Abuse Obscured:
An Ethnographic Account of
Emergency Nursing in Relation
to Violence Against Women

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La violence faite aux femmes est une question de grande importance en matière de santé au Canada et partout dans le monde, mais les services de santé mis en place s'avèrent inadéquats face à ce phénomène. Bien que plusieurs raisons ont été mises d'avant pour expliquer cette lacune, peu de recherches systématiques sur le sujet ont été entreprises. Cette étude ethnographique exécutée dans deux unités d'urgence hospitalières vise à décrire les pratiques infirmières en rapport à la violence faite aux femmes. Des entrevues menées auprès de cinq infirmières œuvrant dans d'autres unités d'urgence s'ajoutent aux observations des participantes et aux entrevues menées auprès de 25 pourvoyeurs de soins et de cinq patients de deux autres unités. Les résultats indiquent que la violence est passée sous silence et que la pratique véhicule les stéréotypes et une approche axée sur les problèmes physiques et la rapidité de traitement. Les perceptions de la gravité de la situation de la patiente influent sur les soins, qui peuvent varier d'une approche caractérisée par « l'absence d'intervention » à une approche active où les intervenants offrent aux patientes certaines options. Cette description permet de mettre en place une base qui améliorera la formation du personnel infirmier et favorisera une pratique plus efficace.

Violence against women is a significant health issue in Canada and around the globe, yet the health-care response has been inadequate. While various reasons for this inadequacy have been suggested, little systematic research has been undertaken. This ethnographic study of 2 hospital emergency units was conducted to describe nursing practice in relation to violence against women. Participant observation and interviews with 25 health-care providers and 5 patients in the 2 units were complemented by interviews with 5 nurses from other emergency units. The findings illustrate that abuse is obscured and practice shaped by stereotyping thinking and a focus on physical problems and rapid patient processing. Perceptions of patient deservedness influenced care that ranged from "doing nothing" to actively offering the patient choices. This description provides a basis for designing meaningful education for nurses and systemic changes that will foster more effective practice.

The health-care response to violence against women remains less than adequate despite widespread acknowledgement that it is a health problem of epidemic proportions. This study examined the relationship

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between the social context of practice and the ways in which nurses recognize and respond to the plight of women who have been abused.

Literature Review

In Canada, the prevalence, frequency, and severity of violence against women are similar to those in other countries around the globe. The Violence Against Women Survey (VAWS) interviewed a randomly selected national sample of 12,300 women. Analyses of these data (Johnson, 1996; Kerr & McLean, 1996; Ratner, 1995; Rodgers, 1994) provide the most comprehensive picture of the problem in Canada to date. The VAWS estimated that one in every two Canadian women over the age of 18 had experienced at least one incident of sexual or physical assault, and that 10% of these women had been assaulted in the preceding year (Johnson; Rodgers). Congruent with global statistics (Heise, Pitanguy, & Germain, 1994), 29% of women in Canada who had ever been married or in a common-law relationship reported being physically or sexually assaulted by their partner at least once during the union (Johnson; Rodgers). Johnson estimates that over 2.6 million women in Canada have been assaulted and that 15% (1.02 million) of those currently in a marital relationship have been assaulted.

In addition to these alarming figures on prevalence, the VAWS estimated the frequency and severity of abuse. In 63% of all cases of wife assault, violence occurred more than once, and 32% of all cases involved more than 10 episodes of violence. In 34% of all cases, the woman feared for her life. In almost half of all relationships with violence, a weapon was used at some point and almost half of those assaults resulted in injury to the woman. In 43% of situations in which the woman was injured, she sought medical attention.

The response of the health-care system to violence against women has been characterized by failure to recognize abuse and by negative attitudes and responses. Most research on recognition of abuse by health-care professionals has been conducted in Emergency units, with 2% to 8% of female trauma patients being clinically recognized as abused. Yet research strategies and identification protocols identify approximately 30% of the same population as abused (e.g., Abbott, Johnson, Kozoil-McLain, & Lowenstein, 1995; McLeer & Anwar, 1989; Olson et al., 1996; Roberts, O'Toole, Raphael, Lawrence, & Ashby, 1996; Tilden & Shepherd, 1987). Similar lack of recognition has been identified in primary-care settings (e.g., Bullock, McFarlane, Bateman, & Miller, 1989; McCauley et al., 1995) and during pregnancy (e.g., Campbell, Oliver, & Bullock, 1993; Campbell, Poland, Waller, & Auger,

1992). The latter is of grave concern, as the VAWS found that 21% of abused women were abused during pregnancy (Johnson, 1996).

