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Knowledge and attitudes of primary care physicians regarding battered women. Comparison between specialists in family medicine and GPs

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Background. Domestic violence is a widespread public health problem and an important part of primary care practice.

Objective. To evaluate the approach of primary care physicians (family physicians and GPs) to the care of battered women.

Methods. A self-report questionnaire containing items about experience, knowledge and attitudes regarding the care of battered women was mailed to a random sample of 300 primary care physicians employed by the two major health management organizations in Israel. The population included family physicians, who have 4 years of residency training in primary care, and GPs, who do not undergo specialization after completing their medical studies.

Results. A total of 236 physicians (130 family physicians and 106 GPs) responded. In general, the physicians had had very little exposure to the problem and estimated its prevalence in the community as less than half that indicated in the medical literature. Compared with the GPs, however, the family physicians reported more exposure to the subject ($P < 0.001$) and had better knowledge of its prevalence and risk factors ($P < 0.001$). They also showed a greater tendency to view the problem as universal ($P < 0.05$) and as part of their professional responsibilities. However, both groups tended not to include the care of battered women with no physical injury within their professional duties.

Conclusions. Physicians should be made more aware of the problem of battered women within the context of their routine professional practice and of the importance of keeping abreast of the subject. Educators should place more emphasis on imparting knowledge and skills in the management of battered women, especially for GPs.

Keywords. Battered women, domestic violence, ethics, family physicians, feelings.

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Introduction

The prevalence of domestic violence is extremely high. In a nationwide survey of 8000 American couples, Strauss *et al.*[1] found that 28% had experienced some act of violence in their life together. In Israel, which has a population of six million, there are an estimated 35 000–120 000[2,3] battered women.

Battered women are extensive consumers of medical services. They present at emergency departments three times more often than women of equal age and socioeconomic status who are not victims of domestic violence.[4] Since primary care physicians frequently are the first in the community to encounter the battered woman,[5] they must be equipped with the necessary knowledge, training and experience to identify the problem and refer the patient to the appropriate support facilities.[6–8] In Israel, primary care is provided by family physicians (FPs) or GPs. FPs undergo 4 years of specialization during which they receive training in the management of

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a wide range of acute and chronic physical and psychosocial conditions and illnesses that are prevalent in family practice, including domestic violence. They attend lectures on the subject, read the appropriate literature and discuss cases of domestic violence with their tutor. GPs do not undergo any specialization training after completing medical studies.

The aim of the present study was to examine the level of exposure of FPs and GPs in Israel to the issue of battered women and their knowledge and attitudes regarding their care.

Methods

Participants

For the purposes of the study, 300 primary care physicians (140 GPs and 160 FPs) employed by the two major health management organizations (HMOs) in Israel, which treat ~90% of the population, were selected at random from the HMO directories. Each was sent a structured, self-report questionnaire and requested to return it by mail within 2 months. Non-responders were reminded by telephone.

Questionnaire

The questionnaire was formulated on the basis of a published questionnaire concerning primary care physician response to domestic violence.[9,10] Items covered the following categories.

(i) *Demographics:* age, sex, marital status, religion, degree of religious observance, place of medical training (Israel or abroad), speciality (FP or GP) and HMO.
(ii) *Degree of exposure to issue:* at medical school, at work, outside work, in the medical literature, during contact with community services and in the media.
(iii) *Attitudes to the care of battered women:* 10 questions on the doctor's attitudes to battered women in general and in relation to his/her professional duties; items were rated on a scale of 1 (absolutely disagree) to 7 (absolutely agree).
(iv) *Questions on knowledge about the prevalence of the problem and risk factors:* two multiple choice questions about the prevalence of battered wives in general in Israel and the prevalence rate of battered wives among pregnant women worldwide, and four questions on risk factors; the attitude and knowledge sections were based on the medical literature.[9,10]

The original questionnaire was assessed for content validity, and all answers were tested on a 5-point scale.[10] The final Hebrew version was tested in a pilot study on 10 GPs and 10 FPs; these physicians were then excluded from the main study.

Statistical analysis

All data were analysed with the BMDP Statistical Software.[11] Data for each section were compared between the groups (GPs and FPs). The Kruskal–Wallis test was used for category variables (up to five values) and analysis of variance (ANOVA) for continuous variables or variables with at least seven values. Results were considered significant when P was <0.05.

Results

Of the 300 questionnaires sent, 236 (79%) were returned, 130 (81%) by FPs and 106 (76%) by GPs.

Demographics

No significant differences were found between the groups (GPs and FPs) for age and sex distribution, marital status, religion, religious observance or HMO.

Exposure

The sources of exposure to the issue of battered women that were analysed by the questionnaire are shown in Table 1. As a whole, the physicians had had little or no exposure to battered women in the course of their medical education or career. Nevertheless, when analysed by group, significant differences were found for each of the items as well as for the total exposure score ($P < 0.0001$) (FPs higher for all).

Attitude

Analysis of the whole cohort showed that most of the responders considered the problem of battered wives a universal one, unrelated to the presence of psychopathology (mental instability or loss of self-control) in the woman but closely related to its presence in the man (Table 2). Both groups believed that wife battering was preventable. They did not consider the problem to be the couple's private concern, though this belief was stronger for FPs than for GPs ($P < 0.04$). Both groups had moderate scores (average of ~4 on a scale of 0–7) for the item on inclusion of the care of battered wives with no physical injury within the duties of medical doctors. However, FPs showed a greater tendency to support this policy than GPs ($P < 0.04$).

Knowledge

Table 3 compares the groups' knowledge about the prevalence of wife battering. FPs were better informed than GPs, giving higher estimates of the rate of spouse assault and among pregnant women ($P < 0.05$ and <0.01, respectively), which were closer to the figures in the literature. Most of the responders in both groups correctly identified the risk factors of wife battering reported in the literature, except for exposure to sexual abuse in childhood (only 54% correct).

