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Inquiring Into Our Past: When the Doctor Is a Survivor of Abuse

Lucy M. Candib, MD; Judith A. Savageau, MPH; Linda Weinreb, MD; George Reed, PhD

BACKGROUND: Health care professionals like other adults have a substantial exposure to childhood and adult victimization, but the prevalence of abuse experiences among practicing family physicians has not been examined. Also unclear is the impact of such personal experiences of abuse on physicians' screening practices for childhood abuse among their patients and the personal and professional barriers to such screening.

METHODS: We surveyed Massachusetts family physicians about their screening practices of adult patients for a history of childhood abuse and found that 33.6% had some experience of personal trauma, with 42.4% of women and 24.3% of men reporting some kind of lifetime personal abuse, including witnessing violence between their parents. These rates are comparable to or higher than those reported in prior studies of physicians' histories of abuse.

RESULTS: Physicians with a past history of trauma were more likely to feel confident in screening and less likely to perceive time as a barrier to screening.

CONCLUSIONS: Given the high prevalence of prior childhood and victimization of both men and women physicians with the associated effects on their clinical work, we recommend that educational and training settings adopt specific competencies to provide safe and confidential environments where trainees can safely explore these issues and the potential impact on their clinical practice and well-being.

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Physical and sexual abuse during childhood and intimate partner violence (IPV) and sexual assault among adults, especially women, are common experiences with adverse effects on later adult emotional and physical health.¹⁻⁹ Among patients in primary care, 20% to 50% report sexual or physical abuse, and 44% report childhood physical, sexual, or emotional abuse.^{6,10} Like other adults,

some physicians have experiences of childhood and adult physical and sexual abuse¹¹⁻¹⁴—experiences likely to have an impact on their health and well-being—but information about the extent of such victimization among practicing physicians is limited.

A personal history of abuse might affect not only physicians' own health status but also how they screen and care for patients

with childhood or adult victimization. Clinical work with patients with a variety of symptom presentations, including multiple somatic complaints, unexplained medical symptoms, chronic abdominal and pelvic pain, substance abuse, and depression, requires that family physicians be able to screen for past and current physical and sexual abuse. However, the effect of the physician's own personal trauma history on his or her willingness to screen patients for a history of childhood or adult victimization is uncertain. Several studies in the 1990s surveyed medical students,¹⁵⁻¹⁷ medical students and faculty at a major medical center,¹¹ women physicians,¹² and practicing physicians^{13,18,19} for specific kinds of abuse. Some investigators asked whether subjects had witnessed physical abuse between their parents.^{12,13,15} A few studies also examined the relation between past abuse experiences and student attitudes toward abused patients¹⁵⁻¹⁷ and on current clinical work¹³ or reactions to clinical vignettes about abuse.^{18,19} Only four of these past studies inquired about exposure to childhood physical or sexual abuse, and these were limited by a vague definition of childhood abuse¹⁸ and

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lack of attention to a possible connection between abuse history and practice patterns.^{11,15,16} No prior studies have focused specifically on family physicians' exposure to childhood and adulthood abuse. While findings from studies more than 10 years old point to a prevalence of prior abuse among students and clinicians that parallels the experience of the general population, no systematic studies have explored this issue among family physicians nor have training interventions emerged to address the potential vulnerabilities of physicians and the possible resulting impact on their clinical work. Our group's recent work¹⁴ is the first that we are aware of to address abuse exposure and its relationship to clinical practice among family physicians. This paper builds on our initial study¹⁴ and provides an opportunity to describe the prevalence of childhood and adulthood abuse among family physicians and the relationship of family physicians' personal exposure of abuse to self-reported screening practices and subsequent responses to positive screens in their clinical work with patients. We address in the discussion the implications of our findings for resident training programs.