Responses by health-care providers to recognized abuse have been characterized as narrowly focused on the physical consequences of abuse and on victim-blaming (Dobash & Dobash, 1988; Kurz & Stark, 1988; Stark & Flitcraft, 1991; Warshaw, 1993). McMurray and Moore (1994) found that women admitted to hospital as a result of abuse experienced disengagement from hospital staff, loss of status, disempowerment and lack of control, stigma and social isolation, and a sense of being misunderstood. The women told of being humiliated, blamed, judged, and made to feel unworthy. Such experiences can have a negative impact on health. In analyzing the VAWS data, Ratner (1995) concludes that contact with health-care providers had a slightly negative effect on the health outcomes of the women. She suggests that these findings may be due to the professional's focus on physical injuries and disregard for the woman's experience.

Some investigators have examined the negative health-care responses, but their explanations are incomplete. After studying the medical records of 153 women who experienced abuse, Shields, Baer, Leininger, Marlow, and Dekeyser (1998) conclude that negative outcomes may be a result of negative attitudes and a lack of knowledge and collaboration among care providers. Gerbert et al. (1996), after investigating the health-care experiences of 31 women, report that the women perceived care providers to be uninterested and unsympathetic. This finding is supported by findings that consistently show negative attitudes on the part of health-care providers towards women who have been battered (e.g., Chung, Wong, & Yiu, 1996; Cochrane, 1987; Easteal & Easteal, 1992; Renck, 1993; Rose & Saunders, 1986). An additional finding of Gerbert et al. was that the women thought the health-care system did not allow providers to deal with anything beyond immediate physical injury.

These studies point to both the attitudes of health-care providers and the structures of the health-care system as influencing the quality of responses to violence against women. However, little systematic study of health-care responses has been undertaken. It should be noted that most research on these responses does not distinguish the practice of nurses from that of other health-care professionals. Despite increasing attention in nursing to violence against women, the practice of nurses in this regard has not yet been described. Further understanding of the health-care system and its response to violence against women might provide a basis for improving that response and, ulti-

mately, outcomes for women. The purpose of this study was to describe the relationship among the social context in which health care is provided, nurses, and care for women who have been abused.

Method

In order to study the context of nursing practice, I used an ethnographic approach. In ethnography, a method of studying social context (Atkinson & Hammersley, 1994; Hammersley & Atkinson, 1983), participant observation and interviews are used to create a comprehensive picture of a specific culture or context. I wanted to pay particular attention to power relations both between patients and health-care providers and among health-care providers, and I wanted to contribute to change through the research process. Hence I used a *critical* ethnographic approach. Critical ethnography is concerned with: (1) relationships and power inequities between individuals and the socio-political framework, (2) transformation of those relationships, and (3) attention to the research process as a form of action (Anderson, 1989; Quantz, 1992; Simon & Dippo, 1986). The study was also informed by a feminist understanding of violence and oppression (Varcoe, 1996), which guided my analysis and critical self-reflection.

Data were collected over 2 years in the Emergency units of two urban hospitals and the communities they served. The reason for my focus on Emergency was that a large number of women who come to hospital Emergency units do so because of injuries inflicted by their abusers or because of health-care problems that result from living under the chronic stress of violence. Thus Emergency is one of the most common points of contact between nurses and women who have been abused (Campbell, Pliska, Taylor, & Sheridan, 1994; Goldberg & Tomlanovich, 1984; McLeer & Anwar, 1989; Pakieser, Langhan, & Muellerman, 1998; Warshaw, 1993). The reason for using two hospitals instead of one was that co-workers in the study might be able to identify individuals by their job title (e.g., social worker, clinical nurse specialist); use of two separate hospitals would serve to protect identities.

