Violence against women: knowledge and attitudes of healthcare providers at the Mexican Institute of Social Security in Morelos, Mexico

Pablo Méndez-Hernández, MS,(1) Rosario Valdez-Santiago, MA,(2) Leonardo Viniegra-Velázquez, MS,(3) Leonor Rivera-Rivera, MS,(4) Jorge Salmerón-Castro, PhD.(5)

Abstract

Objective. To assess the affective, cognitive, and behavioral attitudes of healthcare providers at the Mexican Institute of Social Security (MISS) in Morelos, Mexico; to identify the institutional and medical practice barriers that hinder screening and reference of battered women. Material and Methods. A cross-sectional study was conducted between September and December 1999. A self-administered questionnaire was applied to 269 general practitioners, specialists, and pre- and postdoctoral students working in 30 primary and secondary level of healthcare units in Morelos State. The data collection instrument was designed to assess healthcare providers’ knowledge of and attitudes towards domestic violence during medical office visits. A knowledge index was constructed and analyzed using multivariate regression methods. Results. Ninety percent of healthcare providers had never received training on violence against women. Healthcare providers’ affective and cognitive attitudes after receiving training on the subject were more favorable compared to those with no training. Favorable attitudes were directly related to the number of training sessions. Most participants (63%) showed a moderate degree of knowledge on the subject, whereas 21% were slightly knowledgeable and 16% were highly knowledgeable. Medical personnel with a moderate or high level of knowledge were 2.1 and 6 times more likely, respectively, to have favorable attitudes than those with a low degree of knowledge. Female physicians showed more favorable attitudes towards identifying and referring battered women. Medical personnel interested in further training on the subject of violence against women were 7.6 times more likely to show favorable attitudes than personnel not interested on the subject. Conclusions. Healthcare providers were not sufficiently able to assess and manage battered women. General and family practitioners were more interested in being...
Violence against women is a social and human rights problem, which has considerable effects on the health and welfare of women in Mexico and in other regions of the world. Although violence is a significant cause of female morbidity and mortality, it was only a few years ago that it started to be seen as a public health problem. 

Although the prevalence of violence against women is often underestimated in Mexico, the reported prevalence of domestic violence, in rural as well as urban zones, fluctuates between 30 and 60%. However, the figures recorded at health institutions, as well as at those for law enforcement, are only the tip of the iceberg, since they only capture situations of extreme violence or those where the victims decide to file a complaint, which happens in a minority of cases.

Violence against women is an important problem, among other reasons, for the health damages it causes, such as: a) physical injuries; b) psychological and psychosomatic damages; c) gynecological problems and damages to reproductive health; and d) risk of acquiring sexually transmitted diseases, including HIV-AIDS.

During pregnancy, abuse entails significant risks, for the mother as well as for the unborn child, such as low weight at birth, scarce weight increase in the mother, premature birth, as well as infections and anemia.

In 1993, the World Bank estimated that women in reproductive ages lose 20% of their years of healthy life (YHL) because of violence. In Mexico City, Lozano and collaborators reported that 38% of lost YHL in women are due to violence against them and that this problem is the third most important health problem affecting women in reproductive ages.

Social acknowledgment of this problem has had an impact on the civil and penal codes of the Mexican Republic and led to the Health Secretariat’s regulation of health care for cases of domestic violence, stemming from the publication of the Mexican Official Norm for the prevention and control of domestic violence.

In spite of the progress to date, there still exists social premissiveness around violence towards women, which precludes the detection of the problem and the provision of care in a timely manner, being this the main obstacle to its prevention and control.

Among the elements which make it more difficult to identify and manage cases of violence at the health services, we can point out those which are related to health service providers, the health system and the victims’ reaction of fear.

In the case of abused women, as opposed to other victims of violent crimes, they frequently have difficulty expressing the origin of their injuries. Among the underlying reasons for this behavior, we can point out that they often feel ashamed and guilty for the violence perpetrated against them. Another reason for their silence is the threats coming from their aggressor, including death threats against them or their children.

