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A Cross-Cultural Comparison of Selected Medical Students' Perceptions of Issues Related to Battered Women

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A CROSS-CULTURAL COMPARISON OF SELECTED MEDICAL STUDENTS' PERCEPTIONS OF ISSUES RELATED TO BATTERED WOMEN

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APPROVAL SHEET

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DEDICATION

To all those who have suffered in silence

"We can sit in our corners mute forever while our sisters and our selves are wasted . . . We can sit in our safe corners mute as bottles, and we will still be no less afraid. And I remind myself all the time now that if I were to have been born mute, or had maintained an oath of silence my whole life long for safety, I would still have suffered, and I would still die."

Audre Lorde

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ABSTRACT

The purpose of this study is to discover selected medical students' perceptions of issues related to the treatment and care of battered women. The medical students are in their final years of medical school at three different medical institutions: the Medical College of Virginia, Eastern Virginia Medical School, and University College, Dublin.

The study is exploratory in nature and questions students about their attitudes toward battered women, the services that should be provided to battered women, and their knowledge about battered women. T-tests and cross-tabulations are used to determine differences in medical students' perceptions by gender, nationality, and curricular approach.

The results suggest that gender and national differences do exist in medical students' perceptions of issues related to battered women, yet there are very few differences among students controlling for curricular approach.

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INTRODUCTION

The socialization of future physicians is a primary focus of medical sociology. To understand why medical education is of interest to sociologists, we must recognize that the medical school experience is designed not only to transmit knowledge and technique to future physicians, but also to convey certain acceptable attitudes and values (Colombotos 1969; Freidson 1970; Howell 1974; Fredericks and Mundy 1976; Jaco 1979; Cogswell and Arndt 1980; Scully 1980; Leserman 1981; Medved 1982; Eisenberg 1983; Leiderman and Grisso 1985; Mizrahi 1986; Lavin, Haug, Belgrave, and Breslau 1987; Conrad 1988; Bloom 1989; Fox 1989; Vinten-Johansen and Riska 1991; Downie and Charlton 1992).

The focus of this thesis is on the attitudes of medical students toward one specific patient population, battered women. The medical school years are an important link in the socialization experiences of future physicians. In addition to the technical knowledge and skills that are transmitted, the attitudes and values acquired in medical school are also important in the treatment and care of patients. While the inadequacies of medical school socialization affect the health care of all individuals, this thesis will explore how women

are at special risk by examining selected medical students' perceptions of battered women.

Using a sample of final year students from three medical schools, two in the United States and one in the Republic of Ireland[1], several issues are examined: [1] the effects of gender on medical students' perceptions of battered women; [2] the effects of nationality on medical students' perceptions of battered women; and [3] the effects of the cognitive and affective approaches to medical education on medical students' perceptions of battered women. A questionnaire which measured medical students' attitudes toward battered women, the services medical students felt physicians should provide to battered women, and medical students' general knowledge about battered women was used to determine medical students' perceptions.

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[1] Hereafter, the Republic of Ireland will be referred to as Ireland.

CHAPTER 1

THE SOCIALIZATION OF FUTURE PHYSICIANS

According to Weiss and Lonnquist (1994, 177), socialization is a process by which "a person becomes a member of a group or society and acquires values, attitudes, beliefs, behavior patterns, and a sense of social identity." Although there is some disagreement on the extent to which medical school affects future physicians, there is unusual consensus that four years of undergraduate medical education influence the attitudes, values, beliefs, and behaviors of future physicians to some degree (Colombotos 1969; Freidson 1970; Howell 1974; Ebert 1977; Rhee 1977; Lally 1978; Ross and Duff 1978; Hornung and Massagli 1979; Jaco 1979; Cogswell and Arndt 1980; Leserman 1981; Harrison 1982; Eisenberg 1983; Lavin, Haug, Belgrave, and Breslau 1987; Bloom 1988; Conrad 1988; Light 1988; Fox 1989). Eron (1958, 25), for example, comments on "the profound changes taking place in students as they progress through four years of medical school" and "how alike they all appear at the end of those years." Similarly, Smith (1992, 5), notes that, by the end of the medical school years, the similarities between doctors "far outweigh any differences."

Furthermore, it is documented that the socialization of medical students "sensitizes them to different kinds of patients and predisposes them to define particular behavior patterns in certain ways" (Hornung and Massagli 1979, 65). Thus, the way medical students are socialized to perceive and define patients affects the ways they behave toward patients (Lorber 1975a; Hornung and Massagli 1979; Cogswell and Arndt 1980; Rieker and Begun 1980; Bernstein and Kane 1981; Mizrahi 1986; Potts, Katz, and Brandt 1986). According to Mizrahi (1986), there are two specific systems of classification that future physicians seem to develop as they progress through medical school.

The first system of classification depends on the patient's illness and whether or not medical students find the illness interesting or uninteresting (Mizrahi 1986). Students begin to respond more positively toward patients they believe will contribute the most to their learning and development, while patients with routine or uninteresting illnesses are often treated as undesirable and burdensome (Howell 1974; Scully 1980; Bernstein and Kane 1981; Haas and Shaffir 1984; Leiderman and Grisso 1985; Mizrahi 1986). The second system of classification depends on the patient and whether or not medical students consider the patient to be a "good" patient or a "bad" patient (Mizrahi 1986). The "good" patient is often described by medical students as someone who is clean, articulate, cooperative, and educated (Medved 1982; Mizrahi

1986). As Scully (1980, 91-92) notes, however, a student's desire for an articulate or educated patient does not necessarily mean a desire for someone who "possesses the power of reasoning and judgment or the ability to make knowledgeable decisions." More often than not, when medical students refer to "good" patients, they are referring to middle-class patients who value their health and are willing to respect and submit to the authority of physicians (Scully 1980). A "bad" patient, on the other hand, is described as uncooperative, overemotional, or self-abusive and is often treated as undeserving of medical attention (Howell 1974; Lorber 1975a; Mizrahi 1986). Also, "bad" patients are believed to be unconcerned about their own health and disrespectful toward physicians (Scully 1980; Mizrahi 1986). Thus, these systems of patient classification profoundly affect the medical treatment patients receive by influencing physicians' attitudes towards and relationships with their patients.

In fact, one of the major problems with medicine and medical care is the quality of physicians' relationships with their patients. Often, doctors are accused of being insensitive, disinterested, uncaring, detached, and inaccessible (Cogswell and Arndt 1980; Davis 1980; Medved 1982; Mizrahi 1986; Friedman, Prywes, and Benbassat 1987; Rothstein 1987; Colombotos 1988; Fox 1989; Puckett, Graham, Pounds, and Nash 1989; Rothman 1989; Rawlins 1990; Rothman 1991; Smith 1992). Much research even goes so far as to

identify the medical school experience as the source of physicians' dehumanization (Eron 1955; Eron 1958; Scully 1980; Leserman 1981; Doran 1983; Haas and Shaffir 1984; Lorber 1984; Konner 1987; Bloom 1988; Colombotos 1988; Conrad 1988; Rawlins 1990; Downie and Charlton 1992; Smith 1992). As Becker and Geer (1958, 51) note, when most medical students begin their education, they believe the practice of medicine is "a wonderful thing and that they are going to devote their lives to the service of mankind." Attitudinal surveys reveal, however, that as students progress through four years of medical education, they become more cynical and express a lack of concern for patients as human beings (Eron 1955; Eron 1958; Gordon and Mensh 1962; Rezler 1974; Lally 1978; Haas and Shaffir 1984; Barrett 1985; Conrad 1988). Medical students are socialized on the tenets of curing rather than caring, and they focus on disease entities rather than the patient's experience of illness. Thus, although studies indicate that a physician's personal care and concern is a determining factor in the healing process, medical students become more interested in the technical aspects of their cases and become less interested in helping the sick or sympathizing with their patients as they progress through undergraduate training (Becker and Geer 1958; Gordon and Mensh 1962, 48; Mechanic 1974; Millman 1977; Lally 1978; Scully 1980; Leserman 1981; Mizrahi 1986; Bloom 1988; Conrad 1988; Smith 1992).

Furthermore, researchers conclude that interpersonal

skills are essential to the future of medicine and that "the effectiveness of one's work depends . . . on the qualities of interpersonal relationships that are developed" with patients (Stimson 1977; Fox 1989, 43; Tosteson 1990; Bryan 1991). At the same time, Bryan (1991, 1407) recognizes that medical education has failed to emphasize "these aspects of caring, being sensitive to others, and touching that are the essence of a good physician." Such interpersonal needs are virtually ignored in traditional medical education with the result that "the more medicine is capable of curing people, the less concerned it is about making them feel better" (Campos 1973, 962; Leserman 1981; Harrison 1982; Doran 1983; Rothstein 1987; Conrad 1988; Light 1988; Weiss and Lonnquist 1994).

As a result, many researchers now argue that traditional medical education -- two years of basic sciences followed by two years of clinical sciences -- does not provide future physicians with an education that adequately serves the basic needs of most patients (Engel 1977; Colombotos 1988; Light 1988). As Rothstein (1987, 291) states:

> Medical students . . . should receive an education in more than the scientific and technical aspects of medicine. They should develop an understanding of the physician's role in the community and the health-care system and some insight into how they will personally function in that role. Students should learn about the social and personal consequences of medical decisions, which will enable them to use their knowledge with discretion and judgment. They should learn how to establish meaningful relationships with patients and their families and how to anticipate and deal with the many problems that arise in such relationships.

Furthermore, the World Health Organization defines health as "not only the absence of disease and infirmity, but also a state of complete physical, mental, and social well-being" (Campos 1973, 960). Yet, a number of critics argue that the traditional structure of medical education neglects many aspects of the mental well-being of individuals and ignores the social well-being of individuals altogether. Smith (1992), for example, stresses that when a patient visits a primary-care physician, she brings with her many different needs. A patient brings not just the medical problems that must be diagnosed and treated, but she also brings the "need for information, for reassurance, and for advice about a healthy lifestyle" (Smith 1992, 93-94). In fact, there is growing evidence that an important motivation for seeking care involves a patient's social difficulties and psychological distress, although only the physical symptoms may be apparent at the outset of medical treatment (Pattishall 1973; Mechanic 1974; Stimson 1977; Pahl 1979; Doran 1983; Barrett 1985; Tosteson 1990).

According to Campos (1973) and Doran (1983), there are three basic levels of interaction between a patient's needs and a physician's responses. The first level involves the bio-physical needs of the patient, and these needs take priority over all other needs when failure to do so would result in irreversible physical harm or death for the patient. The second level involves a patient's personal and emotional

needs which accompany the uncertainty and feelings of powerlessness and hopelessness that an illness can create. And then there is the third level in which there exists the potential for growth and self-sufficiency for the patient when she is provided with the proper psychological support and encouragement. All patients have these different types of needs, but instead of being dealt with according to the priority of an individual's condition, they are dealt with according to the priority they are assigned in a physician's medical education and socialization experience (Campos 1973; Dobash and Dobash 1979; Doran 1983; Barrett 1985). This means that a person's bio-physical needs are almost always considered more important than a person's personal or emotional needs even when the personal and emotional needs happen to be more urgent or acute. As Tosteson (1990, 234) acknowledges, all three levels of interaction between a patient and a physician are "essential to a healthy outcome."

As noted earlier, within traditional medical education, physicians receive very little if any, exposure to the emotional and social factors involved in health and illness (Badgley and Bloom 1973; Campos 1973; Dacey and Wintrob 1973; Gadd 1973; Pattishall 1973; Sheldrake 1973; Engel 1977; Rieker and Begun 1980; Ebert and Ginzberg 1988; Kendall and Reader 1988; Cotton 1991; Jonas, Etzel, and Barzansky 1991; Vinten-Johansen and Riska 1991). Doctors are not encouraged to recognize human beings as people, as members of society, and

as unique individuals (Fredericks and Mundy 1976; Stimson 1977; Eichna 1980; Rieker and Begun 1980; Ramalingaswami 1989; Tosteson 1990; Downie and Charlton 1992). The focus of medical education is not a patient with a problem; rather, medical education encourages students to treat a patient's physical symptoms as though they exist independently of the individual (Babbie 1970; Dacey and Wintrob 1973; Pattishall 1973; Engel 1977; Hornung and Massagli 1979; Medved 1982; Doran 1983; Gorlin and Zucker 1983; Mizrahi 1986; Rawlins 1990). As Fox (1989, 43) acknowledges, however, the "capacity to serve others -- to meet their human needs individually, interconnectedly, and as members of a larger community -- is more than a matter of good moral character and higher purpose. It is a form of competence vital to the profession." Physicians must be able to empathize with patients and set the needs of their patients within the contexts of a larger whole. In this way, the elimination of ill-health can be successfully pursued (Foster 1989; Fox 1989; Downie and Charlton 1992). Without an understanding of the wider contexts in which illness may occur, and without a general awareness of the range of non-medical solutions to these problems, doctors "are likely to have little real help to offer" (Pahl 1979, 118).

Thus, many note "a growing divergence between the training of physicians and the needs of their patients" and conclude that medical education has been distorted from its primary purpose of caring for the patient (Eichna 1980; Conrad

1988; Kendall and Reader 1988; Light 1988; Rawlins 1990; Bryan 1991; Cantor, Cohen, Barker, Shuster, and Reynolds 1991, 1002). As Smith (1992, 19) states, the behavior of physicians is "not the result of a conscious decision to do harm, but rather the result of psychosocial conditioning" that leads to such behavior. Thus, we have to restructure the ways doctors are taught, socialized, and professionalized. And while Smith (1992) acknowledges that attitudes and behaviors are not the only problems in the medical system, he stresses that physician behavior is the essential element that must be changed if things are to get better.

The Effects of Medical School on Female Students

Still, one might question whether or not such conformity in medical socialization and professionalization continues to be observed as the medical student population is becoming more diverse with increasing rates of women and racial and ethnic minorities (Light 1988; Martin, Arnold, and Parker 1988; Jefferys and Elston 1989). Women are the largest and the quickest growing minority in medical school. At the end of 1993, the latest available statistics released by the Association of American Medical Colleges reveal that 39.4% of all medical students in the United States are women (Bickel, Galbraith, and Quinnie 1993). These statistics also indicate that 41.8% of all applicants to medical schools for the 1993-1994 school year were women (Bickel, Galbraith, and Quinnie

1993). With such increasing numbers, it is important that we examine the effects of medical school socialization on both men and women. If, as many believe, female medical students will have a great impact on the practice of medicine and the treatment of female patients, we must determine whether medical school produces conformity or whether the attitudes and orientations of female medical students are different from those of their male counterparts.

