

Considering domestic violence in clinical practice

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There are some days when I don't turn on the nightly news. Tragedies and momentous events have occurred far away, but not to anyone on my street or at my work, and I can't do anything anyway. I switch off. We all have strategies to manage information overload and the multiple demands on our resources, but I am reassessing my filter: are the events on the nightly news at a distance or outside my influence?

In this issue, Hegarty et al¹ discuss identifying and responding to men who use violence in their intimate relationships. It might be tempting to turn the page. We may feel destabilised, deskilled, sceptical or horrified by the suggestion that addressing domestic violence could be a common component of general practice.

Women, children and men across all socioeconomic groups experience violence and abuse in family settings, commonly from a male perpetrator. This damages their mental and physical health, and sets up a pattern of relating that may be transferred for generations.² Individuals affected by domestic violence commonly consult with general practitioners (GPs), but the issue of violence is not as commonly raised in consultations.³

Many GPs have been aware of domestic violence and earned the trust of men and women who have disclosed their experiences of abuse and violence. GPs have justified that trust by supporting, educating and advocating for these patients. For these GPs, the recent

conversation in society on domestic violence and abuse brings much needed improvement in specialised services and legal frameworks to this ongoing problem.

Less confident or newer GPs and registrars may benefit from additional knowledge and peer support. We may recall the encouragement we were given as medical students when making a differential list: 'If you don't think of the diagnosis, you will never make it'.

Hegarty et al¹ call for GPs to 'follow a hunch' and pursue conversations with men about domestic violence when needed. We are asked to ensure safety and be wary of distorted beliefs held by our patients. General practice is built on the patient–doctor relationship. We learn more about our patients than the illnesses they present with. Thus, we become skilled and trusted observers in our consultations.

Building and maintaining therapeutic alliances with patients who use or experience violence in intimate relationships can be demanding work. We develop humility, patience and flexibility in balancing our expectations of ourselves and our patients. We may also need to assess if manipulation, coercion and control have affected the patterns of relating in our own lives.⁴ The Royal Australian College of General Practitioners and the National Sexual Assault Domestic Family Violence Counselling Service provide resources^{5,6} that help to further strengthen GP self care. General practices and Primary Health Networks also need to address how they might better support GPs in their frontline work by building resilient workplaces.

Try asking your patients one or two of the 'questions to ask' that Hegarty et al suggest.¹ You may then want to have a lunch room chat with colleagues. Our patients often approach us because we can help set a course through complexity, and both listen to and challenge their perspectives. It takes time, experimentation and courage to examine our own perspectives and consultation styles, and the reward is in the resulting professional growth and satisfaction.

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