Women marginalized by poverty and violence

How patient-physician relationships can help

Susan Woolhouse, MD, CCFP **Judith Belle Brown,** PHD **Barbara Lent,** MD, CCFP, FCFP

ABSTRACT

OBJECTIVE To explore the experiences of women relegated to the margins of society by poverty or violence.

DESIGN Qualitative method of focus groups.

SETTING Shelters and transitional housing in southwestern Ontario.

PARTICIPANTS Thirty-six women staying at shelters or transitional housing.

METHOD Focus groups conducted at five locations explored the women's experiences and interactions with family physicians.

MAIN FINDINGS Two themes emerged from the analysis: power imbalances in patient-physician relationships, and the role of family physicians in creating collaborative relationships. Women who felt demeaned in patient-physician relationships described their family physicians as dominating and intimidating. Women who described relationships as collaborative felt valued and understood.

CONCLUSION Poor or abused women living in shelters who felt powerless in patient-physician relationships felt even more demeaned as they coped with the struggles associated with being poor. Women who had continuous collaborative relationships with their family physicians were able to articulate their needs more readily.

RÉSUMÉ

OBJECTIF Examiner l'expérience des femmes forcées de vivre en marge de la société pour des raisons de violence ou de pauvreté.

TYPE D'ÉTUDE Méthode qualitative de groupes de discussion.

CONTEXTE Refuges et maisons de transition du sud-ouest de l'Ontario.

PARTICIPANTES Trente-six femmes habitant un refuge ou une maison de transition.

MÉTHODE Les groupes de discussion tenus à cinq endroits différents ont étudié le vécu quotidien de ces femmes et leur interaction avec les médecins de famille (MF).

PRINCIPALES OBSERVATIONS L'analyse a révélé deux thèmes principaux: un déséquilibre du pouvoir dans la relation médecin-patient et la nécessité pour le médecin d'établir une relation de collaboration. Celles qui se sentaient dévalorisées dans la relation avec le MF décrivaient celui-ci comme dominant et intimidant. Celles qui disaient avoir une relation de collaboration se sentaient valorisées et mieux comprises.

CONCLUSION Parmi les femmes pauvres ou victimes de violence vivant en refuge, celles qui se disaient rabaissées dans la relation médecin-patient se sentaient encore plus démunies devant les difficultés associées à la pauvreté. Celles qui avaient une relation de collaboration continue avec leur MF pouvaient mieux exprimer leurs besoins.

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Through its theoretical and practical incorporation of the social determinants of health and its commitment to address both psychosocial and environmental factors,[1] family medicine is well placed to deal with the health concerns of marginalized people. Marginalized people are those who exist socially at the edges of society or the community. Because poverty is prevalent in Canada,[2-4] it is important for family physicians to understand it, its effect on health, the experiences of people living in poverty, and how people living in poverty interact with the health care system.

While the health of both men and women is adversely affected by poverty, women are disproportionately affected.[2-12] Because women fall behind men in virtually every indicator of socioeconomic status and constitute the largest group of poor in Canada, they suffer the ill effects of poverty to a greater degree than men.[3,4,6,8,13,14] This phenomenon is sometimes termed the feminization of poverty.

Although there is research examining morbidity and mortality rates among people living in poverty,[1,11,15-19] research examining the actual experience of being poor is still in the early stages. Also, there is little research examining patient-physician relationships from the perspective of marginalized patients who are at high risk for many health problems.

