PHYSICIAN ROLES IN ADDRESSING INTIMATE PARTNER VIOLENCE

PHYSICIAN ROLES IN ADDRESSING INTIMATE PARTNER VIOLENCE: STAKEHOLDER PERSPECTIVES TO INFORM MEDICAL EDUCATION AND POLICY

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Lay Abstract

People who experience intimate partner violence (IPV) are at a higher risk of experiencing a wide range of serious and long-lasting health issues. Politicians and other policymakers framing IPV as a "health issue" have suggested that doctors are well-placed to address these concerns and to support patients who are dealing with IPV, but research suggests that many doctors lack knowledge or skills that are needed to address IPV with appropriate sensitivity. This dissertation examines how doctors learn about IPV in the course of their medical training by 1) analyzing how doctors' roles related to IPV are presented in educational resources and policy documents, 2) interviewing doctors about their perceptions of IPV and their related training, and 3) talking to people who do work related to IPV outside of medicine about their suggestions for improving medical education in the future. Taken together, the studies that make up this dissertation can help to inform educators, politicians, and other policymakers working to improve health care for people affected by IPV.

Abstract

Experiencing intimate partner violence (IPV) is associated with a wide range of mental and physical health conditions that often have profound and enduring consequences in the lives of people, families and communities who are affected. Evidence suggests that many of these health concerns can be mitigated with timely access to medical care which addresses patient safety and needs for support. This has led to health policymakers framing IPV as a “health issue” which physicians are uniquely situated to address. Previous research suggests, however, that many physicians are ill-equipped to respond to patients who have experienced IPV, giving rise to questions about how physicians learn about IPV in the course of their training and how this training might be enhanced in order to improve medical care for people affected by IPV. This dissertation is comprised of three original studies that lie at the nexus of health policy and health professions education scholarship. The first study combines environmental scanning and critical discourse analysis to examine how physicians’ roles related to IPV are represented in training resources created for a Canadian medical audience. The second study uses qualitative description to identify physicians’ perceptions of their own roles in caring for patients affected by IPV and highlights the sites and sources of insight that are impactful in shaping these perceptions. The third study integrates key informant technique and interpretive description to synthesize recommendations from stakeholders outside of medicine about physicians’ roles in addressing IPV, and opportunities to improve medical education and practice in the future. Together, these studies offer a critical perspective on broader implications of constructing IPV as a “health issue” that informs practice for physicians, medical educators, researchers, policymakers, and organizers working to improve health care for people affected by IPV.

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I owe an immense and unpayable debt of gratitude to Dr. Meredith Vanstone for her critical generosity and unwavering support throughout this process. I truly do not know where I'd be without your gracious guidance, Meredith; in thanks, I can only promise to try and emulate your ethic of compassionate, constructive, and justice-minded supervision with my own trainees someday. Thank you for your dedication, and for the inspiration it has provided me.

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The communities I have been a part of while undertaking this research have helped anchor this work, particularly during the last few unmoored years of the pandemic. My appreciation and admiration for the members, organizers, and volunteers of Health Providers Against Poverty, the Sexual Assault Centre: Hamilton and Area, the Care Collective (especially Dr. Loree Erickson), Butterfly - Asian and Migrant Sex Workers Support Network, and the Health Justice Book Club/Canadian Doctors for Medicare are eternal.

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List of Abbreviations

AFMC – Association of Faculties of Medicine of Canada

CACMS – Committee on Accreditation of Canadian Medical Schools

CCFP-EM – Certificate of the College of Family Physicians (Emergency Medicine)

CDA – Critical Discourse Analysis

CEIPV – Children’s exposure to intimate partner violence

CERB – Canada Emergency Response Benefit

CFPC – College of Family Physicians of Canada

CMQ – Collège des Médecins du Québec

COVID-19 – Coronavirus Disease 2019

HPE – Health professions education

ID – Interpretive description

IPV – Intimate partner violence

PGME – Postgraduate Medical Education

QD – Qualitative Description

RISE project – Researching the Impact of Service Provider Education Project

Royal College – Royal College of Physicians and Surgeons of Canada

SACHA – Sexual Assault Centre: Hamilton and Area

TGNC – Trans and Gender Non-Conforming

UGME – Undergraduate Medical Education

VAW – Violence Against Women

VEGA Project - Violence, Evidence, Guidance, Action Project

WHO – World Health Organization

Declaration of Academic Achievement

This dissertation is a sandwich thesis comprised of an introductory chapter (Chapter One), three original studies (Chapters Two, Three, and Four), and a concluding chapter (Chapter Five). Chapter Two has been accepted for publication in *Violence Against Women* and was in press at the time this dissertation was being submitted. Permission to reprint this article as an accepted manuscript is provided under SAGE Publications' Author Archiving and Re-Use Guidelines. At the time this dissertation was submitted, Chapter Four was under consideration for peer-reviewed publication.

Some data described in this dissertation was generated with support for the Researching the Impact of Service provider Education (RISE) Project, a research program led by Melissa Kimber (McMaster University), Meredith Vanstone (McMaster University) and Donna E. Stewart (University of Toronto and University Health Network), and included co-investigators and collaborators located in Ontario, Quebec and Alberta. The RISE Project is funded by the Public Health Agency of Canada (Agence de la santé publique du Canada). The views expressed in this dissertation do not necessarily represent the views of the Public Health Agency of Canada. This doctoral work was also financially supported by scholarship funding awarded to Alice Cavanagh by the Canadian Institutes of Health Research (FBD-170795) and Physician Services Incorporated (RT2-2019).

I, Alice Cavanagh, am the sole author of Chapters One and Five and am the lead author of each of the three co-authored chapters of this dissertation. As the primary researcher undertaking this work, I conceived of and designed each of these studies, led and carried out analysis, and wrote these chapters with guidance, direction, and feedback from my committee members and, in the case of Chapter Three, with another colleague (Dr. Anita Acai) named as a co-author. Each of the co-authored chapters of this dissertation are prefaced with comments expanding on the comments above. I am accountable for all aspects of this work, including both its accuracy and integrity.

Chapter One: Introduction

In August 2013, when newly appointed federal Minister of Health Rona Ambrose rose to speak to the annual general meeting of the Canadian Medical Association, anticipation was high. A month earlier, as part of a cabinet shuffle, Ambrose had replaced previous health minister Leona Aglukkaq; pundits speculated about what the change augured for upcoming negotiations over federal health care funding. They turned to Ambrose's address, her first in her new role, for signs of what was to come (1-3). Instead of funding, however, Ambrose began her remarks by talking about family violence. Invoking the "holistic" understanding of violence she'd brought to her previous work as the Minister of Status of Women, Ambrose declared to her audience of physicians and medical students that the time had come to recognize family violence as "a health issue" (4). Not only was family violence – encompassing intimate partner violence (IPV), child maltreatment, elder abuse, and children's exposure to IPV (CEIPV) – a threat to Canadians' health, but it was also a strain on the Canadian health care system and economy. "As medical professionals," she urged, "you have a vital role to play in helping to address violence by recognizing the signs, reporting violence and ensuring your patients get the physical and mental support they need" (4). A week later, she followed up in the *Toronto Star*, outlining plans to boost training for physicians on family violence as one of her proposed policy initiatives (5).

From a policy research perspective, Ambrose's comments can be read as part of the policymaking process. Problem definition is a discursive process through which policymakers and stakeholders mobilize particular interpretations of an issue to achieve their political goals (6, 7). Causal stories about the genesis of a problem, the symbols used to represent it, or the numbers used to explain it play important roles in shaping policy solutions deemed feasible and politically acceptable (8). Ambrose's framing of family violence as a problem that affects health, health systems, and health care providers served as a strategic appeal to her audience: the terms of the problem as she described them legitimated her proposed policy response – intervention by health care providers, supported by new training and curricula.

This dissertation is comprised of three original studies and adapts a policy lens to examine the implications of framing one form of family violence, IPV, as a "health issue" that demands intervention by physicians and other healthcare providers. Specifically, this research considers how physicians learn to think about IPV and their roles in addressing IPV in the context of their professional practice. This introductory chapter establishes key terminology, surveys important theoretical frameworks that have been used to explain why IPV occurs, and synthesizes literature describing the scope and sequelae of IPV that have fuelled the conception of IPV as a health policy problem. Next, I survey literature addressing IPV as a medical education issue before describing the policy landscape that structures medical education and medical practice in Canada. Finally, I situate this dissertation in relation to the theoretical and personal touchpoints that shaped its conception before turning to review the research questions, methodological underpinnings, and contributions of this work.

Laying the Groundwork: Conceptualizing IPV as Health (Policy) Problem

As defined by the World Health Organization (WHO), IPV refers to behaviours that cause physical, psychological, or sexual harm that take place between people who are currently, or have previously been, in a romantic or sexual relationship (9). IPV encompasses physical violence and sexual coercion as well as psychological and emotional forms of violence enacted through verbal abuse, stalking, financial control, and other coercive behaviours (10). The sub-sections that follow address terminological considerations related to IPV; describe key theoretical frameworks for research, advocacy, and intervention related to IPV that have shaped the context in which this work was produced; survey research that qualifies and quantifies the prevalence and consequences of IPV; and characterize how problematics of IPV have been formulated in health policy contexts.

Defining IPV

Language is power(ful): the terms with which concepts, conflicts, and communities are named, framed, and referred to play a constitutive role in how they are understood. In the context of violence, this is particularly the case. In making decisions about the language used to talk about violence, "we signify our position in relation to both the nature of the violence and 'who is doing what to whom'" (11). Terminology can produce or preclude opportunities for personal, social, and political recognition of harm with material implications for how resources are distributed (12, 13). It also can aid or hamper efforts to conduct research intended to account for the scale, scope and fallout of violence (14).

A wide-ranging vocabulary of related but distinct terms has evolved in the English-speaking world to address instances and patterns of violence that occur in the context of relationships where romantic, sexual, or familial intimacy exists. The term "wife-battering" came to prominence during the second wave feminist movement (15), as growing recognition of the ways that personal and political realities intersect helped reframe private marital violence as part of broader patterns of female subjugation (16, 17). The language of "domestic violence" and "domestic abuse" also emerged in this era, evoking a similar locus of harm and of heteronormative domesticity (18, 19), encompassing violence between cohabiting partners, children, and other family members.

More expansive terminology emerged in the wake of these movements, subsuming violence between partners into different categories of connected harms. The term "family violence" includes violence enacted by people who are kin to one another regardless of where they reside, and foregrounds the nature of familial relationships as important to understanding how and why this violence occurs (17). By contrast, "violence against women" connects harm to women in intimate relationships to other forms of violence directed at women, framing patriarchal dominance as a common cause (20). “Gender-based violence” operates with a similar logic, encompassing all forms of violence that are enacted because of gender identity, but explicitly includes transphobic violence that is often elided in trans-exclusionary and cis-normative discussions that centre cisgender women (19).

I use “intimate partner violence” in this dissertation because it is currently the language most commonly used to describe violence between adult romantic or sexual partners in Canadian health policy, health professions’ education, and health research dialogues to which this dissertation is intended to contribute. I also use this language because, while cis- and transgender women bear the brunt of IPV around the world (21), this terminology also makes space to account for violence that occurs between cisgender men and people of other genders in the presence or aftermath of a relationship characterized by romantic or sexual intimacy.

Other of turns of phrase used in this dissertation also warrant further discussion. Throughout the chapters that follow, I generally refer to people who have been subjected to violence and harm in a relationship as having “experienced IPV.” This phrase side-steps ideologically charged language that invokes conditions of “victimhood” or “survivorship” (22), but also raises questions of its own. People who are enacting IPV *also* experience these encounters and relationships: understanding and addressing why IPV occurs from their perspectives is vitally important work in interventions and broader movements to address these harms (23, 24). Moreover, research examining cycles of violence in and outside of family life suggest the people most likely to enact violence in their relationships are those who have also experienced violence or been exposed to violence themselves (25, 26). This troubles carceral discourses that present “perpetrators” and “victims” of violence as mutually exclusive categories (19), but these vital nuances receive limited attention in this dissertation:

given the interests of this research in identifying how physicians learn about IPV, and the limited attention that people who enact violence receive in medical training related to IPV, questions of "perpetration" largely remain at the periphery of this work.

Understanding the Scope and Sequelae of IPV

IPV is a pervasive form of violence that has profound and enduring effects in the lives of people who experience IPV, their families, and their communities. Global patterns of prevalence reflect that IPV is a gendered form of violence. Around the world 27% of ever-partnered cisgender women between the ages of 15-49 report having been subjected to physical or sexual violence (27). In Canada, where estimates of IPV use prevalence also include psychological forms of violence, this figure rises to more than 40% (28). Transgender women, transgender men, and gender non-conforming people experience a disproportionate burden of IPV: recent evidence suggests that trans and gender non-conforming (TGNC) people are at 2-3 times higher risk of experiencing IPV when contrasted with their cisgender counterparts (29).

Other dimensions of identity and axes of marginalization intersect with gender to shape patterns of IPV prevalence. Research suggests that people who are disabled (30), who are living in poverty (28), who are Indigenous to lands that are colonized (31, 32), and who are living in rural communities (33) are also at an increased risk of experiencing IPV. Immigration status, race, and ethnicity also intersect with these dimensions of identity and experience, however reticence to report or disclose IPV in communities that are criminalized limits how these intersections are reflected in data (34-37).[1]

Experiencing IPV affects health in myriad ways. IPV is a cause of mortality when a person is killed by a current or former partner or when they die by suicide. IPV is a cause of

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[1] These gaps in knowledge identify the limitations of using police report data to determine IPV prevalence in Canada, since only a slim proportion of people affected by IPV ever involve police.

morbidity when violence directly results in physical injuries, disability and mental distress; it is also indirectly implicated in morbidities that stem from the body's stress response, strategies for coping with stress that have deleterious health effects, and denied or delayed access to medical care (38). In cross-sectional studies, adults who have experienced IPV have been found to have higher rates of depression (39-43), post-traumatic stress symptoms (40, 41, 44, 45), and anxiety (40, 41, 43, 46), alongside other mental health conditions and sequelae including substance misuse; they also experience worse cardiovascular health outcomes (47, 48), higher rates of sexually transmitted infections (41, 49, 50), traumatic brain injury (51, 52), adverse perinatal health outcomes amongst other reproductive health issues (53, 54), and other physical health concerns. Children exposed to IPV between their caregivers also experience higher rates of psychosocial, psychological, and physical health issues that come with short- and long- term developmental sequelae (55-57). In Canada, health care utilization directly related to physical forms of IPV accounted for more than 20 million dollars of health expenditures in 2009; real costs – encompassing lost productivity, loss of life, and health and social service use indirectly attributable to IPV – were estimated to surpass seven billion dollars (58).

Theorizing IPV

A variety of explanatory mechanisms and models have been developed to explain and explore why IPV occurs. Biological accounts of IPV focus on "genetic, congenital, and organic causes" of individuals' violent behaviour (59), probing neuropathological mechanisms that play a role in fueling IPV (60, 61). Psychological perspectives, by contrast, adopt a similar focus on individual risk factors for experiencing or enacting IPV, but foreground how abnormal patterns of behaviour, thought, and emotion are implicated in violence (59, 62). The accounts of IPV that have been most influential to this research endeavour – feminist perspectives, sociological theories, and ecological models – eschew the individualizing impulse of biological and psychological explanations for violence, instead highlighting contributions of interconnected familial, social, political, and cultural environments. Feminist perspectives conceptualize IPV as a gendered form of violence, shaped by intersecting forms of oppression that entrench patriarchal modes of power and control (63-65). Although feminist perspectives on IPV have historically centred violence enacted by cisgender men in heterosexual relationships with cisgender women, contemporary applications of feminist theory have challenged gender essentialist accounts of violence to explore how power relations rooted in patriarchal modes of domination suffuse a wide range of relationships and contexts (66, 67). Sociological theories of IPV conceptualize violent behaviour as a product of interpersonal, social, and cultural influences, framing modes of conflict and conflict resolution as learned behaviours that are shaped by exposures and experiences throughout the life course (63). Finally, ecological models for IPV synthesize the causal accounts described above, emphasizing the interplay of individual, relational, community, and societal factors in contributing to the likelihood that a given person might either enact and/or experience IPV (63, 64). Each of these approaches to theorizing IPV can be used to lend support to a variety of policy positions, sketched in broad terms below.

Framing IPV in Health Policy Terms

The problem of IPV has been approached from many public policy directions, each highlighting different understandings of the causes and consequences of IPV and proposing different policy solutions for preventing or mitigating harms. Framed as a criminal legal problem, policies intend to address IPV by foregrounding policing, incarceration, and "victim's rights" (64, 68); framed in economic terms, strategies to address IPV centre financial empowerment and aim to halt public expenditures and losses to productivity associated with IPV (69-71). Efforts to frame IPV as a health policy problem emphasize the morbidity and mortality described earlier, invoking the natural role of the health care providers in responding to “health issues” (64, 72), and citing public health frameworks while formulating policy agendas (73). One such framework is public heath’s tripartite model of prevention: primary prevention interventions, intended to keep IPV from occurring (73, 74), include a range of upstream initiatives like public education, awareness campaigns, and life skills development programs (75-77); secondary prevention interventions, intended to identify people experiencing IPV and to keep it from recurring (73, 74), include access to emergency services including shelter, legal support, and counselling (78-80); tertiary prevention interventions, intended to mitigate harms stemming from IPV after it has occurred (73, 74), include efforts to improve access to health and social services that support people who have experienced IPV (64).

Although many health policy actors stress the role that primary prevention should play in addressing IPV (73, 75), most policy responses that conceptualize IPV as a health problem have focused instead on tertiary prevention efforts that aim to connect individuals with services or access to legal recourse (64). In the policy discourse surrounding these interventions, health care providers are represented as occupying a “unique position” (10) or playing “a critical role” (72) provided they are able to actually identify patients experiencing violence and respond appropriately. As a result, health care providers’ knowledge, skills, and attitudes related to IPV are constructed as natural sites for policy interventions that focus on education and training.

Less than two years after her first speech as health minister, Rona Ambrose was in the news talking about family violence once again as she announced a ten-year plan for investments intended “to prevent, detect and combat family violence and child abuse.” Amongst the initiatives slated to receive funding were efforts to “better equip health professionals with the information and training they need to safely support victims of domestic violence and child abuse" (81).[2] The next section of this literature review synthesizes research describing how physicians learn about IPV and their professional roles in addressing it with the goal of understanding how policy imperatives to improve medical practice related to IPV are reflected in medical education.

Surveying the Literature: IPV in Medical Education

Scholarship examining how physicians learn about IPV has grown in tandem with recognition of associated health impacts and policy initiatives stressing the importance of improving medical care and professional practice (82, 83). This research is primarily descriptive rather than analytical, quantifying or qualifying how IPV and related topics are covered in undergraduate and postgraduate medical education. While this literature is useful insofar as it reflects types of content and activities included in formal medical training, less can be inferred from this literature about how physicians experience these interventions and the impacts on their perceptions and practice related to IPV.

The body of research that quantifies coverage related to IPV in medical education reflects a narrative of uneven progress towards integrating related content in medical education (84): although the percentage of medical schools in North America that addressed IPV increased from the 1980s to 2000s (85-87), the number of American family medical residency programs with curricular offerings related to IPV declined over a similar period (88, 89). On average, in the most recent data available, formal teaching related to IPV amounted to two hours of classroom learning for American medical students (86).

Qualitative research addressing medical education related to IPV is predominantly made up of single-site program evaluations that describe and assess novel curricula or training programs (90-93). In these education interventions, increasing learners' knowledge

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[2] One of these funded efforts – the Violence, Evidence, Guidance, Action (VEGA) Project – played an important role in the genesis of this research project, discussed later in this chapter.

of signs and health sequelae associated with IPV are primary learning objectives (10, 87, 94-97) and IPV is framed with reference to other forms of family violence including child maltreatment (98) or other causes of psychological trauma (99). Only some of the curricula explicitly discuss social, cultural, and structural factors associated with IPV (100, 101). In more recent literature, “trauma-informed” practice has emerged as a guiding dictate for addressing IPV for curriculum planners and learners alike (102, 103), though evidence that this framework works to reduce or mitigate iatrogenic harms is not yet available.

In studies that assess the efficacy of different approaches for teaching learners about IPV, common methodologies, themes and recommendations emerge. Methodologically, efficacy of training has frequently been measured by changes in knowledge, skills, and attitudes about IPV, using adapted versions of the Physician Readiness to Manage Intimate Partner Violence Survey (104, 105). IPV education has been found to be more effective when undergraduate or postgraduate medical learners repeatedly encounter IPV content in different contexts over time (106), through different types of learning modalities (94), and when time spent on IPV training is of a longer duration (96). Learners accord high value to opportunities to observe their preceptors and other physicians responding to IPV as a problem within the purview of medical practice (83, 107). Interestingly, personal experience with IPV is frequently included as a variable in evaluations of education impact, reflecting implicit – but largely unexplored – assumptions about the importance of students’ personal histories in shaping how they learn about IPV (106, 108, 109).

The limited research that examines more personal meanings and sequelae of professional training about IPV has focused on educators and patients. Educators’ lack of knowledge and confidence related to recognizing or responding to IPV have been identified as barriers to the inclusion of related content in curricula (110). Research exploring patients’ expectations and experiences with medical care cite clinicians’ lack of knowledge and negative attitudes regarding IPV as barriers to disclosure and to care-seeking by people subjected to violence (111-113). With regards to these negative attitudes, substantial gaps in the literature point toward a critical avenue for future inquiry: although physicians' perceived biases dissuade patients from disclosing their experiences of IPV, and education programs explicitly seek to change learners' attitudes and beliefs about IPV, no studies have examined the process through which physicians learn to think about IPV and their roles in caring for affected patients.