With respect to health professionals, studies done in this sector show the following situations: a) there is a generalized lack of knowledge among medical personnel of procedures for identification, care and referral mechanisms in cases of violence against women, especially with respect to violence from the sexual partner; b) sometimes, although health personnel wish to provide some sort of care or orientation for their patients, they may find themselves trapped by the limitations of the health system; c) medical personnel perceive the legal responsibility involved in recording cases of violence as a problem, which limits their being recorded; d) the

Key words: battered women; domestic violence; attitudes; awareness; physicians; Mexico
characteristics of medical practice limit interventions in cases of violence against women, and e) finally, we have observed that personal barriers exist which limit health professionals. Among these are a discomfort with talking about violence with their patients, sexist concepts which blame women for the violence perpetrated against them, and the fear that doctors have of offending their patients when asking about this topic.

In this sense, health institutions are a key point for the detection and prevention of damages to the health of women who are victims of violence, be it during a regular consultation or at emergency services, since these last ones have discovered that 20% of cases where health services were demanded, mostly by women (72%), were the result of domestic violence. Also, some have shown that 70% of abused women wait for the medical personnel to start the dialogue around abuse, and if they are asked with empathy, without judgement and in an environment of trust, they do describe the situation of abuse in which they live.

The high prevalence of violence against women, and its medical and psychological sequelae, fully justify its routine detection. Not identifying abuse as such interferes with the real diagnosis, making health services more expensive in terms of time and money because of subsequent consultations and the treatment of sequelae.

Based on the above, this study had as its objective, to evaluate the affective, cognitive and behavioral attitude of medical personnel at the Mexican Institute of Social Security (IMSS) in the state of Morelos, Mexico, during the identification and referral of abused women who seek medical consultation, as well as to identify institutional barriers and those of medical practice, which make it more difficult to manage these women within the health services.

**Materials and Methods**

A cross-sectional study was carried out from September to December 1999, among medical workers of the Mexican Institute of Social Security (IMSS) in the state of Morelos. Two hundred and sixty nine (269) pre-degree interns, specialty residents and general practitioners from the 27 units with first and second levels of care, participated in this study.

The physicians were visited at their work areas and invited to participate in the study; those who agreed to do so, were given a self-applied questionnaire to be filled out during or outside their work shift, and returned up to a week later. Then, when the participants delivered the questionnaire, they received an informational pamphlet on violence against women, and a list of services available in the state of Morelos where they could refer abused women whom they saw during their consultations.

The questionnaire was designed to fulfill the objectives of this study; also, some questions previously asked of doctors at the General Hospital of Mexico, the Health Secretariat (SSA) and the Department of the Federal District (Mexico City), were included.

The questionnaire was previously tested on physicians at SSA and IMSS, and has six sections: the first includes sociodemographic information. The second section evaluated the previous educational level of medical personnel with respect to violence against women. The third one collected information on the cognitive attitude of doctors towards this topic; to measure it, we developed a cognitive index, using 12 questions, and considering the level of knowledge according to the number of correctly answered questions: participants who responded adequately to 1-4 questions were considered to be of low level, medium level was for those who answered between 5 and 8 questions, and high level was for those who responded correctly to 9-12. The fourth section referred to institutional factors and those related to professional practice which medical personnel perceive as barriers to the identification and referral of cases of abused women seeking consultation. The fifth section evaluated the affective attitude of medical personnel with respect to: a) interest in identifying cases of abused women


Measuring the Attitude

The dependent variable was attitude (affective, cognitive and behavioral). Thus, we started with Allport’s25 definition, which is widely accepted, and used it as a basis to systematize representations of attitude: “Attitude consists of a mental and neural state of disposition, organized through experience, which exerts a directive or dynamic influence on an individual’s behavior when facing all objects and situations to which he/she relates”.26 However, in spite of the fact that this definition is quite complete, other authors include the socio-psychological aspect; that is, the individual’s dependence on the group (or community) and, as a consequence, on the norms and values which are the expression of the socioeconomic structure of the social regime and are expressed by the group; like this, we can say that attitude is also a form of orientation of people’s actions, dependent on the group’s norms, which reflects on the individual’s behavior, orienting, regulating and guiding him/her in a certain direction, with an object, a direction and an intensity.27