Both hospitals were located in communities that formed part of a large city. The communities were diverse in terms of ethnic and cultural composition, income, religious preferences, and languages spoken. Both included a large First Nations community as well as people whose first language was Chinese, Korean, Punjabi, Hindi, Farsi, and Tagalog (Statistics Canada, 1996). As with most Canadian hospitals at the time (Hotch, Grunfeld, McKay, & Ritch, 1996), these units had no programs or policies regarding abuse.

Ethical review was conducted by the supervising university and the two study sites. After making presentations at staff meetings, I obtained written consent to observe practice from approximately 85% of all Emergency staff — nurses, physicians, and others. I treated non-return of consent forms (after leaving a second copy for each person) as refusal to participate, and made no observations of those staff members. I obtained verbal consent to observe each patient with whom I had contact and the many health-care providers who came to Emergency from other departments (e.g., lab technicians, porters, ambulance attendants). None refused. No one was approached for an interview. Rather, I informed everyone of my interest and my method, and participants volunteered. As I had a large number of volunteers from whom to choose, I was able to select a diverse sample of nurses and a variety of other health-care providers.

I completed over 200 hours of observation in the two Emergency units. Data collection began with observation, during which time I "buddied" with one of eight nurses who had volunteered. My priority of observation was well respected by most staff members. Within that priority, as an experienced critical-care nurse I was able to contribute to care, mainly by providing comfort and emotional support; I did not administer medications, perform procedures, or chart care.

Interviews were conducted with 30 health-care providers and five women who had been abused. The interview sample consisted of a core sample of 12 Emergency nurses who were observed extensively and interviewed twice. The purpose of the second interview was to obtain clarification and discuss the evolving analysis. I interviewed nine additional Emergency nurses, four from the study sites and five from various other hospitals throughout the province in which the two sites were located. I interviewed nine other health-care providers. These included admitting clerks, social workers, physicians, and hospital administrators. Five women who had personal experiences of abuse also volunteered to be interviewed; I met three as patients in Emergency and two in the community during field work. These women self-disclosed their experience and volunteered while I was obtaining informed consent to observe nursing care or community activities. The interviews lasted from 1.5 to 5 hours (average 2 hours) with nurses and from 1 to 3 hours with others.

All of the 21 nurses interviewed were female and Caucasian, reflecting the underlying populations in the study units. With the exception of one student in an Emergency Nursing program, all had a minimum of 4 years' Emergency nursing experience, with an average

of 9 years. Of the 21 nurses, two were Assistant Head Nurses, five were Nurse Managers, one was a student, and 13 were staff nurses working casual, part-time, or full-time. Eighteen of the nurses had a diploma as their initial nursing education, and three of these also had a bachelor's degree; the other three nurses had a bachelor's degree as their initial nursing education. Thirteen nurses had completed one or more certificates in Emergency, Critical Care, or Outpost Nursing. Of the 17 nurses who specified their personal experiences, 11 had experienced violence in their families. All but three nurses could recall at least one instance of caring for a woman who had experienced abuse. Demographic data for the other nine health-care providers and the five patients could potentially identify individuals; it is therefore being withheld.

Data collection and analysis took place over a 2-year period. All interviews were transcribed, and rough field notes were expanded as they were typed. I combined established approaches to ethnographic analysis, drawing on the work of Atkinson and Hammersley (1994), Clifford and Marcus (1986), Hammersley and Atkinson (1983), and Spradley (1979), with ideas from critical ethnography (Anderson, 1989; Quantz, 1992; Simon & Dippo, 1986). In seeking an analysis of power relations, critical ethnography requires attention to multiple perspectives. Thus I continually sought competing and contradictory perspectives, using tensions between perspectives as points for analysis rather than as problems to be solved or choices to be made. Instead of glossing over contradictions in the data, I sought to create conceptualizations to accommodate multiple and competing perspectives. Other important features of the analysis included involving participants in the analysis to the extent that they were interested (usually through a second interview) and attempting to account for my own biases, particularly with respect to racism. In this I was guided by feminists such as Alcoff (1991), Harding (1987, 1991), Lather (1986), and Opie (1992) and by my dissertation supervisors (Varcoe, 1997).

MacLeod (1997) claims that all research is intervention. I began this research with the explicit intention of having the participants become more aware of violence in their practice, an objective that was realized. Also, as the analysis unfolded, the impact of workplace economics and power became central in our discussions and may have contributed to political action taken in one unit. My greatest challenge was countering the racism that I discovered without alienating staff. I attempted to draw attention to assumptions without criticizing. In this, and throughout the analysis, I was greatly aided by my dissertation supervisors.