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TABLE 1 *Sources of exposure of physicians to battered women [n (%)]*

Source	GPs (n = 106)			FPs (n = 130)			
	None (0)	Little (1)	Much (2)	None (0)	Little (1)	Much (2)	P
Practice[a]	32 (30.5%)	67 (63.8%)	5 (4.8%)	18 (13.8%)	77 (59.2%)	35 (26.9%)	<0.0001
Medical school or residency	87 (82.9%)	15 (14.3%)	3 (2.9%)	81 (62.3%)	44 (33.8%)	5 (3.8%)	0.006
Outside work[b]	59 (56.2)	42 (40%)	4 (52.3%)	54 (41.5%)	68 (52.3%)	8 (6.2%)	0.02
Literature[a]	62 (59.6%)	42 (40.4%)	0	60 (46.2%)	70 (53.8%)	0	0.04
Contact with community services[a]	62 (59%)	35 (33.3%)	7 (6.7%)	50 (38.5%)	61 (46.9%)	19 (14.6%)	0.000
Media[b]	4 (38%)	32 (30.5%)	69 (65.7%)	0	28 (21.5%)	102 (78.5%)	0.01
Mean exposure—total score		4.07			5.28		<0.0001

[a] Two cases missing; [b] one case missing.
Note: statistics by Kruskal–Wallis test.

TABLE 2 *Physicians' attitudes to wife battering (scores)*[a]

Statement	GPs	FPs	P
1. Battered wives are emotionally unstable.	2.71	2.04	0.009
2. A man's tendency to become a wife beater is related to his socioeconomic status.	2.82	2.48	NS
3. Wife beaters tend to lose control over themselves.	5.15	4.76	NS
4. Battered wives are usually intelligent.	1.72	1.72	NS
5. The problem of battered wives with no physical injuries should be a responsibility of medical doctors.	3.45	4.44	0.04
6. No family is invulnerable to violence against women.	4.36	4.88	NS
7. Wife assault is rare among religious families.	3.00	2.43	NS
8. A woman's chances of becoming a battered wife is related to her socioeconomic status.	2.84	2.42	0.009
9. Wife beaters are emotionally unstable.	4.91	4.60	NS
10. Wife beating is the couple's private concern.	1.87	1.32	0.04
Domain: universality (sum score of statements 2, 4, 6, 7 and 8)	26.04	27.82	0.02
Domain: partners' mental stability (sum score of statements 1, 3 and 9)	12.81	11.39	0.01

[a] Items rated on scale of 1 (absolutely disagree) to 7 (absolutely agree).
Note: statistics by ANOVA.

Discussion

The findings of the present study show that the awareness of the prevalence of battered women among Israeli primary physicians is poor, in agreement with other studies in different countries.[10,12–14] The lack of awareness of the prevalence of wife abuse and domestic violence is part of the complex of physician barriers identified by the American Medical Association which derives from a lack of a means of identification and a lack of knowledge about the social and psychological aspects of medical health care.[15,16]

The physicians who specialized in family medicine also reported more exposure to the subject of battered women and were better informed about its prevalence than the GPs. This supports the study of Tudiver and Permaul-Woods[17] showing that certified primary physicians are more aware of the problem, and of Easteal and Easteal[8] and of Kurz,[18] showing that even minimal training in the subject improves physician performance.

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TABLE 3 *Physicians' knowledge of prevalence of wife assault [n(%)]*

Item	GPs	FPs	*P*
What is the prevalence of domestic violence (particularly wife battering) for Israeli couples during their life together[a]			
About			
<1%	4 (3.9%)	0 (–)	
1–5%	28 (27.2%)	19 (14.7%)	
6–10%	27 (26.2%)	40 (31.0%)	0.04
11–20%	28 (27.2%)	43 (33.3%)	
21–30%	12 (11.7%)	21 (16.3%)	
>30%	4 (4.7%)	6 (4.7%)	
What is the prevalence of battered women among pregnant women seeking medical care? (USA)[b]			
About			
<1%	16 (15.5%)	4 (3.1%)	
1–5%	41 (39.8%)	34 (26.6%)	
6–10%	26 (25.2%)	44 (34.4%)	0.08
11–20%	12 (11.7%)	35 (27.3%)	
21–30%	4 (3.9%)	9 (7.0%)	
>30%	4 (3.9%)	2 (1.6%)	

[a] Prevalence in the literature is 21–30% (refs 1–3,12); [b] prevalence in the literature is ~23% (ref. 16).
Note: statistics by Kruskal–Wallis test.

Trute *et al.*[7] noted that nearly all primary care physicians believed it was their responsibility to treat battered women and prevent further abuse; however, in practice, most failed to do so. Nevertheless, the minority that had received special training in the area reported finding it very helpful.

We believe the issue of battered women needs special attention. In its *Year 2000 Health Objectives of the Nation*,[19] the US Department of Health and Human Services (DHHS) made violent and abusive behaviour one of its top priorities. To fulfil its objectives, the DHSS plans to "increase to at least 75% the proportion of physicians, nurses, social workers, teachers and criminal justice professionals who have received training in the identification and referral of people who attempt suicide and people who are victims of sexual assault and spouse, elder and child abuse." Likewise, the regional European *Targets for Health for All*[20] has outlined a series of steps to promote health, which include routine identification, treatment and referral of victims of sexual assault and spousal violence. The use of specific protocols (such as the recently published "Short Domestic Violence Screening Tool"[21]) will contribute towards the fulfilment of such objectives.

In conclusion, though FPs have somewhat more experience and knowledge in the care of battered wives than other primary care physicians, many more educational activities are needed.[22]

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