

Response of Sudanese doctors to domestic violence

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ABSTRACT

Objective: The aim of this study was to assess the awareness, and response of the Sudanese doctors to domestic violence.

Methods: The study was carried out among the doctors of the Police University Hospital, Khartoum, Sudan. Self-administered questionnaires were distributed to all doctors who were attendants at the hospital, one morning in July 2002. The information required from the surveyed doctors included their familiarity, and views on domestic violence as a health problem, number of cases of abuse encountered, barriers to diagnose or screen cases, their views on intervention beyond physical treatment and if they had been taught or trained in domestic violence.

Results: Out of 142 doctors who received the questionnaires, 102 returned it giving a response rate of 71.8%. The respondent's ages ranged from 25-54 years; 53

were female (51.9%); and 32 (31.3%) had experience of more than 10 years. Forty-three doctors (42.1%) had a fair knowledge of the concept of domestic violence, 28 (27.4%) viewed it as a worthwhile health problem and 21 (20.5%) reported encountering 1-2 cases in the last year. Barriers to screen cases included a lack of knowledge and training, insufficient time at clinics and fear of problems with perpetrators. The female gender and long professional experience had positive correlations with a better knowledge regarding violence and the desire to intervene beyond physical treatment ($P < 0.005$).

Conclusion: Our study indicated clearly the missing role of the medical profession in recognition and helping the victims of domestic violence. The authors discussed several suggestions to promote the role of doctors in addressing this problem.

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Violence, in a simple definition, is to exert force so as to injure or abuse. The term "domestic violence" implies the physical or verbal assault exerted by a family member (often the husband) to a woman. The subordinate status of women, worldwide, resulting from long-acting cultural and socioeconomic factors renders them easy victims for violence. The rate of domestic violence is high even in the developed countries where the feminist and other women supportive movements attain the maximum of rights, and equity with males. The situation in the under-developed world is expected to be worse.¹ Why domestic violence is relevant to the medical profession? Violence against women in addition to eroding their self esteem compromises their physical and mental health.² Injuries such as cuts, concussed and

fractures may occur. At least one in five women in the emergency departments have symptoms related to violence.³ Violence can result in depression, anxiety and even suicide.² Some unexplained medical complaints such as chronic headache; fatigue and abdominal pain may be linked to domestic violence.⁴ Pregnancy is reported to increase the risk and pattern of assault to women.⁵ In the dental practice injuries to teeth, jaw and oral soft tissues are common indicators of abuse.¹ By now, it is clear that the relevance of violence to the patients health problems can be similar to the relation between, for example, smoking and ischemic heart disease.

Although the health workers are, theoretically, well situated to intervene in helping victims and prevention

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of domestic violence, up to the present time they are unaware of this role.¹ Many doctors think that their role is limited to the treatment of the bodily manifestations.⁶ In one study, their doctors had asked only 4% of abused women regarding the possibility of domestic violence even in presence of severe injury.⁵ The ill-prepared or uninterested doctor may be harmful by minimizing the abuse and then increases the victims, sensation of entrapment and helplessness.³ Basically, there is a lack of knowledge and training, in managing violence victims.⁷ The doctors may misjudge the victims to be 'hysterical' or 'hypochondriacs'. There is reluctance in asking, in depth, questions regarding injuries (especially inquiry of how and who had caused the injury).⁵ Domestic violence is not considered in the differential diagnosis of injuries due to the abusive partners appear concerned and attentive when accompanying their victims to the medical care.⁵ Even if doctors realized the occurrence of abuse, they fail to go further as of fear of involvement in prolonged court proceedings.³ Unfortunately, some doctors may shake the societal misconception that domestic violence is rare, occurring only in deviant relations (not that appearing normal), or that it is a private matter (and then to be resolved without outside intervention). In fact, the doctor's ignorance of social and psychological dimensions of violence leads to its escalation.³ Recently, there is no under or postgraduate teaching or training in domestic violence in Sudan. Nothing is known with regards to the attitudes of doctors toward this serious problem. Our study is aimed at assessing the awareness and response of Sudanese doctors, to domestic violence, and then to suggest the actions that the medical profession is expected to take to identify the victims, and address their needs for physical treatment, legal assistance and social support.