Methods

In a 2008 survey of members of the Massachusetts Academy of Family Physicians (MAFP) exploring their self-reported screening of adults for a past history of childhood physical or sexual abuse (described in detail elsewhere¹⁴), we embedded five questions about the physicians' own histories of personal abuse or exposure to trauma (witnessing violence between their parents). The five questions (see Table 1) were derived from previously published studies of self-reports of prior victimization.^{7,13,20} We provided the opportunity for respondents to opt out of this portion of the questionnaire. The 54-item questionnaire explored physicians' perceptions of their role in screening and the utility of screening information, their confidence in screening and using this information in patient care activities, the barriers they perceived to screening, and a small subset of sociodemographic questions. In addition to pilot testing, we conducted nonrespondent follow-up with two subsequent reminder letters (the second containing another complete survey packet), as reported elsewhere.¹⁴ The study was approved by the University of Massachusetts

Institutional Review Board for the Protection of Human Subjects.

Data were analyzed using SPSS (V17.0 SPSS, Inc, Chicago, 2009). We used univariate statistics to describe the physician population, their practice settings, and their screening practices; we used bivariate statistics (chi-squares tests for comparison of proportions and *t* tests for comparison of means) to examine relationships between screening variables and gender, practice type, personal exposure to childhood trauma, and years of experience. We computed summary variables for the various groups of screening variables (ie, screening practices, perceived role as a screener, utility of screening, confidence in screening—each measured using a 4-point Likert scale). (See Weinreb et al¹⁴ for details.) We refined the responses to the five questions embedded in the questionnaire about personal exposure to trauma in childhood and/or adulthood into six categories of abuse (Table 1): any abuse (includes witnessing abuse between parents), any direct abuse (excludes witnessing), any abuse as a child, any abuse as an adult, any physical abuse, any sexual abuse. We also examined the numbers of trauma questions endorsed

Table 1: Frequency and Percent Distributions of Physician Self-reported Personal Histories of Abuse*

	Never	Sometimes	Often	Very Often
1. When I was growing up, people in my family hit me so hard that it left me with bruises or marks.	264 (89.5%)	26 (8.8%)	3 (1.0%)	2 (0.7%)
2. When I was growing up, someone tried to touch me in a sexual way or tried to make me touch them.	246 (83.4%)	47 (15.9%)	2 (0.7%)	0 (0.0%)
3. As a teenager or adult, I was forced to have sex or engage in sexual practices against my will.	277 (94.2%)	16 (5.4%)	1 (0.3%)	0 (0.0%)
4. When I was growing up, one of my parents threatened, hit, slapped, kicked, or otherwise physically hurt the other.	260 (88.4%)	29 (9.9%)	4 (1.4%)	1 (0.3%)
5. I feared for my safety, or I have been hit, slapped, kicked, or physically hurt by an intimate or previous intimate partner.	274 (92.9%)	21 (7.1%)	0 (0.0%)	0 (0.0%)

* n=297. Numbers may not total to 297 because of sporadic missing data.

and collapsed the responses into 0, 1, and 2 or more items. We compared participants' responses to questions about their personal trauma histories (compared to those who reported no such experiences) across physician gender, practice characteristics, and primary care screening for patient abuse history barriers (eg, time, discomfort asking questions, fear of re-traumatization) and facilitators (eg, confidence, perceived role, utility to patients).

Results

Of the original 833 surveys mailed to the 2007 MAFP membership, 380 returns were received, for a response rate of 45.6%. Among the 380 returns, 67 were ineligible (eight undeliverable, 26 "not currently performing primary care," two "no time to complete," six retired, 18 not providing care in Massachusetts, and seven not seeing adult patients). Of the 313 completed and eligible surveys, 297 contained responses to the questions about personal history of trauma; a small number ($n=16$; 5.1%) of physicians who completed forms declined to answer these questions. The 297 respondents were not significantly different from other Massachusetts family physicians in terms of gender, race, ethnicity, or practice type, when compared to demographic characteristics of the MAFP membership (data not shown).