In the structure of attitudes, we may distinguish three components: a) the cognitive one refers to the ideas and information that an individual has with respect to the object of the attitude; b) the affective component is related to the feeling of sympathy or aversion towards the object of the attitude, and c) behavioral, indicating the individual’s behavior with respect to the object of the attitude.

In this study, we evaluated the three components of attitudes, cognitive, affective and behavioral, and since the relationship between the affective and behavioral components is not always linear, circumstances were implanted to help obtain trustworthy measurements of the affective component: a) introducing new cognitions and b) offering an environment of privacy and trust where individuals may express their opinions and beliefs.28

Statistical Analysis

A univariate analysis was carried out, estimating means and proportions to see the distribution of variables of interest and to describe the general characteristics. Later on, a bivariate analysis was performed, using the chi squared test and logistical regression models, to obtain estimates of odds ratios (OR) with confidence intervals (CI) of 95%. To control for possible confusing variables, we used the multiple logistical regression analysis.29 The data were recorded using the FOX PRO program, version 6, and analyzed through the STATA statistical program, version 6.

Results

Of the 488 doctors assigned to IMSS in Morelos, we contacted 440 (90%), of which 269 (61%) answered the questionnaire. The characteristics of those who did not respond were similar to those who did, with respect to age and gender. However, when divided by work zone, we found less response at the Regional Hospital in Zone 1 (HRZ 1) in Cuernavaca, when compared to the three remaining units (p<0.001). Sociodemographic characteristics were explored, and the type of medical specialization of interviewed health personnel, which are shown in Table I. As seen in this table, most are men (64%), with an average age of 42 (range, 22-63) and have a spouse or sexual partner (79%). We observed differences according to the type of specialization, for example, general practitioners, family doctors and obstetrician-gynecologists had a greater rate of response when compared with students* and other specialists‡ p=0.042 and p=0.031, respectively.

With respect to the medical personnel’s prior education on violence against women, almost 90% of the participants said they had not received any training on this topic. With respect to the participants*

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* The Morelos delegation is divided into four work zones: HRZ 1 in Cuernavaca, the Family Medical Unit (UMF) 20 in Cuernavaca, the HGZ 7 in Cuautla and the HGZ 5 in Zacatepec.
‡ Pre-degree interns and resident specialty doctors.
§ Emergency medicine, general surgery, pediatrics, internal medicine, psychiatry, traumatology, and other specialties and subspecialties.
# Medical personnel with a “diplomado” or extended education degree, masters and/or doctorate.
who did receive some prior instruction, more than half only had one session, and most of these were family doctors, when compared with specialists in other areas ($p<0.001$). Personnel who did not have a spouse or sexual partner, received at least one class on the topic, compared to personnel with a partner ($p<0.001$). When we relate general attitude of medical personnel towards violence, to the number of trainings they received, we find that the attitude of personnel who received at least one instruction was more favorable, when compared to those who did not receive any instruction ($p<0.04$). The general attitude of those who received 2-4 trainings was relatively more favorable, compared to those who only received one ($p<0.07$). The greater number of trainings was given at the postgraduate level, compared to pregraduate level ($p=0.036$) and in female personnel, compared to male personnel ($p=0.04$).

With respect to the knowledge that medical personnel had on the topic, 21% had a low level of knowledge, 63% a medium level and 16% a high level; we observed a greater level of knowledge among female doctors than among male doctors ($p=0.04$). Other important differences were identified among those who received at least one training on the topic, when compared to those who received none ($p=0.02$); among those who have a postgraduate degree, when compared to those who have a specialization ($p=0.04$); among those who intentionally ask questions to identify abused women, compared to those who do not ask ($p<0.001$), and among medical personnel who do not have a spouse or sexual partner ($p<0.05$).