Previous studies indicate that female medical students' attitudes toward patients and patient care differ from male medical students' attitudes upon entrance to medical school (Leserman 1981; Potts, Katz, and Brandt 1986; Lavin, Haug, Belgrave, and Breslau 1987; Maheux, Dufort, and Beland 1988; Martin, Arnold, and Parker 1988). Leserman (1981) finds that female students possess more liberal and humanitarian values than their male peers. It is also acknowledged that female students are less likely to hold traditional beliefs about physician authority and are more concerned about humanizing doctor/patient relationships than men (Leserman 1981; Lavin, Haug, Belgrave, and Breslau 1987; Maheux, Dufort, and Beland 1988). Similarly, other studies find that females are more patient-oriented, more accepting of feelings, more interested in patients' emotional problems, and more interested in patient contact (Bluestone 1978; Maheux, Dufort, and Beland 1988; Martin, Arnold, and Parker 1988).

However, as students progress through medical school,

Leserman (1981, 150) finds that socialization has "a similar effect on both sexes." Other research also indicates that four years of medical school reduce the initial attitudinal differences between male and female students (Bluestone 1978; Bernstein and Kane 1981; Harrison 1982; Eisenberg 1983; Lorber 1984; Potts, Katz, and Brandt 1986; Maheux, Dufort, and Beland 1988; Martin, Arnold, and Parker 1988). Eisenberg (1983) even states that the similarities between male and female medical graduates outweigh the differences. For example, Lorber (1984, 56) finds that when medical students are asked to describe what kind of patient they like the most and what kind of patient they like the least, the responses of males and females are "monotonously similar." Both sexes prefer patients who "allow them to carry out their tasks with a minimum of fuss, make little trouble, and are cooperative, trusting, and appreciative of their care" (Lorber 1984, 57). On the other hand, problem patients are described by both groups as those with "intractable physical problems, who complain a great deal, are very emotional, anxious, need a lot of reassurance, encouragement, and attention" (Lorber 1984, 57).

Thus, it is argued, female medical students grow to resemble their male counterparts. Some believe this occurs because female medical students have so much to gain by accepting the authority of the physician role. Female students gain "an enhanced sense of competence, a lessened

vulnerability to patients' manipulations, and a greater feeling of control over their clinical work," while the advantages to male medical students of adapting a more compassionate and sensitive stance are much more ambiguous (Kaplan 1979, 115). It is simply more compelling for women to adapt culturally valued masculine traits than it is for men to adapt culturally disdained feminine traits.

Still, socialization is not a complete leveler of attitudinal variation because the conservative influence of medical school is not always strong enough to eliminate or even reduce initial gender differences (Leserman 1981). Especially important for this research, for example, are findings which indicate that female medical students are much more responsive than male medical students to issues pertaining to sex discrimination, contraception, abortion, and appropriate health care for women when they begin medical school and that these attitudes are not altered significantly by four years of medical school socialization (Leserman 1981; Starr 1982; Rose and Saunders 1986; Weisman, Nathanson, Teitelbaum, Chase, and King 1986; Martin, Arnold, and Parker 1988).

CHAPTER 2

THE TREATMENT OF BATTERED WOMEN: A CASE STUDY OF MEDICINE'S MISTREATMENT OF WOMEN

Estimates of the number of women battered each year range from two to six million in the United States alone (Stark, Flitcraft, and Frazier 1979; Straus, Gelles, and Steinmetz 1980; Schechter 1982; Kurz 1987; Mehta and Dandrea 1988; Council on Scientific Affairs 1992; Novello, Rosenberg, Saltzman, and Shosky 1992; Sugg and Inui 1992; Bryjak and Soroka 1994). This means that some woman is beaten by her husband or partner every 7.4 seconds and that women are more likely to be assaulted, injured, or raped by a current or ex-male partner than by all other types of assailants combined (Dobash and Dobash 1979; Stark, Flitcraft, and Frazier 1979; Finkelhor and Yllo 1985; McLeer and Anwar 1987; McLeer, Anwar, Herman, and Maquiling 1989; Duhon-Haynes and Duhon-Sells 1991; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992; Jecker 1993; Bryjak and Soroka 1994). It is acknowledged that approximately fifty percent of the women murdered in the United States die at the hands of a husband or boyfriend (Goode 1971; McLeer and Anwar 1987; Randall 1990b; Council on Ethical and Judicial Affairs 1992; Novello, Rosenberg, Saltzman, and Shosky 1992). Recent

statistics also indicate that the rate of injury to women 15-44 years of age from battering surpasses the rate of injury from car accidents and muggings combined and that approximately thirty to thirty-five percent of all women entering emergency rooms are suffering from injuries or symptoms caused by abuse. In fact, domestic violence is the leading cause of injury and death to all women in this country (McLeer, Anwar, Herman, and Maquiling 1989; Randall 1990a; Duhon-Haynes and Duhon-Sells 1991; Randall 1991; Bryjak and Soroka 1994). Studies on prevalence suggest that between twenty and thirty-three percent of American women will be physically assaulted by a partner or ex-partner during their lifetime (Lewis 1985; Council on Scientific Affairs 1992; Bryjak and Soroka 1994). Therefore, it is vital that we examine the issue of battered women and how physicians are socialized to respond to them (Stark, Flitcraft, and Frazier 1979; McLeer and Anwar 1987; McLeer, Anwar, Herman, and Maquiling 1989; Warshaw 1989; Randall 1990a; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992; Novello, Rosenberg, Saltzman, and Shosky 1992; Sugg and Inui 1992).

It is acknowledged repeatedly that physicians and the medical community as a whole are the most likely category of professionals to encounter battered women (Gelles 1972; Dobash and Dobash 1979; Pahl 1979; Stark, Flitcraft, and Frazier 1979; Borkowski, Murch, and Walker 1983; Finkelhor and Yllo

1985; Rose and Saunders 1986; Bowker and Maurer 1987; Hatty 1987; Kurz 1987; Mehta and Dandrea 1988; Burge 1989; Hamberger and Saunders 1991; Council on Ethical and Judicial Affairs 1992; Sugg and Inui 1992; Jecker 1993). As such, doctors provide "a frontline of identification and intervention" (Council on Scientific Affairs 1992, 3184). Physicians are in a position not only to recognize and care for battered women, but also to assess a battered woman's safety by asking about the extent of the violence, whether or not weapons are involved, and if she has a safe place to go upon leaving the hospital. Such questions establish a baseline of detection for the escalation of violence and, even if not immediately useful, may save battered women additional pain and suffering in the future (Pahl 1979; Kurz 1987; Duhon-Haynes and Duhon-Sells 1991; Council on Ethical and Judicial Affairs 1992).

Even though the most important service doctors can provide battered women is to ask about, identify, and acknowledge the abuse, the identification of battered women occurs at an alarmingly low rate (Millman 1977; Scully 1980; Schechter 1982; Finkelhor and Yllo 1985; Bowker and Maurer 1987; Hatty 1987; McLeer and Anwar 1987; Mehta and Dandrea 1988; Burge 1989; McLeer, Anwar, Herman, and Maquiling 1989; Warshaw 1989; Randall 1990a; Randall 1990b; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992; Novello, Rosenberg, Saltzman, and Shosky 1992; Sugg and Inui 1992; Jecker 1993). In interviews with 374 consecutive female

outpatients seeking routine health-care in a community clinic, Hamberger and Saunders (1991) find that twenty-five percent report spousal abuse in the previous year and that thirty-nine percent report spousal abuse in their lifetime while only two percent of the women report ever being asked about the violence by a physician. Similarly, Stark, Flitcraft, and Frazier (1979) find that emergency department physicians identify only one in thirty-five of their female patients as battered, while a closer inspection of the medical charts indicates that one in four female patients are likely to have been battered. Also, they find that although physicians acknowledge one injury out of twenty is the result of battering, the medical charts indicate that the actual figure is closer to one in four. Just as startling, Kurz (1987) notes that in forty percent of emergency department staff interactions with battered women, no response is made to abuse.

Due to the continuous and injurious nature of domestic violence against women, this lack of response results in abused women visiting physicians more and more often, with increasingly severe physical trauma (Stark, Flitcraft, and Frazier 1979; Kurz 1987; Burge 1989; McLeer, Anwar, Herman, and Maquiling 1989; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992; Novello, Rosenberg, Saltzman, and Shosky 1992). For example, in their study of emergency department physicians' responses to battered women,

McLeer and Anwar (1987) find that seventy-five percent of the battered women seen medically continue to experience ongoing abuse. Statistics also indicate that nearly one battered woman in five presents at least eleven times with trauma to a physician while another twenty-three percent bring six to ten abuse-related injuries to the attention of physicians (Stark, Flitcraft, and Frazier 1979).

Because medical schools and medical education offer future physicians little or no information or training concerning battered women, physicians respond to battered women based on their own personal prejudices and misconceptions (Goode 1971; Pahl 1979; Cogswell and Arndt 1980; Potts, Katz, and Brandt 1986; Rose and Saunders 1986; Bowker and Maurer 1987; Kurz 1987; Burge 1989; Foster 1989; Council on Scientific Affairs 1992; Smith 1992; Sugg and Inui 1992; Jecker 1993). Many physicians graduate from medical school believing that battered women are responsible for their abuse because they provoke their male partners by "talking back," being too domineering, being too bossy, being too flirty, or wearing provocative clothing (Goode 1971; Dobash and Dobash 1979; Kurz 1987; Burge 1989; Council on Ethical and Judicial Affairs 1992; Loseke 1992). In their study of marital violence, Borkowski, Murch, and Walker (1983, 122) even find that many physicians believe such provocation justifies the abuse. As one physician describes his position:

> Some women deserve it or provoke it -- they flirt a bit. The husband's response is an old-fashioned cuff around the ears -- like police used to do with kids -- don't think it does her a lot of harm. Keeps her in line and she knows it -- that's why she stays.

Many physicians also believe that women are battered and remain in abusive relationships because of a masochistic tendency which indicates their need and even their enjoyment of the abuse (Pahl 1979; Stark, Flitcraft, and Frazier 1979; Cogswell and Arndt 1980; Schechter 1982; Borkowski, Murch, and Walker 1983; Kurz 1987; Burge 1989; Council on Ethical and Judicial Affairs 1992). Some physicians believe that certain women are just "drawn to the excitement or danger of the situation" when battered women do not leave their abusive relationships immediately (Dobash and Dobash 1979, 159).

It is also true that physicians often feel that questioning their patients about domestic abuse is too intrusive and a violation of their patients' privacy (Dobash and Dobash 1979; Stark, Flitcraft, and Frazier 1979; Borkowski, Murch, and Walker 1983; Rose and Saunders 1986; Kurz 1987; Burge 1989; Warshaw 1989; Mugford, Mugford, and Easteal 1990; Council on Ethical and Judicial Affairs 1992; Loseke 1992; Jecker 1993). In their examination of primary care physicians' responses to domestic violence, Sugg and Inui (1992) find that privacy concerns are among the most prominent and frequently expressed themes.

Finally, many physicians fear the lack of control and the vast uncertainties that are confronted when treating battered

women because medical education does not equip physicians to deal with such a loss of control or uncertainty (Trautmann 1978; Light 1979; Stark, Flitcraft, and Frazier 1979; Scully 1980; Leiderman and Grisso 1985; Kurz 1987; Light 1988; Burge 1989; Fox 1989; Warshaw 1989). Physicians are trained to deal almost exclusively with physical symptoms and organic illnesses, and when they are called upon to help a battered woman, they often feel inadequate and even helpless (Dobash and Dobash 1979; Borkowski, Murch, and Walker 1983; Bowker and Maurer 1987; Burge 1989). In an attempt to protect themselves from such feelings of inadequacy, physicians often develop authoritative styles of consultation that allow them to better manage their patients and to maintain strict control of the doctor-patient interaction.

Thus, physicians are better equipped to redirect and avoid discussions of abuse when treating battered women (Dobash and Dobash 1979). As Sugg and Inui (1992, 3159) note, the "need to gain control and expediently solve the problem is one of the major obstacles to physicians' willingness to address domestic violence." Thus, a physician adapts to the uncertainties of treating battered women by treating their physical injuries while ignoring the source of these injuries and the greatest threat to battered women's health (Dobash and Dobash 1979; Borkowski, Murch, and Walker 1983; Finkelhor and Yllo 1985). Studies consistently acknowledge that most battered women will reveal the causes of their injuries when

asked by physicians in a compassionate and understanding way, but such prejudices and misconceptions continue to affect physicians' willingness to question battered women about their injuries (Bowker and Maurer 1987; Kurz 1987; McLeer and Anwar 1987; Waitzkin and Britt 1989; Council on Ethical and Judicial Affairs 1992; Novello, Rosenberg, Saltzman, and Shosky 1992).

Therefore, instead of asking battered women directly about their injuries, physicians are more likely to prescribe sedatives and tranquilizers to calm the victims of abuse when such treatment is much more harmful than helpful to battered women. Medication only enables a battered woman to return to her batterer less prepared to defend herself and places her at greater risk for health complications such as drug dependency and suicide attempts (Howell 1974; Lorber 1975a; Dobash and Dobash 1979; Pahl 1979; Stark, Flitcraft, and Frazier 1979; Cogswell and Arndt 1980; Bernstein and Kane 1981; Borkowski, Murch, and Walker 1983; Rose and Saunders 1986; Bowker and Maurer 1987; Mehta and Dandrea 1988; Burge 1989; Warshaw 1989; Mugford, Mugford, and Easteal 1990; Randall 1990b; Council on Ethical and Judicial Affairs 1992; Jecker 1993). According to Corea (1977, 83), however, doctors continue to prescribe such medications just to "get rid of emotional women."

Furthermore, a physician's uncompassionate or unsympathetic response may discourage a battered woman from seeking further help by contributing to her sense of shame and self-blame and to her feelings of helplessness and isolation

(Mechanic 1974; Dobash and Dobash 1979; Finkelhor and Yllo 1985; Rose and Saunders 1986; Hatty 1987; Mehta and Dandrea 1988; Burge 1989; Warshaw 1989; Randall 1990a). A physician's negative response may also define the battered woman in such a way that she is systematically discriminated against by other health care personnel (Mechanic 1974; Stark, Flitcraft, and Frazier 1979; Potts, Katz, and Brandt 1986). Considering such findings, it is not surprising that researchers find health care professionals to be rated below women's shelters, lawyers, social service workers, police, and clergy in their effectiveness in addressing abuse (Bowker and Maurer 1987; Hatty 1987; Mugford, Mugford, and Easteal 1990; Council on Ethical and Judicial Affairs 1992; Jecker 1993).