Framing the Policy Context: Regulating Canadian Medical Education

The regulatory ecosystem that governs Canadian medical education and practice, including that related to IPV, is complex and is shaped by national, provincial, and institutional policymakers. In Canada, where this dissertation was conducted, public health insurance covers health services that are performed by physicians or provided in a hospital setting. Rather than a single national health care system, however, responsibility for health care is largely the ambit of provincial and territorial governments, each with their own publicly funded, taxation-based health insurance plan governed by national standards (114). Provinces and territories have jurisdiction over the regulation of physicians and other health professions, statutorily delegating responsibilities for oversight of the various health professions to provincial professional colleges (115). In this paradigm of professional self-regulation, colleges in each province and territory are responsible for registering physicians, developing and monitoring standards of practice and professional conduct, and investigating and disciplining members over complaints of malpractice (116, 117). For physicians to register with their professional college, applicants must have a medical degree from an accredited or recognized medical school; to practice, they must have completed, or be enrolled in, an accredited postgraduate medical training program (118).

Accreditation for undergraduate medical education – medical school – is overseen in Canada by the Association of Faculties of Medicine of Canada (AFMC) through their Committee on Accreditation of Canadian Medical Schools (CACMS). Uniform standards and elements describing expectations related to medical schools' leadership, academic environment, faculty, as well as curricular design, content, and evaluation are applied to all seventeen Canadian medical schools as part of a cyclical peer-reviewed process of accreditation that occurs every eight years. Accreditation standards are revised in consultation with the AFMC, among other medical professional stakeholders. Although these standards do not address education related to IPV directly, they do stipulate that medical curricula include "instruction in the diagnosis, prevention, appropriate reporting, and treatment of the medical consequences of common societal problems" (119). At the end of their undergraduate medical training, before beginning residency, graduates from Canadian or international medical schools are required to pass the Medical Council of Canada's licensing exam; knowledge and skills related to IPV are among the competencies for medical graduates entering independent practice that are tested on the exam using multiple choice and short answer questions (120).

Canadian postgraduate medical education – residency training – is accredited by the College of Family Physicians of Canada (CFPC; for family practitioners), the Royal College of Physicians and Surgeons of Canada (Royal College; for medical specialists) and by the Collège des Médecins du Québec (CMQ; for physicians in Québec). Like medical schools, all residency programs are accredited on a cyclical basis according to discipline-specific iterations of the *General Standards of Accreditation for Residency Programs* developed by the Canadian Residency Accreditation Consortium (121). Standards for accreditation include preparing residents for practice, with reference to achieving the competencies or learning objectives necessary for independent practice in their field (122). Committees affiliated with the CFPC, Royal College, and CMQ develop and revise these competency frameworks, defining the abilities needed for practice in different medical specialties, encompassing all seven of the roles for physicians described in the CanMEDS framework (123). Competency frameworks for several medical specialties, including emergency medicine, psychiatry, and obstetrics and gynaecology include abilities related to caring for patients affected by IPV (124-126). For example, psychiatrists are expected to be able to work with patients to address IPV as a determinant of health, facilitating access to “needed health services or resources” (125); obstetricians and gynaecologists are expected to be able to “identify features of physical and psychological abuse” while performing clinical assessments and to facilitate access to legal assistance and psychological supports (124).

In addition to accreditation, the CFPC and Royal College also administer certification exams and oversee professional development programs. Participation in accredited continuing medical education activities is mandated by provincial regulatory colleges while programs tracking credit for completed training are administered by the CFPC, Royal College, and CMQ (127). In order to be accredited to provide continuing medical education or professional development courses or sessions, organizers must meet standards described by the Royal College, CFPC, or by the Committee on Accreditation of Continuing Medical Education affiliated with the AFMC. A wide range of activities, including some that address IPV, are eligible for credit as continuing professional development, including online modules (128) and workshops (129).

While regulatory colleges and accreditation bodies shape medical education and practice through the force of law, other actors exert influence through advocacy and education. Professional organizations, including the Canadian Medical Association, the Canadian Federation of Medical Students, and Resident Doctors of Canada, engage in national advocacy campaigns on behalf of Canadian physicians and trainees related to training and working conditions; their provincial and territorial counterparts negotiate with government on behalf of their membership over compensation, engage in policy advocacy, and develop education materials for members and the public around other health issues (130-132). For example, in 2020, an article in Ontario's provincial medical association's member's magazine connected the violence that physicians experience in the workplace with IPV they might be subject to at home, urging members to "unite and support each other in acting against violence" (133).

Beyond the purview of medical regulators and associations, policies that shape medical practice related to IPV include provincial and territorial legislation that mandate physicians to report suspected child maltreatment to child protection organizations in their region (134). In the absence of children living within the home where IPV is occurring, legal protections regarding personal health information prevent physicians from reporting IPV to police or other authorities; the only limitation to this legal purview is in circumstances where patients pose serious risk of imminent harm to themselves or someone else (135). However, growing recognition of CEIPV as form of child maltreatment unto itself (136) is reshaping reporting behaviours amongst physicians and other clinicians (137). This evolution in the definition of maltreatment has been subject to significant debate: proponents argue that recognizing CEIPV as child maltreatment sensitizes frontline workers to its harms, leading to earlier intervention; opponents suggest that child welfare interventions experienced by people subject to IPV – which is more often than not, a child's mother – is punitive and alienating and, discourages them from seeking help for fear of losing custody of their children (138).

Situating the Inquiry: Touchpoints

This dissertation is a product of the theoretical, personal, and practical influences that have shaped its conception, design, and analysis. These "touchpoints" – so termed to evoke the many points of theoretical, personal, and practical contact that helped give this dissertation its shape and structure – are described in the following sections.

Theoretical Touchpoints

In qualitative health research, theory serves many roles, including: linking new inquiry to broader bodies of knowledge; underpinning methodological decision-making; and providing the infrastructure on which analysis occurs (139). In transdisciplinary inquiry – which is research that integrates methods and insights from different disciplinary bodies of knowledge (140) – theory helps to find and define common terms of engagement that make fusion across disciplinary boundaries possible. This transdisciplinary dissertation is informed by theoretical perspectives from health policy research, health professions education research, and feminist research. Each of these are described in turn below.

A Health Policy Perspective.

Health policy research is an interdisciplinary field of study that draws on quantitative and qualitative research methodologies to ask and answer questions about “how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes” (141). Disciplinary theories and frameworks for the study and analysis of health policy seek to illuminate and improve the processes by which problems are defined and policy is made, implemented, and evaluated (142). Theories of health policymaking inform this dissertation in several important ways. My understanding of medical education and training as both products and processes of policymaking arise from encompassing definitions of policy that include formal rules and guidelines issued by governments and institutions. It is also informed by the informal and unwritten practices that develop as these rules and guidelines are interpreted and implemented by practitioners (143). My interest in exploring how a breadth of organizations and stakeholders, also known as policy actors, conceptualize physicians' roles related to IPV, stems from my understanding of medical education as a "policy community" in its own right (6). Through this lens, professional associations, regulatory bodies, medical education institutions, and physicians themselves are made legible as policy actors with vested interests in promoting and pursuing policy agendas that protect and preserve their professional and personal interests.

A Health Professions Education Perspective.

Health professions education (HPE) research – including that which focuses specifically on medical education – is another interdisciplinary field of inquiry. HPE research explores how health care providers acquire knowledge, learn to wield it, and are socialized into performing their professional roles (144-147). Theorists in HPE with an interest in parsing the sociocultural dimensions of education have conceptualized professional training programs as incorporating "formal", "informal" and "hidden" curricula that are part of a process of professional socialization (148-151). In this schema, the formal curriculum refers to officially offered and endorsed learning activities, or what learners are taught (e.g., in the classroom and in practice that are organized and directed by programmatic guidelines) (152). This is in contrast with informal and hidden curricula that play an integral role in shaping what learners actually learn. The informal curriculum refers to teaching and learning experiences that take place during interpersonal interactions with preceptors, other health care providers, patients and classmates (152). The hidden curriculum manifests at the level of "commonly held 'understandings', customs, rituals, and taken-for-granted aspects" of medical education (152), including through values conveyed in policies and evaluation. As learners navigate these curricula – which exist in undergraduate, postgraduate, and continuing medical education – they are socialized to perform their professional roles in specific ways, guided by professional norms and values that are communicated to them in explicit and implicit ways (152). This schema for understanding different elements that shape how physicians learn and their learning environments informs my approach to parsing the process of learning about IPV during medical education.

A Feminist Perspective.

Feminist theory has been broadly applied across many fields of study (153) to illuminate (gendered) inequities in power and the “ideolog[ies] of domination” that perpetuate them (154). IPV has long been a focus of feminist activism and scholarship (154-156) and feminist scholars have theorized IPV as a violent permutation of misogynist cultural ideologies (64, 66). IPV, in this understanding, is a product of interpersonal power dynamics shaped by structural forms of oppression and marginalization. Black feminist accounts of identity as “intersectional” emphasize the overlap and interplay between “multiple grounds of identity” in structuring the social world and dominating ideologies related to race, class, and sexuality that shape experiences of marginalization (157). In health policy research, feminist theory has been used to critique how policymakers wield discursive power (158) and to advocate for more just, equitable, and healthy ways of organizing health care and society (159). In HPE research, feminist theory has been used to parse inter- and intra- professional power inequities (160, 161) and to critique how oppressive ideologies are inscribed in medical ways of understanding bodies and caring for people (162). Adopting a feminist perspective for this work reflects my interest in identifying how power relations between patients, physicians, professions, and other policy actors are sustained and contested in medical education related to IPV. In particular, the constructivist orientation of standpoint feminism offers an “interpretive framework dedicated to explicating how knowledge remains central to maintaining and changing unjust systems of power” (163). Policy discourses framing IPV as a “health problem” have been critiqued for depoliticizing IPV, eliding the structural oppressions that produce IPV as a highly gendered form of violence (164-166). Although presenting IPV as a health issue has strategic political value in terms of resource allocation, biomedical discourses that present being female as a "risk factor" for violence have been subject to criticism for naturalizing gendered power inequities and for rendering resources and support less accessible to communities for whom biomedical institutions are unsafe (165).

Personal Touchpoints

My path to this work began with my experiences volunteering with the Sexual Assault Centre: Hamilton and Area (SACHA). In the course of accompanying people to seek emergency medical care in the aftermath of sexual violence, I sat in on conversations between providers and patients that raised questions for me about how physicians learned to think about violence in the course of their professional training. In becoming a volunteer on the SACHA crisis line, I had practiced validating the distress that callers expressed and reframing their beliefs about their own culpability for the violence they experienced. Providing "options" – offering referrals to resources and accompaniment to access medical care – were a part of our conversations, but usually not a focal point; our goal, instead, was to listen and to make callers feel heard. The imperatives that seemed to guide the health care providers I observed felt radically different to me: providers seemed enmeshed in a system that asked them always to be moving faster and harm seemed to be mostly conceptualized as something that might be swabbed, sampled, or scraped for evidence. Still, the providers I witnessed caring for patients seemed to me to want, very clearly, to be doing the right thing, and to be diminishing the distress rather than amplifying it. I wanted to understand the logics and value that propelled their actions – why they did what they did and what they could do to be better.

At the same time, I was in my first year of a midwifery education program. I relished our classroom discussions about informed choice, bodily autonomy, and health care as a feminist practice even as I struggled with the dawning realization that I did not want to be a midwife. I also wondered about the professional socialization that other health care providers experienced and how the professional culture our training was propagating showed up and shaped the care we provided to patients. Leaving midwifery to pursue a Master's in Gender Studies, I followed this interest towards critical pedagogy in HPE; I was interested in the ways that intersectional feminist theories about education, bodies, agency, and care might reshape medical training. Turning towards health policy for my PhD seemed like a practical step towards realizing emancipatory change – a transdisciplinary field of scholarship that would give me the tools to understand and then engage with the structures and institutions that governed medical training and practice. In the course of my first year of my PhD program, a side-line opportunity to develop an evaluation strategy for education materials created through the Violence, Evidence, Guidance, Action (VEGA) Project (169) helped shift my frame of focus: rather than thinking narrowly about medical education related to sexual violence, I turned my focus towards understanding IPV more broadly, following the opportunity to work more closely with important mentors.

Beginning medical school added new substance and texture to my understanding of the social, cultural, and structural dimensions of medical training that shape medical practice and challenge efforts to change it. The process of coming to identify as a medical student, and with medicine more broadly, has changed my approach to thinking about medical education as a researcher: in some ways my critique feels sharper: I have a working taxonomy for ways the "social side of medicine" can become an afterthought in classes and discussions. In other ways, it feels duller: I wonder whether my critique of subtle and explicit forms of medical violence are muted now that I feel implicated, seeing myself in a doctor's white coat.

Beyond experiences I've narrativized here, other touchpoints have shaped and reshaped the way I have approached thinking about IPV, medical education, and how they intersect. I have been attuned to gender as an axis of power and inequity for as long as I can remember. I am a woman, from two families of women, with friends, mentors, collaborators, and co-organizers who are female and TGNC. I first became involved in feminist activism around violence against women as a teenager, and in peer-led reproductive and sexual health education in university. My early adulthood coincided with movements to hold powerful men and institutions publicly "accountable" for patterns of private violence and enabling indifference. My analysis of gendered forms of violence are well-practiced, an artefact of my experiences, those close to me, and my social and political milieux. Other aspects of my social location and experience mean that there are dimensions of power and inequity that I am less attuned to: I am a white settler of Anglo-Irish descent, living in an urban area in a country that I was born in and am a citizen of; I am able-bodied and cisgender; I am studying in a high-status professional program, following in the footsteps of a parent who is also a physician.

In interrogating how these experiences, exposures, and intersections have shaped this dissertation, my primary strategy for reflexivity has been writing research memos that examine and question universalizing impulses in my thinking and writing (167, 168). In these memos, I have expanded and explored the rationales underpinning my methodological decision-making and reflected on my affective and emotional responses to the process and the products of this dissertation and its components. My aim in this exercise has been to engage in a "reflexivity of discomfort," challenging my interpretations and holding myself accountable for my subjectivity as both an insider and an outsider to medical education and practice related to IPV (170).

Practical Touchpoints

Finally, in practical terms, touchpoints for this dissertation include two Public Health Agency of Canada-funded research programs: the VEGA and Researching the Impact of Service

Provider Education (RISE) projects. Between 2015-2020, the VEGA project developed evidence-based guidance and family violence education materials to assist health care and social service providers in recognizing and responding to family violence, in collaboration with Canadian professional organizations and other stakeholders (169). Following on its heels, the RISE project is an ongoing investigation into the learning needs and preferences of social workers and physicians, seeking to evaluate how resources developed in the VEGA project contribute to their practice (171). Chapters Two and Three of this dissertation make use of data generated in collaboration with the RISE project.

Overview of Research

The overarching aim of this research was to better understand how physicians learn to think about IPV in the course of their professional training and their roles related to caring for patients who have experienced IPV. In undertaking this work, my chief objective was to identify opportunities and generate recommendations to improve education and training for physicians related to IPV.

Research Questions and Objectives

The research questions and objectives that guided this work are summarized in Table 1:

Table 1: Overview of Research Questions, Objectives and Methods

	OVERARCHING:		
QUESTION	How do physicians learn to think about intimate partner violence (IPV) and their professional roles in addressing IPV in the course of their professional training?		
OBJECTIVES	1) Examine how medical education shapes physicians' perceptions of their professional roles in addressing IPV; 2) Identify opportunities to intervene in medical education to improve the care that is available to people affected by IPV.		
	STUDY ONE	**STUDY TWO**	**STUDY THREE**
STUDY QUESTION	How are physicians' professional roles represented in training materials about IPV for a medical audience?	How do physicians perceive their professional roles in addressing IPV? What shapes these perceptions?	How do stakeholders perceive the professional roles physicians should play in addressing IPV?
STUDY OBJECTIVES	1) Inventory supplementary IPV training resources intended for a Canadian medical audience; 2) Critically appraise how physicians' roles in addressing IPV are represented in resources.	1) Describe physicians' perceptions of their roles in caring for patients affected by IPV; 2) Understand influences that shape how physicians come to have these perceptions.	1) Identify how stakeholders working outside of medicine perceive roles physicians currently play related to IPV; 2) Synthesize stakeholder recommendations on how to improve medical care.
STUDY METHODS	Environmental scan/critical discourse analysis	Qualitative description	Key informant method/ interpretive description

Chapter Two critically appraises how physicians' roles related to IPV were represented in supplementary training resources that were gathered from medical education stakeholders across Canada. Chapter Three describes physicians' perceptions of their own roles in caring for patients affected by IPV and their reflections on the sites and sources of insight that were impactful in shaping these perceptions. Chapter Four synthesizes recommendations from stakeholders outside of medicine related to physicians' roles in addressing IPV, and opportunities to improve medical education and practice in the future.

Research Methods

This dissertation incorporates a range of research methods aligned with interpretive and critical paradigms for inquiry (139). I understand this project of knowledge creation through a constructivist lens rooted in feminist standpoint theory, framing the findings and knowledge I have produced as products of a shared process of meaning making rather than representations of objective truth (172). In this process, feminist accounts of power have shaped my analyses, sharpening my attention to the roles that processes of knowledge production play in dominance and liberation. In practical terms, Chapter Two integrates environmental scanning with critical discourse analysis to query how "hegemonic power relations are discursively produced, sustained, negotiated, and challenged" (173) in policy documents and training materials for a Canadian medical audience. Chapter Three draws on principles of qualitative description to identify practicable recommendations for health policymakers and medical educators seeking to improve professional training for physicians related to IPV. Chapter Four uses key informant method and interpretive description to synthesize recommendations from stakeholders with expertise related to IPV *outside* medical education's policy community on how to improve medical training and care for those who have experienced IPV.

Summary of Contributions

Taken as a whole, the three studies that comprise this dissertation generate new understandings of how physicians perceive their roles related to IPV, the influences that shape these perceptions, and strategic opportunities to intervene in education in order to improve medical care for people and communities affected by IPV in the future. Constituencies to whom this work is relevant include physicians and medical trainees with an interest in interrogating or improving their own practice related to IPV, medical educators charged with training physicians how to provide care to people affected by IPV, and researchers with an interest in finding points of productive connection between scholarship in health policy and HPE. Findings from this dissertation are also relevant to policymakers concerned with mitigating and preventing harms associated with IPV, and to organizers in movements to end IPV and related forms of violence who are seeking strategic footholds from which to develop or strengthen health sector collaborations.

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Chapter Two: Conceptualizing Physicians' Roles in Addressing Intimate Partner Violence: A Critical Discourse Analysis of Resources for Canadian Physicians

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KEY WORDS: medical education; intimate partner violence; medicalization

Preface to Chapter Two

This chapter explores how physician roles related to IPV were represented in training materials for a Canadian medical audience. This chapter has been accepted for publication in *Violence Against Women* and is in press at the time at which this dissertation is being submitted. The environmental scan began in April 2020 and was completed in July 2020. I led the environmental scan, and was responsible for conceptualizing the research question, study design, and analytical approach in consultation with Dr. Meredith Vanstone. I led analysis with support from an undergraduate research assistant. Drs. Harriet MacMillan, Melissa Kimber and Stacey Ritz provided feedback throughout the process of study conception, analysis, and writing, and their feedback has been incorporated into this final version of this chapter. Permission to reprint this chapter as a part of this dissertation is provided under SAGE Publications' Author Archiving and Re-Use Guidelines[3].

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Abstract

Resources addressing intimate partner violence (IPV) play a role in shaping how physicians conceptualize and perform their roles in caring for affected patients. This study combines environmental scanning with critical discourse analysis to parse how the roles of physicians were represented in 28 education materials and policy documents about IPV, taking the Canadian training milieu as an example. We developed a cyclical model of three core physician roles in addressing IPV – learning about IPV, identifying patients experiencing IPV, and responding to patients' disclosures of IPV. The construction of these physician roles are suggestive of an ongoing process of the medicalization of IPV.

Introduction

Intimate partner violence (IPV) is defined by the World Health Organization (WHO) as “behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship” (1). Around the world, 30% of ever-partnered women report having experienced IPV at least once in the course of their lives (2). The health impacts associated with IPV are profound, wide-ranging, and economically significant. IPV is associated with acute injuries stemming from physical trauma and chronic stress-related mental and physical health conditions that endure over the life course, leading to increased health care utilization and spending (3-10). Fortunately, research evidence suggests that timely, informed support from a health care provider can play an important role in mitigating both immediate and longer-term sequelae of IPV and gaining access to other supports (11). In view of this, the WHO recommends that education about IPV be incorporated across all stages of medical training (11) but the state of progress towards realizing this goal remains unclear. Indeed, research demonstrates that physicians’ lack of knowledge about IPV can discourage patients from seeking help in health care settings (12-14) and inhibit practitioners from raising concerns with patients (15).