The 297 respondents were evenly split by gender, were predominantly non-Hispanic whites, and had been in practice for an average of 14 years (Table 2). The majority of respondents practiced either in a single specialty group or in a community health center (CHC), and their practice sites were predominantly in urban or suburban settings. Table 1 describes the prevalence of trauma among respondents of the five individual personal trauma questions. Table 3 shows those five personal trauma questions grouped into summative variables with 33.6% of physicians reporting any physical or sexual abuse or personal trauma (including witnessing abuse between

parents). Nearly the same percent (29.5%) reported any direct physical or sexual abuse. While 22.4% reported any personal abuse as a child, half as many (11.2%) reported abuse as an adult. Physical abuse alone was reported by 15.6% of responding physicians; 19.7% reported any sexual abuse. Nearly three quarters (73.5%) reported knowing someone with a history of childhood trauma outside of their professional role as a physician (ie, friend, colleague, family member, etc).

Women respondents reported higher rates of histories of abuse

than men (Table 3). Women's responses showed a significantly higher rate of any kind of lifetime personal abuse (women 42.4% versus men 24.3%, $P=.001$). Women were more than twice as likely as men to have reported abuse as an adult (women 15.9% versus men 6.3%, $P=.009$) and a past history of sexual abuse (women 27.2% versus men 11.8%, $P=.001$). Women were also twice as likely to have reported childhood sexual abuse (women 21.9% versus men 11.1%, $P=.041$) and three times as likely to have reported adult sexual abuse (women

Table 2: Frequency, Percent Distributions, and Descriptive Statistics of Study Sample

	Study Sample* n (%)
Gender	
Male	144 (48.8)
Female	151 (51.2)
Years in practice	
Range	1–42 years
Mean (SD)	14.1 (9.4)
Race	
White	256 (87.7)
African American	2 (0.7)
Asian	30 (10.3)
Native American	3 (1.0)
Other	6 (2.1)
Ethnicity	
Non-Hispanic	287 (98.0)
Hispanic	6 (2.0)
Practice structure	
Solo practice	40 (13.7)
Single specialty group	108 (36.9)
Staff-model HMO	1 (0.3)
Multispecialty group	45 (15.4)
Community health center/FQHC	74 (25.3)
Hospital-based clinic	25 (8.5)
Practice location	
Urban	117 (40.1)
Suburban	119 (40.8)
Rural	56 (19.2)
Patients seen besides adult primary care	
Children	273 (92.2)
Adolescents	278 (93.9)
Young adults	286 (96.6)
Pregnant women	144 (48.6)

Study sample: Some variables may not total to 297 because of sporadic missing data.

* $n=297$

FQHC—federally qualified health center

Table 3: Relationships Between Self-reported Histories of Abuse and Physician Gender

Abuse Histories*	Men Providers n (%) [95% CI]	Women Providers n (%) [95% CI]	Total n (%) [95% CI]	X ² (P Value)
Any abuse	35 (24.3%) [17.3, 31.3]	64 (42.4%) [34.5, 50.3]	99 (33.6%) [28.2, 38.9]	10.80 (.001)
Any abuse (excluding witnessing parental abuse)	31 (21.5%) [14.8, 28.2]	56 (37.1%) [29.4, 44.8]	87 (29.5%) [24.3, 34.7]	8.58 (.003)
Any abuse as a child	26 (18.1%) [11.8, 24.3]	40 (26.5%) [19.4, 33.5]	66 (22.4%) [17.6, 27.1]	3.02 (.082)
Any abuse as an adult	9 (6.3%) [2.3, 10.2]	24 (15.9%) [10.1, 21.7]	33 (11.2%) [7.6, 14.8]	6.90 (.009)
Any physical abuse	20 (13.9%) [8.2, 19.5]	26 (17.2%) [11.2, 23.2]	46 (15.6%) [11.4, 19.7]	0.62 (.431)
Any sexual abuse	17 (11.8%) [6.5, 17.1]	41 (27.2%) [20.1, 34.2]	58 (19.7%) [15.1, 24.2]	10.99 (.001)