As Warshaw (1989, 510) notes, "physicians in other clinical situations would not discharge a patient from the emergency room with a potentially life-threatening condition." When physicians ignore the underlying causes of the injuries they treat -- when they focus on the bio-physical at the expense of the social --, they are ineffective in treating battered women, and they are discharging women back into life-threatening situations. By focusing on bio-physical concerns to the exclusion of social concerns, medical schools train physicians who are not equipped to address the underlying cause of the patient's condition, define preventive measures, and address the most serious threat to the battered woman's life (Borkowski, Murch, and Walker 1983; McLeer and Anwar

1987; Burge 1989; McLeer, Anwar, Herman, and Maquiling 1989; Warshaw 1989; Randall 1990a; Randall 1991; Jecker 1993).

Thus, many calls for medical reform are being issued. Critics are seeking the incorporation of training on interpersonal violence into medical education (Hatty 1987; Burge 1989; McLeer, Anwar, Herman, and Maquiling 1989; Hamberger and Saunders 1991; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992; Randall 1992; Sugg and Inui 1992; Jecker 1993). Research indicates that health professionals who receive moderate to intensive training about woman abuse hold stronger beliefs that battered women should be helped (Rose and Saunders 1986; Jecker 1993). Thus, such reform would be an important step in encouraging physicians to meet the health care needs of battered women.

CHAPTER 3

WOMEN IN IRELAND: A CONTEXT FOR UNDERSTANDING IRISH MEDICAL STUDENTS' PERCEPTIONS OF BATTERED WOMEN

Cross-national comparisons of medical schools, medical education, and medical socialization are described as being conspicuous by their very absence (Jefferys and Elston 1989). However, this study examines the education and socialization of both American and Irish medical students as they relate to selected students' perceptions of issues pertaining to battered women. Therefore, it is important first to look at the social and political conditions that exist for Irish women in general in order to examine any differences that may exist between American and Irish medical students' perceptions of battered women.[2]

Even though the status of Irish women has changed considerably over the past twenty years, Irish medical students are still members of a society where the rights of women are markedly different from the rights of women in the United States (Fine-Davis 1989; Boland 1995). Women in

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[2] Irish medical students may not comprise a representative sample of the Irish population because they are more likely than American medical students to be from urban and middle- and upper-class family backgrounds.

Ireland are changing the Irish political climate; they are redefining much of the Irish social agenda, and they now form a "consistent and notable" presence in Irish politics (Boland 1995). For example, in 1990, it was huge numbers of Irish women who voted for the election of Mary Robinson as President of Ireland thus "radicalizing the symbolic definition" of all Irish women (Boland 1995). Yet, Irish medical students are still socialized in a country where the constitution recognizes "that by her life within the home, woman gives to the State a support without which the common good cannot be achieved," and which both "prohibits divorce and equates the right to life of the mother with the right to life of the unborn child" (Brown 1985; Barry 1988; Robinson 1988, 351; Pyle 1990; Mahoney 1993). Thus, medical students in Ireland are being trained in an environment where the role of women and women's rights continue to have clearly defined limits.

For many years, the maintenance of traditional relations between the sexes has been a goal of much of Irish social policy (Pyle 1990). Because of this, Irish women continue to struggle against many odds. They face moral ideals that encourage a woman to submit to almost any form of treatment her husband considers appropriate and against the policies and responses of social agencies which often demonstrate direct or indirect support for a man's authority over a woman and a husband's authority over his wife. In Ireland, women are not only subjected to violence and sexual harassment, they are

also discriminated against in relation to family law, property law, fertility control, education, and employment (Clancy, Drudy, Lynch, and O'Dowd 1986; Beale 1987; Barry 1988; De Brun 1988; Prendiville 1988; Robinson 1988; Smyth 1988; Breen, Hannan, Rottman, and Whelan 1990; Mahoney 1993). Furthermore, as a Catholic state, pulpits across the country are used to support a "narrow and rigid ideology concerning women" (Barry 1988, 318; Fine-Davis 1989). This ideology is filled with the notions of compulsory motherhood, guilt-ridden sexuality, opposition to birth control, self-sacrifice, and economic dependence (Barry 1988). Therefore, it is not surprising that a positive correlation exists between measures of religiosity and a traditional sex-role orientation (Fine-Davis 1989).

Using a representative sample of the adult population of Ireland in an examination of Irish attitudes toward women, Fine-Davis (1989, 291) finds that seventy-eight percent feel that being a wife and mother are the most rewarding roles a woman could want. Furthermore, despite the fact that the home is the place where most people would prefer Irish women to "fulfill themselves," a majority of the Irish population still believes that it is a man's right to have authority over his wife even in household and family matters. This is closely tied to the fact that approximately forty percent of the sample perceive women to be inferior to men. It is clear, however, that these conservative attitudes do predominate in males, older people, those of lower socioeconomic background,

and those living in rural areas (Fine-Davis 1983; Fine-Davis 1989).

When such conservative beliefs and attitudes are combined with what can only be described as anti-woman legislation, the burden of Irish women is only intensified. Consider the constitutional prohibition against divorce in the Republic of Ireland. As a Catholic state, the Republic's constitution contains an article which specifically forbids the introduction of legislation for divorce. Article 41.3.2 states: "No law shall be enacted providing for the grant of a dissolution of marriage" (Clancy, Drudy, Lynch, and O'Dowd 1986; Beale 1987; Prendiville 1988, 355; Robinson 1988; Breen, Hannan, Rottman, Whelan 1990; Pyle 1990). In 1986, when a referendum was introduced that would remove this prohibition from the constitution, it was defeated by a majority of voters. This occurred despite the fact that opinion polls held before the referendum indicated a majority of the Irish population was in favor of the legislation (Prendiville 1988). Thus, in a society where an estimated 72,000 people are directly involved in situations of marital breakdown, where the government felt compelled to introduce a "deserted-wives" allowance and an "unmarried mothers" allowance in the early 1970s, and where there is persistent overcrowding of battered women's shelters, many observers acknowledge the contradiction between these facts and the referendum outcome (Brown 1985; Clancy, Drudy, Lynch, and O'Dowd 1986; Beale 1987; Prendiville

1988; Smyth 1988; Breen, Hannan, Rottman, and Whelan 1990).

Feminists and others in Ireland argue that divorce is a civil rights issue. The availability of divorce is seen "as an important improvement in the social status and position of women" (Prendiville 1988, 355). But in Ireland, an anti-divorce campaign was waged before the referendum which stressed the effects of divorce on the family (Barry 1988). In effect, the idea of the family was used to benefit men and the state and to restrict the rights and activities of women (Dobash and Dobash 1979). As Prendiville (1988) notes, anti-divorce pamphlets argued that the family -- as the cornerstone of society -- had to be protected and that the family's rights were above all political legislation. One pamphlet clearly stated, "Divorce costs the family its unity, women and children their financial security, society as a whole its stability and ultimately the State its basic foundation" (Prendiville 1988, 359). Again and again, women and children were presented as likely to suffer great economic hardships if the divorce referendum were approved, but no one addressed the legal inequalities within Irish law which would be the real source of such economic hardships.

It is important to recognize that this occurred ten years after the introduction of the Irish Family Law Act which grants courts jurisdiction to bar either spouse from entering the family home where the authorities feel such measures are necessary (Clancy, Drudy, Lynch, and O'Dowd 1986). Such a law

would seem to indicate growing recognition of the increasing level of family breakdown and family violence. Breen and his colleagues (1990, 106) acknowledge, however, that "substantially lower proportions of Irish respondents agree that such 'grounds for divorce' as violence, unfaithfulness, or spouses ceasing to love one another provide 'sufficient reasons' for divorce to occur."

As we discuss the importance of the family in Ireland, it is also important to realize that the only family recognized by the government is the family based on a "valid subsisting marriage" -- a family consisting of a husband, a wife, and children (Robinson 1988, 353). Therefore, constitutional provisions defining the family as the fundamental unit of society and guaranteeing the family special protection, do not recognize many Irish families composed solely of mothers and their children (Brown 1985; Pyle 1990).

Thus, it is not surprising that during the referendum campaign, women were rarely considered as individuals. They were almost always referred to as the wives of husbands and as the mothers of children. Without addressing women as individuals and without questioning the basic inequalities built into marriage -- both legal and social --, the question of the rights of women was not raised as a separate issue. Therefore, the financial, legal, social, and economic conditions of women within marriage were continually approached in a way that failed to challenge the inviolability

of marriage in Ireland.

Further inhibiting the status and power of women in Ireland are restrictions placed on female reproductive rights. Until 1979, when it became available by prescription for married couples only, contraception was completely illegal (Fine-Davis 1983; Brown 1985). In 1985, an act was passed that removed the need for a prescription for non-medical contraceptives such as condoms, but contraceptives are still available only for individuals over the age of eighteen (Clancy, Drudy, Lynch, and O'Dowd 1986; Beale 1987; Fine-Davis 1989; Breen, Hannan, Rottman, Whelan 1990; Pyle 1990).

Furthermore, in 1983, a referendum was held that amended the constitution to prevent the introduction of abortion legislation (Brown 1985; Clancy, Drudy, Lynch, and O'Dowd 1986; Smyth 1988; Breen, Hannan, Rottman, and Whelan 1990). Five years after the referendum, the Hamilton judgement made counselling about abortion and providing information about abortion illegal also (Smyth 1988). However, in the December 1992 election, sixty-two percent of the Irish electorate voted in favor of allowing women to travel abroad for abortions and sixty percent voted in favor of allowing abortion information to be distributed in the Republic demonstrating "a marked change in the attitudes" of the Irish people (Mahoney 1993, 306). Still, it was not until March 1995, after the data for this study had been collected, that the Irish parliament approved the first loophole in the ban on abortion. The

parliament passed a bill that allows doctors to provide names and addresses of English family-planning clinics to pregnant patients. The bill, however, requires doctors to counsel pregnant women on all other options, including keeping the child and adoption. It also bars doctors from phoning or writing to English clinics themselves and allows doctors to refuse to offer family-planning clinic information. ("Ireland Eases Its Abortion Ban" 1995; Ferrie 1995).

The State also reinforces the subordinate status of married women in other ways. For example, a wife's domicile is legally that of her husband, even if they are separated and live in different countries (Beale 1987). A husband is also free to sexually assault and rape a woman simply because she is his wife (Beale 1987; Pyle 1990). Clearly enough, the state has played an enormous role in the fact that the majority of Irish women have never been allowed to claim their reproductive rights or maintain control over their own bodies or lives.

Outside the sphere of reproduction and family life, the Irish government continues to affect the position and status of women. Until 1973, certain occupations were affected by marriage bars which prohibited women from continuing their jobs and careers after marriage. It was not until 1974 that legislation on equal pay was passed and not until 1977 that legislation on employment equality was approved -- all of which were facilitated by directives on equality from the

European Economic Community (Fine-Davis 1979; Fine-Davis 1983; Brown 1985; Clancy, Drudy, Lynch, and O'Dowd 1986; Beale 1987; Fine-Davis 1989; Breen, Hannan, Rottman, and Whelan 1990; Pyle 1990). To this day, the labor force participation of women is relatively low at thirty-one percent compared to seventy-five percent of men, and women's eligibility for unemployment benefits and injury and disability assistance is continually contested by the social welfare system (Clancy, Drudy, Lynch, and O'Dowd 1986; Beale 1987).

After emphasizing the major structural constraints Irish women face, we must recognize that these may affect the views Irish medical students have about women in general. However, we must also acknowledge that considerable attention has been given to the issue of battered women in the last ten years because the rights of women have been gaining the Irish public's attention. Therefore, an environment of awareness has been created. For instance, the first Irish Rape Crisis Center opened its doors in Dublin in 1977, and many actions and campaigns around rape legislation have occurred since that time. Furthermore, in the fall of 1978, an astonishing 6,000 women took part in a "Women Against Violence Against Women" torchlight procession. These events and others have led many to define violence against women as one of the "major mobilizing issues" of the last fifteen years of Irish history (Smyth 1988, 340). As Beale (1987, 3) notes, "campaigns and debates . . . fuelled the pace of change" by challenging

traditional attitudes about the rights and the proper roles of women. Still, however, change always and only ever comes as a price, and Irish women are paying it, with "incredibly high personal interest, literally carrying the burden of change" by themselves (Smyth 1995). One only needs to consider the case of Lavinia Kerwick to demonstrate the tragic price that is being paid by Irish women.

In early 1994, Kerwick made a public statement condemning a judge who adjourned sentence for a year on the man who publicly admitted raping her. The judge based his decision on the fact that the man had no prior convictions and had good references from his employer. Kerwick's pain and suffering were apparently of no consequence to the judge. She appealed publicly to the Minister of Justice and identified herself as a victim of a violent crime "perpetrated against her because she was a woman, because women are open territory" (Smyth 1995). According to Smyth (1995), Kerwick "identified herself as the victim of a justice system which denies women value and status as human beings, entitled to have their rights upheld and respected by the state and its agents."

By speaking out against the Irish government and its agents, Kerwick demonstrates that Irish women have come a long way, but she also reveals that despite the changes that have occurred in the past twenty years, there is still a great deal of injustice in a system that continues to be "based on profoundly unequal power relations between women and men"

(Smyth 1995).

CHAPTER 4

A CASE FOR REFORM IN MEDICAL EDUCATION

With the growing recognition that "much of the content and activities which go into the training of a physician cannot be justified in terms of the improvement of patient care," many suggestions are being made to adapt the traditional medical school education to the changing needs of individuals (Cartwright 1967; Pattishall 1973, 924; Eichna 1980; Rothstein 1987; Conrad 1988; Downie and Charlton 1992). Bloom (1988, 295) even states that the basic structure of contemporary medical education, formulated over eighty years ago, has "crowded out its social responsibility to train physicians for society's most basic health care delivery needs." As a result, increased pressure to humanize medicine and to reawaken social commitment is encouraging some attempts at reform (Badgley and Bloom 1973; Dacey and Wintrob 1973; Engel 1977; Cogswell and Arndt 1980; Rieker and Begun 1980; Doran 1983; Colombotos 1988; Ebert and Ginzberg 1988; Kendall and Reader 1988; Light 1988; Grant and Gale 1989; Puckett, Graham, Pounds, and Nash 1989; Bryan 1991; Carlson 1991; Cotton 1991; Jonas, Etzel, and Barzansky 1991; Vinten-Johansen and Riska 1991; Vance, Prichard, King, and Camp 1992). And it

is the need for more reform and the effectiveness of current reform in influencing future physicians to adapt to the ever expanding needs of a growing number of battered women that are a concern of this research.