Methods. This study was carried out among the doctors of the Police University Hospital (PUH), Khartoum, Sudan. The PUH which is the training centre for the medical students of Elribat University comprises of 200 beds and the entire major and most of the minor specialties. It runs both inpatient and 24-hour emergency. At the time of the study there were 212 doctors (consultants, registrars and house officers) working in PUH. We designed a self-administered questionnaire to serve the aims of the study to be distributed to all doctors who were present one morning during July 2002. We appended to the questionnaire a brief description of the study and its aims. For the purpose of the study we elected to focus on one aspect of domestic violence which is the violence of the husband imparted on wife. In the study area, the social norms and the Sudan panel code prohibits any close male-female partnership except by formal or religious marriage. The information required from the surveyed doctors included: 1. General characteristic: age, sex, and experience period. 2. Familiarity with the concept of domestic violence. 3. Is domestic violence considered as

a worthwhile health problem. 4. If they encountered cases of domestic violence during practice. 5. If they tended to screen suspicious cases for violence. 6. Barriers to diagnose or screen cases of violence. 7. If they would like to interfere in helping victims beyond physical treatment. 8. If domestic violence had been taught in medical school or if they received any postgraduate training.

The analysis of the variables in our study was carried out using the student's t-test. The significant level was determined at $P < 0.005$.

Results. The questionnaire was delivered to 142 doctors, 102 of whom returned it giving a response rate of 71.8%. The respondents, ages ranged from 25-54 years. Fifty-three of the respondents were female (51.9%). On the basis of professional experience, 32 of the respondents (31.3%) spent more than 10 years in clinical practice. We found that 43 doctors (42.1%) had fair knowledge of the concept or definition of domestic violence. Only 28 doctors (27.4%) viewed domestic violence as a worthwhile medical problem. Twenty-one doctors (20.5%) reported that they had encountered 1-2 cases of domestic violence in the last year. They also said that since then, they had tended to screen some of their patients for violence. Barriers to screen or diagnose suspicious cases stated by doctors included lack of necessary knowledge and training, insufficient time and fear of problems with perpetrators. Of the 43 doctors with fair knowledge regarding violence, 30 (69.8%) declared that they would not like to interfere to help the victims beyond the physical treatment. They stated reasons such as fear of step out of medical care, consideration of violence as private matter, fear of offending perpetrators and fear of involvement in endless legal procedures. Of the 13 doctors who would like to interfere, 9 were females. The doctors stated that they did not receive undergraduate teaching or professional training in domestic violence. Few doctors stated that they read it in a medical journal or were told details by a senior colleague.

Table 1 shows the relation between sex and experience of the surveyed doctors and their responses to some of the questionnaire questions. Also, the table statistically correlates the sex and experience duration of the doctors who had a fair knowledge of violence and those who viewed violence genuine health problem and those who accepted to interfere beyond physical treatment. Female doctors tended to have a better knowledge with regards to domestic violence than males, with a statistically significant difference ($p < 0.005$). The females also viewed violence as a genuine health problem and were more ready to interfere beyond physical treatment ($p < 0.005$). The more experienced doctors had better knowledge ($p < 0.005$) but had the same idea like the less experienced in regard to viewing domestic violence as a genuine health problem and in acceptance to interfere beyond physical treatment.

Table 1 - Correlation of sex respondents to their knowledge and attitude towards domestic violence.

Questions (Sex)	Gender			Professional experience		
	Females N=53	Males N=47	p-value	Females N=53	Males N=47	p-value
Having a fair knowledge regarding domestic violence	27 (50.9)	16 (34)	p<0.005	15 (59.3)	25 (34.3)	p<0.005
Viewing that domestic violence is a genuine problem	18 (33.9)	10 (21.3)	p<0.005	8 (25)	20 (28.6)	NS*
Acceptance to interfere beyond physical treatment	9 (16.9)	4 (8.5)	p<0.005	3 (9.3)	10 (14.3)	NS*
NS* - non significant						