Findings

The data permitted, generally, a rich understanding of Emergency nursing and, specifically, a description of practice in relation to abuse. The nurses were dismayed at the extent to which, they believed, they had been either overlooking abuse or, when they recognized abuse, "doing nothing." However, my conclusion is that abuse was obscured by the practices required to keep Emergency running. Further, it was evident that the nurses often went beyond doing nothing.

Abuse Unrecognized

Abuse went largely unrecognized. At both study sites many nurses told me, "We don't see much of it here." Most nurses did not think they saw much abuse, could recall few instances of it, and, during the study period, rarely recognized it. During the 200 hours of observation, more than 20 patients told me about significant past or present abuse by a partner. However, only four of the disclosures occurred in the presence of a nurse (in response to my seeking informed consent), and only one disclosure occurred during the nurse's assessment (in response to trying out some assessment techniques we had been discussing). Two other instances of abuse were brought to my attention. One involved an elderly man with obvious physical injuries, the other a woman with mental health problems who staff suspected was abused because her husband was angry and verbally abusive with staff.

The nurses reported recognizing only "blatantly obvious" abuse. Nurses and other care providers could recall recognizing abuse only when there had been significant physical evidence of it. They believed that they had overlooked less obvious physical and emotional abuse. The following excerpt is typical of the instances of abuse recalled by nurses:

> *It was a Chinese lady that was beaten up by her husband. Actually she went unconscious for 30 minutes. In actual point he could have killed her. She had no thought left, she had strangulation marks, she had petechiae actually, probably struggling…bruise marks to her back and leg…*

Abuse Obscured Through Efficient Patient Processing

Abuse was recognized only when there was serious physical injury, primarily because this fit the pattern of Emergency practice. The prevailing feature of the Emergency unit was unpredictability, and the prevailing sense of the health-care system was one of scarce resources. The

unpredictability of patient flow and acuity in a system with static resources perceived as scarce called for rapid processing of patients. This in turn required nurses to focus their care, to quickly establish and constantly re-evaluate priorities, and to be "prepared for anything."

The predominant pattern of practice was thus one of "efficient patient processing." The patient was first stripped down to a "manageable problem." In the stripping-down process, the person became a patient, and a recorded version of the person was created on a chart and in places such as the unit triage log, white board, and computer system. A manageable problem was usually a physiological label such as "chest pain," "laceration," "fracture," or "overdose," with known solutions. The manageable problem was then processed and the stretchers emptied as promptly as possible. The process was efficient in that patients were moved quickly out of Emergency.

Violence was not foremost in the nurses' minds as they began the process of reducing the person to a manageable problem. They began triaging all patients from the complaint with which the person presented. If the presenting complaint was a direct result of violence, the cause was not necessarily obvious. Complaints ranged from injuries such as fractured jaw or black eye (obvious), to bruising on the arms or face (suggestive), to abdominal pain, pelvic inflammatory disease, or migraine (apparently unrelated to violence). If the presenting complaint was an indirect result of abuse, the cause was not likely obvious. Problems that could be caused by living under conditions of chronic stress and abuse (e.g., chronic bowel problems, arthritis, depression, alcohol abuse) were often difficult to associate with abuse, even for the woman herself. Finally, if the presenting problem was unrelated to violence, such as cardiac dysrhythmia or renal colic, there was often no basis for identifying abuse. For example, the staff were shocked when an elderly woman who had been repeatedly admitted with supraventricular tachycardia disclosed to me that her tachycardia was always associated with assault by her husband. One nurse summarized practice with these words:

> *I suppose part of it is that, one, it is not always blatantly obvious, and two, if you're an Emergency nurse you're probably busy…and if things are not blatantly obvious, that this woman has been abused, you may not just be mentally tuned into seeing what is going on. You're maybe taking the complaint at the time, "I've got a urinary tract infection" or whatever, and treating the woman for that.*