For the last seventy-five years, the basic structure of medical education has remained virtually the same for the American and the Irish health-care systems (Bloom 1988; Ebert and Ginzberg 1988; Bloom 1989). Carlson (1991) reports that of thirty-one countries responding to an American Medical Association survey, ninety-two percent describe their curricula as typically divided between the basic and clinical sciences. The first two years of medical school are filled with an enormous amount of attention to anatomy, physiology, biochemistry, microbiology, pathology, and pharmacology (Ebert 1977; Bloom 1988; Conrad 1988; Ebert and Ginzberg 1988; Downie and Charlton 1992). During this time, students begin to think of disease in the abstract rather than as a condition of the individual, and "the first seed of depersonalization of the patient is planted" (Barbato, Frazier, Leischner, Gunzburger, Loesch, and Yang 1988, 506). Yet, students are expected to memorize much of this material in order to advance to the clinical sciences. When they are incorporated into medical curricula at all, social issues and the sociological factors related to disease are usually presented at the same time that students are inundated with basic science information (Badgley and Bloom 1973; Davis 1980; Rieker and Begun 1980; Downie and

Charlton 1992). Thus, at a time when students realize that they can never remember all of the information presented, social issues often are presented as secondary and as an encroachment on valuable time by professors and given scant attention by students (Gadd 1973; Lally 1978; Davis 1980; Rieker and Begun 1980; Conrad 1988; Bryan 1991).

Concern for certain social issues, such as that of battered women, is leading to some reform in medical education. This reform is not uniform, however (Badgley and Bloom 1973; Dacey and Wintrob 1973; Sheldrake 1973; Perricone 1974; Lally 1978; Rieker and Begun 1980; Rothstein 1987; Bloom 1988; Kendall and Reader 1988; Puckett, Graham, Pounds, and Nash 1989; Downie and Charlton 1992). Some medical schools are instituting reform by offering learning experiences in the behavioral sciences and humanities for their students -- if not as required courses, at least in the form of special conferences, lectures, or seminars (Babbie 1970; Davis 1980; Gorlin and Zucker 1983; Self 1988; Fox 1989; Downie and Charlton 1992). As early as 1982, 72.8% of American medical schools were already incorporating some social and behavioral sciences into their required curricula (Self 1988). Today, a few medical schools are even starting social-action groups for their students that allow the students to actively participate in helping those directly affected by poverty, hunger, or abuse. It is critical to underscore, however, that these various reforms are being instituted voluntarily. The result

is a complete lack of uniformity in their presentation. For example, in their study of physicians responses to battered women, Sugg and Inui (1992) find that sixty-one percent of the physicians in their sample received no training on domestic violence as opposed to eight percent who state that they received good training in this area. Therefore, one must assume that, at best, some future physicians are exposed to the issue of battered women through their medical curricula, but most are not.

The reforms that are being initiated throughout the United States and much of the world fall "fairly neatly" into two broad categories known as the cognitive approach which utilizes a passive style of learning and the affective approach which utilizes a more active style of learning (Self 1988, 228). In a comparison of these two broad approaches, Self (1988) finds that they have similar goals but significantly different objectives, and methods of implementation. And while many note the general uses of the behavioral sciences and the humanities in medical education, there exists no specific literature which compares the effectiveness of these two approaches in encouraging physicians to address the issue of battered women. Such a comparative analysis is listed as a "high priority" for medical sociologists (Colombotos 1988). Before we can begin to examine the effectiveness of the two approaches, however, we must first understand their goals, objectives, and methods

of implementation.

The Cognitive Approach

The goal of the cognitive approach to medical education is to develop a greater level of clinical competence in future physicians. It attempts to produce more effective doctors by contributing to their skills of "critical reasoning and analysis and thereby indirectly to their moral maturity" (Self 1988, 229). The focus is on being able to take "proper care" of patients with more compassion and caring by emphasizing the importance of the patient's feelings and behaviors within the doctor-patient relationship (Gorlin and Zucker 1983; Self 1988).

The objectives of the cognitive approach to medical education reform include broadening the educational experiences and improving the reasoning skills of students through exposure to many of the moral and social issues of medicine. The cognitive approach attempts to discourage the indoctrination of values and encourage open-mindedness and tolerance while sharpening students' perceptions and stimulating their problem-solving capabilities (Clouser 1978; Self 1988).

Finally, the cognitive approach utilizes passive learning techniques such as traditional classes, courses, lectures, seminars, panels, and symposia. For example, at the Medical College of Virginia, a behavioral sciences course is required

in the first year. This course addresses the topic of physician/patient relationships and includes sociological concepts such as role, help-seeking behavior, and the bio/psycho/social model of health. This course also discusses the need for physicians to consider social and environmental factors when treating patients. At other schools, the classical humanities such as philosophy, history, literature, law, religion, and art and the ways in which they relate to medicine are sometimes presented to medical students (Puckett, Graham, Pounds, and Nash 1989). Each course, however, is treated as if it is like the other disciplinary parts of the medical curriculum; a set of facts transferred from the instructor to the student as an endless flow of information with little time for discussion (Burns 1978; Clouser 1978; Self 1988).

The Affective Approach

In the affective approach, the major goal also is to contribute to clinical competence of medical students by increasing compassionate, caring relationships between physicians and patients. To achieve this goal, an emphasis is placed on better understanding oneself in order to better understand patients, and thus, provide better care for patients. Proponents of this approach argue that if four years of medical school are to have any positive effect on physicians' attitudes and orientations toward patients, then

an active learning approach rather than an passive learning approach would seem to hold the greatest potential for change (Babbie 1970; Gorlin and Zucker 1983; Self 1988). In a study of medical students who attended an institution using the affective approach, Gordon (1992) finds that seventy-seven percent of the medical students attribute positive attitudinal and behavioral changes in their professional development to their self-evaluation experiences. Therefore, the logic behind the affective approach is that before we can begin treating the whole patient, we must first nurture the whole physician because a physician who is not healthy mentally or emotionally will not be able to treat patients properly (Clouser 1978; Cody 1978; Gorlin and Zucker 1983; Self 1988).

Supporters of the affective approach to medical education believe that the physician's feelings and behaviors are just as important as the patient's in defining the character of the doctor-patient relationship (Doran 1983; Gorlin and Zucker 1983). Gorlin and Zucker (1983) note that a physician's feelings about a patient and his or her medical and social needs influence diagnostic accuracy, treatment decisions, and even outcomes, and the literature on battered women and their experiences with physicians would seem to lead credence to this view (Millman 1977; Pahl 1979; Stark, Flitcraft, and Frazier 1979; Scully 1980; Medved 1982; Mizrahi 1986; Kurz 1987; Fox 1989; Warshaw 1989; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992; Smith 1992;

Sugg and Inui 1992; Jecker 1993). For example, women who have been battered are often considered by physicians to be "difficult" or "bad" patients because their reactions to or ways of coping with violence may cause them to display unusual behavior. Proponents of the affective approach, however, believe that encouraging medical students to try to understand their own beliefs about victimization may provide them with special insight into difficult encounters with battered women (Burge 1989). Studies indicate that affective learning does help to correct negative or prejudicial stereotypes toward various patient groups (Margolies, Wachtel, Sutherland, and Blum 1983). Also important when considering the treatment of battered women is the fact that affective learning in medical curricula produces physicians who want to deal with uncertainties in diagnoses and prognoses (Barbato, Frazier, Leischner, Gunzburger, Loesch, and Yang 1988).

Some of the objectives of the affective approach are quite similar to those of the cognitive approach. For instance, the affective approach attempts to increase sensitivity and awareness and to encourage open-mindedness and tolerance among medical students (Clouser 1978; Self 1988). In contrast to the cognitive approach, however, the affective approach encourages students to increase their self-knowledge and build better self-concepts. Furthermore, by acknowledging that students have their own problems, predetermined attitudes, and expectations and that such problems, attitudes,

and expectations are likely to affect the course of a student's education, the affective approach forces medical students to deal with their own personal, social, and professional prejudices and biases (Gadd 1973; Eichna 1980; Doran 1983; Margolies, Wachtel, Sutherland, and Blum 1983; Barrett 1985; Fox 1989; Downie and Charlton 1992). According to Self (1988, 231), students are better able to understand and clarify their own values and "stay in touch" with their own feelings and their patients' feelings. In effect, they learn "to take care of themselves so they can better take care of others" (Self 1988, 231).

In definite contrast to the cognitive approach, the affective approach uses more non-traditional activities to achieve its goals and objectives. As Bloom (1988, 297) notes, one could use "the same didactic model that prevails in the conventional curriculum," but such a model only adds to a medical student's memory, "leaving serious questions about whether they have any effect on practice." This approach, however, utilizes experiential learning techniques such as simulated patient programs which incorporate moral and social issues into actual medical cases for student training purposes. An example of such a simulated patient case would be a homosexual with AIDS. In this case, the medical student would be encouraged to face any initial biases that he or she might feel toward the patient even before the biological problems of the case are addressed (Puckett, Graham, Pounds,

and Nash 1989). The affective approach uses retreats and small group sessions also. At the Eastern Virginia Medical School, the objectives of the affective approach are achieved by having students begin their medical school experiences by attending small group sessions to take inventories of their own lives and list all of the social problems with which they have had to cope. These experiences are used to teach skills in stress management, interpersonal communication, burnout and impairment prevention, personal growth and development, and community building (Puckett, Graham, Pounds, and Nash 1989). In sessions such as "Racial Consciousness in Physician/Patient Relationships" and "Stresses on the Physician's Personal Life," medical students are also encouraged to participate in role-playing and communication skills practice sessions which help them to develop the skills and strengths needed to be a modern physician (Puckett, Graham, Pounds, and Nash 1989). Uniquely, the affective approach uses very few formal or traditional courses (Gorlin and Zucker 1983; Self 1988).

CHAPTER 5

FEMINIST THEORY AS A THEORETICAL PERSPECTIVE

Some sociologists have developed theoretical models that attempt to explain the failure of the medical system to respond adequately to women in general and to battered women in particular (Rothman 1989; Rothman 1991). A vital element in each of these models is the recognition that both physicians and patients bring to their encounters "remnants of their upbringings within cultures that value differential characteristics for women and men" (Kaplan 1979, 118). Such remnants can influence both the stance taken by each member of the relationship and the ways in which each perceives and interprets the behaviors of the other (Scully and Bart 1973; Kaplan 1979; Cogswell and Arndt 1980; Bernstein and Kane 1981; Foster 1989). Another important element in each of these models is the recognition that the majority of physicians are male while the majority of patients are female -- even when visits for pregnancy and childbirth are controlled (Howell 1974; Cogswell and Arndt 1980; Scully 1980; Raymond 1982).

Using a feminist perspective, Cogswell and Arndt (1980) note that the patterns of interactions that occur between male physicians and female patients have their foundations in

patriarchy and in its stereotypical views of women. The traditional model of the physician/patient interaction is marked by an unequal distribution of power, and this relationship is even more starkly defined in the male physician/female patient encounter where the appropriate behavior is limited by the roles governing physician/patient interactions and the more general norms governing male/female interactions (Kaplan 1979; Rothman 1991; Smith 1992). Therefore, "medical encounters may reinforce structural patterns of domination and oppression" (Waitzkin and Britt 1989). As the American Medical Association report of the Council on Ethical and Judicial Affairs states:

> Gender bias may not necessarily manifest itself as overt discrimination based on sex. Rather, social attitudes, including stereotypes, prejudices, and other evaluations based on gender roles may play themselves out in a variety of subtle ways (Smith 1992, 26).

One instance in which this subtle discrimination manifests itself is when physicians' stereotypes of women place them at greater risk for being diagnosed without extensive physical examination as having "conditions of psychosomatic etiology" (Cogswell and Arndt 1980, 2). Physicians simply believe that women are so overemotional that their symptoms are unlikely to reflect any real disease or illness. Therefore, they consistently attribute the illnesses of females to psychological causes more often than the illnesses of males, even when the symptoms and the conditions of the cases are similar (Howell 1974; Wallen, Waitzkin, and

Stoeckle 1979; Bernstein and Kane 1981). After a psychological diagnosis, it is also true that women, compared to men, are more likely to have their depressions and anxieties treated by drugs than to be helped to overcome the causes of their distress (Howell 1974; Lorber 1975b; Corea 1977; Dobash and Dobash 1979; Pahl 1979; Stark, Flitcraft, and Frazier 1979; Cogswell and Arndt 1980; Bernstein and Kane 1981; Borkowski, Murch, and Walker 1983; Rose and Saunders 1986; Bowker and Maurer 1987; Mehta and Dandrea 1988; Burge 1989; Warshaw 1989; Mugford, Mugford, and Easteal 1990; Randall 1990b; Council on Ethical and Judicial Affairs 1992; Jecker 1993).

Other sociologists argue that physicians do not treat women as adults. They "talk down" to female patients and ". . . use the medical system to reinforce the idea that women are dependent, helpless, and less competent than men" (Gray and Ackerman 1978; Bernstein and Kane 1981, 600; Rothman 1991). For example, in a study on doctor/patient interactions, Wallen, Waitzkin, and Stoeckle (1979) find that doctors consistently respond to women in a less technical way than they respond to men, even when the questions asked are equally technical. Furthermore, Kurz (1987, 73) argues that physicians and other health care personnel are more likely to respond to the abuse of women who are polite and have no "discrediting attributes." Women who have pleasant personalities, display no hostility or anger, and appear

somewhat submissive are seen by physicians as more deserving of their time (Kaplan 1979; Kurz 1987).

Feminists acknowledge the inevitability of sexism within medicine because most modern medical institutions are embedded in patriarchal cultures (Rothman 1989; Rothman 1991). The case of Dr. Frances Conley, a tenured professor of neurosurgery who publicly resigned from the faculty of the Stanford University School of Medicine because of the rampant sexism of her male colleagues, underscores this point (Smith 1992). As Smith argues, if a brain surgeon who is a woman is "pinched, patted, and patronized" by male colleagues, we should not be surprised that female patients are susceptible to such treatment (Smith 1992, 32). Thus, despite the growing numbers of women in the medical profession, medicine is a socially constructed domain in which masculine values and perspectives about what is normal and healthy or abnormal and sick continue to predominate (Howell 1974; Cogswell and Arndt 1980; Bernstein and Kane 1981; Eisenberg 1983; Martin, Arnold, and Parker 1988; Rothman 1989; Rothman 1991). In support of the institutionalized nature of the problem, Harrison (1982, 205) concludes that "the problem is with some of the basic practices and basic assumptions about women that are an integral part of the profession;" she further argues that "the same system, with women replacing men, would not change it significantly."

Further evidence supporting the inherent sexism of the

medical profession is provided by Broverman and colleagues (1970, 4-5) who find that physicians describe a healthy, mature, and socially competent women as one who is "more submissive, less independent, less adventurous, more easily influenced, less aggressive, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, and less objective." A number of researchers conclude that these stereotypical views have profound effects on the diagnosis, treatment -- as well as the mistreatment -- of female patients (Millman 1977; Stark, Flitcraft, and Frazier 1979; Cogswell and Arndt 1980; Scully 1980; Bernstein and Kane 1981; Leserman 1981; Kurz 1987; Warshaw 1989; Rothman 1991; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992; Novello, Rosenberg, Saltzman, and Shosky 1992; Smith 1992; Sugg and Inui 1992; Jecker 1993).