When medical personnel were asked about health damages resulting from violence, 70% responded correctly with respect to the physical damages, 58% with respect to the psychological ones, while only 41% responded correctly with respect to the sexual damages. Family doctors and general practitioners gave more accurate answers, when compared to other specialists ($p<0.05$, in both cases).

Although more than 90% of the interviewees agreed that violence has major repercussions on women’s health, and that medical personnel are ideal to identify and refer these cases, only 46% showed a favorable general attitude towards this problem. This discordance could be related to institutional barriers and to those related to medical practice which participants describe as obstacles to the identification and referral of cases of abused women. In Table II we may see the proportion of doctors who referred to these obstacles, of which they highlighted the lack of guidelines for detection and management of cases (29%), the private character of violence (26%) and the lack of...

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**Table I**

SOCIODEMOGRAPHIC CHARACTERISTICS OF INTERVIEWED MEDICAL PERSONNEL. MEXICAN INSTITUTE OF SOCIAL SECURITY (IMSS), MORELOS, MEXICO, 1999

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Mean (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>269</td>
<td>2 (22-63)</td>
</tr>
<tr>
<td>Years of medical practice</td>
<td>269</td>
<td>16 (0-37)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Femenine</td>
<td>97</td>
<td>36</td>
</tr>
<tr>
<td>Masculine</td>
<td>172</td>
<td>64</td>
</tr>
<tr>
<td>Legal status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With sexual partner</td>
<td>212</td>
<td>79</td>
</tr>
<tr>
<td>Without partner</td>
<td>57</td>
<td>21</td>
</tr>
<tr>
<td>Doctor’s category</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialists in family medicine</td>
<td>86</td>
<td>32</td>
</tr>
<tr>
<td>General practitioners</td>
<td>54</td>
<td>20</td>
</tr>
<tr>
<td>Specialists in other areas</td>
<td>81</td>
<td>30</td>
</tr>
<tr>
<td>Doctors with graduate degrees</td>
<td>35</td>
<td>13</td>
</tr>
<tr>
<td>Students in undergraduate and specialization studies</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Work shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morning shift</td>
<td>108</td>
<td>40</td>
</tr>
<tr>
<td>Afternoon shift</td>
<td>75</td>
<td>28</td>
</tr>
<tr>
<td>Night shift</td>
<td>86</td>
<td>32</td>
</tr>
<tr>
<td>Place of residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In urban area</td>
<td>196</td>
<td>73</td>
</tr>
<tr>
<td>In rural area</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>

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**Table II**

PERCEIVED BARRIERS TO IDENTIFICATION AND REFERRAL OF CASES OF GENDER VIOLENCE. MEXICAN INSTITUTE OF SOCIAL SECURITY (IMSS), MORELOS, MEXICO, 1999

<table>
<thead>
<tr>
<th>Factors of medical practice</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The private character of violence</td>
<td>26</td>
</tr>
<tr>
<td>They consider it difficult to identify and manage the cases during their medical practice</td>
<td>16</td>
</tr>
<tr>
<td>Institutional factors</td>
<td></td>
</tr>
<tr>
<td>Lack of guidelines for case detection and management</td>
<td>29</td>
</tr>
<tr>
<td>The participation of medical personnel has not been legitimated from the institutional and legal points of view</td>
<td>24</td>
</tr>
<tr>
<td>Lack of time during consultation</td>
<td>22</td>
</tr>
</tbody>
</table>
legitimacy of the physician in interventions in this type of situations (24%). Among the general practitioners, male and female doctors with postgraduate degrees and those who had a greater level of knowledge about the topic, had a more favorable attitude ($p<0.05$ in all cases).

The variables associated with the general attitude and with the attitude needed to identify and refer cases - in the chi squared test as well as in the multivariate logistical regression models - (tables III and IV) were, among others, the level of knowledge on violence and the interest in receiving training in this area.