* Any abuse=questions 1–5 from Table 1 (reported to have occurred “at least sometimes”)
 Any abuse to oneself=questions 1, 2, 3, and 5
 Any abuse as a child=questions 1 and 2
 Any abuse as an adult=questions 3 and 5
 Any personal physical abuse=questions 1 and 5
 Any personal sexual abuse=questions 2 and 3

8.7% versus men 2.8%, $P=.028$). Childhood physical abuse was similarly reported for men (13.9%) and women (17.2%, $P=.431$). The numbers of physicians who had reported intimate partner violence as adults was small, with estimated rates higher in women than men but not significantly different (women: 14/151, 9.3% versus men: 7/144, 4.9%, $P=.18$, Fisher's exact test). Of men and women who experienced at least one form of trauma ($n=99$, 33.6%), 61.6% reported only one form ($n=61$) while 38.4% ($n=38$) reported two or more kinds of trauma suffered. Women were more likely to have experienced more than one form of trauma ($P=.003$).

Trauma and Clinical Practices

Table 4 shows the association between physicians' history of trauma and their practice and screening characteristics. Those physicians with a personal history of trauma were more likely to be moderately or very confident in their ability to screen for a history of childhood abuse than those without an abuse

history (61.6% versus 44.9%, $P=.007$), although their rate of usually or always performing screening did not reach traditional levels of significance ($P=.055$). Those who reported knowing someone outside of their professional role with a history of abuse were also more likely to report a personal history of childhood trauma (88.8% versus 67.3%, $P<.001$), as were physicians more likely to bring up the topic of reported abuse at subsequent visits (44.8% versus 22.7%, $P<.001$). Finally, physicians who reported being less likely to regard time as a barrier to screening were also more likely to report personal childhood trauma histories (mean score 1.73 versus 1.57, $P=.018$). We examined whether the associations above between trauma and clinical practices were different for men and women family physicians and found no statistical evidence of an interaction of history of abuse and sex of physician with reported clinical practices. However, women who reported a history of abuse were more likely to have been in practice a few years longer.

Discussion

This study shows that a substantial proportion of practicing family physicians have a personal experience of childhood and/or adult physical and sexual abuse, comparable to prevalence rates of personal trauma found in the general population. The rate of 11.6% witnessing violence between parents among our surveyed group is similar to the rate of 13% in a national survey.²¹ The rate we found of childhood sexual abuse (21.9% among women and 11.1% among men) is very similar to rates of 25% in women and 16% in men as reported from the ACE study²² and is only slightly less than the rates of 30%–40% among girls and 13% among boys found in a national meta-analysis.²³ Only the rate of IPV among our surveyed group was substantially less (9.3% for women and 4.9% for men) than rates found in the general population (25% women, 11% men).²⁴

While clear comparisons to past studies of abuse in physicians' lives are limited due to a small existing literature with varying target groups and areas of inquiry, several

Table 4: Practice and Screening Characteristics of Family Physicians in Relation to Their Self-reported Personal Histories of Abuse