Medical textbooks also are recognized by feminist writers as a source of support for the sexist notions that exist in the health care system (Scully and Bart 1973; Lorber 1975; Corea 1977; Cogswell and Arndt 1980; Scully 1980; Bernstein and Kane 1981; Foster 1989; Rothman 1991). These texts reveal a persistent bias toward greater concern for a female patient's husband than for the patient herself, and women are consistently described as anatomically destined to reproduce, nurture, and keep their husbands happy (Scully and Bart 1973; Cogswell and Arndt 1980; Foster 1989). Cogswell and Arndt

(1980) state that these texts cite data that reinforce the stereotypes of women as passive, dependent, and masochistic and fail to refer to the data that do not support such a biased view of women. For example, Scully and Bart (1973, 1048) quote one gynecological textbook which states that "an important feature of sex desire in the man is the urge to dominate the woman and subjugate her to his will; in the woman acquiescence to the masterful takes a high place." Furthermore, Cogswell and Arndt (1980) produce the following profile of an average woman from a widely used obstetrics and gynecology textbook: (1) she needs pain, (2) she's a child, (3) she loves rape, (4) she feels like an animal, (5) she needs a psychiatrist, (6) she does not need a clitoris. Even a 1987 medical textbook continues to reflect sexist views by arguing that "highly strung emotional women exaggerate the significance of menstruation while well-balanced individuals disregard it" (Foster 1989, 339).

When medical students and their physician professors are exposed to such attitudes toward women, we can not be completely surprised by their lack of empathy, understanding, or caring for victims of abuse (Scully 1980). Smith (1992, 28) recalls that, as an emergency room physician, he almost never heard rape victims referred to as anything but a "rape case." Some of the comments made by physicians that stand out in his mind: "the stupid bitch was walking alone at two o'clock," "you should have seen this one, miniskirt, no bra,

she was asking for it," and "it wasn't a real rape, she was a hooker" (Smith 1992, 28). Scully (1980, 130) notes a similar view when she quotes an emergency room physician as saying, ". . . there is no kick in seeing a lady who, you know, decided to say that her boyfriend raped her because she had a fight with him in a bar that night."

CHAPTER 6

RESEARCH DESIGN

Theoretical Design

To date, there exists no specific literature which directly addresses the relationship between medical education and medical students' perceptions of battered women (Leiderman and Grisso 1985). Using a feminist theoretical model, this thesis is designed to contribute to the understanding of this issue by exploring the attitudes of medical students towards the care of battered women. Specifically, the study examines: [1] the exposure of medical students, through the medical school curriculum and other sources, to issues concerning battered women; [2] the manner in which gender affects students' attitudes toward battered women; [3] the manner in which the social and political environments of the state affect students' attitudes toward battered women; and [4] the manner in which the method of training affects students' attitudes toward battered women.

Based on the literature reviewed earlier, several hypotheses are developed. The first hypothesis considers findings which suggest that despite the conforming pressures of medical school, female medical students are much more

responsive than male medical students to issues that affect the health care and treatment of women. This is the one area in which gender is a more powerful influence on beliefs and attitudes than is the status of future physician. In situations where female physicians see patients suffering from abuse or the symptoms of abuse to which they themselves are possibly vulnerable, they are more likely to be empathetic, understanding, responsive, and compassionate (Corea 1977; Morantz-Sanchez 1985; Konner 1987). Therefore, the following hypothesis is presented:

Hypothesis One

[a] Female medical students, more than male medical students, will believe that physicians should be more responsive to battered women.

[b] Female medical students, more than male medical students, will believe that medical education needs to provide more information about the treatment and care of battered women.

In terms of a cross-national comparison of medical students' perceptions of battered women, the literature on Ireland is also important in formulating another hypothesis which is as follows:

Hypothesis Two

[2] There will be differences between American and Irish medical students' perceptions of battered women.

This hypothesis, however, should be more precise. Therefore, two corollaries are presented which explain the differences that are expected between American and Irish males and American and Irish females.

In its written laws, the Irish state prescribes a more dominant role for males within the family and within society than does the American state. Because they have experienced and continue to experience the privileges and benefits of male dominance to a greater extent than American males, we expect Irish males to be less concerned about women's issues. Thus, the following corollary is suggested:

Corollary One

[a] American male medical students, more than Irish male medical students, will believe that physicians should be more responsive to battered women.

[b] American male medical students, more than Irish male medical students, will believe that medical education needs to provide more information about the treatment and care of battered women.

Furthermore, according to the written laws of both countries, American women have more freedom and independence to run their own lives than many Irish women. Therefore, because of the restricted and limited roles the Irish state prescribes for women within the family and society, we expect Irish female medical students, as educated women, to be particularly sensitive to women's issues. Therefore, the

second corollary is as follows:

Corollary Two

[a] Irish female medical students, more than American female medical students, will believe that physicians should be more responsive to battered women.

[b] Irish female medical students, more than American female medical students, will believe that medical education needs to provide more information about the treatment and care of battered women.

Finally, the information on the cognitive and affective approaches to medical education suggests that students trained in these different methods could have quite different perceptions of patients. While both methods impart much of the same knowledge to future physicians, only one approach, the affective approach, utilizes active learning and forces medical students to acknowledge that their own social biases can affect their treatment of patients (Lorber 1975). Previous studies of special programs in medical education have revealed that affective learning experiences "foster a more positive orientation toward patients' social and emotional problems" (Rezler 1974, 1026; Barbato, Frazier, Leischner, Gunzburger, Loesch, and Yang 1988; Kendall and Reader 1988). Thus, despite feminist theory which would suggest that the patriarchal cultures in which the American and Irish medical systems are imbedded would prevent any positive effects of an affective medical education, the following hypothesis is

suggested:

Hypothesis Three

[a] Students trained in the affective approach, more than students trained in the cognitive approach, will believe that physicians should be more responsive to battered women.

[b] Students trained in the affective approach, more than students trained in the cognitive approach, will believe that medical education needs to provide more information about the treatment and care of battered women.

Research Instrument

The data to be used in this study were collected in the Spring of 1994 as part of a collaborative research project involving an undergraduate honors student, Poorwa Kenkre, and Professor Kathleen Slevin, Director of Graduate Studies of the Department of Sociology at the College of William and Mary. The initial study conducted by Ms. Kenkre involved the distribution of a questionnaire to selected medical students in order to assess their attitudes toward and knowledge of issues surrounding battered women and their treatment. First and final year medical students at the Medical College of Virginia (MCV) in Richmond, Virginia, and at Eastern Virginia Medical School (EVMS) in Norfolk, Virginia, constituted the sample. The final year questionnaire was distributed to medical students at University College, Dublin (UCD), Ireland a short time later.

The research instrument used to approach these questions

is composed of a questionnaire designed to collect data on the exposure of medical students to issues surrounding battered women. The questionnaire also deals with the medical students' attitudes toward battered women. The instrument contains twenty-three questions, the first six of which are demographic and ask for age, sex, race, year of study, undergraduate institution and major, and intended medical specialty.

Questions seven through seventeen are presented as statements to which respondents are asked to express agreement or disagreement on a scale of one [1] to five [5], with one [1] representing strong agreement and five [5] representing strong disagreement. Questions eighteen and nineteen ask respondents to indicate from a given list which services they feel the medical community should provide to battered women and then rank the services marked according to their perceived importance to battered women on a scale of one [1] to five [5], with one [1] indicating most important and five [5] indicating least important.

Questions twenty and twenty-one pertain to the knowledge that medical students have on issues concerning battered women. In the first question, respondents are asked to rate their knowledge of these issues on a scale between one [1] and five [5], with one [1] indicating not very knowledgeable and five [5] indicating very knowledgeable. Then respondents are asked to indicate from a given list where this knowledge was

obtained.

The last two questions are open-ended and allow respondents to write more thorough answers. In the first question, respondents are asked what role they think the medical community should play in the treatment of battered women, while the second question asks respondents if, and how, they think medical school could better prepare them to work with battered women.

T-tests and cross-tabulations are used to evaluate and describe the relationships between students' responses. The data will be examined to note the effects of gender, nationality, and the varying curricula at MCV, EVMS, and UCD.

Sample

The sample is purposive. Personal contacts at the Medical College of Virginia (MCV), the Eastern Virginia Medical School (EVMS), and at the University College, Dublin (UCD) provided the opportunity to survey at least one cohort of medical students at each institution. Only the responses of medical students in their final year of medical school are being used in this study because this thesis attempts to examine the influence of medical education and socialization on physicians' perceptions of battered women[3]. Any findings

[3] American medical students attend four years of medical school after completing four years of a general undergraduate education, while Irish medical students attend six years of medical school after completing high school.

must be cautiously interpreted, however, because we are not aware of students' perceptions of issues concerning battered women when they began medical school. Obviously, we cannot rule out the influence of maturation itself or other factors not measured in this study.

The sample contains an N of 187 respondents. 39% (n=73) are from MCV, 17.6% (n=33) are from EVMS, and 43.3% (n=81) are from UCD. Of this cohort, 52.4% (n=98) are males and 47.6% (n=89) are females. 56.7% (n=106) are American and 43.3% (n=81) are Irish. Also important for this thesis is the knowledge that 82.4% (n=154) are being educated within the cognitive approach and 17.6% (n=33) are being educated within the affective approach.

The racial make-up of the sample is somewhat uniform. 84.9% (n=158) are Caucasian, 8.1% (n=15) are Asian-American, 2.2% (n=4) are African-American, and .5% (n=1) are Hispanic-American[4]. An additional 4.3% (n=9) marked the category of other[5]. Finally, 66.7% (n=124) of the cohort are under the age of twenty-six. 22.0% (n= 41) are twenty-seven to thirty, 6.5% (n=12) are thirty-one to thirty-five, and 4.8% (n=9) are over the age of thirty-five.

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[4] The usual racial make-up of the population of American medical schools is as follows: 85% Caucasian, 6% Asian-American, 6% African-American, and 4% Hispanic-American.

[5] The unusually high percentage of medical students who marked the category of "other" is related to the cross-national nature of the study. Students attending medical school in Ireland who did not define themselves as "Caucasian" could only define themselves as "other".

Implementation

The questionnaires were completed in two ways: [1] 161 MCV fourth year students were sent the instrument through the mail using address labels provided by the Dean's Office at MCV and [2] 95 EVMS and 117 UCD questionnaires were distributed in classroom settings. The response rates were 45.3% (n=73) for MCV, 34.7% (n=33) for EVMS, and 69.2% (n=81) for UCD.

Presentation of the Findings

Tables I through V present the results of questions seven through seventeen. Although students were asked to express agreement or disagreement with these statements on a scale of one [1] indicating strong agreement to five [5] indicating strong disagreement, the order of the Likert scale is reversed when the findings are reported. Thus, the larger the number, the greater a student's agreement with the statement. Table I summarizes all medical students' attitudes toward battered women controlled by gender. Table II presents the same data controlling for nationality. Tables III and IV summarize medical students' attitudes toward battered women controlled by both nationality and gender, and Table V presents medical students' attitudes toward battered women controlling for the curricular differences between schools. Tables VI and VII present the results of questions eighteen and nineteen. Table VI displays the services medical students believe should be provided to battered women and Table VII reveals the

importance that medical students place on those services. For question nineteen, students were asked to rank the importance of the services on a scale of one [1] indicating most important to five [5] indicating least important, but in Table VII, this scale is reversed. Thus, the larger the number, the more important students believe the service to be. Tables VIII and IX present the results of questions twenty and twenty-one. Table VIII indicates how knowledgeable medical students believe they are about issues concerning battered women while Table IX reveals the sources of medical students' reported knowledge. Finally, Table X presents the results of question twenty-three in which medical students were asked whether or not medical school could better prepare them to work with battered women.

CHAPTER 7

FINDINGS

Questions 7-17: Attitudes Toward Battered Women

Attitudes Controlled by Gender

The data displayed in Table I examine the perceptions of selected medical issues related to battered women controlled by gender. Male medical students express significantly more agreement than female medical students with the following statements: [1] physicians adequately serve the medical needs of battered women, [2] battered women are often neurotic and unstable, and [3] medical training currently provides students with a clear understanding of the social factors relating to patients' health. By contrast, female medical students demonstrate significantly greater agreement than male medical students with the following statements: [1] physicians do not have time to deal with the non-medical needs of battered women, [2] physicians should do more to identify battered women, [3] battered women should be seen and treated by female physicians, [4] physicians are less likely to suspect affluent female patients have been battered, and [5] medical schools should provide students with special training regarding battered women. While the implications of these findings are

TABLE I

Perceptions of Medical Issues Related to Battered Women Controlled by Gender

Perceptions	Mean Score		
	Males (n=98)	Females (n=89)	Sig.
q7: Physicians adequately serve the medical needs of battered women	3.10	2.56	.000
q8: Physicians do not have time for non-medical needs	3.10	3.44	.023
q9: Physicians should do more to identify battered women	3.70	4.17	.001
q10: Non-medical care by nurses	2.82	2.89	NS
q11: Treated primarily by female physicians	2.59	3.31	.000
q12: Unacceptable intrusion of privacy	1.37	1.34	NS
q13: Important to determine cause of injury	4.40	4.44	NS
q14: Battered women are often neurotic and unstable	2.23	1.60	.000
q15: Physicians believe battering less in affluent patients	3.62	4.04	.002
q16: Medical school teaches social factors about health	2.60	2.36	.064
q17: Medical school should provide training about battered women	3.28	3.88	.000

Agreement levels: 1=Strongly Disagree to 5=Strongly Agree

NS=difference(s) is(are) not statistically significant (T-tests)

not completely clear, they do suggest that Hypothesis One is correct in its assumption that female medical students, more than male medical students, recognize the need for physicians to be more responsive to battered women and agree that medical education should provide more information on battered women.

