discuss emotional problems with female doctors, which is consistent with GP data (Britt et al., 1996). The doctors in this study were conscious of patients' possible gender preferences, with more male than female doctors saying that their sex/gender prevented their asking women about their private lives, particularly those culturally distant from their own. Some ethnic minority male doctors felt a stronger sanction against asking women about intimate matters. Most doctors who sought training were empathic, but the female doctors identified with victims and even without training, were less inclined than the male doctors to blame women for provoking the violence. They were more likely than the male to express tolerant attitudes to women who did not leave abusive men. More male GPs than female expressed understanding of why men might abuse, sought family reconciliation or cohesion and came close to colluding with men, through

medicating the women or expressing patriarchal attitudes about difficult partners. This is a tentative observation, as it is a very small sample. While GP gender is important, it is insufficient to explain what informs family doctors' practice. Davis (1988), another feminist researcher, concluded that gender alone could not account for the power asymmetries in medical encounters being produced, reproduced and occasionally undermined by patients (Davis, 1988). Neither could merely professional medical structures of domination account for them either. She argued that gender and power were conflated at both the macro-level of the medical structures of domination and at the micro male doctor/female patient level, still the most prevalent form of patient/doctor encounter (Davis, 1988). Similar to the compassionate professionals Davis studied, the GPs in this study were also concerned, committed and caring professionals. However, the attitudes of some doctors to some patients suggested multiple cultural factors impacting on their relationships with patients and their discourse about them. I turned to Bourdieu's concept of 'habitus', a roughly equivalent but more explanatory term than subjectivity. By 'habitus', Bourdieu refers to our disposition to act implicitly in ways acquired from the cumulative effects of our interactions with significant people, cultures and institutions in our particular historical environment (Bourdieu, 1990). In Bourdieu's account, 'structures do not exist separately from the knowledge we create of them and that knowledge is fluid, shifting, manipulable' (Pringle, 1998). I want to share a few examples, which illustrate how GP 'habitus' may further affect management decisions.

Dr Peter Greenaway is a rural Anglo-Australian, Christian middle-aged GP, committed, compassionate and with a high index of suspicion about violence against women, which he teaches to GP students who train at his practice. As a result of this raised index, he asked an alcoholic female patient, a 'perpetrator' of partner abuse when she was drunk, about her childhood. She recounted a childhood of chronic rape, both anal and vaginal by her father. After several counselling sessions – Dr Greenaway, who was self-taught in rational emotive therapy – reported that she was 'cured'.

'I taught her just to face the gargoyle, just to face what had happened in her life, and just to come to peace with that however much she ran away, this memory was in her head, she just had to, you know, she either ran away from it or came to peace with it.'

Q: Was that your prime goal? You said you had negotiated goals with her...

My prime goal with her was that she forgave her father. And that was a very, very confrontational goal for her.'

Family reconciliation informed several male GP management decisions in this study. In this case, the empathic doctor may recognise his patient's victimhood and see beyond her medical symptoms to inquire about childhood abuse, but if his habitus synthesises masculine, middle-class, rural Christian Anglo-Celtic family values, as Dr Peter Greenway's does, he chooses several times a messianic path to forgiveness and family reconciliation over other courses of action. In other cases with couples, GPs would encourage women to remain in the 'carer' role for her abusive partner, not see the violence until it was lethal when a close 'doctor/couple relationship' had developed or to break confidentiality by attempting to speak with the male partner without her permission. A Canadian research team also found in a nationwide family doctor survey, that the 'dual relationship' with the couple could affect the doctors' management irrespective of the level of violence the woman was enduring (Ferris et al., 1997; Ferris et al., 1999). Perceptions of family/couple stability and the privileging of the professional relationship may endanger the woman, if reinforced by gender, ethnic and religious values in the doctor's habitus.

In this study a GP's habitus may not necessarily be consistent. Dr Jill McPherson, a young Anglo-Celtic GP, married to a Greek husband, and working in a Community Health Centre outpost in a very disadvantaged area, saw many ethnic minority women and couples. She was principled and enlightened in her work with migrant and refugee communities. She understood systemic contexts and used holistic management with all patients, including those with partner abuse issues, inquiring about their presenting problems and also their wider employment, migration, financial and housing issues. In contrast, despite her professional awareness of diverse systemic issues impacting on illness, it was not consistently applied, as in the case of this older female Koori (which means Southern Australian Aboriginal) patient:

They're actually part Koori...we got her to go back to TAFE, and she did some Aboriginal studies, and she decided then and there that she must be part Koori because she had been one of these, supposedly

adopted children, she went back through it and sure enough, she was a stolen child kind of thing, and she's in fact only one ... she's one eighth Koori, but she has now redefined her whole identity, and the whole family's identity. It's very financially lucrative too. Which she's aware of every financial perk in the system. So everything has been re-identified in terms of them being Koori.