Research that addresses the scope of training and education that physicians receive related to IPV is largely descriptive, quantifying or qualifying coverage in undergraduate or postgraduate medical education (UGME or PGME) (11, 16-21) or evaluating outcomes stemming from specific education programs for practicing physicians (11, 16-20, 22-24). Free educational materials related to IPV are both available and accessible online, and previous research has demonstrated the growing utilization of similar resources amongst physicians (25, 26). As of yet, however, no study has sought to analyze the landscape of free training materials related to IPV that are available to physicians online, despite evidence that the use of online resources can impact physicians’ perceptions of their knowledge and readiness to respond to patients affected by IPV (27). To address this gap in the literature, we conducted a critical discourse analysis (CDA) of contemporary IPV resources for practicing physicians. Our objective was to examine how physicians' roles in addressing IPV were represented across these education materials, taking the Canadian training milieu as an example.

Methods

Study Design and Methodology

This research was carried out as part of the first phase of a larger sequential mixed methods research project examining physicians' and social workers' preferences regarding education about IPV and other forms of family violence (28). The current project addresses one component of this project, focused only on physicians. We conducted an environmental scan to ensure the IPV resources we examined in our CDA represented the full breadth of those available to physicians. Environmental scanning is a flexible, yet rigorous, approach to "seeking, gathering, interpreting and using information" (29) that is well-suited to contexts where data span a wide range of non-traditional sources. For this study, because training and education materials are not typically published in peer-reviewed journals, a search strategy using academic databases was not viable. Instead, we used environmental scanning methodology to devise a systematic search strategy targeting organizations involved in resource development.

Search Procedure and Inclusion Criteria

We began our search by compiling a list of 150 Canadian organizations with potential involvement in developing resources related to family violence for physicians (see Table 1). This list was reviewed and revised by a consulting group of Canadian practitioner-scientists with expertise in family violence to ensure comprehensiveness before searching began. These individuals were engaged as part of the national advisory board for the larger project and represent a variety of health professions and academic disciplines (28). We used the site search function on Google.com to search each organization’s website, combining clusters of search terms related to IPV or child maltreatment with another cluster relating to various resource formats (see Table 2). The progress of these searches, as well as any identified resources, were tracked by team members using shared online spreadsheets (see Appendix 1). Prospective resources were reviewed by two team members to verify their eligibility and their areas of focus and intended audience. The final list of identified resources was re-circulated to the expert consulting group to ensure its comprehensiveness. Searching began on April 7, 2020, and finished four months later on July 2, 2020. The present study is a secondary analysis of the subset of resources identified in the scan that addressed IPV for an audience of physicians.

Eligibility

We defined an “IPV resource” as a policy document or training material focused on describing or developing knowledge, attitudes, skills, or behaviours that a physician should possess related to IPV. For inclusion in this analysis, IPV resources had to: (a) have been released or revised since 2000 and be available in English; (b) be accessible for free online, without requiring registration; (c) be for a Canadian audience, reflected by having been produced or explicitly endorsed by any of the Canadian organizations included in our initial search list; and (d) be complete enough to facilitate the present discourse analysis (for example, we excluded slide decks from presentations where the presenter or the intended audience were unclear, or where audio recordings of the presentation accompanying the slides were not available).

Data Extraction

As resources were provisionally identified, we used a data extraction form (see Appendix 2) to record key details about each resource. We collected the name of each resource, the URL at which it was collected, the organizations involved in producing and disseminating it, the region on which it focused (if any), the date it was released and last updated, the modes of content delivery it employed, any specific target audiences it identified, as well as specific patient populations centred within the resource. This data served two purposes: to help determine whether a given resource met criteria for inclusion in the present study and to generate a "face sheet" for each resource that provided context during analysis. All resources that were identified that met the inclusion criteria were imported into N-Vivo: text-based resources were included as PDFs, while video and multimedia resources were transcribed and annotated with descriptions and screenshots of on-screen imagery and figures.

Data Analysis

We used CDA to analyze our data. CDA considers how "hegemonic power relations are discursively produced, sustained, negotiated, and challenged in different contexts and communities" (30). Close critical analysis of texts, images, and other discursive formations afford insight into the ways that communications are constitutive of social power dynamics (31, 32). In all discourse, but particularly in the context of resources intended to shape medical practice, claims to truth and legitimacy have material effects in the world. For example, in the context of this work, claims and directives about how physicians *should* address IPV in their medical practice works to structure what forms of care and aid are accessible to those experiencing IPV.

In keeping with principles of CDA, our coding framework evolved iteratively through group discussion: an initial reading of the resources, informed by a review of relevant literature, was used by AC to develop a formative codebook covering a broad range of areas of potential interest. Three coders (AC and two research assistants) subsequently coded and re-coded the resources to refine these codes before AC revised the codebook to its final form, focusing on the question “how are physicians’ roles represented in training materials about IPV for a medical audience?” In this final stage of analysis, we identified excerpts from resources that implicitly or explicitly offered normative guidance related to IPV for physicians. AC then inductively grouped and regrouped these codes until a final model encompassing all of the roles physicians play in addressing IPV was realized.

Results

We reviewed more than 22,000 search results and identified 28 resources that met inclusion criteria for the present analysis. These resources were produced by 22 organizations between 2003-2020 (see Table 3 for a complete list of included resources); 23 resources were education materials with a primary audience of practitioners and/or health care administrators and five were reports with a primary audience of health policymakers. Of the resources for practitioners, most were targeted for a general audience of physicians and other health care providers; four targeted physicians from specific specialties – namely family medicine, emergency medicine, orthopaedic surgery, and psychiatry. The majority of resources we identified (26) were text based, including practice guidelines (7), reports (5), fact sheets (5), pamphlets (3), newsletter articles (2), and other miscellaneous training resources (4); one multimedia module and one video were also identified.

In analyzing these materials, we identified three connected roles (summarized in Table 4) that physicians are expected to perform related to IPV: *learning* about IPV, *identifying* patients experiencing IPV, and *responding* to patients’ disclosures of IPV. The cyclical relationship between these roles is depicted in Figure 1. The *learning* role includes both formal education and training experiences and self-directed learning in independent practice. Physicians are expected to learn continually so that they are primed to identify and respond to patients in their care who are experiencing IPV. The *identifying* role, by contrast, is performed in the context of encounters with patients and/or their family members as physicians learn or suspect their patients are affected by IPV. Once patients are identified, the *responding* role is enacted during patient encounters, as physicians provide support and referrals, and continues afterwards, as physicians document their interactions with patients in their medical records and discharge their legally mandated reporting obligations if they have concerns related to child maltreatment.

Learning

Learning about IPV, also formulated passively as "knowing" about IPV, is represented as a core, ongoing expectation all physicians in these resources. Physicians are expected to learn about IPV before, during and after they participate in the care of patients they know or whom they suspect to be affected by violence. Starting in their undergraduate medical education (33, 34), being knowledgeable about the nature, prevalence, and sequelae of IPV is constructed as necessary for "good medical practice" (35). As training progresses into residency, expectations around learning evolve, encompassing familiarity with community resources and information related to patient care that is contextually relevant to the medical discipline in which they practice (34, 36). Physicians are expected to identify deficits in their knowledge related to IPV and "pursue professional development opportunities to gain necessary skills" in a self-directed manner (37). Attending training courses for continuing professional development, seeking out case consultations, and participating in peer reviews with colleagues are all described as potential opportunities to learn (38).

Almost all of the resources considered in this analysis portray the central motivations for physicians to learn about IPV as increasing their capacity to recognize signs and symptoms of abuse and their preparation to solicit and respond to disclosures of IPV. Honing these active skills is described as an intervention that may “save a life” (39) and as a “lifeline” (40) to patients experiencing abuse. By contrast, contextual or theoretical knowledge about IPV is positioned as less central to medical practice: although several of the resources describe “risks” or “risk factors” that increase the likelihood of experiencing IPV (37, 41), these risk factors are presented with limited discussion of the mechanisms and contextual factors that explain how these risks are produced.

Identifying

While learning about IPV is represented as an ongoing preparatory physician role that occurs outside the immediacy of patient care, identifying and responding to IPV are constructed as action-oriented roles that are largely operationalized during encounters with an individual patient. Perceiving and asking about IPV are presented as central, related components of the identifying role, encompassing recognizing patient “presentations that may be suggestive of undeclared abuse” (42) and directly asking patients whether they are experiencing IPV. These facets of the role are coupled in most of the more recent resources (43), reflecting current guidance *against* universal screening for IPV; earlier resources are more equivocal about the use of screening (44, 45)

‘Perceiving’ is variously described in these resources, in some instances, passively, as being “sensitive” (36, 41) of signs and symptoms of abuse, and in others, actively, as “detecting” (37, 39, 46) patients experiencing violence. Resources note that physical injuries may be indicative of violence, but that patients may try to hide or offer alternative explanations for how these injuries arose (36, 43, 47). Beyond physical injuries, the signs and symptoms of IPV that these resources discuss are often vague. Anger, sadness, anxiety, fear, and fatigue are all described as “emotional signs” of IPV (47). A wide array of chronic physical health concerns (48, 49), as well as drug and alcohol abuse (50), are also noted as indicators. Although perceiving abuse is largely portrayed as an attentiveness to presenting signs or symptoms and observations of the patient, the perceiving role also includes observation of interactions with others accompanying the patient, including a partner and children (51). Certain care-seeking behaviours – delaying care, or missing appointments – are also noted as possible indicators of abuse (40, 47).

Reflecting the nature of IPV as a gendered form of violence, the signs and symptoms of IPV described in these resources are often framed, either explicitly or implicitly, in relation to gender. For instance, a provincial protocol for "Women Victims of Abuse" includes parallel lists of signs that a man is being abusive and that a woman is experiencing abuse that feature many of the same entries on both lists (37). Gender, in this instance, is produced as the key explanatory variable that instructs physicians in interpreting their patient's behaviour as indicative of "being abusive" versus "experiencing abuse." The physician's role focuses on identifying victims of violence (usually female); notably, any role physicians might play in identifying people who are violent to their partners, or in supporting men who are victims of IPV regardless of the gender of their partner, pass largely undescribed. Gender non-conforming people are centred in only one resource with a specific focus on queer and trans communities (52).

Asking about IPV either based on presenting signs, symptoms, and potential risk indicators (sometimes referred to as case-finding) or using universal screening is described in nearly all of the resources we examined. Approaches to asking about IPV are carefully delineated in both affective terms – physicians should ask "without pressure" (53), and "non-judgementally" (42, 52) – and in procedural terms – ask "routinely" (37) or with the use of a validated screening tool (35, 44). Several resources identify pregnant patients as particularly vulnerable to IPV, necessitating increased attentiveness to these concerns on the part of physicians (35, 36, 38). Examples of specific language and phrasing to use while asking about violence abound (46, 52, 54), and several resources also include follow-up replies that help direct the conversation towards initiating the *responding* role. Spontaneous disclosure of IPV by a patient is rarely described in these resources (36). Contextual factors – including trust in the patient-provider relationship, and privacy in the clinical environment – are described as necessary to facilitate disclosure, either unprompted or in response to a provider's questioning (34-36).

In these resources, the act of asking about IPV is represented as serving a dual purpose: it creates opportunities for patients to disclose experiences of IPV, while also making clear to patients that IPV falls within the clinician's scope of practice. This discursive function of asking about IPV is recognized explicitly in these resources: the Canadian Orthopaedic Association states explicitly that part of the value of asking patients about IPV is "convey[ing] that healthcare professionals view IPV as an important health issue and that they are open to discussing it and providing assistance" (35). Asking about violence, in the clinical context, figures as a form of action unto itself, albeit one that necessarily demands further response.

Responding

Following immediately after a patient is identified, or identifies, as experiencing violence, 'responding' is constructed as the subsequent role physicians play in addressing IPV. 'Responding' encompasses several interconnected actions, such as providing support, assessing and making plans to address immediate safety concerns, assessing patients' mental and physical health and social needs, and either providing treatment to patients directly or making referrals to other clinicians and community resources. Part of the physician's role also includes actions related to legal responsibilities, most commonly described as documenting information in patients' medical records and making mandated reports to child protection agencies or to police where indicated.

Resources reviewed in this analysis situate physicians' immediate response to disclosures of IPV as critically important to establishing "an effective therapeutic relationship"(42). In their response, physicians are instructed to be "non-judgemental" (35) and "validating" (37, 49), reinforcing that whatever violence a patient may experience is not their fault; clinicians are also enjoined to offer their support "unconditionally" (38, 55), and to centre "the patient's individual concerns and decisions" (34). In cases where abuse is suspected, but patients deny violence is an issue, physicians are instructed to respect patients' decision not to disclose. Indeed, showing respect for patients' autonomy is represented as centrally important to providing a "safe" (48) response to a disclosure of IPV across the resources reviewed for this analysis: physicians are instructed to clearly delineate the limits of doctor-patient confidentiality and to obtain informed consent from patients before making referrals except where mandated by law (48, 53). Physicians are encouraged to problematize and define the interpersonal violence in their patients' lives both passively, in the form of posters and reading material in their offices, and actively, in the form of "offer[ing] information" (41) and "emphasizing the unacceptability of violence" (46). Similarly, in the resources reviewed in this analysis, graphic representations of the process of responding to IPV suggest unidirectional pathways between disclosures of violence, safety planning, and referrals to community resources, offering little guidance to physicians in caring for patients who are more ambivalent about, or who outright reject, their attempts to offer intervention (39, 46).

After providing immediate emotional support to patients, physicians are instructed to assess the patient's mental or physical health concerns and offer either treatment for those concerns or referrals as appropriate given their scope of medical practice. Referring patients to "community resources" figures prominently in this facet of the responding role (36, 37, 45), but the nature of these resources or the extent of assistance they can provide are seldom described. Conducting or facilitating a safety assessment to appraise any imminent risk to a patient is also featured as a core component of responding to disclosures of violence, with resources providing widely varying degrees of detail (39, 56). Making plans to follow-up with the patient and clearly charting the encounter and results of the safety assessment are the final features of this role as described in these resources. Documenting is framed in terms of producing evidence that "could be of benefit to the patient sometime in the future" (35), and physicians are encouraged to describe any violence mentioned by a patient with specificity and objectivity, avoiding any personal editorializing (36, 39). Scheduling a follow-up with a patient is portrayed as the natural conclusion to the responding role, proffering an opportunity to appraise whether IPV has escalated, and to see whether patients have followed through on accessing supports or any referrals.

Discussion

Our analysis found that resources for a medical audience consistently constructed three interconnected roles for physicians in addressing IPV. On an ongoing basis, physicians are expected to *learn* about IPV, in order to *identify* patients they provide care for who are affected by IPV, and then to *respond* to these patients in a wide array of ways.

The construction of these aspects of the physician role, as reflected in the resources reviewed for this paper, bear the hallmarks of a process of medicalization. Medicalization describes a process through which social and political facets of "everyday life" are redefined in relation to illness and health; through this process, broad swaths of human experience come to be understood as objects of medical expertise, and are thereby made subject to medical intervention (57). In the context of IPV, medicalization has been critiqued for concealing the varied structural oppressions implicated in producing trends related to IPV victimization and perpetration observed at a population level (58-60). Centering the public health impacts of violence has strategic political value in shaping resource allocation, but biomedical discourses that present socially mediated identity categories as “risk factors” for violence naturalize power inequities, and render resources and support less accessible to communities for whom health care spaces are hostile or unsafe (59).

Physicians play an important role in medicalization, helping not only to address or “solve” their patients’ medical problems, but also to frame how these problems are understood by patients themselves. Schön describes this “problem-setting” as a function of professionalization in many settings, that enables professionals to “impose … a coherence which allows [them] to say what is wrong and in what direction the situation needs to be changed” (61). This process of ‘naming’ and ‘framing’ problems is foundationally discursive and is shaped, inevitably, by physicians’ own subject positions, values, ideologies, and privilege (62). In clinical settings, physicians typically control the discourse and are able to assert their preferred framing of an issue, save in circumstances where patients are either very persistent or persuasive (63). Through this process of medicalization, physicians are empowered to impose an understanding of IPV that is “matched to their professional knowledge and know-how” on their patients, channelling their response accordingly (64).

Evidence reflecting an ongoing process of medicalization of IPV can be seen in the following features of these resources: physician roles in addressing IPV are constructed as active and interventionist; IPV is problematized as a health issue that can be effectively addressed in a medical setting; physicians are positioned as having the professional authority and medical knowledge to “educate” patients about IPV (39, 48). At times, the impetus towards physician intervention that animates these resources operates even in contravention of best medical evidence. For example, although research examining the impacts of routine IPV screening suggested limited or no benefits to patients as early as 2001 (65), instructions outlining an approach to “family violence screening in emergency departments” in the absence of any concerning signs or symptoms is featured prominently in two resources published in 2008 (39). Even later resources – including, more concerningly, best practice recommendations published in 2019 – also advocated physicians take a proactive approach to identifying patients experiencing violence: orthopedic surgeons are encouraged to “routinely ask all female patients about IPV” (35), despite strong evidence underscoring the lack of benefit from universal screening (66).

These examples, where a medicalized push towards intervention seems even to overstep medicine’s own epistemological claims to authority, are striking. Other examples are more insidious. For example, although the responding role is constructed as encompassing both passive supportive elements and action-oriented referrals, the active facets of this physician role are centred across many of these resources. Physicians’ medico-legal responsibilities related to reporting suspected child maltreatment feature prominently in many resources, as do inducements to physicians to “reframe” violence for their patients as unacceptable or untenable, producing their epistemic authority over their patients’ own experiences. In one resource of fourteen bullet points describing “issues to keep in mind when addressing IPV,” eleven describe specific actions a physician should take (i.e.: risk assessment, safety planning, documenting, arranging for follow-up, providing referrals) (40); in another, after a patient discloses IPV, a suggested expression of support is “there are things we can discuss that can help” (34). Although affective guidance – related to the tone a physician should strike, or the type of environment they should foster for patients – is abundant, these instructions, which address what many physicians report finding most difficult about responding to IPV, are often vague one-liners. None of the resources reviewed in this analysis offer specific examples of what a physician might say if a patient denies suspected abuse or how to respond when a patient chooses not to pursue a proffered referral; likewise, although affirming the agency of patients who decide to stay in violent relationships is constructed as centrally important to empowering patients, what support looks like in this context is left to physicians to construe on their own.

The process of responding by "referring" is left similarly open-ended. It is suggested that physicians "have a list of local resources and support information on hand," but the nature or constraints of the supports implicitly presumed available are rarely described (40). In part, this reflects a practical limitation: available referrals of the manner of those mentioned in these resources are contingent on location, among other factors, and policies impacting the types of services available can vary widely. This vagueness also serves to obscure political realities – linked to both the medicalization and criminalization of IPV by way of policy choices governing the allocation of limited public funding – that circumscribe what community resources do exist to address the needs of people experiencing violence. Presupposing the availability of broadly termed "community resources" belies waitlists for publicly funded counselling and limitations on how people and families experiencing violence can access emergency shelters; it also obscures larger holes in the social safety net related to access to legal counsel and to financial support, governed by immigration status, that may discourage people from leaving violent relationships.

While this analysis has primarily focused on parsing physician roles in addressing IPV, other subject positions are also necessarily produced in these resources as well. People experiencing violence are represented primarily in their role as patients or as parents, omitting other roles they may also occupy in their families and in their communities. The assemblage of "risk factors" and health outcomes associated with the "condition" of experiencing violence are made central to patients' identities, while communities mentioned as requiring special "cultural considerations" for assessment, treatment, or most at risk of being affected by violence are implicitly portrayed as being especially violent. Given the role physicians play as mandated reporters of suspected child maltreatment – increasingly defined to include children's exposure to IPV – the implications of increased suspicion towards communities that are singled out via "culture" can have serious consequences for families.

This is not to say that physicians should not learn about how "culture" is implicated in shaping patterns of violence and abuse, but rather that careful attention must be paid to how culture and context are framed in these resources. Attending to structural forces that give rise to marginalization and disparities in exposure to violence, and in health and wellbeing more broadly, enables physicians to better appreciate proximal opportunities to address patients' immediate safety and health concerns, as well as distal opportunities for political advocacy and solidarity with communities' organizing efforts (67). It also opens up space for physicians to recognize their own biases and to more empathetically engage with patients affected by violence (68).

In addition and in contrast with the "abused patient's" hyper-visibility, the role of people who commit IPV is largely peripheral to the medical encounters imagined in these resources. Defined by their male gender, their over-bearing presence, and their risk of committing future violence, people who are violent in relationships are not portrayed in these resources as patients whom physicians might encounter on their own. Finally, patients who have experienced IPV in the past are also largely absent from these resources. Although evidence is included in virtually all these resources that describes the enduring health effects of IPV even after patients have left violent relationships, the principles for caring for people with historical trauma related to violence is not a primary focus in these materials.

Strengths and Limitations

This study's main strengths lie in its novel application of environmental scanning and CDA methodologies and is the first study we are aware of to use a systematic approach to assemble and analyse training resources that address IPV for a medical audience; similarly, it is the first study we could find that uses CDA to parse how IPV is represented in the medical education context. Limitations of our study relate to challenges in assembling a truly comprehensive picture of the Canadian IPV resource landscape: our methodology did not seek to determine which of the resources we reviewed were most influential in the medical milieu, or which are less commonly made use of by practitioners or policy makers to shape medical practice. It also did not seek to evaluate resources' use of evidence-based pedagogical approaches or their impacts on physician knowledge, attitudes, skills and behaviours. Additionally, our dataset did not include resources that required registration. Although this was by design – we wanted to see what was most readily available to practitioners seeking to bolster their skills and knowledge related to IPV – other forums for training related to IPV that shape the practice of Canadian physicians include in-person training and online training that requires registration or specialized access.