Attitudes Controlled by Nationality

Table II compares the responses of American and Irish medical students. The data indicate that American medical students express significantly more agreement than Irish medical students with the statements [1] physicians adequately serve the medical needs of battered women, [2] it is important for physicians to determine the causes of patients' injuries, and [3] medical training currently provides students with a clear understanding of the social factors relating to patients' health. Irish medical students, however, demonstrate significantly more agreement than American medical students that [1] physicians do not have time to deal with the non-medical needs of battered women, [2] the non-medical needs of battered women are better dealt with by nurses, [3] battered women should be seen and treated by female physicians, [4] it is an unacceptable intrusion of privacy to ask a patient if her injuries are due to abuse, [5] physicians are less likely to suspect that affluent female patients have been battered, and [6] medical schools should provide students with special training regarding the treatment of battered

TABLE II

Perceptions of Medical Issues Related to Battered Women Controlled by Nationality

Perceptions	Mean Score		
	American (n=106)	Irish (n=81)	Sig.
q7: Physicians adequately serve the medical needs of battered women	3.01	2.62	.004
q8: Physicians do not have time for non-medical needs	2.89	3.75	.000
q9: Physicians should do more to identify battered women	3.93	3.92	NS
q10: Non-medical care by nurses	2.47	3.37	.000
q11: Treated primarily by female physicians	2.57	3.41	.000
q12: Unacceptable intrusion of privacy	1.12	1.67	.000
q13: Important to determine cause of injury	4.51	4.30	.051
q14: Battered women are often neurotic and unstable	1.89	1.98	NS
q15: Physicians believe battering less in affluent patients	3.71	3.97	.037
q16: Medical school teaches social factors about health	2.70	2.22	.001
q17: Medical school should provide training about battered women	3.48	3.69	.085

Agreement levels: 1=Strongly Disagree to 5=Strongly Agree
NS=difference(s) is(are) not statistically significant (T-tests)

women. While these findings do support Hypothesis Two and suggest that American and Irish medical students view the subject of battered women differently, the implications of such findings are unclear. Therefore, we need to examine these differences further.

Attitudes Controlled by Gender and Nationality

The data in Tables III and IV allow further examination by displaying the differences that exist between the responses of American and Irish male medical students and the responses of American and Irish female medical students. In Table III, the data indicate that American male medical students express significantly more agreement than Irish male medical students with these statements: [1] physicians adequately serve the medical needs of battered women, [2] physicians should do more to identify battered women, [3] it is important for the physician to determine the cause of patients' injuries, and [4] medical training currently provides students with a clear understanding of the social factors relating to patients' health. However, Irish male medical students demonstrate significantly more agreement than American male medical students with the following statements: [1] physicians do not have time to deal with the non-medical needs of battered women, [2] the non-medical needs of battered women are better dealt with by nurses, [3] battered women should be seen and treated by female physicians, [4] it is an unacceptable

TABLE III

Perceptions of Medical Issues Related to Battered Women Controlled by Gender and Nationality

Perceptions	Mean Score		
	American Males (n=65)	Irish Males (n=33)	Sig.
q7: Physicians adequately serve the medical needs of battered women	3.26	2.78	.013
q8: Physicians do not have time for non-medical needs	2.92	3.45	.019
q9: Physicians should do more to identify battered women	3.81	3.48	.085
q10: Non-medical care by nurses	2.47	3.51	.000
q11: Treated primarily by female physicians	2.37	3.03	.008
q12: Unacceptable intrusion of privacy	1.12	1.87	.001
q13: Important to determine cause of injury	4.53	4.15	.050
q14: Battered women are often neurotic and unstable	2.09	2.51	.039
q15: Physicians believe battering less in affluent patients	3.51	3.84	.063
q16: Medical school teaches social factors about health	2.73	2.36	.060
q17: Medical school should provide training about battered women	3.30	3.24	NS

Agreement levels: 1=Strongly Disagree to 5=Strongly Agree
NS=difference(s) is(are) not statistically significant (T-tests)

TABLE IV

Perceptions of Medical Issues Related to Battered Women Controlled by Gender and Nationality

Perceptions	Mean Score		
	American Females (n=41)	Irish Females (n=48)	Sig.
q7: Physicians adequately serve the medical needs of battered women	2.63	2.51	NS
q8: Physicians do not have time for non-medical needs	2.85	3.95	.000
q9: Physicians should do more to identify battered women	4.12	4.22	NS
q10: Non-medical care by nurses	2.46	3.27	.001
q11: Treated primarily by female physicians	2.87	3.68	.002
q12: Unacceptable intrusion of privacy	1.12	1.53	.000
q13: Important to determine cause of injury	4.48	4.41	NS
q14: Battered women are often neurotic and unstable	1.57	1.62	NS
q15: Physicians believe battering less in affluent patients	4.02	4.06	NS
q16: Medical school teaches social factors about health	2.65	2.12	.010
q17: Medical school should provide training about battered women	3.75	4.00	NS

Agreement levels: 1=Strongly Disagree to 5=Strongly Agree
NS=difference(s) is(are) not statistically significant (T-tests)

intrusion of privacy to ask a patient if her injuries are due to abuse, [5] battered women are often neurotic and unstable, and [6] physicians are less likely to suspect that affluent women patients have been battered. These findings support Corollary One and suggest that American male medical students, more than Irish male medical students, recognize the need for physicians to be more responsive to battered women by making more of an effort to detect those women who are victims of abuse. However, both groups of male medical students are similar in their belief that medical school should provide more training about battered women which was not anticipated in Corollary One.

In Table IV, the data indicate that there are no significant differences between American and Irish female medical students on six of the eleven attitudinal measures. American female medical students, however, are significantly more likely than Irish female medical students to agree with the statement: medical training currently provides students with a clear understanding of the social factors relating to patients' health. Also, Irish female medical students are significantly more likely than American female medical students to agree with the statements: [1] physicians do not have time to deal with the non-medical needs of battered women, [2] the non-medical needs of battered women are better dealt with by nurses, [3] battered women should be seen and treated by female physicians, and [4] it is an unacceptable

intrusion of privacy to ask a patient if her injuries are due to abuse. Thus, while differences do exist between American and Irish female medical students' attitudes towards battered women, both groups of females are very similar in their beliefs on a majority of the issues which was not anticipated by Corollary Two. Both American and Irish female medical students agree that physicians need to be more responsive to battered women and that medical education should provide more information on this issue.

Attitudes Controlled by Curricular Approach

The data displayed in Table V indicate that there are no significant differences between the responses of medical students trained in the cognitive and affective approaches on seven of the eleven attitudinal measures. However, students trained in the cognitive approach do express significantly more agreement than students trained in the affective approach that [1] physicians do not have time to deal with the non-medical needs of battered women, [2] the non-medical needs of battered women are better dealt with by nurses, [3] battered women should be seen and treated by female physicians, and [4] it is an unacceptable intrusion of privacy to ask a patient if her injuries are due to abuse. Affectively trained medical students only express more agreement than cognitively trained medical students with the following statements: [1] physicians are less likely to suspect that affluent patients

TABLE V

Perceptions of Medical Issues Related to Battered Women Controlled by Curricular Approach

Perceptions	Mean Score		
	Cognitive (n=154)	Affective (n=33)	Sig.
q7: Physicians adequately serve the medical needs of battered women	2.88	2.66	NS
q8: Physicians do not have time for non-medical needs	3.38	2.69	.001
q9: Physicians should do more to identify battered women	3.93	3.90	NS
q10: Non-medical care by nurses	2.98	2.27	.000
q11: Treated primarily by female physicians	3.00	2.63	.058
q12: Unacceptable intrusion of privacy	1.41	1.12	.000
q13: Important to determine cause of injury	4.43	4.37	NS
q14: Battered women are often neurotic and unstable	1.96	1.81	NS
q15: Physicians believe battering less in affluent patients	3.82	3.84	NS
q16: Medical school teaches social factors about health	2.51	2.38	NS
q17: Medical school should provide training about battered women	3.53	3.77	NS

Agreement levels: 1 = Strongly Disagree to 5 = Strongly Agree
NS = difference(s) is(are) not statistically significant (T-tests)

have been battered and [2] medical schools should provide students with special training regarding the treatment of battered women. These differences in agreement, however, are not significant. Thus, Hypothesis Three is not supported because there appear to be very few differences between cognitively and affectively trained medical students about most issues concerning the treatment and care of battered women.

Questions 18 and 19: Services Provided by Physicians

Gender Differences

Overall, female medical students believe the medical community should provide a significantly greater number of services to battered women than male medical students believe the medical community should provide. Female medical students indicate that the medical community should provide a mean of 4.57 services to battered women compared to a mean of 4.17 services desired by male medical students. Furthermore, the data in Table VI reveal that female medical students are significantly more likely than male medical students to indicate referral to mental health services, referral to social workers, referral to women's shelters, and referral to legal advocacy are services the medical community should provide to battered women. Also, when asked to rate the importance of certain services to battered women, the data in Table VII indicate that the only service rated significantly

TABLE VI

What Services Should Be Provided to Battered Women?

Medical Students	Med. Care	Refer to Mental Health Service	Refer to Social Workers	Refer to Women's Shelter	Refer to Legal Adv.
Males	96.9%	78.6%	92.9%	79.6%	69.4%
Females	98.9%	88.8%	100%	89.9%	79.8%
Sig.	NS	.030	.009	.026	.052
American	99.1%	91.5%	98.1%	88.7%	73.6%
Irish	96.3%	72.8%	93.8%	79.0%	75.3%
Sig.	NS	.000	NS	.035	NS
American Males	98.5%	87.7%	96.9%	83.1%	69.2%
Irish Males	93.9%	60.6%	84.8%	72.7%	69.7%
Sig.	NS	.001	.041	NS	NS
American Females	100%	97.6%	100%	97.6%	80.5%
Irish Females	97.9%	81.3%	100%	83.3%	79.2%
Sig.	NS	.014	NS	.026	NS
Cognitive	98.1%	81.2%	96.8%	83.1%	72.7%
Affective	97.0%	93.9%	93.9%	90.9%	81.8%
Sig.	NS	.036	NS	NS	NS

NS=difference(s) is(are) not statistically significant (Cross-Tabulations)

TABLE VII

How Important Are These Services to Battered Women?

Medical Students	Med. Care	Refer to Mental Health Service	Refer to Social Workers	Refer to Women's Shelter	Refer to Legal Adv.
Males	4.62	2.59	3.37	2.84	2.34
Females	4.37	2.55	3.39	3.04	2.27
Sig.	.045	NS	NS	NS	NS
American	4.72	2.90	3.27	2.94	1.79
Irish	4.21	2.14	3.51	2.95	2.86
Sig.	.000	.000	.088	NS	.000
American Males	4.80	2.88	3.40	2.87	1.86
Irish Males	4.28	2.00	3.31	2.78	3.08
Sig.	.008	.003	NS	NS	.000
American Females	4.60	2.92	3.06	3.03	1.69
Irish Females	4.17	2.22	3.65	3.05	2.71
Sig.	.034	.011	.013	NS	.001
Cognitive	4.43	2.48	3.44	2.91	2.43
Affective	4.84	3.04	3.04	3.11	1.64
Sig.	.000	.016	.051	NS	.008

Importance Levels: 1=least important to 5=most important
NS=difference(s) is(are) not statistically significant (T-tests)

higher by male medical students is medical care. Thus, these findings offer further support for Hypothesis One and indicate that female medical students, more than male medical students, believe physicians should be more responsive to battered women.

Cross-National Differences

American medical students believe the medical community should provide a significantly greater number of services to battered women than Irish medical students do. American medical students believe battered women should be provided with an average of 4.50 services by the medical community while Irish medical students believe battered women should be provided with an average of 4.17 services. The data displayed in Table VI also indicate that American medical students are significantly more likely than Irish medical students to indicate that referral to mental health services and referral to women's shelters are services the medical community should provide to battered women. When rating the importance of these services, the data in Table VII reveal that American medical students rate medical care and referral to mental health services significantly higher than Irish medical students. Irish medical students, however, rate referral to social workers and referral to legal advocacy significantly higher than American medical students do.

To understand further these differences between American

and Irish medical students, the differences between American and Irish males and American and Irish females are once again examined. The data indicate that American male medical students believe the medical community should provide a significantly greater number of services to battered women than Irish male medical students do. American male medical students believe battered women should be provided with 4.35 services while Irish male medical students believe battered women should be provided with 3.81 services. The data in Table VI reveal that American male medical students are significantly more likely than Irish male medical students to indicate that referral to mental health services and referral to social workers are services the medical community should provide to battered women. Also, the data displayed in Table VII indicate that American male medical students rate medical care and referral to mental health services significantly higher than Irish male medical students rate this service. However, Irish male medical students rate referral to legal advocacy significantly higher than American male medical students rate this service. Thus, American male medical students believe the medical community should provide a greater number of services to battered women, and they generally attach more importance to these services than Irish male medical students offering further support for Corollary One.

American female medical students believe the medical

community should provide a significantly greater number of services to battered women than Irish female medical students do. American female medical students believe battered women should be provided with 4.75 services while Irish female medical students believe battered women should be provided with 4.41 services. Also, the data in Table VI indicate that American female medical students are significantly more likely than Irish female medical students to indicate that referral to mental health services and referral to women's shelters are services the medical community should provide to battered women. When asked to rate the importance of certain services to battered women, the data displayed in Table VII indicate that American female medical students rate medical care and referral to mental health services significantly higher than Irish female medical students rate these services. However, Irish female medical students rate referral to social workers and referral to legal advocacy significantly higher than American female medical students. Overall, however, these findings suggest that American female medical students and Irish female medical students are more alike than different in their responsiveness to battered women which was not anticipated in Corollary Two.

Cognitive/Affective Differences

Once again, these findings indicate that there are few actual differences between cognitively and affectively trained

medical students. Affectively trained medical students believe the medical community should provide 4.57 services to battered women while cognitively trained medical students believe the medical community should provide 4.31 services to battered women. Furthermore, the data in Table VI indicate that affectively trained medical students are significantly more likely than cognitively trained medical students to indicate that referral to mental health services is a service the medical community should provide to battered women. Also, according to the data displayed in Table VII, cognitively trained medical students rate both referral to social workers and referral to legal advocacy significantly higher than affectively trained medical students rate these services. Affectively trained medical students, however, rate both medical care and referral to mental health services significantly higher than cognitively trained medical students.

Questions 20 and 21: Perceived Knowledge About Battered Women

Gender Differences

Interestingly, the data in Table VIII indicate that male medical students rate themselves slightly more knowledgeable about issues concerning battered women than female medical students rate themselves. Also, the data displayed in Table IX reveal that male medical students are significantly more likely than female medical students to designate medical

TABLE VIII

Medical Students' Reported Knowledge of Issues Related to Battered Women

Medical Students	Level of Knowledge (Mean Score)
Males	2.68
Females	2.64
Significance	NS
American	2.93
Irish	2.32
Significance	.000
American Males	2.92
Irish Males	2.24
Significance	.000
American Females	2.95
Irish Females	2.38
Significance	.006
Cognitive	2.64
Affective	2.78
Significance	NS

Knowledge Levels: 1=not very knowledgeable to 5=very knowledgeable
NS=difference(s) is(are) not statistically significant (T-tests)

TABLE IX

Sources of Medical Students' Knowledge of Issues Related to Battered Women

Medical Students	No Info.	Current Events	Medical School	Personal Exp.	Clinical Exp.
Males	16.3%	81.6%	51.0%	28.6%	59.2%
Females	12.4%	77.5%	34.8%	30.3%	41.6%
Sig.	NS	NS	.012	NS	.008
American	15.1%	80.2%	65.1%	34.0%	67.9%
Irish	13.6%	79.0%	14.8%	23.5%	28.4%
Sig.	NS	NS	.000	.059	.000
American Males	15.4%	87.7%	67.7%	35.4%	72.3%
Irish Males	18.2%	69.7%	18.2%	15.2%	33.3%
Sig.	NS	.026	.000	NS	.000
American Females	14.6%	68.3%	61.0%	31.7%	61.0%
Irish Females	10.4%	85.4%	12.5%	29.2%	25.0%
Sig.	NS	.026	.000	NS	.000
Cognitive	11.0%	79.9%	39.6%	28.6%	46.8%
Affective	30.3%	78.8%	60.6%	33.3%	69.7%
Sig.	.002	NS	.013	NS	.008

NS=difference(s) is(are) not statistically significant (Cross-Tabulations)

school and clinical experience as sources of information about issues concerning battered women.