	Self-reported History of Personal Trauma** (All Five Personal Trauma Questions)			
	Never	At Least Sometimes	Statistic	P Value
Physician gender				
Male	109 (55.6%)	35 (35.4%)	$X^2=10.80$	.001
Female	87 (44.4%)	64 (64.6%)		
Practice Type				
Non-Community Health Center (CHC)	149 (76.8%)	70 (70.7%)	$X^2=1.29$	.256
CHC	45 (23.2%)	29 (29.3%)		
Care for other patients besides adult primary care: pregnant women				
No	105 (53.8%)	45 (45.5%)	$X^2=1.85$	.174
Yes	90 (46.2%)	54 (54.5%)		
Percent of adult primary care female patients believed to have a history of childhood trauma				
< 10%	43 (21.9%)	19 (19.2%)	$X^2=0.30$	.585
> 10%	153 (78.1%)	80 (80.8%)		
Percent of adult primary care male patients believed to have a history of childhood trauma				
< 10%	116 (59.2%)	58 (58.6%)	$X^2=0.01$	.921
> 10%	80 (40.8%)	41 (41.4%)		
How often do you ask about a history of childhood trauma among new and established male and female patients?				
Rarely/never/sometimes	145 (74.7%)	62 (63.9%)	$X^2=3.69$	.055
Usually/always	49 (25.3%)	35 (36.1%)		
How confident are you in your ability to screen for a history of childhood abuse?				
Not at all/somewhat	108 (55.1%)	38 (38.4%)	$X^2=7.36$	.007
Moderate/very	88 (44.9%)	61 (61.6%)		
To what extent do you think it is your role as a physician to screen for a history of childhood abuse?				
Not at all/small extent	48 (24.5%)	15 (15.5%)	$X^2=3.13$	.077
Moderate/great extent	148 (75.5%)	82 (84.5%)		
How useful to the patient do you think it is for a family physician to screen for a history of childhood abuse?				
Not at all/somewhat	59 (30.3%)	23 (23.2%)	$X^2=1.61$	.204
Moderate/very	136 (69.7%)	76 (76.8%)		
Do you know someone with a history of childhood trauma outside of your professional relationships?				
No	64 (32.7%)	11 (11.2%)	$X^2=15.79$	<.001
Yes	132 (67.3%)	87 (88.8%)		
If patient reveals a childhood abuse history, refer patient to a mental health specialist				
Rarely/never/sometimes	44 (22.4%)	30 (30.3%)	$X^2=2.16$	.142
Usually/always	152 (77.6%)	69 (69.7%)		
If patient reveals a childhood abuse history, discuss history in some detail with patient				
Rarely/never/sometimes	93 (47.7%)	37 (38.1%)	$X^2=2.39$	.122
Usually/always	102 (52.3%)	60 (61.9%)		

(continued on next page)

Table 4: continued

	Self-reported History of Personal Trauma** (All Five Personal Trauma Questions)			
	Never	At Least Sometimes	Statistic	P Value
If patient reveals a childhood abuse history, discuss medications to help relieve persisting symptoms Rarely/never/sometimes Usually/always	128 (65.6%) 67 (34.4%)	63 (64.9%) 34 (35.1%)	X ² =0.01	.907
If patient reveals a childhood abuse history, bring up abuse history at subsequent visits Rarely/never/sometimes Usually/always	150 (77.3%) 44 (22.7%)	53 (55.2%) 43 (44.8%)	X ² =14.95	<.001
Time as a barrier to screening: sum score Mean*** SD	1.57 0.51	1.73 0.57	t=2.38	.018
My patients are unlikely victims of childhood abuse as a barrier to screening: sum score Mean*** SD	2.80 0.45	2.86 0.40	t=1.12	.265
Discomfort with screening; little I can do to help patients as a barrier to screening: sum score Mean*** SD	2.59 0.36	2.66 0.31	t=1.47	.143
Years in practice Mean SD	13.8 9.5	14.7 9.2	t=0.83	.407

* n=297. Numbers may not total to the individual cohort n because of sporadic missing data.

** Variables were scored as 1="Never," 2="Sometimes," 3="Often," and 4="Very Often"; the variable was collapsed to "Never" versus "At Least Sometimes" for analytic purposes.