Conclusion

This study has considered how the roles that physicians play in addressing IPV are constructed in resources for Canadian physicians. Combining environmental scanning methodology with CDA, we identified three connected physician roles – learning about IPV, identifying patients experiencing IPV, and responding to patients' disclosures of IPV – that were produced in resources with a medical audience. Our conjecture is that these formulations of the physician role, and of IPV itself, reflect a process of medicalization; physicians are instructed to adopt an interventionist stance in addressing IPV, and encouraged to frame IPV in their own and in their patients' understandings as a health issue that can be effectively addressed in a medical setting. This process of medicalization has material implications not only for providers, but most significantly for patients, structuring what resources and support are accessible to those experiencing IPV.

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Figure 1: Overview of Physician Roles in Addressing IPV

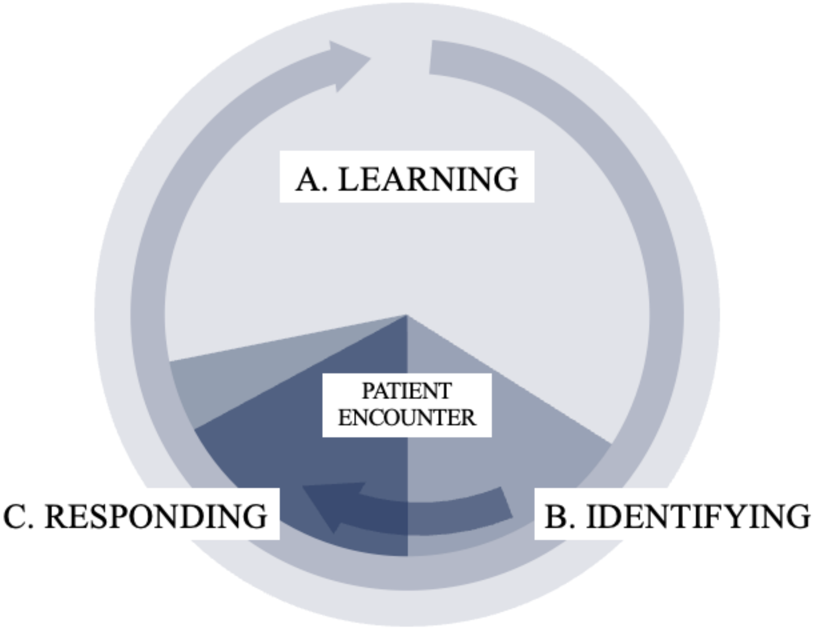

Table 1: List of Organizations Initially Identified for Website Search

Physician Colleges	Physician Associations	Federal Government	Provincial/Territorial Governments	Specialty-specific organizations	Research-Oriented Organizations	Service-Oriented Organizations	Policy-Oriented Organizations
Federal or provincial/ territorial regulatory bodies that govern medical practice.	Federal or provincial/ territorial medical advocacy organizations that represent physician interests.	Departments or agencies of the federal government of Canada.	Departments or agencies of any of the provincial or territorial governments.	Advocacy organizations that represent physicians in psychiatry, paediatrics, emergency medicine or family medicine.	Organizations with a primary focus on producing research, at or apart from, post-secondary institutions.	Organizations with a focus on service provision or supporting service provision.	Organizations with a primary focus on policy research or advocacy.
- The Royal College of Physicians and Surgeons of Canada - College of Family Physicians of Canada *Alberta* - College of Physicians & Surgeons - College of Family Physicians *British Columbia*	- Canadian Medical Association - Doctors of BC - Alberta Medical Association - Saskatchewan Medical Association - Doctors Manitoba - Ontario Medical Association - New Brunswick Medical Society - Doctors Nova Scotia	- Public Health Agency of Canada - Status of Women Canada (renamed Women & Gender Equality Canada in December 2018) - Department of Justice Canada - Health Canada - Mental Health Commission of Canada	*Alberta* - Health Services - Ministry of Culture, Multiculturalism & Status of Women - Myhealth.alberta.ca - Ministry of Children's Services - Ministry of Community & Social Services - Ministry of Justice &	- Canadian Academy of Child & Adolescent Psychiatry - Canadian Academy of Geriatric Psychiatry - Canadian Academy of Psychiatry & the Law - Canadian Association of Emergency Physicians	- Center for Research & Education on Violence against Women & Children - FREDA Centre for Research on Violence Against Women & Children - RESOLVE network - Muriel McQueen Fergusson Centre for	- Women's Shelters Canada - Canadian Shelter Transformation Network - Ontario network of sexual assault/ domestic violence treatment centres - BC Society pf Transition Houses	- Canadian Women's Foundation - Native Women's Association of Canada - Saskatchewan Towards Offering Partnership Solutions (STOPS) to Violence - Canadian Centre for Child Protection

- College of Physicians & Surgeons
- College of Family Physicians

Manitoba
- College of Physicians & Surgeons
- College of Family Physicians

New Brunswick
- College of Physicians & Surgeons
- College of Family Physicians

Newfoundland & Labrador:
- College of Physicians & Surgeons
- College of Family Physicians

Nova Scotia
- College of Physicians & Surgeons

- Medical Society of Prince Edward Island
- Newfoundland & Labrador Medical Association
- Northwest Territories Medical Association
- Yukon Medical Association
- Society for Rural Physicians of Canada

- Crown-Indigenous Relations & Northern Affairs
- Formerly: Ministry of Indigenous Services
- Health Canada/ Indigenous Health
- Truth & Reconciliation Commission of Canada
- National Inquiry into Missing & Murdered Indigenous Women & Girls
- Canadian Human Rights Commission
- Department of Justice Canada
- Victims Services (within Justice Canada)

Solicitor General

British Columbia
- Ministry of Health Services
- Ministry of Children & Family Development
- Minister's Advisory Council on Indigenous Women
- Ministry of Public Safety & Solicitor General
- First Nations Health Authority
- Ministry of Mental Health & Addiction

Manitoba
- Health & Seniors Care
- Status of Women Secretariat

- Canadian Paediatric Society
- Canadian Psychiatric Association

Family Violence Research
- Le centre de recherche interdisciplinaire sur la violence familiale et la violence faite aux femmes (CRI-VIFF)
- Centre for the Study of Social & Legal Responses to Violence

- Ontario Federation of Indigenous Friendship Centres
- Ending Violence Association of Canada
- Women's College Hospital Violence & Health Research Program
- Alberta Public Health Association
- Public Health Association of British Columbia
- Manitoba Public Health Association
- Public Health Association of New Brunswick & Prince Edward Island
- Newfoundland & Labrador

- YWCA Canada
- Child Welfare League of Canada
- Association of Alberta Sexual Assault Services
- Inuit Tapiriit Kanatami
- Assembly of First Nations
- Métis Nation of Canada
- White Ribbon
- Immigrant & Refugee Communities Neighbours, Friends & Families
- Coalition of Provincial & Territorial Advisory Councils on the Status of Women

- College of Family Physicians

Prince Edward Island

- College of Physicians & Surgeons
- College of Family Physicians

Ontario

- College of Physicians & Surgeons
- College of Family Physicians

Québec

- Collège des médecins
- Collège québécois des médecins de famille

Saskatchewan

- College of Physicians & Surgeons
- College of Family Physicians
- First Nations Health & Social Secretariat
- Department of Families
- Department of Justice,
- Department of Indigenous Reconciliation & Northern Relations

New Brunswick

- Department of Health
- Department of Social Development
- Department of Justice & Office of the Attorney General
- Department of Aboriginal Affairs
- Women's Equality Branch
- Ministry of Public Safety

Newfoundland & Labrador:

Public Health Association

- Northwest Territories & Nunavut Public Health Association
- Public Health Association of Nova Scotia
- Ontario Public Health Association
- Saskatchewan Public Health Association
- Centre for Addictions & Mental Health

- Yukon Medical Council	- Department of Health & Community Services - Department of Justice & Public Safety - Ministry of Children, Seniors, & Social Development - Office for the Status of Women *Northwest Territories* - Health & Social Services, - Department of Justice *Nova Scotia* - Department of Health & Wellness - Department of Justice - Department of Community Services - Advisory Council on the

Status of Women

Nunavut

- Department of Health
- Department of Family Services
- Department of Justice
- Status of Women Council

Ontario

- Ministry of Health & Long-Term Care
- Ministry of Children, Community & Social Services
- Ministry of Women’s Issues
- Indigenous Affairs
- Ministry of the Solicitor General

Prince Edward Island

- Department of Health & Wellness

- Department of Family & Human Services
- Department of Justice & Public Security
- Advisory Council on the Status of Women

Québec

- Ministère de la Santé et des Services sociaux
- Ministry of Families, Seniors & the Status of Women
- Ministry of Justice
- First Nations of Quebec & Labrador Health & Social Services Commission

Saskatchewan

- Health Authority

- Ministry of Social Services
- Ministry of Justice

Yukon

- Department of Health & Social Services
- Department of Community Services
- Women's Directorate
- Department of Justice

Table 2: Search Terms used for Environmental Scan

IPV SEARCH TERMS		CHILD MALTREATMENT SEARCH TERMS		RESOURCE SEARCH TERMS
(“intimate partner violence” OR “intimate partner abuse” OR “domestic violence” OR “domestic abuse” OR “battering” OR “dating violence” OR “dating abuse” OR “violence against women” OR “gender-based violence”)	OR	(“child abuse” OR “child neglect” OR “child mistreatment” OR “child endangerment” OR “child * abuse” OR “child exposure to IPV” OR “child exposure to domestic violence” OR “family violence”)	AND	(“curriculum” OR “webinar” OR “resource” OR “training” OR “education” OR “workshop” OR “manual” OR “guide” OR “handbook” OR “tool”)

Table 3: Resources Included in Study Analysis

Resource:	*Producer:*	*Resource Type:*	*Resource Format:*	*Release Year:*	*Audience:*
Intimate Partner Violence	Canadian Psychiatric Association	education material	practice guidelines	2012	practitioners
Domestic Violence Prevention & Reduction in British Columbia (2000-2010)	The FREDA Centre for Research on Violence Against Women & Children	policy document	report	2011	policy makers
Intimate Partner Violence Position Statement & Best Practice Recommendations	Canadian Orthopaedic Association	education material	practice guidelines	2019	practitioners
IPV Consensus Statement	Society of Obstetricians & Gynaecologists of Canada	education material	practice guidelines	2005	practitioners
Woman Victims of Abuse Protocols	Women's Equality Branch, Government of New Brunswick	policy document	report	2014	policy makers
Standards Of Care: Ontario Network of Sexual Assault & Domestic Violence Treatment Centres	Ontario Network of Sexual Assault/Domestic Violence Treatment Centres	education material	practice guidelines	2014	practitioners, administrators
What The Health Care Community Can Do About Family Violence: Booklet	Government of Alberta	education material	summary pamphlet	2008	practitioners
Intimate Partner Violence: Broaching a sensitive topic with patients	College of Physicians & Surgeons of Ontario	education material	newsletter article	2019	practitioners
Health Effects of Family Violence	National Clearinghouse on Family Violence	education material	summary pamphlet	2003	practitioners

Emergency Medicine: Key Features of the Priority Topics for the Assessment of Competence in Family Medicine at the Enhanced Skills Level	College of Family Physicians of Canada	education material	curriculum document	2017	practitioners
IPV Systematic Review Summary	VEGA Project	education material	practice guidelines	2019	practitioners, administrators
Healthy Babies, Healthy Families: Postpartum & Postnatal Guidelines	Nova Scotia Department of Health	education material	practice guidelines	2003	practitioners, administrators
Recommendations From the Domestic Violence Death Review Committee	The Domestic Violence Death Review Committee, Department of Public Safety, Chief Coroner’s Office, Government of New Brunswick	policy document	report	2014	policy makers
When She Tells You About the Violence: Tips for General Practitioners	Battered Women's Support Services	education material	summary pamphlet	2018	practitioners
What The Health Care Community Can Do About Family Violence: Information Sheet	Government of Alberta	education material	fact sheet	2008	practitioners
Trauma & Violence-Informed Approaches to Policy Practice	Public Health Agency of Canada	education material	guidebook	2018	practitioners, policymakers
Overcoming Barriers & Enhancing Supportive Responses: The Research on Sexual Violence Against Women A Resource Document	Centre for Research & Education on Violence against Women & Children	education material	literature review	2012	practitioners

Document, Monitor, Collaborate: A Primer on Domestic Violence Risk Assessment & Management	Center for Research & Education on Violence against Women & Children	education material	video module	2016	practitioners
Suffering In Silence: An Assessment of The Need for A Comprehensive Response to Sexual Assault in Nova Scotia	Nova Scotia Sexual Assault Services Planning Group; endorsed by Department of Community Services, Nova Scotia	policy document	report	2008	policy makers
Trauma-Informed Practice in Different Settings & With Various Populations – A Discussion Guide for Health & Social Service Providers	Nova Scotia Health Authority, IWK Centre	education material	training guide	2015	practitioners
Providing Trauma-Informed Care to 2SLGBTQ+ Patients	Native Women's Association of Canada	education material	fact sheet	2019	practitioners
Transforming Our Response to Sexual & Reproductive Health	Native Women's Association of Canada	education material	fact sheet	2018	practitioners, administrators
Hospital Guidelines for The Treatment of Persons Who Have Been Sexually Assaulted (3rd Edition)	Ontario Hospital Association	education material	practice guidelines	2018	practitioners, administrators
3 Considerations for Supporting Women Experiencing Intimate Partner Violence During the Covid-19 Pandemic	Centre for Research & Education on Violence against Women & Children	education material	fact sheet	2020	practitioners
A Strategic Framework to In New Brunswick End Violence Against Wabanaki Women	New Brunswick Advisory Committee on Violence against Aboriginal Women	policy document	report	2008	policy makers

Dealing with Distress from Patients' Trauma	Alberta Medical Association	education material	newsletter article	2010	practitioners
Why VEGA? Video	VEGA Project	education material	video	2019	practitioners
Intimate Partner Violence in a Pandemic	Centre for Research & Education on Violence against Women & Children	education material	fact sheet	2020	practitioners

Table 4: Summary of Physician Roles in Addressing IPV

Role	Description	Examples
A. Learning	Physicians are expected to engage in ongoing, self-directed *learning* about IPV in preparation for performing the *identifying* and *responding* roles.	- "Health care providers are encouraged and supported to engage in ongoing professional activities including educational opportunities, case consultations and peer review sessions to maintain skill and competency levels." (38) - "These strategies include education and training for health care professionals to help them recognize the signs of violence and abuse and to respond sensitively, respecting the diverse needs of victims from vulnerable population groups." (33) - "Learn how to spot the signs of family violence in all its forms, such as physical abuse, psychological abuse, sexual abuse and neglect. • Make family violence education part of your ongoing professional development. • If you lack experience in this area, seek opportunities to gain experience." (39)
B. Identifying	Physicians are expected to *identify* patients affected by IPV by perceiving signs that may be suggestive of abuse and by asking patients directly if they are experiencing IPV.	- "The role of emergency room staff includes detection of women who are victims of intimate partner violence" (37) - "It is especially important for mental health clinicians to be alert to the signs and symptoms of IPV exposure, and to practice case finding for IPV in the assessment of patients who present with psychological signs or symptoms (such as depression, anxiety disorders, including PTSD, chronic pain, eating disorders, sleep disorders, psychosomatic disorders, self harm, substance abuse, some personality disorders, and nonaffective psychosis) or physical signs or symptoms (see above), which are known to be associated with IPV exposure." (34)
C. Responding	Physicians are expected to *respond* to patients who disclose IPV or who they suspect are experiencing IPV by providing	- "If abuse is confirmed, your immediate goals are to ensure the person is safe and to provide support. (Tell them, 'It is not your fault. You deserve to be safe. Help is available.')"(47)

emotional support, medical treatment, and referrals to community resources; by assessing patient safety; by documenting in the patient’s medical record; and by reporting concerns related to child maltreatment if they arise.	- “Essential elements of health sector response include documentation, risk assessment, addressing the safety of children present in the home, facilitation of a safety plan, and effective referral and follow-up.”(36) - “When abuse is suspected, or confirmed, ensure that management includes the patient’s informed consent and agreement to the plan, reports to authorities as appropriate, and a disposition that ensures the safety of the patient and other vulnerable parties (e.g., children, elders).”(42)

Appendix 1: Hand Search Tracking Sheet

Searcher Initials	**Search Date**	**Organization**	**Resource URL**	**Path Resource Identified**		**Resource Inclusion Criteria**		**Include Resource?**	**Additional Notes**
	DD/MM/YY	*Name of Organization from Master List*	*Permalink to Resource*	*Check Applicable*		*Check Off all Criteria that Apply*		*Y/N/Borderline*	*Include any further comments*
				☐	Directly through Google Search	☐	Addresses Family Violence (defined as IPV, CM, or CEIPV)		
				☐	Through a Webpage (w/ Linked Resources)	☐	Addresses audience that includes MDs		
				☐	Resource Requiring Registration	☐	Developed/adapted for Canadian audience since 2000		
						☐	Produced/explicitly endorsed by organization		

Appendix 2: Data Extraction Form

Resource Name:

Resource URL:

Organisation(s):
(Note the name or names of the organisation or organisations involved in producing the resource)

Region:
i.e.: National, Provincial - Ontario, Regional - Toronto

Release Date:
(Include Year and Month if Available)

Last Updated:
(Include Year and Month if Available)

Mode(s) of Content Delivery:
(Check all that apply)

- Video Vignettes
- Training Manual
- Infographic
- Report
- Webinar
- PowerPoint Presentation

Other:

Target Audience(s), if stated:

Community/ies of Focus, if any:

Date Accessed:

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Chapter Three: “A different appreciation”: A Qualitative Description of Canadian Physicians’ Perceptions of Their Roles Related to IPV and Relevant Learning Experiences

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Preface to Chapter Three

This chapter explores how physicians perceive their roles related to IPV and the sources and sites of understanding that shaped these perceptions. Data collection, in the form of semi-structured interviews, began in August 2020 and was completed in December 2020. I contributed to the design of the study, including developing specific questions for the interview guide, conducted interviews as a part of a team of qualitative researchers, and led the present analysis with support from Dr. Anita Acai and in consultation with Dr. Meredith Vanstone. Drs. Harriet MacMillan, Melissa Kimber and Stacey Ritz provided feedback throughout the process of analysis and writing, and their feedback has been incorporated into this final version of this chapter.

Abstract

Intimate partner violence (IPV) can have wide-ranging implications for the health of those effected. Although physicians and other health care providers can play an important role in helping to mitigate these ill effects, research suggests that physicians may not be adequately prepared by their professional training to respond to patients experiencing IPV with the requisite sensitivity. To assist medical educators seeking to improve training related to IPV for physicians, we set out to describe how Canadian physicians perceived their roles related to IPV and the nature of the learning experiences that helped to shape these understandings. Guided by tenets of qualitative description, we analyzed data gathered through semi-structured interviews with 57 residents (n = 29) and practicing physicians (n = 28) from Alberta, Ontario and Quebec. Participants practiced emergency medicine (*n* = 14), family medicine *(n* = 10), obstetrics and gynaecology (*n* = 8), paediatrics (*n* = 12), and psychiatry (*n* = 13). Physicians in our study perceived their roles in addressing IPV as narrowly focused around identifying patients who were experiencing IPV and connecting those patients with community resources and other clinicians. Participants framed their most impactful learning about IPV in experiential terms and described three common sites in which these experiences occurred: 1) in clinical settings; 2) in "classroom" settings; and 3) outside their professional training or practice. Both medical educators and health policymakers must contend with the primacy of experience in shaping physicians' understandings of their roles if they wish to reshape what resources and support are accessible to those experiencing IPV. Strategically incorporating opportunities for interdisciplinary, experiential learning related to IPV may play a role in better preparing physicians to support their patients affected by IPV.

Introduction

Intimate partner violence (IPV) refers to behaviours that threaten or cause “physical, psychological or sexual harm,” enacted between people who are currently, or have previously been, in a romantic or a sexual relationship (1). IPV is a prevalent form of gendered violence around the world (2), the burden of which is disproportionately borne by cisgender and transgender women and gender non-conforming people (1, 3). Although IPV is associated with a range of negative health and psychosocial sequelae (4, 5), timely and compassionate support can help mitigate these ill effects (6-8). Policymakers and patients alike include physicians amongst health care and social service providers who are well-situated to support people experiencing IPV (8-12), but physicians’ readiness to address IPV varies (13, 14). Moreover, research with women who have navigated deciding whether to disclose their own experiences of IPV to physicians suggests that practitioners’ stigmatizing attitudes about IPV may hamper them from serving as effective sources of support (12, 15).

In part, these attitudes may be attributable to the processes through which physicians learn about IPV and their related roles in the course of their professional training. Beyond biomedical knowledge, medical schools and residency programs are also charged with sensitizing future physicians to the social, environmental, and political issues that shape their patients’ lives (16-18). One aspect of these efforts is reflected in the calls for a “universal education” about IPV that begins early in medical training and incorporates strategies for both recognizing and responding to IPV (19-21). In tandem with this advocacy, a substantial body of medical education research has been developed that quantifies the content of formal curricula and the number of hours of teaching trainees receive, as well as outcomes associated with specific training initiatives around the world (22-25). In short, these studies largely relate how physicians and other health care providers are *taught* about IPV.