Women and their children living in poverty often seek shelter services[8] because they have difficulty finding affordable housing and are seeking a place of safety. Woman abuse has no economic boundaries, and the relationship between poverty and violence is multifaceted.[13,20-22] Poverty, or fear of poverty, prevents women from escaping abusive situations, and violence makes it difficult for women to leave impoverished conditions.[6,13] The high levels of abuse and trauma[23,24] that homeless and poor women experience lead to health problems.[22,25,26] When they visit physicians, these women often have difficulty being assertive in their relationships with health care providers because they have low self-esteem and feel demeaned.[22,27,28] If they feel marginalized in patient-physician relationships, they will have difficulty accessing adequate health care.[28]

Dr Woolhouse *is a family physician practising inner-city medicine in Toronto, Ont.* **Dr Brown** *is a Professor at the Centre for Studies in Family Medicine, Thames Valley Family Practice Unit, at the University of Western Ontario (UWO) in London.* **Dr Lent** *is an Associate Professor in the Department of Family Medicine at UWO and Acting Medical Director of the Victoria Family Medical Centre.*

METHOD

This study used the qualitative method of focus groups[29-32] because they enable participants to share insights, perceptions, and experiences in a permissive and unthreatening environment.[29,30] This method is frequently used in family practice research.

Recruitment

Notices inviting women to participate in discussion groups about their health concerns were posted at individual agencies. Women were asked to sign up at the main office of the respective agency. Each sign-up sheet had space for 10 women, allowing for drop-outs and cancellations. Informed consent was obtained from each participant.

Focus groups

Focus groups were conducted and moderated by the principal author (S.W.) with guidance and contributions from the coauthors. To allow key themes to emerge, each focus group lasted approximately 2 hours. Field notes were made at the end of each focus group. Participants were asked to describe health concerns they had had or difficulties they had experienced in having a particular problem addressed. Probes were used as necessary (eg, What could physicians do better to help women in situations like yours? What did your doctor do that was helpful?). Each focus group was audiotaped and transcribed verbatim.

Setting

Five focus groups were conducted: two at women's shelters, two at transitional housing units for

abused women, and one at a shelter for women seeking safety from abusive partners. Groups met in London, Ont, a large city, and two midsized towns, St Thomas and Stratford, Ont.

Analysis

We used constant comparative analysis. After each focus group, the transcript was read independently by each investigator to identify central issues. The investigators then met to compare and combine their independent analyses beginning with the key words, phrases, or concepts used by participants. This allowed for further exploration and expansion of emerging themes identified in earlier focus groups. Theme saturation was reached by the fourth group. During the last focus group, participants were asked if the themes from earlier groups were important themes for them also.[30,32] The last stage in the analysis was reduction of data; congregation of ideas, experiences, and opinions into major themes; and identification of key quotations to illustrate these themes.

Ethics approval for this study was received from the University of Western Ontario's Review Board for Health Sciences Research Involving Human Subjects.

FINDINGS

Thirty-six women participated in the focus groups with an average of seven per group. Average age of participants was 35.4 years; most women were separated, divorced, or single. Three quarters of the women reported having children, and almost three quarters were surviving on less than $1000 a month and using some sort of social assistance. The most common reasons for staying at shelters or transitional housing were lack of affordable housing or needing to be in a safe place. More than half the participants had seen a family physician within the last month, and two thirds had seen their particular physicians more than five times in the past year.

Two dominant themes emerged from focus group analysis: power imbalances within patient-physician relationships and the positive role of family physicians in creating collaborative relationships.

Power imbalances within patient-physician relationships

Some women experienced discrimination in their relationships with their family physicians. Discrimination was a recurring theme during focus groups. At times, participants thought the care they received from their family physicians was suboptimal because they were poor: "But you can just see the wheels turn and just because I live in a place like that [shelter], it does not mean that there's something going on [accused of child abuse]."

Women also described feeling demeaned in their relationships with their family physicians. Physicians' behaviours were described as paternalistic, intimidating, and dominating: "He has a power over you." Family physicians who behaved this way were viewed as unapproachable. A perception of physicians as infallible made it difficult for women to express dissatisfaction with their care.

> Do you encounter many people who feel that they are being…defensive of their doctor even though they are dissatisfied?…I wouldn't want him to know I am saying bad things about him even though I get upset about some aspects of my treatment.