The nurses thought that the need to quickly and efficiently process patients was escalating under "health-care reform." They saw this esca-

lation not only as affecting their ability to recognize abuse, but also as limiting their ability to engage with all patients: "We totally ignore the psychosocial needs of the patient. We don't do anything." They expressed considerable distress at being unable to provide what they considered adequate care: "I get really angry when I don't have the time to spend with the patients, and yet…there are lots of times that I'm thinking, thank God they don't want it." Nurses saw time and resources as scarce commodities limiting their ability to attend to "psychosocial" needs in general and abuse in particular. Repeatedly they explained that they could not afford to deal with anything except physical priorities:

> I think you feel guilty because you're trying to nurse the whole person but you can't. You've got to narrow it down to what is your biggest problem…if you're upset about it go see your doctor tomorrow. That's how we tend to operate, which is kind of callous but if we said to everybody, "And how do you feel about this, and is there anything else going on at home that maybe caused this that we can help you with?" you would be with the patients that want to talk for hours.

Thus, despite the distress it caused them, the nurses saw themselves as unable to engage with patients and thus unlikely to recognize anything but the most blatant physical abuse.

> If you've got abdominal pain because you're depressed because you're being abused at home, I'm unlikely to pick that up. I'm more likely to trot in there after the doctor has found nothing wrong and say, "You can go home now. How are you going to get home?" The reason for that…is because you might only have that one patient but you've got to get her out because in 10 minutes you might have eight of them.

Abuse Obscured Through Stereotypical Thinking

> …there's also a Native population that drink a lot and there's a lot of physical violence in the family units, and so you certainly get twigged when certain people come in to the Emergency Department.

In addition to the need to focus on physiological problems, stereotypical ideas tended to obscure abuse. Nurses and other health-care providers associated abuse with direct physical trauma, poor people, or racialized people. Nurses usually said that they should be looking particularly for bruising, and tended to not name other forms of physical injury, other health problems, or non-physical problems as suggestive of abuse. Throughout the study, most health-care providers racialized violence and associated it with poverty. I was constantly directed to go to other hospitals where certain racialized groups and poor people were thought to be more concentrated. Most accounts I was given

about patients who had experienced abuse were marked by the ethnic-ity, religion, or language group of the patient, signifying "not white." The women were identified as Inuit, Indian, Native, Chinese, Iranian, East Indian, Farsi, Muslim, Asian, and so on. In fact there were few accounts of abuse in which the woman was *not* racialized.

Violence was anticipated predominantly among poor and racial-ized people, and conversely not anticipated among white and middle-class or wealthy groups. Nurses repeatedly told me that, concerning violence, they were "more comfortable" questioning and talking to some women than others.

> I'll just say, "maybe this could be," rather than, really, "look, let's deal with this, I think there is some violence here," which I would do with the Indian women, which I probably wouldn't do with the [wealthy] ladies. That's where I'm at.

This differential scrutiny and anticipation of violence suggests that abuse is less likely to be recognized among affluent white patients than among poor or racialized ones, and that women in the latter groups are more likely to be falsely suspected of having been abused. The follow-ing examples illustrate these dynamics:

> I mean, the husband was there and he was in a suit and he was on his way to work…and the medicine cabinet she had opened while they were in the bathroom…and she lacerated the top of her eyebrow. That was the history that I got…and the nurse, who is an excellent nurse, jokingly said, "So he's been hitting you again, has he?" which at that particular time they both laughed and said, "Yeah, I bet everybody at work is going to be thinking that"…but it could have very easily been true. [emphasis added]

One day several staff members greeted me by saying, "We've got one for you." A young woman had been admitted with paralysis and aphasia. She had been admitted before, and organic and psychiatric explanations for her symptoms had been ruled out. The staff suspected that her husband abused her because he was angry and hostile towards the staff. When I later spoke to the woman's brother, he was very frus-trated with the staff for offering no explanations for his sister's condi-tion and for assuming violence was an issue. There were no indications of abuse. The family spoke Arabic and little English.

For the most part, the health-care providers reported that they rec-ognized abuse only when it was blatantly obvious — that is, in the face of significant physical evidence or a statement by someone (e.g., ambu-lance attendant, police officer, family member, friend) that abuse was

the problem. Instances of abuse that were recalled almost exclusively concerned obvious physical abuse, racialized women, or poor women.