Less clear, however, is the nature of the process through which physicians actually *learn* about IPV and their related roles in the course of their professional training. This distinction – what is taught versus what is learned – represents a longstanding area of interest for medical education scholars working to uncover implicit “informal” and “hidden” dimensions of medical curricula that shape physicians’ attitudes and perceptions of their roles from early in their training (26). Experiences with other care providers, learners, and teachers play an important part in shaping how physicians perceive their professional responsibilities and their attitudes towards their patients and colleagues; so too do experiences with the organizational cultures and policies of clinical and educational institutions (27). In the context of IPV, however, the nature of the experiences that shape how physicians understand IPV and their related roles is unknown: although “experiential learning” is a recommended component of IPV training for health care providers (28), the experiences that physicians themselves find impactful in shaping their attitudes and perceptions of their roles related to IPV have yet to be qualitatively described in the literature. To address this gap, and to support medical educators in harnessing experience to better prepare physicians to serve patients affected by IPV in the future, we set out to understand how Canadian physicians perceive their roles related to IPV and to describe the learning experiences that help to shape these understandings.

Methods

Study Design

Data for this study were collected during the first phase of a sequential multiphase mixed methods implementation research project evaluating the impacts of a family violence education intervention for health and social service providers (29). The qualitative strand of the first stage of this research was exploratory in nature, examining Canadian physicians’ and social workers' learning needs and implementation preferences related to training about IPV and child maltreatment. The design of the present analysis was informed by principles of qualitative description (QD). QD is a naturalistic method for qualitative inquiry that seeks to develop "rich description" of phenomena of research interest (30, 31). Rather than developing theory to interpret data, researchers aim to produce analyses that faithfully capture participants' subjective experiences (32). In this respect, QD has been described as a "low-inference" methodology (31), however researchers' situated perspectives necessarily inform and structure the process and products of QD (32). The present analysis draws on data from interviews conducted with resident and practicing physicians, focusing on their responses about IPV; our aim was to identify how Canadian physicians perceived their roles related to IPV and to develop a robust description of the learning experiences physicians deemed impactful to their understanding of IPV and their related professional roles.

Sampling and Recruitment

Participants were recruited via email study notices distributed by collaborating stakeholder organizations – namely, the national specialty-specific professional associations for emergency medicine, family medicine, obstetrics and gynaecology, paediatrics, and psychiatry in Canada. Additional recruitment materials were also circulated via investigators' social media (Twitter) and professional networks. A criterion sampling strategy (33) was used in order to collect a diversity of medical perspectives; a target sample size of approximately fifteen participants per medical specialty was set. Data sufficiency was determined using the concept of "information power" as articulated by Malterud and colleagues: the relative breadth and lack of specificity of our aim – understanding physicians experiences learning about IPV and their perceptions of their roles – militated towards a relatively large sample for a qualitative study (34).

Prospective participants were eligible for inclusion in the present study if they were (a) 18 years of age or older; (b) a trainee or practicing physician residing in Alberta, Ontario, or Quebec; (c) currently involved in providing direct patient care at least one day per week; and (d) able to provide informed consent and complete an interview in either English or French. Amongst prospective participants who initially responded to the study invitation, participants were screened and purposively selected to ensure our dataset included a balance of physicians from across the specialties of interest who were still in training and who had completed their postgraduate medical education.

Data Collection

Data were collected using semi-structured interviews carried out by AC, AA, and research assistants with training in qualitative interviewing. Interviews were conducted in English or French via a web-based video conferencing platform (Zoom) and were subsequently audio-recorded and transcribed. Interviews conducted in French were orally translated to English by a professional translator and then transcribed. Both written and verbal consent for the interview, and for audio recording, were obtained by participants. Interviews typically lasted between 45 minutes and an hour, and participants were offered a $75.00 honorarium for their participation. The interview guide included questions about participants' professional experiences with IPV, how they perceived health implications related to IPV, their roles in caring for patients affected by IPV, and their related learning experiences and preferences. The interview guide was piloted with members of the research team, and early analysis of interview data proceeded concurrently with data collection, facilitating subsequent refinements to the interview guide. Throughout the process of data collection, which took place between August and December of 2020, members of the research team met on regular basis to ensure interviewers shared a common understanding of the goals of the study and cohesive interpretation of the interview guide, and to share reflections and identify challenges. To aid in establishing the trustworthiness and rigour of our research process, an "audit trail" (35) was constructed throughout data collection: team members tracked study progress using shared documents hosted on a secure server and wrote reflexive memos after conducting each interview that they synthesized in batches and shared with other members of the research team for discussion.

Data Analysis

Our staged analytical process combined principles of content and thematic analysis (30, 36). Staged coding was collaboratively led by AC and AA. Using QSR NVivo (released in March 2020), analysis progressed from line-by-line coding, identifying participants' accounts of learning experiences related to IPV and their related roles, to thematic coding, developing sub-categories to organize data. Adapting constant comparative analysis techniques from grounded theory (37, 38), these categories were compared, contrasted, and re-grouped until settled coding frameworks encompassing physicians' roles and learning experiences related to IPV were reached (see Tables 1 and 2). Formative findings were shared with the other authors of this study at key junctures for their input and direction as data analysis progressed. All interview transcripts were coded by either one or both of the research team members leading analysis.

Reflexivity

Our situated perspectives as health professions education (HPE) researchers (AA, AC, MK, SR, MV) and as clinicians or clinicians-in-training (AC, HM, and MK) shaped our approach to this study. Although medicine's "hidden" and "informal" curricula (27) did not explicitly structure our interview guide's coding framework, working familiarity with these concepts in both academic and clinical contexts sensitized our analytic attention to the learning experiences participants described that were outside of formal medical training.

Ethics

Research ethics approval was obtained from review boards affiliated with the three academic universities that served as hubs for study recruitment (Conjoint Faculties Research Ethics Board at the University of Calgary [Project #20-0338]; Hamilton Integrated Research Ethics Board [Project #9140]; and McGill University Research Ethics Board [Project #20-06-038]).

Results

We conducted interviews with fifty-seven physicians working in emergency medicine (*n* = 14), family medicine *(n* = 10), obstetrics and gynaecology (*n* = 8), paediatrics (*n* = 12), and psychiatry (*n* = 13). Our sample was evenly split between resident physicians (*n* = 28) and physicians in independent practice (*n* = 29). Participants were recruited from Alberta (*n* = 22), Ontario, (*n* = 23) and Québec (*n* = 12), and interviews were conducted in French or English, based on participant preference (see Table 2).

The physicians we interviewed perceived their roles in addressing IPV as focusing on *identifying* patients who were experiencing IPV and *connecting* those patients with community resources and/or other clinicians and service providers (see Figure 1). Assessing patients' safety and providing direct support were also described by some participants as ancillary aspects of the physician role. In describing how they *learned* about their roles in addressing IPV, physicians in our study described a diverse array of experiences that informed their practice related to IPV that were defined by a few common features (see Figure 2). Contrasted with didactic training that addressed IPV in general or abstracted terms, participants in our study placed a high value on experiences where they learned about the outfall of IPV in personal terms. Experiences that illustrated constraints in the health care system and in the broader landscape of services and support related to IPV were also impactful. The experiences that physicians described as most meaningful to their practice took place in clinical settings, through interactions with patients or other members of the health care team. Some participants also valued classroom learning experiences, particularly those that harnessed patient or provider narratives. A small number of physicians we interviewed (5) shared learning experiences that took place outside of their professional training or practice that also informed their work.

Perceptions of Professional Role

Participants uniformly described *identifying* patients experiencing IPV as a part of their professional role related to IPV. Identifying encompassed perceiving "verbal or physical cues" that IPV might be a concern for a patient [502, practicing family physician] and asking patients "the question" about whether they were experiencing IPV in their relationship(s) [251, practicing emergency physician]. Participants described their identifying role as focused on recognizing "victims" of IPV in the context of a current relationship; only the psychiatrists included identifying patients with past histories of IPV as a part of this role, and only the forensic psychiatrists described efforts to identify patients who enacted IPV.

Participants also described *connecting* patients to other clinicians (most often social workers), and to community resources and services as the other primary professional role:

> I view the social worker as the big helper. For us, particularly within a hospital setting where it's hard for us to find exactly who to go to with a lot of these issues, … our social workers know everything. I feel like they're the library book of everything. I feel like they are the best point of contact as to who to reach out. [605, practicing obstetrician]

Assessing patients' safety, providing immediate support in the form of medical treatment, and following up on subsequent visits were issues also described, but framed as prefatory roles in relation to providing patients with connections and referrals. Participants did not discuss documenting encounters with patients related to IPV as a core facet of their medical practice.

Participants reported providing their patients with ongoing supportive counselling as a part of their roles, but also expressed ambivalence and uncertainty about their capacity to effectively provide this support:

> I think that's still a learning point for me – to try and get more comfortable in being sensitive and … to make it a safe space for the patient or their family members. I don't pretend to be an expert at it; I think that [it's] challenging. [302, paediatrics resident]

This mirrored the apprehension participants described when their patients denied IPV was a concern or declined to be connected with other resources. This was especially pronounced for participants from medical specialties where patient relationships were necessarily time-limited (e.g., emergency medicine, obstetrics). Although all of the participants characterized IPV as affecting patients' health, some physicians expressed feeling reticent to raise concerns about IPV in view of what they perceived as the inadequate support or resources they had to offer:

> [If] I say, 'Oh, go to your local women's shelter,' she's going to say, 'There's no women's shelter here in [name of rural town].' So, then I'm kind of stuck. What am I supposed to say in terms of getting her to safety? [505, family medicine resident]

Qualities of Impactful Learning Experiences

Regardless of their medical specialty or stage of training, participants in our study were almost uniformly aligned about the value they felt they derived from experiences that conveyed the implications of IPV in personal terms. Three participants referred to meeting or hearing about patients who had been directly affected by IPV as making associated signs or struggles newly "real" to them [509, family medicine resident; 305, paediatrics resident, 307, paediatrics resident]. The emotional dimensions of these experiences – their "psychological impact" in the words of one practicing emergency physician [202] – were core to why physicians found them so striking:

> "I don't [know] exactly what the right w- [pause] but intense. It's very engaging, it's very memorable, it's [trails off]. Because there's kind of a horrifying nature to

> it, you don’t easily forget it, and I think that helps ingrain what follows from it too” [307, paediatrics resident].

Personal accounts also helped to contextualize participants’ understanding of the reticence some patients might feel disclosing their experiences to physicians:

> “[Talking to elderly patients about their past experiences has] been really informative for me, particularly in understanding why women don’t seek help or delay seeking help and not judging them for that. Because I think that there is a strong… There is a strong culture [in medicine]. […] There’s this swift and easy judgment for women that, if you don’t leave immediately, that it speaks poorly of them.” [606, practicing obstetrician]

Confrontations with the limitations of the care or supports that physicians could offer people experiencing IPV were the source of powerful learning experiences for participants in this study. Reflecting on their decision to engage child protection services after an encounter with a patient they suspected was experiencing IPV, one participant connected the deep conflict they felt in a situation with the impactfulness of the learning they derived:

> “Maybe that is good learning just to have a realistic understanding of what we can do but I think a challenging part of training and learning in medicine often has to do with the clash of the ideals that were taught and the reality of the systems that we work in and limitations of them.” [402, resident psychiatrist]

After describing a similar experience, a pediatrics resident ruefully expressed that the process of trying to support a mother in urgent crisis gave them a “different appreciation” of what they could actually offer to people experiencing IPV:

> “We say, ‘we’ll get you this’, ‘we’ll get you that’ but sometimes in these emergent, urgent situations you come out in the middle of the night, you’re limited in what you can actually do and the impact that you can actually have.” [301, resident pediatrician]

Unsurprisingly, given the distress these experiences of constraint and powerlessness evoked, participants also highly valued learning experiences in which they heard about, saw, or participated in care that was “successful” in supporting patients effectively. Exposure to these interactions helped to personalize general guidance about caring for people affected by IPV, offering templates for future practice that participants expressed gratitude to have experienced.

The notable exception we found to the broad consensus around the impactfulness of learning experiences that help to personalize IPV came from a psychiatrist in our study whose professional work meant they frequently worked with people who had committed IPV. Rather than privileging personal accounts of those affected by IPV, this participant instead emphasized the importance and impactfulness of learning experiences that gave them access to reliable evidence and expert insight they saw as crucial to their forensic work:

> "I just want a researcher to tell me what actually works and what doesn't work. … There's different kinds of learning but if I'm trying to prevent somebody from getting stabbed or raped, I actually want to hear what genuinely works, what does the data say? [410, Practicing Psychiatrist]".

This participant directly acknowledged that their learning needs were likely different from other physicians in our study by virtue of their specialized practice, but strongly urged that training for *all* health care providers should incorporate evidence based strategies for addressing IPV to complement experiential learning.

Sites of Impactful Learning Experiences

Across our dataset, physicians described three main sites in which their most meaningful learning experiences related to IPV occurred: clinical work environments, classroom settings, and outside of their professional training or practice.

Experiences in clinical settings.

Learning experiences that took place in medical work environments were the most widely cited category of experiences in this study. These environments facilitated interactions with patients, preceptors, and colleagues from many different professions that physicians cited as critically important to shaping their understanding of IPV; they also forced participants to directly confront how systems pressures structured their practice environment in meaningful ways.

Interactions with patients were centrally impactful learning experiences for the participants in this study. These experiences helped directly illustrate personal sequelae of IPV, the barriers patients face in accessing services and supports, and illuminated unexpected challenges or insights for physicians seeking to address IPV with their patients. One family medicine resident recalled having an unanticipated emotional response while serving a patient who shared their ethnicity and culture: “I spoke my language with them and I found it a bit harder to address because it felt like I was speaking to like a cousin or a sibling.” [506, family medicine resident]. Another practicing family physician, recalled how experiences interacting with patients over many years had taught them to listen to their “intuition” when questions related to IPV came up:

> “If the patient’s consistently refusing to do a PAP or a breast exam or if you have visits left, right and centre that a patient won’t [explain], be kind of dismissing. It’s small things like that and I think that takes time to learn, time to identify.” [501, practicing family physician]

The learning value of clinical experiences with patients was such that two separate participants described these interactions as “irreplaceable” [204, emergency medicine resident; 509, family medicine resident], however, practicing physicians we spoke with also described how patients were frequently shielded from trainees in medical school or early in residency:

> “You don’t want a lot of providers involved in that, especially the trainee or an R1 [first year resident] or a Junior Resident. You especially don’t want to be asking someone or getting them to repeat the same question multiple times, not to re-traumatize them” [203, practicing emergency physician].

This is just one example of the ways in which learning experiences in clinical settings were produced, precluded, mediated or catalysed by interactions between participants and other members of the health care team. Talking with other physicians about patient encounters were core to the value that participants in this study derived from these experiences:

> “I think the de-briefing with staff is probably the really instrumental or key piece to that to actually help me understand. I think something dramatic could happen in front of me but if I didn’t have a staff to help me break it down, it would not have been as profound” [406, psychiatry resident].

Experiences directly observing other physicians addressing IPV with patients were also impactful learning experiences for participants, offering physicians in our study models for engaging around IPV with patients that they later sought to emulate or avoid. This was particularly true when physicians saw their supervisors or colleagues address IPV in ways they felt were inadequately sensitive; participants in our study described the distress that arose from these experiences as core to why they were so impactful, catalysing their resolve to “do better” in their own practice. Interactions with health or social service providers who were not in medicine also played a role in shaping how physicians in this study understood IPV, particularly where their specialized expertise related to IPV offered participants opportunities to gain or hone contextually specific skills.

Experiences in the classroom.

Although physicians in this study recalled receiving formal classroom education related to IPV, few of the participants we interviewed identified these experiences as impactful to their practice or understanding of IPV. The classroom experiences participants described were primarily didactic, but some also recounted participating in role-play or group discussions. These experiences took place while participants were in medical school, in residency, and, in a few cases, as a part of accredited continuing medical education opportunities.

Much of what participants described as finding effective or valuable in a classroom context resonated with their descriptions of what was important to them in clinical learning experiences. Participants who reported having had no or limited clinical experiences related to IPV reported that they highly valued formal curricular interventions that allowed them to hear directly from patients about their personal experiences with IPV and accessing health care. Recalling a “riveting” lecture that incorporated testimony from a speaker whose concerns had been dismissed by emergency room physicians, one participant remarked: “I will always remember that [speaker’s] face and like how I felt. Those are things that stick with you more” [204, emergency medicine resident]. Beyond testimony from patients, physicians we interviewed also proffered accounts of impactful classroom learning experiences that featured guest speakers with expertise and experience as community service providers. According to these participants, classroom learning experiences were useful for learning about resources they could make use of in their work in the specific communities in which they practiced.

Experiences from outside professional practice.

Finally, A small number of participants in this study described or alluded to experiences from outside clinical or classroom settings that played a role in shaping how they understood IPV and their related professional roles. For some, these experiences came from earlier academic training, past professional work outside of medicine, or from volunteer work. For others, these experiences were more personal, including accounts of supporting close family members or friends’ dealing with IPV. Reflecting on how their “outside” experiences with IPV shaped their professional practice, one participant described them as part of an inextricable package that informed their approach to addressing IPV:

> “I can’t take that part of me away. It definitely impacts how I see these things at work, and it brings a level of knowledge that I didn’t have previous to that. I can’t separate that from my clinical self” [608, obstetrics resident].

Another participant described how supporting a friend experiencing IPV propelled them to seek reading and other resources that had subsequently informed their clinical practice.

Discussion

IPV is associated with a broad range of physical and mental health problems that extend across the life course (4, 5). Physicians have been identified as well positioned to recognize and respond to these health concerns (9, 10, 12). Participants in this study perceived IPV as a concern with relevance to their practice, and understood *identifying* patients affected by IPV and *connecting* patients with referrals as their core roles in addressing IPV. This study described experiences that Canadian physicians identified as important and impactful to shaping their understanding of IPV and their related professional roles. Clinical learning experiences that involved interacting with patients helped to make IPV "real" for participants in our study, who highly valued opportunities to learn about IPV in personal terms. The emotional dimensions of these interactions were core to their impactfulness for physicians, as were their capacity to vivify constraints that made it challenging for physicians to provide or connect patients with support. Clinical experiences that involved interactions with other health care providers were also impactful for physicians. Classroom learning experiences and experiences from outside of physicians' professional training or practice were also cited by some participants as meaningful to their understanding of IPV and their related professional roles. These findings add nuance to past research efforts to characterize what physicians *know* and are *taught* about IPV by highlighting the central importance that physicians ascribe to experience in shaping *how*, exactly, they *learn*.

Our main finding – that physicians consider learning experiences with patients, supervisors, and peers to be their most important sources of learning related to IPV – resonates with sociocultural accounts of (medical) learning as an intrinsically interactional and experiential process that gained favour in the early 20th century (39, 41). Writing in the 1930s, Soviet psychologist Lev Vygotsky theorized that a "zone of proximal development" opened up as school children engaged with their teachers and peers: these social interactions produced learning opportunities that were not otherwise possible (42, 43). Theorists of "expansive learning" extrapolate Vygotsky's concept further to describe the multiple reciprocal processes of meaning-making that unfold in exchanges within and between communities: through these interactions, discursive meanings that shape the material world are both created, contested, and re-constructed (44-46). In the context of medical education related to IPV, these communities might include health policymakers, stakeholders in medical education, physicians and other health professionals, and people affected by IPV; their contested and co-created meanings might include the scope and nature of physicians' roles in addressing IPV and types of training physicians need to be well-equipped to perform their roles.

These findings have implications for stakeholders in health policy calling on physicians to address health concerns raised by IPV, as well as for medical educators seeking to respond to those calls with new curricula and training. From a health policy perspective, the finding that physicians perceive connecting their patients with other referrals as core to their role(s) in responding to patients experiencing IPV raises an important distinction between where care is most accessible and where care is accessed. In Canada, where this study was conducted, public health insurance covers health services that are performed by physicians or provided in a hospital setting (47). This means that referrals to social workers, psychologists, and to non-medical clinicians who practice *outside* of hospital settings typically require private payment (48). Although shelter and outreach services are provided freely, these and other community resources addressing the needs of people experiencing IPV are commonly constrained in the scope and extent of services they can provide by virtue of limited public funding, high demand, and geographic unavailability (49-51).

Participants offered a variety of reasons for framing referrals and resources as a central feature of their response to IPV: for some, it reflected a desire to do *more* to help patients and recognition of the complexity of the factors implicated in IPV; for others, it reflected awareness of practical constraints in their practice environment, and discomfort related to having had only limited related professional experience or education. Either way, this emphasis on referral seemed to foreclose potential opportunities to build supportive relationships with patients affected by IPV, serving to construct physicians as another “closed door” for people who are experiencing violence and who want assistance.

From a medical education perspective, our findings have several implications for leaders in medicine seeking to better prepare physicians to support patients experiencing IPV. Given the importance that participants ascribed to experiential learning in shaping how they understood and performed their roles related to IPV, education interventions that deploy experience strategically are worthy of further investigation. Participants in this study highly valued experiences observing and debriefing with other physicians but also accorded similar value to experiences working with other types of clinicians. With this in mind, facilitating interdisciplinary observerships and rotations could broaden the scope of experiential learning opportunities related to IPV, and allow physicians to learn from practitioners outside of medicine with different disciplinary knowledge and skills. In developing experiential curricula related to IPV, however, the effects that exposure to trainees or additional practitioners can have on patients seeking medical assistance are critical to consider when developing experiential curricula related to IPV. Accordingly, medical educators should explore how indirect experiential learning opportunities—for instance, interdisciplinary case review discussions related to IPV—may help shield patients from less experienced trainees. Similarly, incorporating narrative accounts from people affected by IPV describing their experiences, both positive and negative, in seeking health care in undergraduate medical education offers another way to harness the power of experience to help attune new trainees to principles for supportive engagement with patients affected by IPV. Finally, encouraging physicians to role-model critically reflexive “reflection-on-action” for trainees after caring for patients affected by IPV could provide opportunities for shared learning through experience, cultivating skills in reflection for a next generation of physicians (52).