We also evaluated - through multiple logistical regression - the affective attitude of medical personnel, in the referral of cases of women who had been abused by their partners; the only significant variable was gender, that is, that women showed 2.1 times a better attitude towards referring these cases of violence than men, with CI 95% 1.18-4.47, ($p=0.04$).

We explored if they had at some time identified a case of violence towards women and 78% responded affirmatively. Also, with respect to how many cases they had identified in the last three months, 68% said they had only detected 1 or 2. Family doctors, as well as general practitioners, identified a greater number of cases than specialists in other areas. On the other hand, 70% considered that the abused woman is the one who should give a clue, so that the doctor may ask her about her problem with violence, and only half believed that violence towards women is a problem that is frequently encountered in medical practice.

### Table III

**Variables which, when related to general affective attitude, showed a greater statistical association. Mexican Institute of Social Security (IMSS), Morelos, Mexico, 1999**

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Affective attitude of medical personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds ratio</td>
</tr>
<tr>
<td>Medium level of knowledge*</td>
<td>2.10</td>
</tr>
<tr>
<td>High level of knowledge*</td>
<td>6.05</td>
</tr>
<tr>
<td>Gender‡</td>
<td>2.30</td>
</tr>
<tr>
<td>Interest in being trained in this area§</td>
<td>7.26</td>
</tr>
</tbody>
</table>

Model adjusted by age, legal status and doctor’s category

* The reference group is the one with low level of knowledge
‡ The reference group is the group of males
§ The reference group is that of participants who said they were not interested in being trained

With respect to the type of actions carried out by medical personnel in order to identify cases, 68% ask questions to identify abuse in women only when they have suspicions that it is a case, 6% do it as a routine, and 26% never do it. After identifying a case of violence, medical personnel say they do the following: a) 38% talk with the patients, trying to help them; b) 32% provide medical treatment and c) 25% refer the cases to institutions or persons who can provide specialized care.

With respect to the interviewees’ personal experiences with violence, 21% said they had been victims of some sort of violence coming from their partner (49% psychological, 27% physical, 13% economic and 9% sexual), with violence against women being more frequent ($p=0.04$). Sixteen percent (16%) said they had been violent towards their partner (58% psychological, 32% physical, 6% economic and 4% sexual), with no difference between the genders. At the same time, 44% of the personnel mentioned knowing someone who was close to them, in their social circle, who had this problem.

### Discussion

One of the limitations of this study is given by the sample size, which is reflected in the magnitude of the confidence intervals. This situation may be explained by the scarce disposition of medical personnel, mainly of specialists and subspecialists, to participate in studies on this topic. This situation is in and of itself an important finding which coincides with previous studies on this problem.¹¹,¹²
and is a methodological challenge to be considered by those who are interested in researching this theme. Among the reasons that explain this refusal of medical personnel, we can point out the discomfort they feel when talking about this topic, besides the demands of clinical practice. Another reason is the inaccessibility of certain hospital areas where the specialists are found.

In this sense, when the lack of participation is greater in a certain group of individuals, it may cause underestimates or overestimates of the associations. In this case, it is possible that the difference in attitudes shown by specialists and subspecialists (less favorable), when compared to general practitioners and family doctors, obstetrician-gynecologists, postgraduate physicians and female doctors, could have been more important.

The first finding we wish to highlight is that close to 90% of medical personnel at IMSS Morelos, do not have any training on this subject; among those who did receive some training, most of them did it on their own, while the rest got it in an obligatory manner through their educational training, and most trainings were at the postgraduate level.

This generalized lack of knowledge on the problem is the variable which best predicts the general attitude and the attitude to be identified during the medical consultation with abused women; this finding is consistent with the studies carried out in the country and at the international level. For example, Ferris found, in a national sample of 963 family doctors in Canada, that most of these demanded more education and training on this problem since they considered they did not have enough elements to face the situation with their patients.