Cross-National Differences

As noted in Table VIII, American medical students rate themselves significantly more knowledgeable about issues concerning battered women than Irish medical students rate themselves. Furthermore, American medical students are significantly more likely than Irish medical students to claim medical school, personal experience, and clinical experience as sources of information about battered women as indicated by the data displayed in Table IX.

The data in Table VIII reveal that American male medical students rate themselves significantly more knowledgeable about issues concerning battered women than Irish male medical students rate themselves and that American female medical students rate themselves significantly more knowledgeable about issues concerning battered women than Irish female medical students rate themselves. American males are significantly more likely than Irish males to designate current events, medical school, personal experience, and clinical experience as sources of information about battered women in Table IX. Also in Table IX, American females are significantly more likely than Irish females to claim medical school and clinical experience as sources of information about issues concerning battered women. However, Irish female medical students are significantly more likely than American

female medical students to indicate that current events are a source of information about battered women.

Cognitive/Affective Differences

Finally, the data in Table VIII indicate that affectively trained medical students rate themselves slightly more knowledgeable about issues concerning battered women than cognitively trained medical students rate themselves. Furthermore, affectively trained medical students are significantly more likely than cognitively trained medical students to designate medical school and clinical experience as sources of information about battered women in Table IX.

Question 22

What role do you think the medical community should play in the treatment of battered women?

When asked what role the medical community should provide in the treatment of battered women, medical students agree on several points. Virtually all agree that the most important role of the medical community in the treatment of battered women is to "provide needed medical care." One male student expresses an opinion that captures the comments of many when he writes, "the medical community serves as the frontline in the intervention and treatment of battered women." Also, a female student suggests, "The medical community can and should . . . serve as a starting point for help and recovery for battered women." Another female student adds, "The medical

community should act as the backbone of services needed for the treatment of battered women."

Others believe that physicians have a duty to "look for the warning signs" of abuse and identify battered women. As one male student states, it is extremely important for physicians to "make a concerted effort to identify battered women." Another student captures this same idea when he says, "Physicians should be able to pick-up on the physical signs and/or mental signs of battery." Finally, a third male student strongly believes, "All practitioners should have special training in how this type of patient would present to their particular specialty/subspecialty and be made aware of the options available to the patient and practitioner."

A majority of the medical students believe that, once identified, "these patients should be given appropriate referrals" to other services and agencies. One male student states, "The physician should know what agency in the community, whether it be social work or law enforcement, can give the patient protection." Another student gives a slightly different angle on this same issue when he says, "The medical community has a duty, if it is known that a woman is battered, to refer her to social services." As one female student put it, "it is essential to offer [a battered woman] this information and not assume that she will get it herself." Another female student feels strongly that a battered woman "must not be discharged from care unless she has been referred

to some other agency better capable of assisting her." Finally, a third student captures the idea of several other students when she says, "The medical community may be the first and possibly only group to come in contact with battered women -- the opportunity should be taken to offer them as many services as possible at that time, as they may not have the opportunity again." Thus, the comments of these students strongly suggest that the medical community has a responsibility, as one female student believes, to be "the link between a [battered] woman and the other services available to her."

Gender Differences

Not surprisingly, there are differences between male and female responses. Many female medical students, both American and Irish, believe that the medical community should play a stronger role in addressing the importance of the issue of battered women. One female student expresses this sentiment when she says, "the medical community should be an advocate for women's mental and physical health rights." Another student captures this idea in her comment that "the medical community needs to devote more time to all aspects of [women's] lives which affect their health."

Furthermore, American and Irish female medical students believe the medical community has a duty to be more understanding of and sensitive to the many needs of battered

women. As one female student notes, "The medical community needs to pay more attention to the needs of battered women. Physicians need to be better trained in not only medically treating these patients but also emotionally helping them and understanding them." Female students seem to agree that "women would be more likely to discuss such problems" if the medical community appeared as if it were really concerned and "willing to help." Also, female medical students agree that the medical community should be a source of emotional support for battered women. Thus, a majority of the female students agree that physicians should "always be supportive and sensitive." One female student states, "The point at which these women need medical care may often provide their first opportunity for a confidential, supportive relationship." Another female student feels strongly enough to say, "The most important thing is to give these women emotional rather than medical support." Still, a third female student believes physicians need to "provide the emotional support and strength [battered women] need to escape their situation."

Finally, American and Irish female medical students believe the medical community should strive to demystify the problem of spousal abuse and destigmatize battered women. One student captures the comments of many when she says, "The medical community could help alleviate the embarrassment and stigma associated with battered women." Generally, female medical students express the belief best summed up by one

student who remarks, "The more allies a battered woman has, the more strength she might feel."

Cross-National Differences

There are distinctions between the responses of American and Irish medical students. Unlike their American counterparts, Irish male and female medical students emphasize the role of the medical community as a source of help for the batterer. As one male student notes, physicians should "contact the batterer, establish precipitating factors, and find solutions." They believe the medical community has a responsibility to provide more active treatment for offenders. One student expresses this idea when she says, "The medical community should . . . recognize this is a major problem for all parties involved, male and female." Irish male and female medical students agree that the medical community should "encourage both partners to seek help." As one female student suggests, "The medical community should refer such women, their children, and their partners to family therapy." Another student adds, "Counselling and family therapy should always be carried out."

Question 23

Could medical school better prepare you to work with battered women?

The data displayed in Table X indicate that an overwhelming majority of the medical students surveyed believe

TABLE X

Could Medical School Better Prepare Physicians to Treat Battered Women?

Medical Students	Yes	No	Significance
Males	75.0%	25.0%	.005
Females	89.9%	10.1%	
American	77.8%	22.2%	.071
Irish	86.4%	13.6%	
American Males	74.6%	25.4%	NS
Irish Males	75.8%	24.2%	
American Females	83.9%	16.1%	NS
Irish Females	93.8%	6.3%	
Cognitive	81.6%	18.4%	NS
Affective	83.3%	16.7%	

NS=difference(s) is(are) not statistically significant (Cross-Tabulations)

medical school could have better prepared them to treat battered women. Several students comment that they cannot remember ever discussing the issue of battered women in medical school. As one male student states, "I cannot recall the subject [of battered women] as a topic of discussion at any time during the past four years. Another student captures this same idea when she says, "Medical students receive no

training on the recognition of abuse in women or the skills to approach these women." Finally, a third student feels strongly that she "had absolutely no preparation for working with battered women." As one female student indicates, "this implies that the doctor has no responsibility, no role."

There is general agreement that medical schools need to increase students' awareness of battered women by educating them about the signs and symptoms of abuse. One student summarizes the comments of many when he says, "Medical school should better prepare students to work with battered women by providing more education on the signs [of abuse] observed in battered women." Another student captures this same idea when she says, "Medical school could better prepare us for dealing with battered women by teaching us the signs and symptoms to look for . . . and the best ways to elicit information from the woman."

Also, students agree that medical schools should educate students about the general resources available to battered women. As one female student notes, "We should be given information on the facilities available to battered women and how they should go about getting in touch with these organizations." Another student expresses this same sentiment when she says, "Medical students should be educated as to where they can refer a battered women for the best help possible."

Several students refer to the coverage of child abuse in

pediatrics clerkships and suggest that other departments such as Obstetrics and Gynecology or Internal Medicine "take the initiative" on the issue of battered women. One student captures the comments of many when he says, "There is a lot of focus on child abuse during medical school, and it would be appropriate to include more training on recognizing and interviewing in cases involving battered women." As one female student puts it, "medical students are taught in pediatrics to 'think abuse' with each patient and this should be emphasized with female patients because, too often, a woman's hesitancy to go back home is not explored further." Finally, a male student suggests, "More lectures regarding this topic should be incorporated into the core lectures during the Obstetrics/Gynecology course."

Gender and Cross-National Differences

There are, however, some differences between the responses of male and female medical students and between the responses of American and Irish medical students. Unlike male medical students, American and Irish female medical students believe medical schools should try to put an end to the shame, embarrassment, and stigma felt by battered women. A student expresses this sentiment when she says, "Medical schools should help alleviate the embarrassment and stigma associated with battered women by helping medical students better understand the reluctance of these women to reveal the sources

of their injuries." Unlike their American counterparts, Irish medical students, both male and female, believe medical school could better prepare them to treat battered women by helping them understand the sources of the abuse. Thus, one student recommends that medical schools "discuss the factors leading to abuse" with their students. Another student feels strongly that it is important for medical students "to understand why abusers become abusers" in order to really help battered women.

Less than twenty percent of the medical students -- a majority of whom are male -- argue that medical school could not better prepare medical students to treat battered women. Some believe medical students "are adequately trained to identify, to treat, and if necessary, to refer battered women." One male student feels strongly enough to say, "I think the schools do teach this subject, and I haven't found this issue particularly tricky or tough to handle or diagnose."

Others believe the treatment of battered women is not something that can be taught to future physicians. One student captures this idea when she says, "Dealing with battered women is something one cannot learn about." Another female student states, "You simply cannot teach a student how to deal with this problem." One student gives a slightly different angle on this argument when he says, "One's ability to treat and counsel [battered women] should be an inevitable

development of education at medical school."

Several students agree that there is too much information to cover in medical school and too little time to cover it all. As one student notes, "The medical school curriculum is overloaded already." One female student suggests, "If physicians are going to be advocates for care, they will do so individually. There is not enough clinical time to cover this issue for the entire medical school population." Another male student adds, "It is increasingly alarming to me that physicians are being called upon to address an ever-widening circle of social concerns. To increase our training in social problems risks distracting our education from medical issues." One male student sums up the comments of several others when he remarks, "There is too little time to learn what we need to learn now. To focus on such a specific section of society would be impossible."

Some students believe the treatment of battered women should not be emphasized because "battered women are only a very small percentage of the social problems" that physicians encounter. As one female student puts it, "Medical school should prepare [medical students] to deal with patients in general and not concentrate on any one group." Another female student comments, "It is difficult in the scope of the four year education to concentrate very strongly on any particular issue. There are many other problems a physician must face that are as important as battered women."

Some students believe the issue of battered women does deserve attention, but they do not believe special training regarding battered women should be incorporated into the medical school curriculum. These students agree that the treatment of battered women "is something that should be learned in . . . residencies." As one male student remarks, "Although it is identified as a commonly encountered problem, [the treatment of battered women] is something best learned once it is seen clinically and not from textbooks."

CHAPTER 8

DISCUSSION OF THE FINDINGS

Domestic violence is the leading cause of injury and death to women in the United States (McLeer, Anwar, Herman, and Maquiling 1989; Randall 1990a; Duhon-Haynes and Duhon-Sells 1991; Randall 1991; Bryjak and Soroka 1994). In fact, experts estimate that approximately one-third of all American women will be physically assaulted by a husband, boyfriend, or lover during their lifetime (Lewis 1985; Council on Scientific Affairs 1992; Bryjak and Soroka 1994). These statistics make the subject of battered women a critical health-care issue which must be addressed by the medical community. Yet, some future physicians continue to believe that special training about battered women "risks distracting [medical] education from medical issues." As the most likely category of professionals to encounter battered women, however, all physicians must learn to respond to this issue with great seriousness and concern (Gelles 1972; Dobash and Dobash 1979; Pahl 1979; Stark, Flitcraft, and Frazier 1979; Borkowski, Murch, and Walker 1983; Finkelhor and Yllo 1985; Rose and Saunders 1986; Bowker and Maurer 1987; Hatty 1987; Kurz 1987; Mehta and Dandrea 1988; Burge 19689; Hamberger and Saunders 1991; Council on Ethical and Judicial Affairs 1992; Sugg and

Inui 1992; Jecker 1993).

The Detection of Battered Women

The most important service a physician can provide to a battered woman is to identify her injuries as abuse. Yet, the identification of battered women by physicians occurs at an extremely low rate (Millman 1977; Scully 1980; Schechter 1982; Finkelhor and Yllo 1985; Bowker and Maurer 1987; Hatty 1987; McLeer and Anwar 1987; Mehta and Dandrea 1988; Burge 1989; McLeer, Anwar, Herman and Maquiling 1989; Warshaw 1989; Randall 1990a; Randall 1990b; Council on Ethical and Judicial Affairs 1992; Council on Scientific Affairs 1992; Novello, Rosenberg, Saltzman, and Shosky 1992; Sugg and Inui 1992; Jecker 1993). Interestingly, the data from this study suggest that the responsiveness of physicians to battered women is affected by a physician's gender, and to a lesser extent, by a physician's nationality.

Male medical students, both American and Irish, are much more likely than their female counterparts to agree that physicians adequately serve the medical needs of battered women. This could be a reflection of the lack of information and training on battered women that is available in medical school. With no such information or training, male medical students may be responding to the issue of battered women based on personal prejudices and misconceptions (Goods 1971; Pahl 1979; Cogswell and Arndt 1980; Potts, Katz, and Brandt

1986; Rose and Saunders 1986; Bowker and Maurer 1987; Kurz 1987; Burge 1989; Foster 1989; Council on Scientific Affairs 1992; Smith 1992; Sugg and Inui 1992; Jecker 1993). Male medical students may see battered women as overemotional or self-abusive and undeserving of medical attention (Howell 1974; Lorber 1975a; Mizrahi 1986). These tendencies are obviously suggested when we see that the American and Irish male medical students are much more likely than their female counterparts to agree that battered women are often neurotic and unstable patients.