Limitations

It is important to address the potential impacts of selection bias on our study findings. Physicians who volunteered to participate in a study about their training needs and preferences related to family violence were likely already amongst those with higher levels of related interests and initiative: to whit, almost all of the participants we spoke with expressed a desire to learn more about IPV, and several described training they had undertaken of their own volition. This is unlikely reflective of the general level of interest and engagement around IPV amongst physicians, and represents one form of selection bias that shaped our findings. As well, we recruited physicians from medical specialties with professional associations that were already engaged in developing and evaluating family violence education interventions. As a result, caution should be taken in extrapolating our findings to physicians practicing in other medical fields with less institutional engagement and support related to IPV. Another limitation of this study relates to our recruitment strategy: most of the participants who replied to our study invitation reported urban practice locations. Given the disparate concentration and availability of IPV resources in urban areas (53, 54), it is likely that physicians practicing in rural areas would have fewer resources available to share with patients, perhaps resulting in a different perception of their role in responding to patients affected by IPV. Finally, in keeping with our sociocultural approach to this work, we wish to emphasise that our findings were shaped by the Canadian context in which we, and the study participants, live and practice; these findings reflect our culturally mediated understandings of both IPV and medicine in ways that are elemental and inextricable from this work, and should be interpreted with this in mind.

Conclusion

This study examined how physicians learn about their professional roles in addressing IPV. Analyzing in-depth interviews with physicians from five different medical specialties, we found that participants perceived their roles as first identifying patients who were experiencing IPV and next providing those patients with support in the form of referrals and connections to other resources and clinicians. Participants reported that experiential learning played a primary role in shaping these role perceptions. Ultimately, both medical educators and health policymakers must contend with physicians' emphasis on the primacy of experience in determining understandings of their roles if they wish to reshape what resources and supports are accessible to those experiencing IPV.

Table 1: Coding Framework

Primary Code	Secondary Codes	Tertiary & Quaternary Codes
Physicians' roles in addressing IPV	Identifying patients experiencing IPV	Perceiving signs of IPV
		Asking about IPV - Current relationship - Past relationships
	Responding to patients experiencing IPV	Providing referrals or connections
Impactful learning experiences	Characteristics of impactful learning	Addresses IPV in personal terms
		Illustrates challenges in providing care
		Offers templates for future practice
	Sites of impactful learning	Clinical settings - Interactions with patients - Interactions with colleagues - Interactions with supervisor
		Classroom settings - Interactions with patients - Interactions with specialized service providers
		Outside of professional training or practice - Academic training - Past professional work - Volunteering - Personal experiences

Table 2: Demographic Characteristics of Study Participants

Characteristic	*n* = 57	Percentage
Professional Affiliation		
Emergency Medicine (Royal College or CCFP-EM qualified)*	14	25%
Family Medicine	10	18%
Obstetric Medicine	8	14%
Pediatrics	12	21%
Psychiatry	13	23%
Training Stage		
In Residency	29	51%
Training Complete	28	49%
Gender Identity		
Female	44	77%
Male	12	21%
Trans or Gender Non-Conforming	0	0%
Chose Not to Disclose	1	2%
Practice Community		
Urban	48	84%
Rural	6	11%
Both	3	5%
Province		
Alberta	22	39%
Ontario	23	40%
Québec	12	21%
* Royal College or Certificate of the College of Family Physicians (Emergency Medicine)		

Figure 1: Overview of physicians’ perceptions of their roles related to IPV

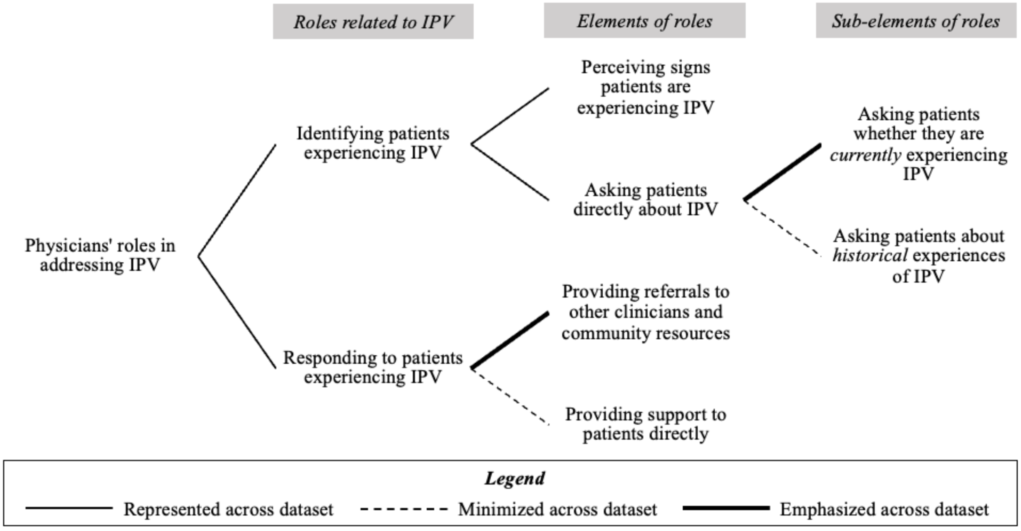
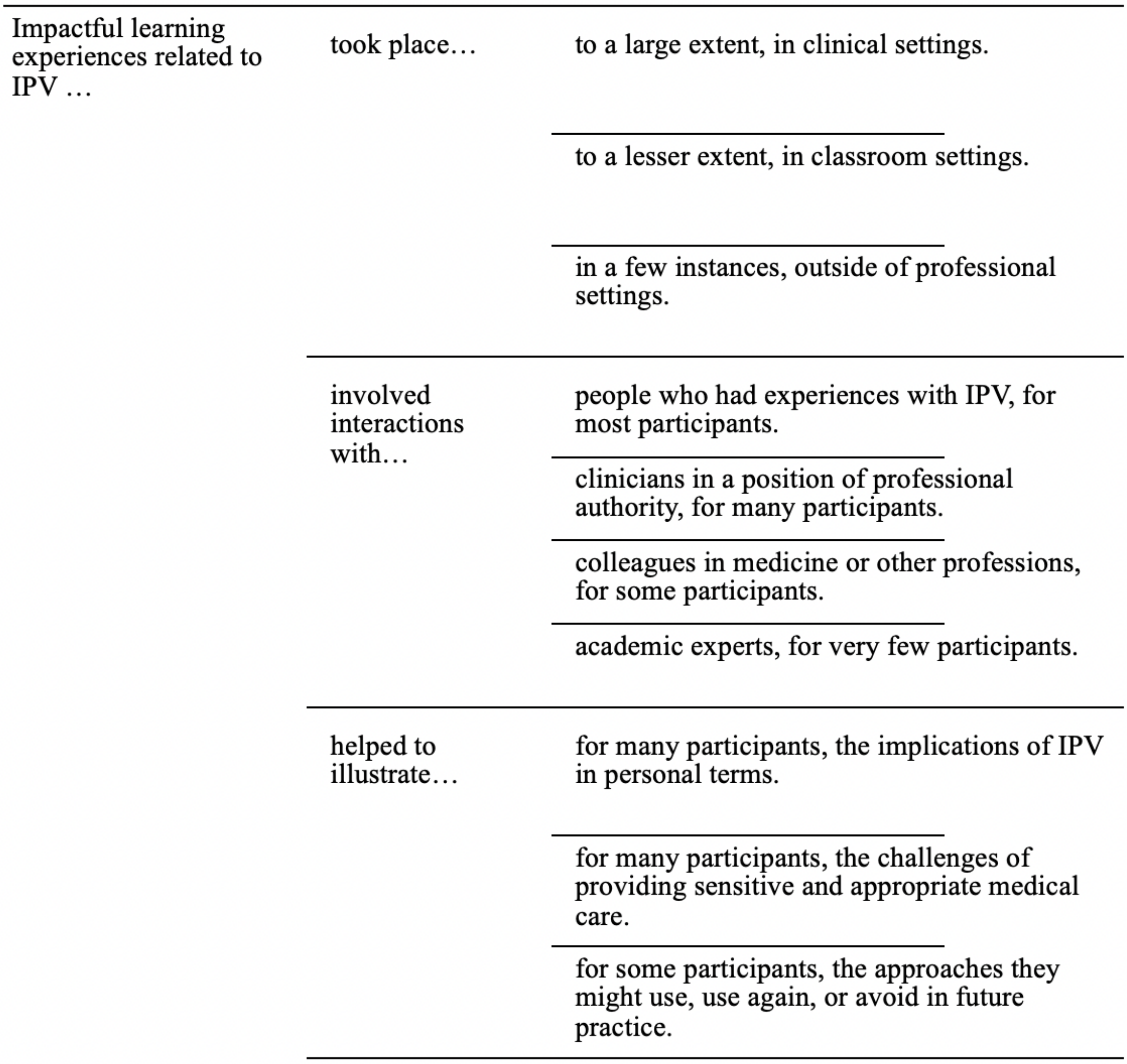


Figure 2: Qualities of impactful learning experiences related to IPV



Impactful learning experiences related to IPV …	took place…	to a large extent, in clinical settings.
		to a lesser extent, in classroom settings.
		in a few instances, outside of professional settings.
	involved interactions with…	people who had experiences with IPV, for most participants.
		clinicians in a position of professional authority, for many participants.
		colleagues in medicine or other professions, for some participants.
		academic experts, for very few participants.
	helped to illustrate…	for many participants, the implications of IPV in personal terms.
		for many participants, the challenges of providing sensitive and appropriate medical care.
		for some participants, the approaches they might use, use again, or avoid in future practice.

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Chapter Four: Physician Roles in Responding to Intimate Partner Violence: Stakeholders' Priorities and Perspectives

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Preface to Chapter Four

This chapter explores how stakeholders outside of medicine perceive the knowledge, skills, attitudes, and behaviours physicians should have related to IPV. Data collection, in the form of key informant interviews, began in January 2022 was completed in May 2022. I conceptualized the study and drafted the study protocol and research ethics materials with guidance from Drs. Meredith Vanstone, Harriet MacMillan, Melissa Kimber and Stacey Ritz. I led data collection with support from an undergraduate research assistant and carried out analysis in consultation with Dr. Meredith Vanstone. Drs. Harriet MacMillan, Melissa Kimber and Stacey Ritz provided feedback throughout the process of analysis and writing, and their feedback has been incorporated into this final version of this chapter. This chapter is currently under consideration for publication at a peer-reviewed journal.

Abstract

Background: Intimate partner violence (IPV) disproportionately affects cisgender women and trans and gender non-conforming people. IPV is associated with a wide range of mental and physical health concerns, but research suggests that physicians often lack knowledge and skills to adequately respond to patients experiencing IPV. In order better integrate physicians' contributions into intersectoral responses to IPV, we asked stakeholders with expertise and experience related to IPV about the knowledge, skills, attitudes, and behaviours they wanted them to have.

Methods: Guided by principles of interpretive description, and using key informant method, we conducted unstructured interviews with 18 stakeholders with professional experience and expertise related to IPV outside of medicine. Data collection and analysis proceeded iteratively; "thoughtful practitioners" outside the research team were recruited at key junctures to provide feedback on formative findings.

Results: Stakeholders indicated that "attending to power" should be a core principle for medical practice related to IPV. Attending to power encompassed *understanding* interactional, organizational, and structural power dynamics related to IPV and purposefully *engaging* with power, by taking action to empower people subjected to violence. Specific recommendations for practice concerned four focal contexts: relationships between partners, between patients and providers, between providers, and in social systems and structures.

Conclusions: Strengthening physicians' capacity to attend to power dynamics relevant to their practice related to IPV is an important step in improving medical care for people experiencing IPV and integrating physicians' contributions into broader landscapes of services and supports.

Introduction

Intimate partner violence (IPV) is a pervasive form of violence around the world that can have profound and enduring health implications for those who experience it. Globally, cisgender women and trans and gender non-conforming (TGNC) people bear a significant majority of the burden of IPV (1, 2). Distress and injuries stemming from IPV are associated with higher rates of many negative health outcomes, including chronic mental and physical health conditions and increased substance misuse and suicidality (3, 4), fueling recognition of IPV as a health problem that merits a health sector response (5, 6). As a part of this response, policy makers and patients have identified physicians as well situated to support people affected by IPV (7-11); medical education curricula (and medical education research) related to IPV have proliferated accordingly (12-14). Many people subjected to IPV, however, still indicate reluctance to disclose their experiences to health care providers citing fears related to the removal of their children from their care and retaliation from their partners, as well as concerns about receiving unsupportive responses (11, 15, 16). Moreover, research with people who *have* disclosed their IPV experiences to a health care provider suggests that many practitioners lack the necessary knowledge and skills to respond to their disclosures with the requisite sensitivity (17). Further work is necessary to ensure physicians are well-prepared to address the needs of people they serve who experience IPV.

One part of this work relates to better understanding how physicians fit into the broader landscape of health and social services and supports that seek to address the needs of people subjected to IPV. Although referring patients who disclose IPV to appropriate supports is widely recommended in guidance for physicians (7, 18), the perspectives of the practitioners on the receiving end of these referrals are rarely included in medical education research related to IPV training for physicians. Likewise, insights from advocates and activists working outside of health care to reduce the prevalence and impacts of IPV are also largely absent from this literature. In part, this may reflect normative assumptions in medical education about who “counts” as a stakeholder with interests, concerns, or perspectives that are relevant to how medical training is designed and delivered. Incorporating perspectives from those doing work related to IPV outside of medicine may help to better integrate the role and contributions of physicians into an intersectoral response, improving IPV prevention efforts as well as access to care and support for people experiencing IPV. With this in mind, we asked stakeholders with expertise and experience related to IPV who work outside of medicine about the knowledge, skills, attitudes, and behaviours they wanted physicians to have related to IPV.

Methods

Study Design

We used interpretive description (ID) to guide our study design. ID is a flexible methodological approach used to conduct applied qualitative health research (19-21). Originally developed by nursing scholars (20, 21), ID blends constructivist and interpretivist paradigms to produce tentative truth claims that represent and interpret phenomena of clinical interest (19, 22). Criteria used to appraise ID studies include the credibility of claims made in relation to the data and the congruence and accessibility of the epistemological, methodological, and interpretive design of the work (21). In contrast with methodologies that frame developing new theory as an end goal unto itself, ID frames informing clinical practice as the primary objective for developing and deepening insight into human experience. With this study, our objective was to generate recommendations to enhance physicians’ clinical practice related to IPV by drawing on the expertise of stakeholders outside of medicine.

Participants and Sample

Drawing on a methodological tradition that originated in anthropology and ethnography (23, 24), we used key informant technique to strategically identify participants with particular insight into our research topic. Key informants are members of a community or field of practice with unique access to and understanding of a phenomenon of research interest (24-26). For the purposes of this study, key informants were defined as stakeholders with professional experience related to IPV, working in a field outside of medicine in a front-line or client-facing, managerial, or policy-oriented role. We excluded physicians and medical trainees from our sample. We did not explicitly seek to recruit participants to represent an embodied "patient perspective" in this study (27), but neither did we seek to exclude participants who had experiences of IPV or experiences with navigating the health care system in its wake. Instead, our aim was to identify participants doing professional and/or advocacy work related to IPV that meant they would have uniquely informed perspectives on improving medical care for people affected by IPV. Additional inclusion criteria included the ability to participate in an interview in English and working in Ontario, Canada.

Key informants with a wide range of focal expertise related to IPV were purposively identified through quota and theoretical sampling strategies. Initially, we devised a sampling matrix (see Appendix 1) based on the sectors we sought to incorporate perspectives from (including IPV-specific services, health care, education, social services, government, the criminal-legal system, and advocacy) and the nature of the roles (frontline, managerial, or policy-focused) in which participants might work, acknowledging that some prospective participants would do work that spanned these boundaries. Members of the research team began populating the sampling matrix by drawing on and canvassing their professional networks to identify prospective participants thought to have particularly astute insights that were relevant to our study. Once interviews began, we engaged in snowball sampling, asking participants to recommend other prospective key informants, particularly those who they perceived to hold informed perspectives that differed from their own. As data collection progressed in tandem with analysis, we used a theoretical sampling strategy, identifying developing areas of interest in our analysis and directing our recruitment efforts towards identifying stakeholders with relevant expertise.

Data Collection

Key informants participated in 45-60-minute-long in-depth interviews conducted over Zoom by either AC, the lead investigator, or an undergraduate research assistant. Permission was obtained from each participant to audio-record their interview, and to recontact them in the future for clarification as needed. Interviews were structured using an iterating interview framework that included three sections intended to: 1) situate the participant's expertise related to IPV; 2) understand their perceptions of medical care available to people affected by IPV; and 3) elicit their recommendations for future improvement of professional training for physicians as well as for medical care for people affected by IPV. In lieu of a standardized demographic form, in the course of the interview participants were asked to reflect on aspects of their identity (if any) that they felt were relevant to interpreting or understanding their perspectives.

Data Analysis

Data collection and analysis proceeded concurrently while constant comparative analysis was used to identify and subsequently develop "interpretive possibilities" in the data (22). NVivo qualitative data analysis software was used to organize the data, and coding took place through iterative stages: the lead investigator immersed herself in the data, listening to audio recordings, reviewing transcripts, and re-reading and annotating field notes. Next, she identified overarching themes that were present in this data, asking for input and clarification from participants in subsequent interviews through a process of interim member-checking: a thematic coding template was developed, applied to new interviews, and subsequently refined and revised through a process of continual synthesis and comparison between findings from different participants. Data collection was stopped when members of our research team were in agreement that our findings were credible, recurred across interviews, and could be used to generate recommendations for future training related to IPV. Data collection began in January 2022 and concluded in May 2022. Strategies to ensure the rigour of our analysis and the quality of our research findings included memoing to foster researcher reflexivity, use of interim member-checking, and input from clinicians in the field at key junctures in analysis and as "thoughtful clinicians" (22, 28), to provide oral feedback on the applications and resonance of the focal concepts, themes, and recommendations developed in analysis.

Ethical Considerations

Research ethics approval for this study was provided by the Hamilton Integrated Research Ethics Board (Project #13770).

Results

We interviewed 18 stakeholders with diverse expertise and frames of engagement related to IPV (see Table 1 for an overview of participants). Although we did not initially approach our participants with questions eliciting their perspectives on power, power recurred as an important theme across the interviews we conducted. Our interview framework evolved with analysis to foreground these questions of power.

In their interviews, participants described a broad range of ways that they wanted physicians to better understand, wield, and yield social power in their work related to IPV. One cross-cutting theme related to the importance stakeholders ascribed to physicians' ability to understand and engage with the different ways that power shaped their professional practice. We called this "attending to power." The synthesis of our analysis that follows considers the different understandings of power that participants in our study evoked in their interviews before turning to explicate our conception of what it means for physicians to attend to power. The analysis concludes with recommendations that participants gave around opportunities for physicians to attend to power in four focal contexts – between partners in relationships in which IPV occurs, between patients and providers, between providers, and in social systems and structures. Participant quotes are identified by a professional description chosen by the participant.

Conceptualizing Power

In describing power dynamics that they saw as relevant to physicians' work related to IPV, stakeholders provided examples that resonate with three distinct theoretical conceptions of power: 1) interactional power in social relationships; 2) organizational power in institutions; and 3) structural power in society. In the literature, interactional power is conceptualized as an individual's capacity to exert influence over the actions of other people (29). Reflecting on the hesitation someone experiencing IPV might feel when asked about IPV, one participant framed fear of a violent partner as a facet of interactional power that deters disclosure:

> Definitely she will say no […]. She's going back home with the same abuser […]. If she stayed by herself [in the doctor's office] for a long time, they're suspicious, like 'What were you saying? What did you say?' [Program coordinator, culturally specific social service provider]

Organizational power, by contrast, refers to the ways in which institutional hierarchies, infrastructure, and policies organize and shape the actions and interactions of individuals operating within their confines (30). Organizational power is reflected in the barriers to interprofessional collaboration that one participant described at the siloed post-secondary institution in which they worked:

> There's just a few layers horizontally between the folks who work in health centres, and then staff who do student services. Not that there's not overlap [in our work], just that those are distinct positions in the [post-secondary institution's] system. [Service provider, post-secondary sexual violence support service]

Finally, structural power operates at a discursive level to produce knowledge and value systems that circulate through society and shape how people interact, how institutions are organized, and how resources are distributed (31, 32). Reflecting on the evolution of terminology they used in their work addressing violence in relationships – terms including “domestic violence,” “woman abuse,” “gender-based violence,” and “violence against women” – several participants connected changes in language to changing political priorities and motivations: “It is women, it is folks from the 2SLGBTQIA+ community [that disproportionately experience IPV], right? But if [policy makers] don’t use those terms then […] it’s not as specific. You’re not held to account” [Gender based violence service provider].

Attending to Power

Attending to power in the context of physicians’ work related to IPV refers to understanding how power operates and purposefully engaging with power in order to empower people experiencing IPV. Virtually all of the stakeholders consulted in this project stressed the importance of physicians’ understanding of power in relationships affected by IPV, but also offered a wide range of other contexts where they thought it necessary for physicians to understand the mechanics of power at work. For instance, participants wanted physicians to understand how their personal identities and professional power in health care spaces shaped their interactions with patients and other providers: participants stressed the necessity that physicians recognize the weight that medical opinion carries in a variety of contexts. Beyond just understanding these dimensions of power, though, stakeholders also underscored the importance of translating this understanding into action: “It's not just recognizing that violence against women exists, but I think it's also recognizing how [physicians] can intervene and some of the challenges of intervening” [Director of programs and services, women’s shelter]. Attending to power encompasses connected imperatives to understand and to respond to power dynamics that participants in our study described.