Women who described feeling marginalized during patient-physician relationships subsequently mentioned many negative experiences. These included feeling rushed, not being heard, and being considered unimportant (and hence further marginalized).

> Yeah, I always feel rushed. I always feel like they're trying to get to the next appointment so they can get through the day or they are behind their schedules and they need to catch up.… Like you're inconsequential.

Other women shared stories about feeling demeaned when physicians doubted their experiences. Some participants thought their concerns were not heard and questions about their health

not answered. Because one woman's fears were not acknowledged, she felt her family physician was not listening to or believing her—a feeling shared by many participants

> My mom was diagnosed with breast cancer at 40 years old....I have a lump on the same breast and... I kept asking my doctor "Why can't I have a mammogram?" And he wouldn't explain it to me. I was in the shelter here for a couple of months, and... they had a thing on breast cancer [when] it was explained to me why [mammograms are ordered], what a mammogram would be, how it would be of no use to me.... My family doctor I'd asked since I was 19, and I did not ever get a straight answer.

When women felt uncared for and unsupported within patient-physician relationships, they were less likely to take an active role in their health care. The feeling of being unimportant to her family physician played a role in this woman's decision not to pursue a mammogram: "Well, I'm supposed to have them [but] if [family physicians] don't care, I won't care."

Positive role in creating collaborative relationships

Although some women felt demeaned by their family physicians, other women described collaborative patient-physician relationships. The collaboration was experienced as a nonhierarchical relationship in which participants felt valued and understood. Participants were able to express their concerns safely and comfortably. Having their family physicians take time to listen to their concerns was crucial for all participants.

> He [respondent's family physician] takes time. He'll ask me [questions] like "Is there anything else?" or "Did you have any other concerns?" or I can just ask questions and he doesn't make you feel like an idiot for asking them. It's like no question's a stupid question.

Invitations to ask questions created a comfortable atmosphere in which women did not feel intimidated by their physicians' position in the relationship. Women described the qualities in family physicians that fostered collaborative relationships. The importance of having a family physician who expressed concern was emphasized repeatedly.

> Well I had a doctor a few years ago;... she would say, "If you're having a problem, call me"... gave me her beeper number even.... I never actually called her, but just knowing that she was there caring.... Because you're all alone for the first time, and it just seems like someone cares.

Empathic, caring physicians were central to establishing trust and rapport for these women. Also, having long-term, trusting relationships was a key factor: "If you have a particular doctor that you see, year after year after year, they get to know you and know how you act, how you talk, and they can pick up on things maybe better." Long-standing relationships with their family physicians served as an essential source of emotional support during difficult times. The concept of continuity was paramount for many women.

> My doctor cares about me. My doctor called my mom... and called here and told me to make an appointment, told me to get checked out and make sure I was all right. Oh yeah, I love my doctor. I've been with him for 10 years.

Collaborative patient-physician relationships supported and facilitated health-promoting behaviours, such as better attention to prevention and women's increased ability to advocate for themselves. If women felt trusted and supported in their relationships with physicians, they returned repeatedly. This was often despite barriers, such as lack of transportation. "Transportation has always been a real problem for us. It's just that sometimes the bus is really, really inconvenient...." Another said, "She's [her physician] in London and I won't change her even now that I live out of town. I don't care."

Women who felt safe and supported tried to take their physicians' advice. One participant's decision to attend her yearly physical examination was

supported through her 20-year relationship with her family physician. Her children's appointments also served as an opportunity to give informal reminders: "… because of the kids I go, … and she says one's coming up or I'm due for one [physical]."

Last, many women expressed their feelings and concerns to their family physicians more easily if they experienced the relationship as empowering. For women who often felt they had lost control over many aspects of their lives, the ability to exert control over decisions involving their health was empowering.

> She listened to me from the beginning;… I set the rule right from the beginning. I said this is how it's going to be. If you're going to prescribe a drug for me, I want to know what it is, what it does, why it does that, and what it's going to do for me, and if it's not working … I don't want to feel like I have to stay on it.