When abuse was recognized, the response of health-care providers fell into three overlapping patterns: *doing nothing, influencing choices,* and *offering choices.* No participant used only one pattern of practice, although one or two patterns tended to predominate, and during the interviews the nurses struggled with the ideas represented by all three.

Doing Nothing: The Undeserving Victim

Nurses reported that their most common responses to abuse were to: recognize cues yet not pursue them; deal with obvious physical injuries but do nothing further; or shift responsibility to someone else such as a physician, social worker, or family member. Nurses characterized these responses as "doing nothing." The reasons they gave for doing nothing were the same as those they gave for failing to recognize abuse: focusing on physical problems, not knowing what to do, lacking adequate resources. However, embedded in each account were reasons why doing nothing served the interests of health-care providers:

I just remembered another case of a woman who was brought in by her son and I could swear on a stack of bibles that he had been abusing her. We really didn't do anything about the situation, we sent them right back out…the son with the mother, because, again, we were so busy treating the situation… The son was raising Cain and being difficult, saying his mother had a broken nose, and the plastic surgeon said no she doesn't, he said yes she does, and the idea was, just get this guy out of here, he is just being unreasonable that he thinks that his mother has a broken nose and we are telling him she doesn't. So the idea was to just him out of the place. But I'm sure he had been abusing her. The way he told the tale, he was waiting for someone to say, "What happened, are you having problems?" His mother was senile.

Repeatedly doing nothing served the interests of maintaining efficiency and functioned effectively with the dominant pattern of practice.

Doing nothing was justified and supported by viewing the woman as an undeserving victim. The nurses and other health-care providers routinely made judgements about the extent to which patients deserved care, and women who had been abused were no exception. In fact several factors frequently interpreted as signifying undeserving status (perceived to be abusing alcohol, using Emergency frequently or inappropriately, failing to take steps to improve one's life) were also perceptions that the health-care providers commonly held about abused women. In the account above, senility may have been perceived as ren-

dering the elderly woman undeserving of intervention. In the account below, the physician appears to draw on his attitudes towards alcohol abuse, First Nations people, and women to judge the patient undeserving of care:

> *...a young Native Canadian woman was found with her pants down in the park and she was extremely drunk...there's a strong possibility that she had been assaulted. [The physician] walked into the room...and in front of the patient and two nurses he said, "This is a societal derelict and I am too embarrassed to even call [the sexual assault team] over an issue like this." He said, "Put her to bed and let her sober up and then she can go home."*

Doing nothing may allow health-care providers to avoid some of the emotional costs of dealing with abuse, but, to the extent that they see doing nothing as insufficient, it may create feelings of inadequacy. Doing nothing overlapped with other forms of intervention at the point at which health-care providers challenged the adequacy of ignoring cues, dealing only with the physical consequences of abuse, or shifting responsibility to others.

Influencing Choices: The Deserving Victim

The health-care providers recalled instances of having gone beyond doing nothing, to intervening. One of the ways in which nurses and others intervened was to guide the woman towards what they thought were the best choices.

Influencing women's choices was associated with women who were judged as deserving. In addition to social status, the severity of the physical injury seemed to influence the extent to which women were judged as deserving. Instances of having influenced choices were associated with women who had been seriously abused physically. For example, one nurse judged a woman who had been sexually assaulted as less deserving than another because she was drunk and because the other woman was "an actual date rape" and had "marks around her neck." Another nurse recalled with empathy actively helping "one lady who came in with very battered chest and breasts, lots of bruising." Because health-care providers tended to recognize only blatantly obvious abuse, and routinely judged acuity based on the extent of physical injury and risk, it is not surprising that their interventions were associated with serious physical injury. The severity of the physical abuse contributed to their perceiving the woman as deserving, and thus requiring them to "do something."

The influence exerted by the health-care providers ranged from offering suggestions, to "convincing," to making decisions for the woman. The choices towards which they guided the women were largely limited to disclosing the abuse, calling the police, and leaving the relationship:

> *The nurse asked the woman if the boyfriend had raped her. The woman repeatedly said, "I don't want to get anyone in trouble." The nurse said, "Eventually, after repeated questions, she admitted he had raped her." At this point the nurse and the physician decided to send the woman to [another hospital] for the sexual assault exam. (field notes)*

> *I said, "There's no need to stay in something like this. No matter what you might have said or done it doesn't warrant being beaten for it. That's not necessary." I had her to the point where she was convinced, and I got Social Services involved, and they came and talked to her and were all ready to set her up to go to the [transition house] and everything.*

Many nurses described instances of staff wanting to call the police even though the woman asked them not to, and most expressed frustration at their lack of success in persuading women to make the limited choices.