Attending to Power Between Partners

In more concrete terms, participants offered wide-ranging recommendations for how they wanted to see physicians attend to power in the context of their work related to IPV. All of the stakeholders interviewed in this study agreed on the importance of physicians understanding basic information about how power operates between partners in relationships where IPV occurs. This included being aware of the varied forms and tactics of violence and control – beyond and including physical force – that might be used to exert interactional power over a partner. They also wanted physicians to be aware of the diversity of relationships in which IPV could occur. They further agreed that physicians should recognize the ways in which structural power inequities connect IPV and other forms of violence and oppression, severely limiting the availability of accessible community resources, and shaping patients’ decision-making about whether to stay in violent relationships. To attend to these mechanics of power, participants called for physicians to cultivate their capacity to recognize patients experiencing different forms of IPV and provide ongoing support to patients as both appropriate and desired. In doing so, however, stakeholders stressed that physicians must temper their expectations about the immediate impact their actions might have:

> I guess I would like [physicians] to appreciate the long game where it's not just like, they're going see someone, be like, ‘Oh I'm more attuned to the fact that you're experiencing IPV, I'm going to tell you about this woman shelter, you're going to leave and everything's going be fine’. Because we haven't even gotten to all the problems with like, availability and access to resources. [Service provider, post-secondary sexual violence support service]

Despite these cautions, stakeholders we interviewed still expressed optimism about opportunities for physicians to attend to power dynamics between partners by capitalizing on the organizational power afforded to them in health care settings to try and facilitate safer spaces within their clinical practice. Suggestions included making it routine practice to speak to all patients without their partner present and offering patients known to be experiencing IPV the option of meeting with other support services under the guise of medical appointments. Contextualizing these recommendations in terms of the challenges people experiencing violence face in connecting or contacting services, one participant explained "[medical appointments are just] such a rare point of contact with victims of domestic violence while they're in the domestic violence" [Former child protection worker/civil litigator].

Attending to Power Between Patients and Providers

In order to be effective in their efforts to care for patients experiencing IPV and attend to power between partners, stakeholders also stressed the crucial importance of physicians working to understand and to engage with the mechanics of power that shape patient-provider interactions. Several participants described how the interactional power imbalance between patients and providers might evoke the imbalance between partners in a violent relationship to explain the wariness or distress patients might feel when engaging with physicians: "[As a patient], you walk into a physician's office, [and the doctor] already has tremendous authority in the space, over your body. And if you've experienced abuse, […] it can replicate the traumatic experiences" [Senior manager, violence against women (VAW) service provider]. Other participants connected this imbalance to physicians' mandated reporting obligations related to suspected child maltreatment, noting how structural forms of oppression often amplify marginalized parents' concerns around how disclosing IPV might lead to loss of custody: "This system is so racist, particularly in the way [it] judges whether people are eligible or capable to take care of their children […]. [People experiencing IPV] really worry that any report of that violence will lead to losing their children" [Organizer, migrant sex worker advocacy group]. To aid in attending to these power imbalances, stakeholders we interviewed urged physicians to adapt their behaviour in concrete ways to try and mitigate or address patients' fear or discomfort and shift the balance of power. Suggestions included engaging in ongoing informed consent discussions with patients about all aspects of their care, clearly explaining the limitations of doctor-patient confidentiality related to suspected child maltreatment, and mirroring the language patients use when talking about their experiences related to IPV. Stakeholders also stressed close attentiveness to patients' body language and power dynamics in clinical spaces when talking about IPV and allowing patients to direct conversations about IPV in keeping with what feels "safe" or "right" to them. Participants acknowledged the way that organizational factors – for instance the physical layout of clinical spaces, the limited availability of interpretation services, and institutional policies related to documentation – constrained medical practice, but urged physicians to work "creatively" *with* their patients *within* systems in pursuit of providing person-centred care. One stakeholder explained how this ethos could also extend to shaping how physicians report suspected child maltreatment:

> Yes [physicians] have an obligation to interact with children's aid but there are ways to connect with helping resources or supportive resources that maybe can offer a softer landing […]. What is the language that you use to describe the situation that was relayed to you? Is this your perception or is this what was said to you? How do you prepare the person that you're working with for the possibility of you having to contact [Children's Aid]? What are the mechanisms that you're offering or attempting to create bridges with so that that person can be supported while they're going through that process? [Trauma counsellor, service provider for criminalized people]

This active formulation of attending to power in patient-provider interactions reflects the importance participants ascribed to physicians working *with* patients to support them in navigating fractured health and social service systems, as opposed to simply making referrals or reports in isolation.

Attending to Power Between Providers

Outside of the immediacy of patient-provider relationships, many of the participating stakeholders also described power dynamics between physicians and other people doing work related to IPV. These observations were most prominent in interviews with stakeholders whose professional work interfaced directly with physicians. Participants described feelings of interprofessional tension as well as examples of constructive and respectful collaboration. Feelings of frustration were particularly acute amongst stakeholders with experience in the child welfare system who characterized many of the physicians they dealt with as reticent to share information, even where mandated by law. Three separate participants with training as social workers alluded to the structural power dynamics reflected by the differential weight accorded to testimony from physicians versus social work perspectives in legal proceedings: "it's annoying, because [the] courts will ask us for 'expert evidence' and if the courts are asking for expert evidence, apparently being a social worker doesn't count" [Child protection worker]. Stressing the multi-faceted needs of people subjected to IPV, other stakeholders reflected that it was important for physicians to understand their own scope of practice related to IPV relative to what other service providers could offer. These same providers also noted how structural power dynamics fostered barriers to connection between those working in different organizations or systems: reflecting on challenges bridging workers in the health sector with those providing homelessness and violence against women services, one participant noted that "by funding alone, the services are siloed" [Director of programs and services, women's shelter], hampering collaboration. To attend to these power dynamics, several stakeholders encouraged physicians to actively participate in efforts in their communities to coordinate services related to IPV across sectors:

> If you have physicians at those coordinating tables, their understanding of the experiences of [patients and service providers] dealing with IPV may grow. Like there might be points where we're missing this communication, right? […] Sitting at coordinating tables allows you to understand other systems better […]: how you could be delivering services differently or [be] more responsive or aware. [Senior manager, VAW service provider]

For the stakeholders we spoke with, fostering relationships between physicians and other service providers working in different organizations and sectors was perceived as an opportunity for education and as a gateway to new partnerships.

Attending to Power in Social Systems and Structures

The final power dynamic that stakeholders addressed in their interviews relates to how power operates in social systems at a structural level to entrench IPV as a pervasive form of violence. All of the participants in this study discussed their work related to IPV with reference to connected forms of oppression and marginalization, expressing similar expectations for what they felt was important for physicians to understand in order to attend to structural inequities shaping their patients' lives:

> I think that [it's about] putting that context into the discussion around IPV, [similar to] when people say that being Indigenous is a 'risk factor' for diabetes […]. It's not really being Indigenous, it's the history of colonization, and socio-economic factors and all those other things that have been imposed on us. [Education leader, post-secondary institution]

Several participants also expressed a desire to see physicians attend to power by mobilizing politically around IPV, reflecting on the advocacy opportunities afforded to physicians by virtue of their profession:

> I would love for [Canadian medical associations] to use any of their clout to get better services. I mean, really, for anything, for any social welfare state stuff, but specifically for domestic violence. […] Ongoing counseling for the kids, ongoing counseling for the women. Those pieces that the doctor can't do but could advocate for would be really cool. [Former child protection worker/civil litigator]

Some participants offered caveats to this encouragement however, stressing that physicians should reflect critically about their roles in collective action: "Any kind of advocacy should be bottom up, right? We have an amazing doctor, they know what is happening from their perspective, but what is actually happening from [the perspective of] the people using [the services]?" [Organizer, migrant sex worker advocacy group]. For these stakeholders, attending to power in advocacy work was also a process of cultivating critical reflexivity around the limitations of a physician's situated (and often privileged) perspective.

Discussion

In this qualitative study of stakeholders' perspectives on the skills, knowledge, attitudes and behaviours physicians need to care for patients affected by IPV, we identified attending to power as a key principle for practice. Attending to power encompasses *understanding* various facets of interactional, organizational, and structural power dynamics across a variety of contexts relevant to IPV. It also entails purposefully *engaging* with power with the intention of empowering people subjected to violence. Our analysis resonates with accounts of social power as multi-faceted, ever-present, and deeply relevant to practices of medicine and medical education (29, 33). It also fits within a broader canon of feminist research related to IPV that foregrounds issues of power, oppression, and empowerment as key to understanding, addressing, and preventing violence (34, 35).

In urging physicians to attend to power in the course of their professional practice related to IPV, our intent is not to imply that physicians are unilaterally powerful or capable of definitively redressing any of the power inequities they observe or participate in. Indeed, accounts in the health sciences have identified feelings of powerlessness and moral distress as a factor in burnout for health care providers (36-38). This underscores the observations of participants in this study that the structural power dynamics facing patients experiencing IPV are far more complex and intractable than what any one health care provider might fairly be expected to address alone. Instead, we conceptualize attending to power as an opportunity to forge solidarity and alliances in pursuit of a world without IPV. This resonates with accounts in medical education literature that suggest that participating in collective action – one strategy for attending to unjust structural power dynamics – can be a partial answer to the feelings of distress that arise from caring for people who are suffering in an unjust society

(39, 40). In lieu of formalized training to support physicians in assuming the formalized role of the "health advocate" (41), however, we suggest that medical educators wishing to integrate attending to power into professional education for physicians focus on honing trainees' capacity to understand how power shapes the health of their patients, to critically reflect upon their own nascent power as providers, and to engage with the people they serve with empowerment as a core principle for practice (42, 43).

The rich expertise and wide-ranging professional experiences related to IPV that participants shared in their interviews are chief amongst the strengths of our analysis; so are the clearly established process and logics we followed while identifying key informants. In keeping with principles of ID, the process of iterative feedback through which our analysis progressed was rigorous. Recognising that members of our research team and key informants both came to this study with their own investments and attachments to power, we incorporated opportunities for reflexive discussion throughout study design, data collection and analysis. Our strategy of asking key informants to qualify their positionality in their own words in lieu of using a standardized demographic form may be useful to other qualitative researchers hoping to engage participants in reflexive interviews.

Limitations of our study relate to constraints of our sample. Specifically, to aid in narrowing the scope of our recruitment efforts, we limited our sample to the province of Ontario. As a result, our analysis reflects the experiences of people working within one landscape of IPV resources and support and may resonate less in other jurisdictions where health and social policy contexts are different. As well, although we did not recruit participants in view of their professional training, the preponderance of social workers in our sample is also notable; more than half of the participants in this study reported that they had received professional training in social work during their interviews. This reflects not only the predominance of social workers employed in fields and positions that are related to IPV, but also echoes accounts of the role that power differentials play in fueling interprofessional tensions between social workers and physicians in other contexts (44). Future inquiry developing or applying our concept of “attending to power” should include perspectives from service providers working in other roles, and from advocates working outside of regulated health professions to further probe the nuances of how power operates between providers. Finally, although we did not ask participants about their personal experiences with IPV, more than half of the stakeholders we interviewed disclosed having experienced IPV at some point in their lives; even so, these results should not be interpreted as an account of survivor preferences or patients’ priorities for their medical care. Further research examining the perspectives of people subjected to IPV on the strategies for attending to power described in this paper represent a critical next step in taking up the findings of this work.

In conclusion, this study has examined the manifold permutations of social power that shape medical practice related to IPV across a range of contexts. In integrating insights and recommendations from stakeholders addressing IPV while working in diverse sectors, we developed the concept of attending to power as a crosscutting principle for physicians seeking to support their patients experiencing IPV. Medical educators and policymakers seeking to strengthen physicians’ response to IPV in the future should explore opportunities within medical training to bolster physicians’ capacity to understand and engage with power in service of supporting their patients.

Table 1: Overview of Participant Roles

#	Role	#	Role
1	Coordinator, sexual assault crisis line	10	Director of programs and services, women's shelter
2	Sexual assault nurse examiner	11	Senior manager, violence against women (VAW) service provider
3	Former child protection worker/civil litigator	12	Coordinator, traumatic brain injury organization
4	Service provider, post-secondary sexual violence support service	13	Feminist lawyer/advocate
5	Child protection worker	14	Family guidance counsellor
6	Education leader, post-secondary institution	15	Program coordinator, culturally specific social service provider
7	Settlement services provider	16	Trauma counsellor, service provider for criminalized people
8	Worker, family court support program	17	Organizer, migrant sex worker advocacy group
9	Outreach worker, violence against women program	18	Gender based violence service provider

Table 2: Summary of Recommendations for Practitioners

Context	*Physicians can* ***understand power*** *by knowing that …*	*Physicians can* ***engage with power*** *by …*
Between Partners	- IPV encompasses many forms of violence that perpetuate power and control. - decisions "to leave" are complicated, are shaped by many factors including forms of marginalization related to IPV. - people experiencing IPV may not have access to other "private" supportive spaces.	- being aware of the range of presentations IPV can have and offer ongoing support as appropriate and desired by the patient. - respecting patient autonomy and recognizing how their preconceptions about IPV shape their practice. - strategizing around how to work within their places of practice to create safer spaces for patients subjected to IPV.
Between Patients and Providers	- power dynamics between patients and providers are shaped by many factors (including duty to report suspected child maltreatment). - patients' access to, and ease/comfort navigating, health care settings and systems may be limited by their experiences with IPV, amongst other factors.	- deploying strategies to shift power towards patients in conversations about IPV, including mirroring patients' language, being aware of body language/physical space, centering patients' values/priorities, amongst other strategies. - "softening the landing" where possible and appropriate when reporting concerns related to suspected child maltreatment by informing/including/advocating for parents subjected to IPV. - strategizing with patients about what support they can offer in securing access to resources in, and beyond, health services.
Between Health/Social Service Providers	- the scope of their expertise related to IPV, including what they can do to support patients, what other	

	service providers can offer, and what constraints those services are under.	- learning from other practitioners and service providers about their practice, expertise, and understandings related to IPV. - being familiar with first-line supports related to IPV in their communities, including what those services can/cannot provide. - fostering collaborative, respectful relationships with other health and social service providers.
In Systems/Structures	- how professional power accorded to medicine/physicians shapes the landscape of accessible support. - the origins of, limits to, and strategic opportunities for using medical power to advance efforts to end IPV and related forms of violence and oppression. - connections between IPV and other forms of violence/ marginalization.	- honing their capacity to “think laterally” with patients to support them in navigating and obtaining what *they need* from health/social service systems. - working in solidarity with groups and communities affected by IPV and connected forms of violence/marginalization.

Appendix 1: Blank Sampling Matrix

	Frontline	*Managerial*	*Policy-Focused*
IPV-specific services			
Health Care			
Education			
Social Services			
Government			
Criminal-Legal system			
Advocacy			

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Chapter Five: Conclusion

The three original studies that comprise this dissertation have taken different approaches to examining how physicians learn to think about IPV and how this translates to their roles related to caring for patients. Chapter Two offers insights into the discursive production of physicians' roles in training and policy documents with a Canadian medical audience. Chapter Three describes Canadian physicians' own perceptions of their roles, and the sites and sources of insight that structure these perceptions. Chapter Four examines how stakeholders outside of medicine conceptualize physicians' roles related to IPV and their recommendations about knowledge and skills needed for physicians to perform these roles effectively. In this final chapter of the dissertation, I will synthesize the core findings from each of these studies, before considering the cross-cutting contributions of this work, summarising points of connection and tension between the studies. Next, I will discuss the implications of my findings as they are relevant to several of the key constituencies for this work including physicians, medical educators, researchers, policy makers, and for individuals and organizations working against IPV. Finally, I will offer some points of consideration for readers regarding the strengths and limitations of this dissertation, my reflexive disposition while conducting this work, and opportunities to continue the work of improving medical care for people affected by IPV moving forwards.

Summary of Findings

Each of the studies conducted in this dissertation affords different insights into the process through which physicians come to understand their professional roles related to IPV, along with their understanding of IPV itself. In the following sections, the findings from each of the dissertation chapters are reviewed, with particular attention to their answers to the research question that spurred this inquiry: *how do physicians learn to think about IPV and their professional roles in addressing IPV in the course of their training?*

Chapter Two: Conceptualizing Physicians' Roles in Addressing Intimate Partner Violence - A Critical Discourse Analysis of Resources for Canadian Physicians

Working from the evidence about physicians' lack of preparedness to effectively address IPV with their patients (1-3), the critical discourse analysis presented in Chapter Two identified an undercurrent of medicalization in education materials gathered through a pan-Canadian environmental scan. Physicians were encouraged to conceive of IPV as a "medical issue" within their scope of practice, and to become attuned to myriad "risk factors" for, and "symptoms" of, violence, evoking the notion of performing a medical act of diagnosis. The tasks of identifying and responding to patients experiencing IPV were framed as connected components of physicians' roles in addressing IPV. Physicians were urged to actively identify patients experiencing IPV, to help those patients name and frame their experiences as IPV, and to provide those patients with support, including referrals, to enable them to leave their relationships.

A range of assumptions underlie the ideas about physicians' professional roles related to IPV that were present in these training materials. Community resources addressing IPV and related concerns were presumed to be available and readily accessible. Patients "affected by IPV" that physicians might encounter were "victims" rather than "perpetrators" of IPV; the latter were portrayed only as looming threats to patients and not as people who might come into contact with the health care system as patients with specific health care and social service needs. IPV was presented as a "present tense problem" insofar as resources primed physicians to develop knowledge and skills related to caring for patients who were *currently* subjected to IPV in a relationship, but not those patients with histories of experiencing, or of being exposed to, IPV in the past. Finally, IPV was framed in terms that evoke a medical diagnosis and subsequent treatment, belying a complexity of needs beyond those readily met by biomedical health care providers.

In sum, this analysis of education materials for a Canadian medical audience suggests that physicians are expected to think about their professional roles related to IPV through an interventionist lens, focused on helping people who are experiencing violence end and leave relationships where IPV is occurring. This construction of physicians' roles does not address the needs of people with historical trauma related to IPV or the reality that people who enact IPV also require and seek medical care and may have histories of trauma themselves. Resources acknowledged that physicians should provide an entry point to other services and supports for people affected by IPV, but emphasized physicians' role as a source of support without providing concrete guidance as to how to care for patients navigating the aftermath of IPV. Nor did they tangibly address how to provide effective care within the constraints of the health care system, or how to implement affective instructions as vague as "create a supportive environment." These expectations for physicians' practice related to IPV can be interpreted in many ways. Through one lens, the medicalization of IPV might be read as an artifact of pragmatic efforts to connect people in distress with support that might be otherwise challenging to access (4-7). Through another, medicalization appears as a means of consolidating medical power and authority over another dimension of experience that might be otherwise addressed by different service providers or sectors of society (8, 9). Through yet another lens, medicalization could be interpreted as a pernicious attempt to obscure the strained social safety net, saddling physicians with yet another responsibility to "treat" downstream manifestations of social problems with structural roots – poverty, sexism, racism, colonization, ableism – that there is little political will to address (10, 11).

Chapter Three: "A Different Appreciation": A Qualitative Description of Canadian Physicians' Perceptions of Their Roles Related to IPV and Relevant Learning Experiences

Drawing on interviews with practicing physicians and medical residents in five medical specialties across three provinces, the analysis presented in Chapter Three explored the concepts and sociocultural context that help constitute how physicians in Canada perceive their roles related to IPV. Identifying patients who were currently experiencing IPV and referring those patients to other resources, services, and supports composed the central roles that participants in this study understood themselves as playing. Participating psychiatrists also included identifying patients with historical trauma related to IPV as part of the identifying role that was relevant to their work in caring for people suffering with various forms of mental distress. Participants across all of the included specialties expressed uncertainty or a lack of confidence about their ability to support patients affected by IPV effectively and identified both personal knowledge deficits and systems-level challenges as hampering the care that they could offer. Many participants mentioned social workers as those best equipped to provide effective ongoing support to people experiencing violence. When asked about how they came to understand their roles related to IPV, physicians stressed the impact of direct clinical experience in shaping their perceptions: clinical experiences with patients and other providers were framed as core sources of insight, while experiences in classroom settings and outside of professional training or practice were secondary sources.

Findings from this study resonate with sociocultural theories of learning that emphasize the importance of interaction and collaboration in the process of acquiring new ideas, knowledge, and skills (12). This analysis suggests that physicians construct their understanding of IPV and of their professional roles in addressing it through experiences engaging with other people across a variety of contexts. Clinical encounters engaging with patients help to vivify and complicate what physicians conceptualize as key concerns and challenges facing people subjected to IPV. Interactions observing or engaging with other care providers in and out of medicine proffer new templates (both constructive and obstructive) for addressing IPV that physicians may choose to adopt or eschew in their own practice. Interactions and experiences that take place beyond the bounds of professional training and practice are also impactful to physicians, informing their subsequent professional work. Finally, classroom encounters also shape physicians’ perceptions of IPV and their related roles, particularly when they strategically integrate experience. This might take the form of simulated interactions with patients that offer physicians the opportunity to practice (and observe others practicing) addressing IPV in a professional setting; it might also include engaging speakers and instructors to share their own experiences and stories about seeking and/or providing medical care in the context of IPV.