Female medical students, however, are much more critical than male medical students of the care that currently is being provided to battered women. American and Irish female medical students are much more likely than male medical students to agree that physicians should do more to identify battering among their female patients. Irrelevant of nationality, female medical students are also much more likely to agree that physicians are less likely to suspect battering among their more affluent patients. Perhaps these findings reflect the generally less traditional beliefs about physician authority and the greater concern about humanizing doctor/patient relationships that are evident in female medical students early in their medical careers (Leserman 1981; Lavin, Haug, Belgrave, and Breslau 1987; Maheux, Dufort, and Beland 1988). It could also be that female medical students are more patient-oriented and more interested in the

emotional problems of their patients (Bluestone 1978; Maheux, Dufort, and Beland 1988; Martin, Arnold, and Parker 1988). More likely than not, however, the greater responsiveness of female medical students may be due to defensive attribution which suggests that "the more the observer identifies with a victim, the more the observer will sympathize and empathize with the victim" (Rose and Saunders 1986, 429). This greater sensitivity to the treatment and care of battered women is certainly reflected in female medical students' beliefs that medical schools should provide special training about battered women. Of general importance, the findings of this study suggest that previous research which indicates that female medical students grow to resemble male medical students as they progress through medical school is too broad in its scope. Instead, it appears to be the case that certain issues elicit gendered responses from women medical students. Certainly, our findings speak to the need for further explanation of this.

There are other reasons why the detection of battered women occurs at extremely low rates. Male and female Irish medical students, for example, are much more likely than their American counterparts to agree that physicians do not have time to deal with the non-medical needs of their battered patients. One of the more practical reasons for this finding could be that the Irish system of socialized medicine really does create a great backlog of patients that need medical

attention. It has been noted that this occurs in Britain where the demand for medical care exceeds the supply and where hundreds of patients are placed on enormous waiting lists until a physician becomes available to schedule them for an appointment (Weiss and Lonnquist 1994).

Male and female Irish medical students are also more likely than American medical students to agree that the non-medical needs of battered women should be taken care of by nurses. This, too, could be a reflection of the greater time constraints placed on Irish physicians, but it could also be a reflection of greater gender divisions in Ireland. Because the majority of nurses are female, male medical students in Ireland may feel that women are better able to deal with the emotional problems that battered women often experience. Female medical students in Ireland may also believe that as women, nurses are more sensitive and capable of providing the attention that battered women really need. Male and female Irish medical students are also more likely than American medical students to agree that battered women should be seen and treated by female physicians which adds further support to these suppositions.

Also, previous research indicates that many physicians do not attempt to identify battered women because they feel that questioning women about domestic violence is too intrusive and a violation of their patients' privacy (Dobash and Dobash 1979; Stark, Flitcraft, and Frazier 1979; Borkowski, Murch,

and Walker 1983; Rose and Saunders 1986; Kurz 1987; Burge 1989; Warshaw 1989; Mugford, Mugford, and Easteal 1990; Council on Ethical and Judicial Affairs 1992; Loseke 1992; Jecker 1993). This study suggests that concerns over privacy are a major issue for Irish medical students. Irish medical students, both male and female, are significantly more likely than American medical students to agree that it is an unacceptable intrusion of privacy to ask a patient if her injuries are due to abuse. This could be a reflection of the strong political and social climate in Ireland to place family relationships outside the realm of public concern and responsibility[6]. In Ireland, it seems to be the family's rights and the family's stability that are most important to policy makers and a large percentage of the population. To question a woman about abuse could lead to "the prognosis that a woman must leave her partner" which, in turn, could challenge "schemes of interpretation defining family stability as a primary value" of Irish society (Loseke 1992, 148).

In contrast to the Irish medical students, American male and female medical students are much more likely to agree that it is important for physicians to ask about and determine the cause of patients' injuries. This could be related to the fact that American medical students, both male and female, are also more likely than their Irish counterparts to agree that

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[6] This could be especially true of the current sample of Irish students, over forty percent of whom are from more conservative rural areas.

medical training currently provides students with a clear understanding of the social factors relating to patients' health. Thus, American medical students may be getting more information about how important it is for physicians to detect abuse. It is true that American medical students are not receiving special training about battered women, but the detection of child abuse is a very important part of the American medical education curriculum. Therefore, American medical students are more likely to see the need for physicians to question their patients about what would have previously been considered personal family matters. As Konner (1987, 24) notes, American medical students are learning "the first lesson of interacting with patients: the doctor is not entitled to be reluctant. However awkward the situation, however discouraging or confusing or ugly the disease, however apparently withdrawn the patient, the doctor must step across the barrier in interpersonal space that everyone else must properly respect."

The Role of the Physician

The primary goal of any physician is to attend to the medical needs of patients, but the role of the physician is more broadly defined. Physicians are often expected to deal with patients' mental and social well-being in addition to their physical well-being (Downie and Charlton 1992). As Smith (1992) notes, patients bring many different needs to

their physicians. Although only the physical needs may be apparent at the outset, patients also bring to their physicians personal and emotional needs created by the uncertainty of illness and injury (Campos 1973; Pattishall 1973; Mechanic 1974; Stimson 1977; Pahl 1979; Doran 1983; Barrett 1985; Tosteson 1990). All of these needs are present when battered women visit physicians, and when physicians address only the physical needs of battered women, they succeed in supporting the abusive situation (Stark, Flitcraft, and Frazier 1979). Physicians who treat only a battered woman's physical needs deny the reality of her situation. A purely medical solution does not uncover the real cause of her injuries, and a battered woman is made to feel that her concerns are not real.

Thus, it is interesting to note that female medical students believe the medical community should provide a significantly greater number of services to battered women than their male counterparts. Female medical students are much more likely to agree that battered women need referrals to mental health services, social workers, women's shelters, and legal advocacy as well as medical care. Female medical students are more likely than male medical students to suggest that physicians have a real responsibility to be the "link between a [battered] woman and the other services" that she so desperately needs. Once again, perhaps women are more sensitive and concerned about the psychological, emotional,

and social problems of their patients. As noted earlier, female medical students believe physicians should be better prepared "in not only medically treating patients, but also emotionally helping them and understanding them." It could also be that, as women, female medical students recognize their own vulnerability when they come into contact with battered women making them more determined to do whatever may be necessary to help these women overcome their problems.

Furthermore, American medical students believe the medical community should provide a significantly greater number of services such as referrals to mental health services, social workers, women's shelters, and legal advocacy to battered women than their Irish counterparts. Once again, this could be a reflection of the problems created by the Irish medical-care system. Irish medical students may realize that time constraints will make it very difficult for them to provide all of the services needed by battered women. It could also be true that Irish society, because it is less affluent than American society, may have fewer of these services available for battered women. Thus, even if Irish medical students want to provide more services to battered women, they may know that these services are simply not available. Still, it could be that some Irish students feel that referring battered women to other agencies is too intrusive and that family violence is a family problem that should be dealt with at home.

What Do Medical Students Know About Battered Women?

After all that has been said about the gender differences in medical students' perceptions of battered women and their treatment and care, it is interesting to note that male medical students rate themselves as more knowledgeable about issues concerning battered women. Perhaps it is related to previous research on gender and self-confidence which suggests that males and females differ on estimates of their competence (Dweck, Goetz, and Strauss 1980; Rapoport 1981; Haertel, Waldberg, Junker, and Pascarella 1981; Safir 1986; Licht, Stader, and Swenson 1989). Women underestimate their competence while men engage in self-enhancing bias (Bar-Tel and Frieze 1977; Berg, Stephan, and Dodson 1981). It is possible that women realize the complexity of the issue of domestic violence while men do not. Statements by male medical students such as "I haven't found this issue particularly tricky or tough to handle or diagnose" suggest that this supposition is possible.

Furthermore, American medical students rate themselves much more knowledgeable about issues concerning battered women than do Irish medical students. Perhaps this is once again related to the fact that American medical students believe their medical school experiences provide them with good information regarding the social factors about patients' health. It is certainly true that American medical students are significantly more likely than Irish medical students to

indicate that medical school and clinical experiences have been sources of information on issues related to battered women.

Differences Between the Cognitive and Affective Approaches

This study found that there are very few differences between students trained in the cognitive approach and students trained in the affective approach suggesting that feminists are correct to assume the inevitability of sexism within medicine. After all, both American and Irish medical students are being educated in patriarchal cultures (Rothman 1989; Rothman 1991). This finding, however, should not discourage further research on different approaches to medical education and training. Previous research has found that these two methods of training medical students do produce physicians who respond differently to various patient groups, but perhaps this study indicates that such differences are truly issue specific (Margolies, Wachtel, Sutherland, and Blum 1983). Furthermore, the number of cognitive students surveyed was over four times greater than the number of affective students surveyed, and there were no Irish students to represent the affective approach. Thus, a more balanced sample of cognitively and affectively trained medical students may have produced different results.

Overall, the results of this study offer some encouragement for the future treatment and care of battered

women. As the largest and quickest growing minority in medical school, women physicians may create a medical community that is more responsive to the various needs of battered women (Light 1988; Martin, Arnold, and Parker 1988; Jefferys and Elston 1989). Through their interactions with male colleagues, growing numbers of female physicians may encourage all physicians to become more attuned to the needs of battered women. However, males are still a powerful majority in the medical profession, and they have a great deal of power in the higher echelons of academic medicine. Therefore, women physicians can not be expected to correct the problems with medical education by themselves. Both men and women have to work to change the institutions of medical education from the top down. The fact that many of the students in this study recognize the importance of incorporating information about the treatment and care of battered women into the medical curriculum is encouraging in this respect. Although current medical educators and physicians may not be responding to the threat of domestic violence, many future educators and physicians certainly seem to realize the need for change.

CONCLUSION

Violence against women is not merely a health issue; it is a social issue, a personal issue, and a legal issue, and physicians are not solely responsible for alleviating this problem. However, physicians need to acknowledge the role they can play in breaking the cycle of abuse. Even though every physician can not be expected to deal with all the issues pertaining to battered women, "each ought to be aware of the panoply of special services becoming available and to refer patients accordingly" (Vinten-Johansen and Riska 1991, 98). According to Bowker and Maurer (1987), physicians simply need to "take the time to find out the problem and make the proper referrals."

Although the medical curricula often is described as "overloaded" and "glutted" with information, it remains true that domestic violence is the leading cause of injury and death to women (Bryjak and Soroka 1994). Therefore, the treatment and care of battered women can not continue to be ignored in the education of future physicians. It is important for physicians and medical educators to realize that the role of the physician is not static. As times change, people's health is threatened by new diseases and social problems, and physicians must adapt. How is it possible for

a profession to realize that scientific knowledge changes every day and that they have to continue being students of scientific knowledge but not realize that they also have to be willing to deal with the changing social conditions that affect people's health?

As early as the mid-nineteenth century, physician Mary Bates chided women physicians who preached the doctrine that "there should be no sex in medicine" (Morantz-Sanchez 1985, 210). Dr. Bates warned them, "So long as there are men and women patients, there will be sex in medical problems . . . and women need women physicians to understand their ailments best" (Morantz-Sanchez 1985, 210). Her words are as true today as they were then. Women physicians simply contribute a greater diversity of background which "results in a more flexible profession with a wider sympathy and sense of responsibility" (Downie and Charlton 1992, 74). The results of this study certainly demonstrate that this is the case in the treatment and care of battered women. Overall, gender is the strongest indicator of how responsive a physician will be to battered women.

While there are no studies that pertain specifically to the education of medical students concerning the issue of battered women, this study represents an important opportunity to begin to bridge a gap that exists in the literature. Furthermore, because of its cross-national emphasis, it allows for an unique opportunity to explore how the role of the state

in women's lives may influence medical students' perceptions. However, it should be noted that any summary interpretations of the data presented in this study must be regarded as strictly applicable only to those medical students who responded to the questionnaire. Beyond this, it may be assumed that the results can be extended to apply in a more tentative manner to the medical student population in general and to physicians as a whole. Whether these findings can be given further application than this will be left to the reader's considered judgement. And while this study has certain limitations -- its cross-sectional design and its small and purposeful sample, for instance --, it is hoped that the findings and conclusions drawn will encourage other studies, both national and cross-national, that will examine the education of physicians who are vital to the physical, mental, and social well-being of generations to come.

Appendix:

Questionnaire of Fourth Year Students

ID Number

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4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

PLEASE USE A #2 PENCIL

SURVEY OF MEDICAL STUDENTS

The following survey will be used as a part of an Honors thesis that will explore the medical community's reaction to battered women. For the purpose of this study battered women are defined as adult women who are (or have been) in established relationships with men who intentionally physically abuse (or abused) them in ways that caused physical pain and injury.
Thank you for helping with this project by answering these questions.

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1. Age: ☐ under 26 ☐ 27 - 30 ☐ 31 - 35 ☐ over 35
2. Sex: ☐ male ☐ female
3. Race: ☐ Caucasian ☐ African-American ☐ Hispanic-American ☐ Asian-American ☐ Other
4. Year of medical study: ☐ 1 ☐ 2 ☐ 3 ☐ 4
5. Undergraduate Major and Institution: _____
6. Intended Medical Specialty: _____

Please rate the following statements on a scale of 1 to 5 (with 1 indicating strong agreement to 5 indicating strong disagreement).

	1 STRONGLY AGREE				5 STRONGLY DISAGREE
7. Currently, physicians adequately serve the medical needs of battered women.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Physicians do not have time to deal with the non-medical needs of their battered patients.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. Physicians should do more to identify battering among their women patients.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. The non-medical needs of battered women's care are better dealt with by nurses than by physicians.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. Ideally, battered women should be seen and treated by female physicians.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12. It is an unacceptable intrusion of privacy to ask a patient if her injuries are due to abuse.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. When the cause of injury is unclear, it is important for the physician to determine the cause of patients' injuries.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14. Battered women are often neurotic and unstable.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15. Physicians are less likely to suspect that affluent women patients have been battered.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16. Medical training currently provides students with a clear understanding of the social factors relating to patients' health.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
17. Medical schools should provide students with special training regarding the treatment of battered women.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

ID Number

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

18. Which, if any, of the following services should the medical community provide battered women? (Mark all that apply):

- ☐ A. medical care
- ☐ B. referral to mental health services
- ☐ C. referral to social workers
- ☐ D. referral to women's shelters
- ☐ E. referral to legal advocacy
- ☐ F. other: _____

19. Of the ones that you have marked, rank the above services in order of importance, with [1] indicating the most important to [6] indicating the least important.

A.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
B.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
C.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
D.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
E.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
F.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

20. How knowledgeable do you think you are of issues concerning battered women? Rank on a scale of 1 to 5 (with 1 indicating not very knowledgeable to 5 indicating very knowledgeable).

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

21. Which of the following have been sources of information about battered women for you? (Mark all that apply):

- ☐ I have not had any information.
- ☐ undergraduate education
- ☐ current events
- ☐ medical school
- ☐ personal experience
- ☐ clinical experience
- ☐ other: _____

Please take a couple of minutes to answer the following questions:

22. What role do you think the medical community should play in the treatment of battered women?

_____

_____

_____

_____

_____

_____

23. Could medical school better prepare you to work with battered women? ☐ Yes ☐ No

Please explain: _____

_____

_____

_____

_____

_____

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