Influencing choices served the interests of the hospital and the health-care system to the extent that women were directed towards existing solutions and resources. It was also congruent with the pattern of practice in that women could be processed efficiently if they accepted the choices offered, and it served the interests of the health-care provider in that doing something generated less of a sense of inadequacy than doing nothing. However, a woman's unwillingness to be influenced was a source of frustration for health-care providers, often leading them to view her as less deserving and justifying their decision to do nothing further. A nurse describes the case of a "non-white" woman who presented repeatedly with migraine. She had been "offered help before and returned" to her abusive partner.

> *So not only was her physical problem not dealt with, but she wasn't given any empathy or respect, because people said, "Hey, she's had the choices, she's had the opportunity, there she is behind the curtain, Social Work is dealing with it," and nothing further was done or said.*

Influencing choices overlapped with a different pattern of intervention at the point at which health-care providers questioned the efficacy of influencing choices, shifted the focus of their frustration to the "system," and examined the limits to women's choices.

Offering Choices: The Woman with Agency

> *…I try, when we get to that point, I usually try and let her make that decision. I just say, "You've got alternatives, these are your alternatives, would you consider making any of these alternatives a choice for you today?"*

Strikingly different from the constructions of the woman as a deserving or undeserving victim were constructions of her as having personal agency. The approaches to care that accompanied these latter constructions were characterized by *offering choices* to the woman. Notably, in recalling these instances the health-care providers used terms similar to those used by the women I interviewed, and described care that the women requested. In contrast to *influencing* choices, *offering* choices was characterized by giving up control. It comprised strategies such as listening, respecting choices, and encouraging the woman to return to Emergency. Notably as well, nurses' experiences of "success" were characterized by offering choices. For example, when asked to elaborate on an experience that she described as successful, one nurse said:

> *…if anything, it was just absolutely listening to her and kind of opening doors and getting her to look at her options and where her supports lay and where her possible areas of danger lay, and having her tell this to me brought them all out on the table and kind of made a turning point for her. She could see them in front of her and…said them out loud and they became real, and you did that by just sitting and listening.*

Sometimes offering choices ran counter to the interests of health-care providers because it required emotional and time commitments, and sometimes it ran counter to the interests of the organization and the pattern of practice because it reduced efficiency. However, offering choices could also serve the interests of the health-care provider, depending on how he/she framed those interests. Offering choices sometimes caused frustration, but this was directed less at the woman than at the "system," as the health-care provider encountered limitations to women's choices. Similarly, offering choices could serve the interests of the organization if, for example, the interests were framed in terms of patient satisfaction.

Nurses struggled to reach a decision on the best approach. Repeatedly their sense of responsibility was at odds with their view that the women needed to decide for themselves:

> *Is it acceptable to…give them 10 or 15 minutes, and if that is enough and it has got them started…"this is important, people do listen, people do care," is it acceptable to let them go home then and follow up with their family doctor, if that is what they want to do? I have this gut feeling:*

"No. Get out of there. It's not going to get better." This is my feeling, but I don't know. They say that [abusers] will abuse again and again and it gets worse, so my gut is if I know about it, I have got to fix it, so I don't know if that's okay. What if she gets killed overnight?

However, those nurses who had sufficient experience with recognizing abuse to reflect on their practice had moved towards greater respect for the woman's agency and autonomy. For some nurses, participating in the research helped them to clarify and develop their thinking along similar lines: "I think you are beating your head against a wall if you tell someone, 'You have to leave and you have to go here,' because that's not going to work." "It is us rearranging our thoughts and our attitudes to fit what is best for the client, rather than what we think is best." Whether through experience or critical reflection, they often came to think that listening and not being judgemental were the essential skills. One nurse said she would have to "learn to listen and not talk so much, and cue words to get them to talk." These ideas were accompanied by a greater sense of confidence in their own practice:

I think maybe I'm doing more than I think I'm doing sometimes, maybe I am empowering more…by just telling them that this doesn't have to be the way it is… What seemed to me to feel like the biggest change [was when] I said to somebody who had been abused, "Today may not be the day."