*** For each barrier variable, a higher score indicates it is less of a barrier.

findings merit attention. Compared to the deLahunta study,¹¹ probably the most similar in target group and areas of inquiry to our study, we demonstrated higher levels of lifetime abuse (29% versus 24%) and exposure to child abuse (22% and 15%) among practicing family physicians versus their sample of medical students and diverse clinical physician faculty at a university medical center. Lifetime sexual abuse was also considerably higher in our sample compared to this earlier study. However, as in comparison to studies of national prevalence, we found a somewhat lower rate of reported interpersonal violence as an adult for the total group of family physicians (7.1%) as well as lower rates for men (4.9%) and women (9.3%)

compared to past study samples of physicians where rates ranged from 12%^{13,17} to 23%.¹⁶

Our study found similar rates for family physicians witnessing violence between their parents (11.6%) compared with Rodriguez (15%)¹³ and Ambuel (16%).¹⁵ With regard to reported rates of childhood abuse exposure, one in five family physicians surveyed in our study reported a positive history of either childhood physical or sexual abuse compared to somewhat lower rates reported in prior studies (deLahunta, 15%¹¹ and Cullinane, 13%¹⁶). Only one study conducted among Wisconsin medical students described higher rates of childhood abuse (one in three) compared to those reported by our sample.¹⁵ Direct comparisons

between studies are difficult because of varying definitions of abuse and different historical circumstances. Our finding of a higher rate of past personal experiences of violence among family physicians compared to deLahunta's respondents¹¹ might result from the differing interpretations today of what constitutes the term abuse compared to such understandings in 1995. Also, comfort in recognizing and disclosing abuse has increased in the past 15 years. Alternatively, physicians choosing to enter family medicine may have a greater experience of physical or sexual abuse in their lives, perhaps leading them to choose a specialty where they would work with families. Practicing family physicians may also be more comfortable acknowledging a

history of abuse, or physicians with a past history of abuse may have been more likely to complete and return the survey. Regardless of the potential explanations and the challenges of making comparisons, overall, our results, with the exception of IPV, appear to point to even higher rates of family physicians' lifetime exposure to childhood and adulthood victimization than have been described previously. Our study results bear repeating in subsequent studies of physicians, especially family physicians, given these new findings.

We found significant relationships between an exposure to abuse and practice patterns. While the nursing literature contains multiple studies examining a possible relationship between prior abuse in the nurses' lives and their approach to patients with victimization,²⁵⁻³¹ the possible association between a personal history of abuse and physicians' clinical strategies has previously received limited attention. A study performed before 1991 of child health professionals (social workers, psychologists, pediatricians, and psychiatrists) found that those with a personal history of abuse were more likely to believe allegations of abuse in clinical vignettes compared to colleagues without a history of abuse.¹⁸ Rodriguez' 1995 survey of California primary care physicians found that while 15% had witnessed violence between their parents, and 20% of women and 10% of men reported personal experience of intimate partner abuse or fear for their safety, these experiences did not correlate with their report of screening for IPV in their clinical practice.¹³ In contrast to a small (n=38) qualitative study of mostly family physicians in an HMO, suggesting that identifying with a battered patient might lead a woman physician not to screen because it would imply her own vulnerability and lack of control,³² we found the reverse: that family physicians with a personal history of trauma—both men and women—were more confident in screening.

Concern that screening for abuse might re-traumatize patients with an abuse history is a possible explanation for clinicians' avoidance of screening.²⁵ The risk of re-traumatization did not emerge as a significant barrier to screening among either non-abused or abused physicians in our study.¹⁴ However, re-traumatization of clinicians, also called secondary trauma, is a recognized issue for professionals with a past history of abuse who work with patients with trauma.^{18,29,33} Nurse educators²⁶ have called for educational and health care systems to address the needs of health care professionals with a personal history of abuse, yet medical educators have not taken on this challenge.