Another aspect that was explored is the relationship with the number of training programs on violence and the identification of signs and symptoms by health personnel. In our study, we found that those who have received more training, are able to identify a greater number of signs and symptoms, compared to those who haven’t been trained. This is consistent with what was reported by Pearson and collaborators, who surveyed obstetrician-gynecologists in the U.S. in order to know their methods and attitudes towards the identification of domestic violence in their patients; of these, 34% said they did not have enough training. In this study, we found that physicians with more training on the subject were more likely to identify violence in their patients.

On the other hand, it is evident that the majority of health personnel rarely suspect violence in their patients, and so, in most cases, they do not ask them questions on this topic, and only suspect its presence in those cases which are very obvious, since women request health services for injuries caused by physical violence. In this sense, we may state that requirements are not satisfied for the identification, management and referral of abused women seeking care at the health services.

With respect to the number of cases that medical personnel identify, Fawcett reported that 70% of health personnel at the General Hospital of Mexico (SSA) and at the Department of the Federal District (Mexico City), identified between 1 and 5 cases per month; Reid and Glasser found that 56% of their sample have identified more than 10 cases during all of their working life. In our study, 68% said having identified from zero, up to two cases in three months. In the three situations, the number of cases is insufficient since, according to the average number of patients seen by doctors per shift at IMSS Morelos, they are only identifying 1% of the total number of estimated cases of abused women.

With respect to the attitude needed to refer abused women to specialized services, the only significant variable was gender of medical personnel, while the general attitude and the attitude needed to identify cases were also associated with the variables mentioned in tables III and IV. The fact that the attitude for referring cases of abused women showed little consistency with respect to the other attitudes, was probably due to the fact that it was measured with only four questions, while general attitude was measured with 40, and the attitude for identifying cases was measured with 17 questions.

When comparing the results of our study with those of similar studies, with respect to previous instruction of medical personnel on this subject, the studies by Gremlillion and Alpert, both done in 1998 in the U.S., stand out. What they found was that 54% of medical schools in that country offer educational programs on intrafamily violence, and that more than a third - out of 1521 clinical practitioners in different disciplines - never received any instruction on violence. Another work by Reid SA and Glasser M, done in 1997, in the western USA and Glasser M, done in 1997, in the western

U.S., found that 75% of physicians have not been trained to face this problem. In Mexico, the study done by Díaz-Martínez and Esteban-Jiménez stands out, which explored the inclusion of thematic contents on intrafamily violence in diverse academic activities at 11 medical schools throughout the country. Results show that 90% of surveyed institutions do include contents on intrafamily violence. Nevertheless, more than half approach the themes in an indirect manner; that is, they are only mentioned in a tangential way. Moreover, those institutions providing some sort of instruction, do it through extracurricular activities, such as courses, workshops, extended education or dissemination activities. There were no reports of an activity that dealt with the themes specifically in the curriculum. It also became clear that most institutions lack specialized agencies for the treatment of intrafamily violence and that actions being taken seem to need greater orientation and support.

Previous studies show that more than 67% of women expect health personnel to ask them about the violence they suffer and more than 60% of medical personnel expect the abused woman to be the one to approach the subject of her experiences with violence during the consultation. In this study, we found that more than 70% of medical personnel believe that the abused woman is the one who should initiate the conversation about violence.

Once a case has been identified, it is ideal to refer it to institutions and trained personnel who can provide specialized help; however, Fawcett reports that 43.9% of health personnel refers the victim to the hospital psychologist and 36.6% to the social worker. In our study, more than a third of medical personnel referred it to institutions and trained personnel who can provide specialized help; however, Fawcett reports that 43.9% of health personnel refers the victim to the hospital psychologist and 36.6% to the social worker. In our study, more than a third of medical personnel referred it to institutions and trained personnel who can provide specialized help; however, Fawcett reports that 43.9% of health personnel refers the victim to the hospital psychologist and 36.6% to the social worker.