Indeed, the women who had experienced abuse agreed. For example, one woman who disclosed abuse (and with whom we had spent no more time than with the other patients) remarked later in an interview, "I got more attention from you two than I got in 9 years from my husband." An elderly woman, who chose to remain with her abusive husband, cried as she said, "Thank you for letting me talk, thank you for listening." All the women interviewed spoke about the importance of listening and not telling them what to do. I asked the women what they thought nurses ought to do concerning women who have been abused. One replied, "I think the listening and not necessarily taking an authority position always over a woman." Another said, "Sometimes all it takes is to listen, because by the time you have finished a conversation you know exactly what to do."

Discussion and Implications

The most profound influence on nursing practice in relation to women who have been abused was the pattern of efficient patient processing, driven by the notions of scarcity that pervade the health-care system. This finding is consistent with that of Ellis (1999). In that study, nurses

identified lack of privacy and lack of time as the primary barriers to care. The drive to move patients through Emergency necessitated a focus on physiological concerns and thus obscured many non-physical issues and all but the most obvious abuse. These patterns of practice left nurses feeling chronically inadequate. In her study of Emergency units, Malone (1996) reports that staff often felt like "failures as they try to pick up the pieces for failing or absent families, communities and social programs" and that their frustration "can contribute to the stigmatization of HU [Heavy User] patients, missed clinical diagnoses, and reduced nurse morale" (p. 176). Staff nurses alone cannot rectify the failings of the social and health-care systems. Malone concludes that nurses need to acknowledge the limits of their control and responsibility, and must refuse to accept blame for restrictions imposed by health-care structures. It is critical that the development of programs to deal with violence against women take into account the context of practice, what is feasible within prevailing resources and patterns of practice, and the extent to which these need to change. The findings suggest that fundamental health-care improvements are required, concurrent with improvements to practice specific to abuse. Little evaluation research has been conducted (Chalk & King, 1998), and research is sorely needed to identify health-care outcomes associated with various nursing approaches to violence against women.

Health-care providers racialized violence throughout the period of the study. Racialized women are often required to expose their partners and communities to racism when seeking help related to abuse (Agnew, 1998; Crenshaw, 1994; Dobash & Dobash, 1992; Mosher, 1998). In Canada, widespread racism has been found within mainstream social and legal services for abused women (Agnew). Although Barnett (2000) questions whether racism deters help-seeking from the justice system, racialization of violence by the health-care system may compound other deterrents to disclosure. Paradoxically, such racialization may foster unfounded suspicions by health-care providers concerning abuse among racialized groups and expose those groups to racist stereotyping; conversely, it may lower the index of suspicion for abuse among other groups. Limandri and Sheridan (1995) identify racism and classism as problematic in the prediction of violence, as they have a way of "unmindfully influencing clinical judgment" (p. 15). Kelly and Radford (1998) argue that "we lack studies which elucidate the legacy of colonization and attempt to unpick the sexual organization of racism" (p. 63). Clearly, education, practice, and future research related to violence against women must incorporate antiracist strategies.

This study found that decisions concerning patient deservedness for various forms and levels of care included subjective judgements about patient acuity and social judgements about patients. Social judgementalism in nursing is not a new concern, but, as Johnson and Webb (1995) illustrate, the emotional costs of caring, and their role in social judgement, are insufficiently recognized. As with the Johnson and Webb investigation, nurses in the present study experienced significant moral distress over the judgementalism they observed in others and their own as well. Racism and classism may function in concert with the stigmatizing nature of abuse just as they do with HIV status, as described by Bunting (1996). Educational interventions and further research into ways of limiting social judgementalism are needed.

The nurses in this study rarely recognized abuse. When they did recognize it, they provided care that they considered inadequate. They generally blamed themselves, although they were aware of the significant limitations imposed by their practice setting. Improved practice in relation to violence against women requires more than concerned nurses. Care that is effective in terms of health-care outcomes, rather than merely efficient in terms of patient processing, requires political will and adequate resources.

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