There was other evidence in these examples, of the fluidity and inconsistency of professional and cultural influences impacting on GP perceptions and practice.

In addition, a professional emphasis in family medicine on the patient/doctor relationship can interfere with GPs' ability to see the impact on children. Privileging the relationship with the adult patient and not wanting to threaten it, being unaware of the close links between partner and child abuse and of its symptoms and damage, being sceptical of the effectiveness of child protection services intervention, GPs in this study almost never asked about the impact on children.

It seemed therefore, that while gender and power in the doctor/patient relationship play an important part, far more complex dynamics are interwoven in the ways in which patients in these GP narratives were constructed and consequently in the ways their doctors chose to manage them. What then are the implications of this diversity for those who wish to enhance the quality of care GPs can provide to their patients.

Implications of diversity and habitus for enhancing GP quality of care

First and foremost, although my study is not generalisable as the sample is small and self-selected, these data are from those doctors who were sufficiently motivated to seek training. I believe that many GPs are likely to have potentially similar practices, but it is unsafe to assume that after short CPD, practising GPs are prepared and ready to offer quality care to women, when and if women, or men, disclose. My evaluation found that while the GP participants gained confidence and knowledge during the projects, very little behaviour changed. This is also consistent with other evaluation studies (Women and Violence Project RACGP 1996; Davis et al 1999). The rates of

reported disclosure and referrals rose only slightly. Ironically, attitudes and beliefs about male patients who abused were those most effectively challenged through the skills of the educators. This is the result of their commitment to confront the GPs with their own attitudes to men who abuse and enhance their understanding of which perceptions they bring into the consultation. Without time to rehearse skills, this training was in danger of encouraging empathy with the male patient without enhancing the doctors' skills. A further conclusion is that it is unwise to seek to require GPs to screen all women.

Diversity is not however, the central issue in quality of care. My previous and this current study found that despite patient diversity, the experience of enduring abuse results in the same patterns of suffering and damage in women and behaviours among the men who abuse (Head et al 1995). These patterns are global (Heise et al., 1999). Similarly what women wanted from their GPs was also remarkably simple and consistent. It is found in other studies of cultural and linguistically diverse patients – i.e. supportive, non-judgmental and informed care and expertise (Small et al., 1999).

Most importantly, the doctors in this study did not indicate awareness of the impact of their own attitudes and values on the patient and the outcome of the consultation. Epstein proposes a strategy for critically self-aware medical good practice he calls mindfulness:

Exemplary physicians seem to have a capacity for critical self-reflection that pervades all aspects of practice, including being present with the patient...and defining their own values. This process of critical self-reflection depends on the presence of mindfulness. A mindful practitioner attends in a non-judgmental way, to his or her own physical or mental processes during ordinary everyday tasks to act with clarity and insight (Epstein, 1999).

If doctors were trained to cultivate the critical self-reflection Epstein recommends, they would be insightful about the potential impact their individuality could have on their domestic violence practice. Mindfulness is a critical addition to the repertoire of skills a doctor requires to work effectively with intimate partner abuse and the many other sensitive psychosocial aspects of medical practice. It needs to be taught at undergraduate level, and be focussed on particularly when GPs are being accredited, so that when

doctors are practising, continuing professional development merely refreshes the skills and upgrades knowledge already present. Ethical and practice guidelines and standards around working with partner and other forms of abuse in families should encourage and support recognition of the importance of safety, confidentiality and reflexivity in practice.

Conclusion

In this paper, I have attempted to illustrate the diversity of the forms of violence both presenting and what is perceived in general practice and how GPs subjectivities or habitus affects what they look for, inquire about and diagnose, how they understand the scale and prevalence of the problem in general practice and therefore what further need for expertise they should seek. In addition, diversity in habitus affects how they construct who is a deserving or undeserving victim, who may be a perpetrator or what is happening within the couple. Finally, while children are virtually invisible due to the privileging of the adult doctor/patient relationship, habitus or the diversity in subjectivities may also profoundly shape the GPs' management decisions. There are however, patterns of experience, which their diverse patients present to them and GPs need a heightened awareness of the unique self who is present in their consultation with patients. I propose that an emphasis in medical education around psychosocial issues, including partner abuse, should be to teach mindful practice – alerting GPs to the impact their gender, class, ethnicity and religious beliefs may have on their practice. In addition, standards, guidelines and greater inter-sectoral collaboration may bring GPs into closer contact with greater multi-disciplinarity, attitudes and beliefs different to their own about the nature of intimate partner abuse, its victims and its solutions.

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