Responding to intimate partner violence:
what role for general practice?

The high prevalence of violence perpetrated by men against their wives, partners and girlfriends is now recognised around the world and is rooted in gender inequality.[1] In general practice based studies, physical or sexual abuse in the last 12 months ranges from 6–23% and lifetime prevalence from 21–55% of women patients.[2] Although female violence against their male partners is also a reality, the severity and coercive control[3] typical of male violence, dwarfs violence by women. Intimate partner violence, which may be physical, sexual or emotional, is a major public health problem because of the long-term health consequences for women who have experienced it and for their children who witness the overt violence and coercion.

It does not follow that there is necessarily a specific role for health services in responding to the problem, other than the management of acute injuries and treatment of the long term sequelae of abuse, such as chronic pain, gynaecological problems, depression and posttraumatic stress disorder.[4] After all, there are many social and economic problems, like overcrowded housing or poverty, that have powerful individual and public health consequences, for which there is no specific preventive role for healthcare professionals. The difference with partner violence lies in the fact that many women experiencing abuse believe that their doctor can be trusted with disclosure[5] and in the practical support that healthcare professionals can offer women who disclose recent abuse. The isolation that abused women experience as a direct result of their partner's control over their relationships with friends, family and professionals, means that their GP may be one of the few people that they can turn to. Yet our role is not as clear as in child protection, where our duty of care is explicit, albeit difficult to discharge.[6]

Debate about the public health impact of partner violence is largely over, although better epidemiological research will uncover more precise associations between violence and chronic conditions. Debate about the legitimacy of asking about abuse and responding appropriately to its disclosure has also been largely resolved. There are a few notable exceptions to this consensus, including Fitzpatrick, who does not accept a definition of domestic violence that includes emotional and sexual violence and believes estimates of prevalence are hyperbolic and politically motivated because he is not aware of that many cases among his patients.[7] Although epidemiological research is challenging in this area, good quality studies find the same magnitude of abuse as poorly designed ones.[2] The triad of papers devoted to partner violence in this issue reflects a growing recognition that asking about and responding appropriately to abuse is part of general practice work.

One of the questions that has attracted a lot of debate is whether we should be screening for partner violence.[8] Consistent with previous studies, Boyle's survey on the acceptability of routine enquiry in three healthcare settings, including general practice, showed that most women found it acceptable.[9] But acceptability is only one of the criteria for a screening programme.[10] A key criterion that is not yet fulfilled is the effectiveness of interventions following screening, as Fiona Duxbury reminds us in her discussion paper.[11] This has not stopped the department of health in the UK recommending, despite all the rhetoric about evidence-based policy, that 'all trusts should be moving towards routine enquiry'.[12]

The debate over screening is not resolved by re-naming it 'routine enquiry'. Even though this may loosen the strict requirements of the public health screening model, it does not remove the need to show that routine enquiry is effective and safe.[13] Duxbury focuses on the identification of partner violence when women present with mental health problems. In her opposition to routine enquiry about partner violence, she overlooks the identification of women and their families experiencing violence who do not present with low self-esteem, depression or posttraumatic stress disorder.[11] In Hegarty and colleagues' study of 1257 consecutive women general practice patients in Australia, only half the women who had ever experienced physical and emotional abuse or combined severe abuse were depressed.[13] Therefore, the problem of identifying the majority of women experiencing recent violence remains. In an east London general practice-based study we found that only one in seven women who had experienced physical violence from a partner had this noted in her medical record.[14] In the absence of routine enquiry, we need to know whether we can increase disclosure from those women who want to disclose by selective enquiry; and whether training in selective enquiry increases disclosure.

Lo Fo Wong *et al* report a trial in the Netherlands testing whether training of GPs in 'active questioning' increases disclosure of partner violence.[15] We already have reasonably strong evidence that training of clinicians in screening does increase disclosure rates.[7] The increased disclosure in Lo Fo Wong's study, following a 1.5 day course, is of a similar magnitude as that found after interventions to promote screening. On the other hand, the duration of the training makes it difficult to implement in general practice. It is an intriguing additional finding of this study that even 1.5-hour focus groups increased disclosure rates, although not to the same extent. It is not clear whether the GP responses to this disclosure were appropriate, effective or even just safe after such a short training, given that we cannot assume any professional competence in relation to partner violence when it is still barely visible in the curricula of most medical schools and postgraduate training in the UK and the rest of Europe.

The debate about routine enquiry or screening is a distraction from the main issues: how to make it easier for women to disclose current (and past) abuse if they want to and how we can be confident that

our response is appropriate and effective. Barriers to asking still need to be tackled through education of clinicians using the methods that have been tested in controlled studies,[16] including Lo Fo Wong's trial. Good quality research on effective responses is sparse, although referral to a domestic violence advocate seems to improve outcomes for women experiencing current abuse.[17] Validation of a patient's experience, recording their story (both in a medicolegal and witnessing sense), and non-judgmental support are already central to good general practice. Coupled with an offer of referral to a local advocacy service, such as Women's Aid or Victim Support, our response should be part of a coordinated community response[18] to a major cause of distress and ill health that ends twice a week, in the UK, in a violent death.[19]

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The Quality and Outcomes Framework of the GMS contract:
a quiet evolution for 2006

A new contract for general medical services delivered by general practices was introduced in the UK in April 2004. A Quality and Outcomes Framework (QOF) was an integral part of the new contract and rewarded practices for delivering more evidence-based care. This marked a fundamental shift in the way general practice was resourced with a mixture of capitation, fee for service and performance-related pay.

The QOF has been described both as 'an initiative to improve the quality of primary care that is the boldest such proposal on this scale ever attempted in the world'[1] and also as a threat to the 'professional basis of general practice, indeed its very existence as a speciality'.[2] The division of opinion is reflected in uncertainty whether it has made any difference to patient care.

Theoretically, the introduction of 146 largely evidence-based indicators, 76 in 10 clinical areas, should lead to more consistent care and positive changes in patient-related health outcomes. QOF may have ended personal professional autonomy in some aspects of primary care, with disincentives to offer substandard care or be out of date with clinical opinion. It would, however, be wrong to claim that current improvements in health care are all QOF-related. Substantial improvements occurred in the clinical quality of care for coronary heart disease, diabetes and asthma before its introduction.[3] However, there are some early indications from the Quality Management and Analysis System (QMAS) data and from modelling work[4] that QOF has continued to encourage improvements to clinical care. QOF may also have created a 'comet's tail' effect between practices, initially demonstrating the existence of health inequalities, but also creating a force that pulls all in its wake. In the 1990s, data on performance-related pay for cervical screening showed that coverage was consistently higher in affluent areas between 1991 and 1999, but that it also led to a narrowing of the ratio rates of inequality between affluent and deprived areas.[5] It is possible that QOF may have a similar positive effect on the inverse care law, with practices in more deprived areas starting