DISCUSSION

Two broad themes emerged from focus-group analysis: power imbalances within patient-physician relationships and how family physicians help in creating collaborative relationships. Inadequate social, community, and financial supports often place insurmountable demands on poor and abused women. Not meeting basic needs puts them at a disadvantage and makes accessing health care challenging.

Power imbalances

Some participants described negative encounters with their family physicians and called the physicians intimidating and dominating. Participants felt rushed, not heard, and unimportant in encounters with these physicians. This made women feel further marginalized and reinforced the feelings of shame associated with living in poverty. The exclusion these women felt from society at large was echoed in their relationships with their family physicians.

Some women living in shelters and transitional housing described experiences where their health concerns were inadequately addressed. For most, this is likely not due to receiving poor care or to physicians' bad intentions. It is more likely that these women have different needs and complexities created by the circumstances in which they live. Also, these women were exposed to power based on sex and expertise and would have found it more difficult to express themselves in relationships.[28,33] This is consistent with research examining patient-physician relationships among women who have been abused.[22]

Earlier studies have identified abuse as a risk factor for low self-esteem and decreased ability to assert oneself.[13,27] A history of abuse can create barriers to communication that lead to patients being less satisfied with care.[22] Our study suggests that women living in shelters and transitional housing, who were often survivors of abuse, felt dissatisfied with their care, not only because of poor communication, but also secondary to feeling intimidated and powerless within patient-physician relationships.

Physicians must be aware that women living in shelters and transitional housing are less likely to articulate their health needs. Women in this high-risk group should be asked regularly and directly about their needs, fears, and expectations regarding their health, the visit, and their physicians.

Role in creating collaborative relationships

Many women shared stories of positive encounters with their family physicians. These encounters were clearly related to feeling supported and being treated as collaborative members in patient-physician relationships. Women who experienced support, collaboration, and safety in their relationships with their family physicians thought continuity of care was of paramount importance.

What was apparent throughout all the groups was that women who described close and trusting relationships with their physicians had usually been with those physicians for a long period. Women offered social and psychological support tended to go out of their way, despite barriers, to maintain relationships with particular physicians.

The benefits of continuity of care in primary care have been well documented and include increased patient satisfaction, reduced hospitalization, and better recognition of patients' needs.[12,34] Continuity of care can help family physicians minimize barriers to health care, both by diminishing the effects of marginalization and by fostering a balance of power in patient-physician relationships.

What we can do

This study highlights the unique issues of a group of marginalized women. It illustrates and reinforces the influence of patients' situations on patient care. These women felt isolated and had little family and financial support.[35] They lived in inadequate housing and lacked a sense of belonging to a community.[35]

As family physicians, we are reminded that finding common ground is strongly influenced by the context of our patients' lives. Management plans must be specific to each patient's context. Advocacy is also specific to context. Ways in which family physicians advocate for their female patients in circumstances similar to those of our participants might be very different from the ways in which they advocate for other patients. For instance, advocacy could take the form of supporting a patient's application for housing, filling out a form for a medication not covered on the formulary, or describing to Children's Aid Society staff a patient's efforts to meet her child's needs in challenging circumstances.

Providing a supportive, empowering environment that is context-specific translates into more sensitive and appropriate management and advocacy strategies and overall better patient care. Women in marginal circumstances who have traditionally had negative experiences with the health care system and health care workers are reluctant to seek out care. A good relationship with a family physician can be very important in the lives of these women. Family physicians should realize the potential benefits that providing support to such vulnerable patients can have.

EDITOR'S KEY POINTS

- This qualitative study explored patient-physician relationships with women who were staying in shelters and living on the margins of society due to poverty or abuse.
- Some of these vulnerable women felt demeaned by family doctors who were paternalistic or intimidating or did not appear to care about them.
- When family physicians listened well and appeared to care, these women felt safe and described patient-physician relationships as empowering, something very important to women who felt they had lost control over many aspects of their lives.
- Continuity of care that resulted in trusting relationships over time was highly valued by these women.