Discussion. Doctors response to violence. Our study clearly indicated the missing role of the medical profession in responding to the problem of domestic violence in our country. The poor knowledge and negative attitudes of the Sudanese doctors towards domestic violence is similar even to the well-developed world.³ The grievances of the situation arose from that the doctors are often the first, and only individuals to whom a victim may present.⁸ Our doctors like their peers worldwide lack the necessary knowledge and tools to help the abused patients, and even more, may lack the concept that domestic violence is a public health problem (viewing it as a social or legal issue). Fortunately, the high response rate of participation in our study indicates the desire of the medical community to have a positive role in addressing the problem. One of the aims of our study was to identify the factors that relate to the doctors response to violence. According to our study, there is a gender difference in knowledge and response to violence. The female doctors had better knowledge and were more ready to interfere to help the victims, than their male compartments. The sensitivity of the issue to females makes them more ready to sense the abuse and to interfere to help. In accordance with our findings, a previous study recorded that a high screening rate of domestic violence was associated with the female gender.⁹ Another factor to affect the doctors response to violence was the duration of professional experience. As there is no formal teaching or training in violence, the self-acquired experience (gained in years) is the only way to help the victims. Older doctors may be more aware of the social and legal organizations that can help victims. The type of clinical practice of doctors may affect their sensitivity to recognize and respond to violence. Rounsaville and Weissman¹⁰ stated that doctors working in emergency departments are the most likely to have access to violence victims. Other studies suggested that doctors working in the obstetrical and psychiatric departments are more sensitive to detect violence.^{9,11}

Barrier to screen violence. A crucial question to be answered is that why doctors in the majority of cases fail

to recognize or help the recognized cases beyond the physical treatment. The doctor usually complains of a lack of knowledge and training for diagnosing and care of victims.¹² There are no clinical guidelines to clear the ambiguities of the symptoms and signs of abuse. The patients themselves are reluctant to disclose abuse out of feelings of shame, or fear further abuse, or thinking that the medical system is not beneficial. The pressure of time in our busy clinics precludes discussion of abuse (even when doctors are aware of it). Not only the clinics are congested with patients, but the woman is usually accompanied by her relatives (including the perpetrator). Our country lacks the societies or organizations to offer social or legal help for victims. Therefore, some doctors recommend discussing the domestic violence to open Pandora's box.¹³ Furthermore, there is no defined role for doctors to intervene. They feel discomfort with the topic fearing of threatening their role as competent professionals, or even defining violence as private area (not to be discussed with the patients).^{14,15}

What is expected of doctors. Ideally the doctors are expected to screen for expected cases, validate that butting is wrong, documenting symptoms and signs and referring the victims to the concerned authorities that can help them (the assess, validate, document and refer approach).⁸ This approach is timesaving and should be integrated into the care delivery systems.⁸ The doctors are expected to have a high index of suspicion of violence and the clues to its presence. The abusers usually show dominating behavior during the visits. They do not only prevent their wives from speaking to any are alone, but they tend to answer addressed to her.⁴ They tend to control victim, by facial expressions or direct criticism.⁴ Clinically, there are no stereotyped features for the abuser, most are normal mentally, physically and socially. Some victims tend to offer frequent visits to the clinic with different, unexplained sets of, mainly, functional and psychosomatic complaints. The minimum that is expected of doctors is a careful history and examination for the suspected

cases. Such cases should be interviewed in private and confidential settings, with a supportive fashion and non-disjudgmental language.¹⁶ Otherwise, they will remain silent and then the abuse escalates. Although the doctors alone cannot change the cultural and social customs that may give rise to violence but can have much to offer beyond the physical treatment of injuries. They must be aware of the societal (and professional) misconceptions that lead to, or aggravate violence and to correct them. Doctors should acknowledge the injustice of violence and give a clear message to the abusers, victims and community that battering is a public health problem and not at all, a private matter. Thus, the issue of domestic violence can be destigmatized and the victims accept its disclosure and discussion. Also, the doctors should familiarize themselves with the voluntary and governmental services that can support the victims. There is a bad need for establishing a national multidisciplinary program shared by doctors the concerned, social and legal authorities, medical schools and non-governmental organizations to offer protection, legal assistance and prevention and rehabilitation programs for the victims. Some reform in the curricula of medical schools is needed to introduce specific courses to impart knowledge and develop awareness and intervention abilities in the further doctors.

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