With respect to the institutional barriers and the medical practice which make it more difficult to identify and refer the cases of abused women, we discovered the following: In our study, as well as in the studies by Valdez R, 2002 and Alpert, we see the lack of norms, guidelines for case identification and management, as well as the scarce social legitimacy of the personnel’s interventions in this health problem, as the main institutional causes. This situation could be modified if the Mexican Official Norm (NOM-190-SSA1-1999) were applied, which was put into force in March, 2000. Nevertheless, the application of this norm does not guarantee changes in the health personnel’s behavior. It is more likely that the social response, together with ideological and political trends, will be the ones to promote changes. With respect to the barriers existing in medical practice, we observe that these are mainly due to lack of knowledge about this theme and an absence of skills needed to face these cases. Also, some physicians manifest a lack of control and frustration when facing the patient’s response, since they don’t know what the effect of their advice might be.

With respect to the violence involving medical personnel, Sugg and Inui 1992 found that 31% of women doctors and 14% of men, reported violence coming from their spouse or sexual partner; in our study, 21% of interviewees reported being victims of violence, and this was more frequently reported by women. At the same time, 16% of medical personnel say they have been violent towards their partner; this shows that health personnel - just like any other person - are immersed in the same sociocultural circumstances that determine inequality between the genders. For this reason, training medical personnel around the topic of violence is necessary, considering they need specialized help to solve their own conflicts, before those of their patients.

Women doctors show more empathy and less shame when talking about violence during the consultation, because, it seems, they feel they are at greater risk than the men. Besides, we have observed that patients reveal more information to the women doctors; however, most medical personnel are men, and generally they are less interested in the topic.

Up to now, violence towards women is a topic that has not been approached directly in medical teaching and practice, and one of the aspects that needs to be dealt with immediately is the scarce and mistaken information that medical personnel have about the problem. In this sense, it would be enriching to go deeper into this aspect of generalized lack of knowledge, since not even the most basic needs of identification, management and control of health damages resulting from violence, are being satisfied. And although interventions have been carried out - in the U.S and Canada - to try to...
Violence against women the response of medical personnel

improve the mechanisms for identification, recording, health care services, social services and the strengthening of laws to protect the rights of women who are the victims of violence, programs and solid and effective strategies have not yet been established. In Mexico, evaluations are being done to see what the training needs are, what type of doctors and health personnel would better respond to training in this area, since we have seen that, as a routine, nurses and social workers ask more questions to identify abuse in women seeking health services, than doctors. This study shows that in spite of the fact that general practitioners, family doctors and obstetrician-gynecologists, physicians with graduate degrees and women, have a greater level of knowledge, better affective attitude, identify a greater number of cases and have received more training, women who are victims of violence are not identified, registered and provided with satisfactory care.

Based on the above, the limitations of the biomedical approach towards interventions in cases of family violence become clear; thus, the incorporation of this type of themes is justified - in the medium and long terms - from a social perspective, in curricula of undergraduate and graduate programs, as well as in extended education, in the medical area as well as in other areas related to health and human rights.

In this sense, interventions should offer, as an indispensable requirement, sufficient training to allow health personnel to develop solid and clear criteria with respect to the role they and their clinical practice play in the identification, registry, prevention and care provided to women for health damages resulting from violence; it is also important to consider the inclusion of the rest of the health personnel in programs and interventions. However, although we have seen that training of health professionals considerably increases their knowledge, skills and confidence, when carrying out activities for identification, it is also known that without structural changes in the different institutions involved in providing care for victims of violence, as well as extended medical education, it is unlikely that training alone will be enough to lead to important changes.

Our objective is to get health personnel to recognize the magnitude, characteristics and repercussions of the problem, and the opportunity they have to support abused women in the search for solutions to their problem since, sooner or later, they will seek care for health problems caused by the violence they suffer. Finally, it becomes necessary to consider that the actions of health personnel will have an impact on the work performance and life quality of the women who are abused by their partners.

References