POINTS DE REPÈRE DU RÉDACTEUR

- Cette étude qualitative examinait la relation médecin-patient chez des femmes hébergées en refuge ou en maison de transition et vivant en marge de la société pour des raisons de pauvreté ou de violence.
- Certaines d'entre elles se sentaient dévalorisées par un MF trop paternaliste, intimidant ou apparemment peu soucieux de les aider.
- Quand le MF se montrait attentif et soucieux d'aider, les patientes se sentaient en sécurité et décrivaient la relation médecin-patient comme valorisante, ce qui est important pour des femmes pensant avoir perdu le contrôle sur plusieurs aspects de leur vie.
- La continuité des soins résultant d'une telle relation de confiance était hautement appréciée de ces femmes.

Limitations

This study does not deal with the challenges of women who do not speak English or who are recent immigrants. Also, participants were recruited from shelters and transitional housing, so findings might not reflect the experiences of women living on the streets or women who use informal supports, such as friends, for shelter. Further study is needed to explore how continuity of care affects low-income patients' health and health care system use. Last, how family physicians can empower marginalized women deserves more study.

Conclusion

This study shows that poor or abused women living in shelters who felt powerless within patient-physician relationships felt even more demeaned as they coped with the daily struggles of living in poverty. Participants who maintained continuous collaborative relationships with their

family physicians articulated their needs more readily. Finding common ground is strongly influenced by the context of patients' lives, so our management plans and ways in which we advocate must be context-specific. Family physicians should realize the potential benefits of supporting such vulnerable women.

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Contributors

Drs Woolhouse, Brown, *and* **Lent** *designed the study, conducted the focus groups, gathered and interpreted the data, and prepared the article for publication.*

Competing interests

None declared

Correspondence to: **Dr Susan Woolhouse**, *c/o* **Dr Barbara Lent**, *Victoria Family Medical Centre, 60 Chesley Ave, London, ON N5Z 2C1; telephone (519)-433-8424; fax (519)-433-2244; e-mail* **apple.house@sympatico.ca**