As is typical of survey research, a limitation of our study is the possibility that nonrespondents may have differed from respondents in ways that could affect our conclusions. A response rate of 45.6%, though not ideal, is not unacceptable when surveying physicians. Our study was also limited by the use of the self-report of screening behaviors, the self-report of abuse, and the omission of inquiry regarding neglect, emotional abuse, and other kinds of adverse childhood experiences in the physicians' lives. The prevalence of abuse among the physicians in our studies may also be underestimated because 16 physicians opted out of the inquiry into personal trauma or because of worry about confidentiality or denial or repression of personal experiences. Endorsement of screening practices may be inflated because of social desirability and expectations that the researchers, known to many family physicians in Massachusetts, would be looking for a positive response. The study was conducted only among practicing family physicians in Massachusetts and might reflect regional and specialty characteristics. However, our study is unique in being the only recent study of this topic and the only one specifically addressing the

abuse experiences of a large sample of practicing family physicians.

Implications

Our study shows that a history of abuse, both physical and sexual, both in childhood and adulthood, is common among family physicians. While the clinical literature points to lasting effects of abuse on patients' later mental and physical health, we have not acknowledged the extent of abuse, and potential vulnerabilities, among ourselves as physicians. Nor have our training programs recognized that a significant subgroup of trainees will have experienced prior victimization affecting their caregiving experience and practice. We have not prepared ourselves or our programs to address the issues that are likely to arise when we expect trainees to inquire into patients' histories of childhood and adult physical and sexual abuse. The topic is a difficult one for educators as disclosure of abuse requires a setting of safety, yet training settings are not consistently safe settings for personal disclosures. Nevertheless, the recently published description by the Academy on Violence and Abuse (AVA) of competencies regarding violence and abuse for health care systems, academic institutions, and individual learners makes a clear statement: training programs must "assure learner safety and promote self-care."³⁴ Not addressing such personal issues during training may predispose young physicians to later mental and physical health problems. Our finding that prior abuse is common among physicians suggests a connection, as with other adults, to later addiction and depression, conditions known to be excessive among physicians.³⁵⁻³⁸

The AVA lists four specific requirements for training programs to meet the above competencies:

(1) Recognize that many learners are survivors of interpersonal violence or know someone who is a survivor and that others may find the content personally difficult.

(2) Discuss the prevalence of violence and abuse among providers and how personal experiences may shape provider behaviors during training sessions and acknowledge the impact training may have.

(3) Make available accessible, non-discriminatory, and profession-specific counseling and mentoring programs.

(4) Offer appropriate support and mentoring.³⁴

Various pathways are available to family medicine educators to address the prevalence of histories of abuse among trainees. One is to structure our training programs such that each resident has specific, consistent, and personal long-term supervision, as in psychiatric residencies, in which s/he might disclose how personal issues are affecting work with patients. Such supervision could be arranged outside the training programs to maintain safety and confidentiality. Should residents require psychotherapy, their supervisor would be well placed to arrange treatment. This strategy maintains individual privacy but is likely to be costly and does not address with the group of trainees the importance of prior abuse nor its impact on their work together.

Alternatively, we can restructure our training programs from the beginning to acknowledge that a history of abuse is common, that a portion of any given group will have had experiences of abuse, and that the impact of such history is likely to emerge within the stressful years of residency. We can teach our trainees that physicians, like their patients, will also be vulnerable to the sequelae of trauma exposure and will require attention to the development of ongoing self-care practices. We can recognize up front that histories of abuse will pose challenges both for the residents with this history and those who work with them as colleagues. Faculty can model an acceptance of their own vulnerability and what they have learned from it, thus enabling residents to see that an

apparent liability can also emerge as a strength. If we knew, for instance, that one third of our residents had a history of, say, rheumatoid arthritis, or a history of childhood cancer, or a history of complex trauma from motor vehicle accidents, we would incorporate this knowledge into our training. Addressing these needs directly, we would devise safe and supportive strategies for residents as they faced patient care responsibilities that posed challenges for their own past histories. Knowing as we do now, from our work and that of others, that one third of our residents likely do have a history of physical or sexual abuse, we have the obligation to modify our programs to offer the flexibility, safety, and confidentiality necessary for trainees to address these issues. The challenge lies before us.

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