Chapter Four: Physician Roles in Responding to Intimate Partner Violence: Stakeholders’ Priorities and Perspectives

Combining interpretive description and key informant method, this study solicited recommendations from stakeholders with expertise related to IPV about the knowledge, skills, attitudes, and behaviours that could enable physicians to provide effective care to people affected by IPV. Across these interviews, power was a central, recurring theme: participants wanted physicians to *understand* different forms of power that were relevant to their practice, and to work to *address* those forms of power in order to empower people experiencing IPV. I developed the concept of “attending to power” to reflect this dual imperative and consolidated participants’ recommendations for physicians around four focal contexts. In the context of relationships where IPV was occurring, participants wanted physicians to understand how power and control operated between partners and to strategize around how they might facilitate safer spaces for patients in their places of practice. In the context of relationships between providers and patients, participants stressed the importance of understanding the many permutations of power that shape patient-provider interactions and identified practical strategies for physicians seeking to empower patients navigating health and social service systems. In the context of relationships between health and social service providers, participants wanted physicians to understand the scope of practice and constraints other service providers worked within, and to foster collaborative relationships. Finally, in the context of the broader systems that structure what supports are accessible to people experiencing IPV, participants urged physicians to understand connections between IPV and other forms of marginalization and to work strategically in solidarity with affected communities to end violence.

Findings from this analysis help to illustrate some of ways that interpersonal, organizational, and structural forms of power give shape to physicians' professional roles, including those related to IPV. Given what is understood about the acculturative functions of medical education – the role professional training plays in inculcating new physicians with shared professional values, attitudes, and ideas – the power dynamics that participants in this study described can be understood, at least in part, as products of the formal, informal, and hidden curricula that constitute how doctors learn about IPV (13). These power dynamics can also be problematized as challenges that medical education has a role in trying to solve. In order to reshape how physicians learn to think about IPV and their related professional roles, this analysis suggests that professional training programs can – and should – support physicians in strengthening their analysis of the ways that power shapes health, illness, and the practice of medicine in the context of IPV and beyond. The next section will consider how the findings from this study fits with the two preceding it, to identify the broader contributions and insights from this dissertation.

Cross-Cutting Contributions

Together, these chapters tessellate to produce a broader picture of how physicians in Canada perceive their roles related to IPV, how these perceptions evolve, and how interested stakeholders might endeavour to intervene in medical training to improve care for people subjected to IPV in the future. The following sections synthesize findings from each of the preceding chapters around these three themes, highlighting particular areas of congruence and conflict across the studies.

How Physicians Perceive Their Roles

The three studies that comprise this dissertation offer a multi-layered account of ways in which physicians perceive their roles related to IPV. Identifying patients *currently* experiencing IPV was commonly recognized and constructed as core to physicians' related roles in all three studies, while identifying patients who had experienced IPV in the past was featured only peripherally, if it all. Similarly, although people enacting violence were represented as potential obstacles that physicians might need to circumvent to speak to "victims" of IPV privately, none of the studies identified roles for physicians that directly addressed caring for people who might enact violence themselves. Although roles for physicians in "identifying" patients experiencing IPV recurred in all of the studies, the constructions of what "responding" should entail, and which providers are best situated to perform those responses varied. Resources analyzed in Chapter Two described a multi-faceted approach to responding to patients and their children, while physicians interviewed in Chapter Three largely conceptualized their role in responding to IPV as connecting patients with other resources, services, and service providers. The individual scope of the responding role articulated in both of these studies also lies in contrast with the imperative to attend to power in a structural sense that stakeholders imagined for physicians beyond the immediacy of a single patient-physician encounter.

Other points of discord concern how physicians' roles related to IPV were portrayed relative to those of other service providers, community resources, and care providers. The discussion of medicalization reflected in the resources analyzed in Chapter Two are nuanced by the findings in Chapter Three: that physicians perceive IPV as better dealt with by other care and service providers. Findings from Chapter Four highlight how professional hierarchies and institutional silos shape interactions between providers but also illustrate the depth and breadth of expertise in addressing IPV that is located outside of medicine. These findings underscore the need for intersectoral collaboration both in education and in practice related to IPV.

How Physicians Learn to Think About Their Roles Related to IPV

The studies included in this dissertation also afford new insight into the process through which physicians come to understand their roles related to IPV. Findings from Chapter Three about the primacy of experiential learning in shaping how physicians address IPV resonate with findings from Chapter Four about the influences of organizational and structural forms of power in the practice environment. Taken together, these findings help to contextualize the disjuncture noted above between the interventionist roles constructed for physicians in training materials in Chapter Two, and physicians' perception of their roles as connectors as described in Chapter Three — what physicians learn in the course of their professional training is shaped as much by informal interpersonal forms of learning and by the policies and politics of institutions as by what is relayed in formal teaching contexts (13). In the context of IPV, this dissertation helps to illustrate that what physicians learn to think about their roles related to IPV is mediated both by informal and hidden curricula that unfold in the course of training and practice.

Interestingly, although formal curricular interventions intended to promote reflective practice are increasingly common and credited with cultivating critical competencies for medical practice including cultural safety (14, 15), the value of personal and professional reflexivity related to caring for patients experiencing IPV was not mentioned in the resources surveyed in Chapter Two and was only indirectly addressed by physicians interviewed in Chapter Three. This is in striking contrast with the critical importance that stakeholders interviewed in Chapter Four placed on physicians' capacity to reflexively identify and engage with their own power as actors, as well as with the power vested in the practice environments and broader political contexts in which they work. This finding gestures towards the importance of continuing efforts and inquiry in medical education that examine how best to cultivate critical consciousness and reflexivity in physicians (16, 17).

Opportunities to Intervene

Finally, taken together, the studies described in the foregoing chapters suggest promising avenues for education interventions intended to improve medical care related to IPV in the future. Insights from Chapter Three about the value of experiential opportunities for interprofessional exchange illustrate possibilities for learning about other providers' practices, skillsets, experiences, and challenges, building mutual respect and fostering new collaboration. In this vein, the practical strategies that stakeholders interviewed in Chapter Four described using to create safer spaces for patients experiencing IPV could help to remedy the vagueness in the affective instructions for physicians identified in resources in Chapter Two; they could also aid in improving the quality of the connections and referrals physicians described providing to their patients in Chapter Three.

Despite these points of resonance and opportunities for connection, however, the scope of imagination around what physicians can and should offer to patients experiencing IPV is significantly different in each of these three studies. Systemic resource constraints that shape what support physicians can offer and what people experiencing IPV can access featured as prominent themes in Chapters Three and Four, but were not addressed by the resources we analyzed in Chapter Two. The construction of physicians' roles related to IPV that emerged in Chapters Two and Three both stressed identifying and responding to IPV in situ but lacked the same emphasis on understanding the broader social, cultural, and political contexts of violence that emerged so clearly in Chapter Four. Ultimately, although the experiences, insights, recommendations, and resources that served as data for this dissertation shared a common sense of the importance of improving medical care for people who experience IPV, the disjuncture between what these studies imagine as necessary to enact that improvement are an important challenge for the varied stakeholders for whom findings from this dissertation are relevant. The next section identifies these stakeholders and identifies key findings with relevance to their work.

Takeaway Messages

The findings of this dissertation are relevant to a variety of constituencies with influence or interest in how physicians learn to think about IPV and care for affected patients. The following section summarizes the points of interest and implications of this work for physicians, for medical educators, for researchers, for policy makers, and for individuals and groups organizing around IPV.

For Physicians in Training and Practice

The first constituency for whom this work is relevant are physicians and medical trainees. This dissertation illustrated both challenges and opportunities for addressing IPV in medical practice. Impediments to addressing IPV that were noted in these studies – time pressures, resource constraints, lack of certainty about how to respond to patients' disclosures or ongoing needs for support – mirror those identified in other accounts of the challenges that clinicians face while supporting patients experiencing IPV in health care settings (18-20). Fortunately, relatively low-barrier, informal interprofessional learning opportunities related to IPV were both accessible and highly valued by physicians who shared their perspectives for this dissertation. This echoes literature highlighting the particular relevance, applicability and efficiency of subject-specific learning that takes place through informal exchanges (21-23). Physicians and medical trainees with an interest in improving their capacity to respond to people affected by IPV may wish, as participants in Chapter Three did, to shadow colleagues in social work and nursing with particular expertise related to IPV, or debrief and discuss cases in interprofessional teams. Stakeholders we interviewed, many of whom were among the practitioners that physicians might wish to learn from, were also largely supportive and welcoming of enhanced communication, collaboration, and consultation with their colleagues, provided these physicians were attuned, and attending to, the power dynamics that shaped their practice.

For Medical Educators

The second constituency with a stake in the findings of this dissertation is medical educators. In this research, learning related to IPV in clinical and classroom settings was perceived as most impactful by physicians when it incorporated dimensions of experience that helped to personalize implications of IPV and possibilities for constructive modes of caring for affected patients. Our findings connect with threads of scholarship in medical education that have theorized and evaluated impacts of interprofessional (24) and narrative-based pedagogical practices (25) and explored the varied implications of involving patients and “patient perspectives” in medical education (26, 27). Our findings also raise questions about how best to ensure that the experiences physicians so valued when learning about IPV are accessible, but also do not engender or amplify distress for patients, providers, or trainees (28-30). To help mitigate these potential harms, medical educators may wish to consider creative ways to harness and integrate experience across all levels of medical training. In pre-clinical medical training this could include sharing patient or provider narratives that help to vivify challenges and opportunities for making health care spaces sources of support; in clinical training in medical school and residency, this could include participating in multi-disciplinary case review meetings and, when trainees are more equipped to engage with patients sensitively, opportunities for interprofessionally supervised practice; in formal continuing medical education, this could include developing new training initiatives with experts from outside of medicine, who can share their disciplinary expertise. Our findings suggest that incorporating opportunities for physicians to learn from clinicians and service providers working in fields beyond medicine with expertise related to IPV is a valuable tactic in efforts to better prepare physicians to care for patients, but also necessitates that physicians and trainees are primed to attend to the various operations of power that shape these interactions. With this in mind, I suggest that incorporating curricular elements that aim to develop physicians' capacity to "attend to power" at all stages of medical education will be beneficial in the context of IPV but also in other arenas where structural forms of oppression, marginalization and violence are framed as "health issues" (31-34).

For Researchers

A third group for whom the findings from this dissertation are relevant are researchers with an interest in medical education. Taking up the concerns of this research directly, future inquiry is needed to explore and address overlooked aspects of IPV in medical education. This includes training addressing the complexities of caring for people who enact IPV (35, 36), principles for practice when serving people navigating the outfall of historical experiences with IPV, and reconciling how cycles of violence mean that these two issues are intrinsically connected (37, 38). This also means exploring how to ensure medical training and practice environments are supportive for physicians and medical trainees who experience IPV themselves (39, 40). As well, researchers might also extrapolate or explore other contexts besides IPV where the concept of attending to power is relevant, including, for example, while serving people who are incarcerated (41, 42), when caring for people who have experienced violence from law enforcement (43, 44) or in health care settings (45, 46). Perspectives of people who experience IPV, amongst other forms of violence, are critically important to include in work exploring the applications of attending to power in these and other contexts. The concept of attending to power between providers may also provide a useful provocation for medical education researchers collaborating with scholars and clinicians enmeshed in other professional modes of inquiry and practice, each with their own rich disciplinary traditions. This dissertation illustrates the depth of insight and theoretical richness that are brought to medical education inquiry when perspectives from other professions and outside of health care are integrated into our work and offers one template for future research integrating the expertise of non-physician key informants.

For Policy Makers

Fourth, findings from this dissertation also have relevance to policy makers working to address IPV at a systems level. Findings from this research show that physicians *can* have a valuable role to play in helping to support people who are affected by IPV, but that the complexity of the issues that IPV can engender often require more support than what physicians – or the health care system as whole – can provide. IPV *is* a health issue, but it is also a justice issue and a community issue that demands transformative solutions that breakdown rather than entrench siloed ways of thinking about people and their needs for support (7, 47). Framing IPV as a health (policy) issue offers strategic advantages for those policy actors seeking to mobilize resources, attention, and support, but can also work to narrow the field of vision through which IPV is understood. This narrowing necessarily elides the complexity of people's lives and needs for support when they are experiencing violence. Policy makers working to address IPV in health care and beyond would themselves be well-served by attending to power, seeking to create policy architecture that empowers the people living within it by recognizing and responding to their multi-faceted needs.

For Those Working Against IPV

Finally, findings from this dissertation are also relevant to organizers and organizations working outside of health care contexts to support people experiencing IPV or to prevent violence more broadly. The studies that comprise this dissertation illustrate that although physicians are encouraged to conceptualize IPV within a framework that privileges their own diagnostic and interventionist authority, many feel themselves to be ill-prepared to actually meet their patients' needs. This self-identified need for more skills and greater knowledge points towards an opportunity and an opening for intersectoral collaborations that may help better integrate physicians – and the attendant social and political capital that they are granted by virtue of their professional status – into broader movements against violence.

Critical Considerations

In engaging with this dissertation, several critical considerations are important for readers to bear in mind. The following section brings together some of the key limitations of this inquiry as well as final reflections on how the theoretical, personal, and practical touchpoints outlined at the outset of this dissertation shaped the subsequent work.

Strengths and Limitations

Although each of the preceding chapters have individually addressed their respective strengths and limitations, a number of crossing-cutting qualities of the dissertation as a whole are worth drawing out in further detail. Strengths of this dissertation include the diversity of the types of data and methods used in each study, the breadth of participant perspectives amplified, and the novel combination of theoretical perspectives from health policy and medical education. The range of data sources and methods integrated across this dissertation add depth and nuance to this inquiry, each affording different vantage points of intrinsically multi-faceted issue. Similarly, the breadth of perspectives represented in the samples for each study – in Chapter Two, a pan-Canadian scan of education materials, in Chapter Three, a large sample of physicians practicing in different specialties and provinces, in Chapter Four, the voices of stakeholders seldom included in medical education research – are another strength. Finally, the integration of theoretical constructs from scholarship in health professions education (HPE) and health policy gesture towards a new avenue for transdisciplinary inquiry in the future, using the tools of policy analysis to examine medical education as a form and process of policymaking unto itself.

Limitations of this dissertation relate to the dimensions of health care related to IPV that are missing from our analysis, and caveats around extrapolating this work beyond the context in which it was conducted. As has been noted throughout this chapter and in those before it, the interest of this inquiry in examining how physicians come to understand their roles related to IPV lent this work a narrow focus on people who experience IPV. This reflects a limitation of this inquiry insofar as it reinforces an existing dearth of information and evidence for guiding health care practice with people who enact violence; it also tacitly serves to reinforce binary thinking about "perpetrators" and "victims" of violence that obscures the reality that people who enact violence also experience violence as well. Future research is needed to address this issue. The narrow focus of this work on *physicians'* training and practices related to IPV also represents a limitation: practitioners, researchers, and educators in nursing have a long tradition of research and advocacy related to IPV (48, 49), and are also amongst the practitioners implicated in policy makers' calls to conceptualize IPV as "a health issue" with relevance to their professional practice. Although this dissertation specifically set out to examine how IPV is addressed in medical education, this singular focus also entrenches silo-ed disciplinary thinking in HPE research and practice. Future comparative inquiries that consider how nurses and other practitioners learn to think about IPV and their related professional roles are likely to proffer valuable insights with applications to medical education that were beyond the ambit of this work. Another caveat to consider in interpreting findings from this dissertation concerns the Canadian context in which these studies were undertaken. At individual, community, and systems levels, culture plays a vitally important role in shaping whether and how IPV is problematized as an issue of social or political concern (50-52). Similarly, the structure and funding of health care systems and regulatory mechanisms and norms in medical education influence the roles physicians play, the types of health care that are available, and the broader range of services and supports that are accessible to patients in health care and beyond (53-55). The findings of this dissertation reflect one context – Canadian medical education and practice – shaped by distinctive structures, funding and regulatory mechanisms, and cultural norms and may resonate differently in contexts where policy infrastructure and norms are significantly different.

Reflexive Observations

The introduction of this dissertation describes the theoretical, personal, and practical points of contact that helped to give shape to this inquiry. This research is also, inexorably, a product of the period in which it was produced.

I began working on this dissertation in earnest in January 2020, two and a half months before life as I had previously known it came to halt because of the Coronavirus Disease 2019 (COVID-19) pandemic. Almost immediately after schools and public spaces closed, conversations in my orbit turned to how enforced isolation would affect people experiencing IPV and children living in violent homes. The stress of the pandemic and related losses of income, security, and connection to community were seen as fuel for private fires that, in an era of "social distance," could burn unchecked (56, 57). Structural forms of marginalization implicated in increasing risk of IPV mapped neatly on to those that increased pandemic-related risks to health and security (58-60). Added barriers to safety included inflamed xenophobia and racism targeting East Asian communities, and heightened surveillance and criminalization related to public health measures (62, 63).

From a health policy perspective, watching rapid processes of policymaking unfold in response to the perceived threats of the pandemic was instructive: early in the pandemic, new problems were defined and new policies were formulated and implemented within a matter of days and weeks (64, 65); political will to act and implement seemingly radical social policies – for example, a permutation of basic income in the form of the Canada Emergency Response

Benefit (CERB) – materialized overnight (66, 67). In some sense, I found these moments of rapid change exhilarating, seeing new evidence that seemingly immutable political facts might also be subject to revision; in another sense, as evidence immediately mounted that the brunt of the pain of the pandemic would be borne by people and communities who were already most oppressed (68), I found them enraging. Distinctions between the interpersonal forms of violence at the heart of my academic interests and the structural forms of violence that were apparent in COVID-19 policy responses began to blur, seeping into my thinking about this work. These influences are reflected in this dissertation by my recurring insistence that physicians and policymakers alike must attend to and contend with the structural roots of IPV rather lapsing into treating IPV as a health issue alone.

From a health professions education (HPE) perspective, this period also offered lessons about possibilities for rapid adaption and barriers to change. In response to the perceived moment of crisis that the pandemic engendered in health care and beyond, actors in every niche of the ecosystem organizing and regulating Canadian medical education refashioned long standing policies and procedures (69-71). Adaptations in professional training programs led to substantive changes to formal, informal and hidden curricula of medical education, effects of which are still being realized and explored by researchers around the world (72-74). By contrast, in the same period of 2020, enduring Canadian crises of anti-Black and anti-Indigenous racism were highlighted through community mobilization in response to the deaths of Regis Korchinski-Paquet and Joyce Echaquan.[4] Although many

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[4] In May and June of 2020, protest movements responding to law enforcement violence inflicted on Black communities in the United States grew and rapidly spread around the world. In Toronto, where I lived while writing this dissertation, the death of Regis Korchinski-Paquet catalysed renewed energy and attention towards movements for police abolition and non-police crisis response (76, 77). Korchinski-Paquet was an Afro-Indigenous women who lived with mental illness and who fell to her death after police responded to a call from her mother for help de-escalating a domestic dispute (78). Months later, at the end of September 2020, video of racist abuse that Joyce Echaquan endured from health care workers prompted international news coverage and public condemnation (79-81). Echaquan, an Atikamekw woman from Manawan, was hospitalized in Joliette, Quebec and livestreamed video of staff verbally abusing her and ignoring her cries of distress in the hours before she died (82).

actors in the Canadian medical education policy community responded to these incidents with statements calling for action (83-86) or committing to addressing anti-Black and anti-Indigenous racism in health care (87-90), the extent to which meaningful change has arisen from these expressions of support is unclear. In the process of writing this dissertation, these events helped to fuel my reflection on the common roots of law enforcement violence, medical violence, and IPV and are reflected in the emphasis I've placed on moving from knowledge to action in medical education, mobilizing in solidarity with people and communities most affected by connected forms of violence.

Finally, feminist perspectives perfused the ways I experienced and interpreted the events described above, which, along with many others, were influential to the process and products that came from engaging in this inquiry. Standpoint feminism holds those of us involved in inquiry accountable for the ways in which our processes of knowledge production work to preserve and to disrupt unjust systems of power (91). My reflexivity of discomfort – a reflexivity that asks me to be accountable for the subjectivities reflected in this dissertation (92, 93) – has challenged me to consider how ideas represented in this work reflect my situated perspectives as both insider and outsider to medical education and medical practice related to IPV. In conducting this dissertation, I've been preoccupied with concerns about the possibilities for unforeseen harm that might come from this work, wondering what I might be missing or obscuring by virtue of my partial perspective or how, in the words of Patti Lather, I "might contribute to dominance in spite of [my] liberatory intentions" (94). On this note, I conclude with the reflection that although this iteration of my work is static and will cease to evolve after it goes to print, the work itself – of attending to power, of interrogating old beliefs, and of reimagining better ways of being a researcher, a physician, and a person in the world – must, and will, necessarily continue.

Conclusion

Using a policy lens, this dissertation has examined implications of framing IPV as a "health issue" in medical education. Integrating different qualitative methodologies, this work has probed influences that shape how physicians learn to think about IPV and their related professional roles and identified strategic opportunities and recommendations for medical training in the hopes of helping to improve care for people affected by IPV in the future. Although this inquiry begins from, and ends with, recognition and insistence that medical care for people, families, and communities affected by IPV can and must be made better, more must also be done. Structural problems like IPV demand structural solutions that are developed and implemented with close attention to the ways in which power pervades social interactions and organizes society. Physicians, health care providers, educators, researchers, and policymakers have roles to play in this work, as do we all.

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