References

1. Watson WJ, Wetzel W, Devanesen S. Working with inner-city families: an ecological approach for the family physician. *Can Fam Physician* 1991;37:2585-92.
2. National Council of Welfare. *Poverty profile 1998: a report by the National Council of Welfare*. Ottawa, Ont: Public Works and Government Services Canada; 2000.
3. Ross DP, Scott KJ, Smith PJ. *The Canadian fact book on poverty, 2000*. Ottawa, Ont: Canadian Council on Social Development; 2000.
4. Hurtig M. *Pay the rent or feed the kids: the tragedy and disgrace of poverty in Canada*. Toronto, Ont: McClelland & Stewart; 1999.
5. Canadian Research Institute for the Advancement of Women. *CRIAW fact sheet: women and poverty*. Available from: **www.criaw-icref.ca/factSheets/Poverty_fact_ sheet_e.htm.** Accessed 2004 June 1.
6. Cohen M. Impact of poverty on women's health. *Can Fam Physician* 1994;40:949-58.
7. National Health and Welfare. *The active health report of women*. Ottawa, Ont: National Health and Welfare; 1990.
8. Burg MA. Health problems of sheltered homeless women and their dependent children. *Health Soc Work* 1994;19(2):125-31.
9. London Social Planning Council. *1998 London homelessness survey: a snapshot of homeless people in shelters and drop-ins during the 24 hour period from March 23 to March 24*. London, Ont: London Social Planning Council; 1998.
10. Statistics Canada, Housing, Family and Social Statistics Divisions. *Women in Canada: a statistical report*. 2nd ed. Ottawa, Ont: Industry Canada; 1995.
11. Lipman EL, Offord DR, Boyle MH. Single mothers in Ontario: sociodemographic, physical and mental health characteristics. *CMAJ* 1997;157:639-45.
12. Forrest CB, Starfield B. Entry into primary care and continuity: the effects of access. *Am J Public Health* 1998;88(9):1330-6.
13. Gurr J, Mailloux L. *Breaking the links between poverty and violence against women: a resource guide*. Ottawa, Ont: Health Canada, Family Violence Prevention Division; 1996.
14. Band PR, Gallagher RP, Threl WJ, Hislop TG, Deschamps M, Smith J. Rate of death from cervical cancer among native Indian women in British Columbia. *CMAJ* 1992;147:1802-4.
15. Pappas G, Queen S, Hadden W, Fisher G. The increasing disparity in mortality between socioeconomic groups in the United States, 1960 and 1980. *N Engl J Med* 1993;329(2):103-9.
16. Hwang SW. Homelessness and health. *CMAJ* 2001;164:229-33.
17. Hwang SW, Bugeja AL. Barriers to appropriate diabetes management among homeless people in Toronto. *CMAJ* 2000;163:161-5.
18. Shennan AT. Factors in low birth weight. *CMAJ* 1997;157:1737-9.
19. Gaetz S, O'Grady B, Vaillancourt B. *Making money: the Shout Clinic report on homeless youth and employment*. Toronto, Ont: Central Toronto Community Health Centres; 1999.
20. Wells LM. Social workers and homelessness: an Alberta case study. *Can Soc Work* 2000;2(2):118-31.
21. Davies L, McMullin JA, Avison WR, Cassidy GL. *Social policy, gender inequality and poverty*. Ottawa, Ont: Status of Women Canada; 2001.
22. Plichta SB, Duncan MM, Plichta L. Spouse abuse, patient-physician communication, and patient satisfaction. *Am J Prev Med* 1996;12(5):297-303.
23. Usatine RP, Gelberg L, Smith MH, Lesser J. Health care for the homeless: a family medicine perspective. *Am Fam Physician* 1994;49(1):139-46.
24. Goodman L, Saxe L, Harvey M. Homelessness as psychological trauma. *Am Psychol* 1991;46(11):1219-25.
25. McCauley J, Kern DE, Kolodner K, Derogatis LR, Bass EB. Relation of low-severity violence to women's health. *J Gen Intern Med* 1998;13:687-91.
26. Bassuk EL, Dawson R, Perloff J, Weinreb L. Post-traumatic stress disorder in extremely poor women: implications for health care clinicians. *J Am Med Wom Assoc* 2001;56(2):79-85.
27. Raphael D. *Inequality is bad for our hearts: why low income and social exclusion are major causes of heart disease in Canada*. Toronto, Ont: North York Heart Health Network; 2001.
28. Candib LM. *Medicine and the family: a feminist perspective*. New York, NY: Basic Books; 1995.
29. Krueger RA. *Focus groups: a practical guide for applied research*. Newbury Park, Calif: Sage Publications; 1988.
30. Brown JB. The use of focus groups in clinical research. In: Crabtree BF, Miller WL, editors. *Doing qualitative research*. 2nd ed. Thousand Oaks, Calif: Sage Publications; 1999. p. 109-23.
31. Morgan DL. *Focus groups as qualitative research*. 2nd ed. Thousand Oaks, Calif: Sage Publications; 1997.
32. Brown JB, Sas G. Focus groups in family practice research: an example of family physicians' approach to wife abuse. *Fam Pract Res J* 1994;14(1):19-28.
33. Malterud K. Strategies for empowering women's voices in the medical culture. *Health Care Wom Int* 1993;14:365-73.
34. Sweeney KG, Gray DP. Patients who do not receive continuity of care from their general practitioner—are they a vulnerable group? *Br J Gen Pract* 1995;45:133-5.
35. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. *Patient-centered medicine: transforming the clinical method*. Abingdon, UK: Radcliffe Medical Press Ltd; 2003.