Hiding in Plain Sight:

A Discourse Analysis of Australian Registered Nurses' Capacity to Care for Female Intimate Partner Violence Presentations to the Emergency Department

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Abstract
The incidence of Intimate Partner Violence (IPV) in Australia is rising. Women experiencing IPV seek assistance through Emergency Departments (ED). Women exhibit help-seeking behaviours to nurses who work in emergency over medical or allied health professionals. Nurses' capacity to recognise the need to care for women experiencing IPV is essential.

The aim of this study was to explore nurses' capacity to care for women who have experienced IPV through outlining inhibiting factors that limit care and create a discourse that contributes to addressing these factors. Pre (n=10) and post (n=6) focus groups (FGs) were undertaken with nurses who work in ED. In between the FGs an intervention was applied to prompt change to caring practices. The discourse generated from the FGs was subjected to a Foucauldian discourse analysis from a poststructural feminist perspective. Participants' capacity to care was found to be based on the values they formed on IPV, as shaped by their post-registration training. The formation of *boundaries* was fundamental in inhibiting the participants' capacity to care. Challenging *boundaries* through educational inquiry into nursing values can be effective in shifting perspectives of IPV. The raising of awareness of IPV in our communities serves as a vital tool in eliciting cultural behaviour change within EDs and within nursing culture.

Key words: Intimate Partner Violence, Domestic Violence, Emergency Department, Registered Nurses, Critical Discourse

Introduction

Intimate partner violence (IPV) is the most common form of violence against women in the 21st century (Gerard, 2000; Hooker et al., 2016; Australian Bureau of Statistics, 2015; World Health Organisation [WHO], 2012). While there are many forms of gender-based violence women may experience, the most current statistics report that one in three Australian women will experience IPV at some point in their lifetime and two die every ten days as a result of IPV incidents (Australian Bureau of Statistics [ABS], 2017). National statistics confirm the gendered nature of violence in Australia, reporting that men are more likely to be assaulted by a male stranger, and women are more likely to be assaulted by a former or current male partner, or a male family member (ABS, 2018b). The gendered nature of violence also becomes increasingly clear when the types of violence women experience are analysed. Women represent 89% of reported sexual assaults, 60% of which were in a private dwelling (ABS, 2018a). Statistics suggest that one in five Australian women will experience sexual assault in their lifetime (Australian Institute of Health and Welfare, 2019; Black et al., 2011). Despite the high prevalence of different forms of

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interpersonal violence experienced by women, it has been reported that only 28% of all women who have experienced IPV seek help (Biroscak et al., 2006; Hooker et al., 2016). Of that help-seeking group, 48% will visit their general practitioner and 50% will exhibit help seeking behaviours at an emergency department (ED) (Van Der Wath et al., 2013; Yonaka et al., 2007; Svavarsdottrir & Oligosdottir, 2008). The high incidence of women experiencing violence who access care from EDs provides a critical opportunity for registered nurses who work in ED to identify and respond to IPV. In this paper we report the results from an Australian qualitative study that explored the capacity of metropolitan registered nurses working in EDs (hereafter simply refered to as "nurses") to provide care to women who have experienced IPV.

Background

IPV is defined as any behaviour within a current/past intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. As defined by the World Health Organisation (WHO), IPV is inclusive of different forms of violence/abuse (e.g., physical, verbal, social, emotional, and economic abuse, sexual assault/abuse, or coercion) as well as coercive, controlling tactics that establish a power imbalance between partners.

Intimate Partner Violence Presentations in Emergency Departments

In a study that analysed IPV presentations in a sample of 11 urban and metropolitan EDs, between 6% and 30% of women who experienced IPV came to ED primarily for symptoms related to abuse (Dearwater et al., 1998). Further, statistics indicate that 40% of all women presenting to ED who had experienced assault attributed their physical injuries to IPV (Biroscak et al., 2006). Contextualising these help seeking behaviours within EDs is of key importance. A 2013, South African study reported that for 65% of the time, help-seeking behaviours in ED were exhibited towards nursing staff (Van Der Wath et al., 2013). The response of nurses is particularly important as nurses who work in ED spend more time, and have greater opportunity to build trust and rapport with their patients when compared to other health professionals in this setting (Casella, 2015; Musso et al., 2015). Despite being well placed to assist women who have experienced IPV, others report that nurses perceive feeling under-prepared on how to address IPV and unsure of clinical pathways and protocols within their institution for referrals of suspected or confirmed incidences of IPV (Basu & Ratcliffe, 2014; Ramsden & Bonner, 2002; Sampsel et al., 2009; Van Der Wath et al., 2013; Robinson, 2010). Furthermore, nurses repeatedly report feeling under-supported by their workplace and under-educated on IPV in their community and perceive that addressing IPV is a problem outside of their scope of practice (Campbell et al., 2001; Loughlin et al., 2000). International statistics indicate that up to 80% of nurses who are untrained in the care of patients presenting with IPV feel uncomfortable approaching the topic of IPV with women who are suspected of having experienced IPV (Oktay, 2013). The consequences of ED nurses' perceptions of their incapacity to care for patients experiencing IPV include worsening of presenting symptoms (Hooker et al., 2016) and in some cases, patient mortality (ABS, 2018a). Therefore, the capacity of nursing staff to care for patients presenting with IPV poses an important and significant challenge, as do the the attitudes, values, and beliefs of nurses and how these might be influenced by an educational intervention.

What is capacity?

The complex interactions between a nurse and a patient are shaped by nurses' beliefs about best practice. These beliefs are held by nurses, as relevant for that group of nurses, and also, as directed by the institutions that govern nurses (Murray et al, 2007). Nursing capacity refers to the intersection of these beliefs, when they are enacted on nurses (i.e., the structurally directed role of a nurse, and the individual nurse's understanding of their role). This interconnection of the social and structural expectation of nurses, and nursing responses to these beliefs or expectations, form the subjective ability of that nurse to be able to perform care. For example, in the Advanced Life Support (ALS) training of nurses, what is expected of a "competent" nurse is to provide ALS as dictated by governing bodies such as

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the Australian Resuscitation Council or the Australian College of Critical Care Nursing. This structural expectation interacts with the nursing culture of ALS trained nurses within their own ED as to what a 'well-trained' ALS nurse is, and further interacts with the nurse's intimate understanding of the role of an ALS-trained nurse. These factors combine to constitute the care that nurses are able, willing, and capable of providing to their patients, and are referred to as nursing capacity. The ability, willingness, and capability of nurses are key when considering nursing capacity in the presence of IPV. Capacity outlines that the beliefs of nurses, along with the beliefs held by the structures that govern nurses together dynamically constitue best practice and optimal nursing capacity.

Methods

A critical qualitative study grounded in the principles of post-structural feminism was designed to explore registered emergency nurses' capacity to care for women who had experienced IPV and presented to ED. The study design was underpinned by the principles of action research, both participatory action research (Minichello et al., 2004) and knowledge in action (Stringer, 2007; Minichello et al., 2004). Participatory action research involves participants in a process of collective, self-reflective enquiry in order to understand and improve situations by facilitating change (Minichello et al., 2004). This is achieved by involving participants that will be directly affected by the research (Stringer, 2007; Minichello et al., 2004). Simultaneously, knowledge in action takes everyday experiences (in our case the interaction between nurses and women who have experienced IPV) and allows participants/researchers to dissect the social constructs behind it (Stringer, 2007), thus, acknowledging the interrelationship between knowledge and power in seeking empowerment of individuals to enable change (Stringer, 2007; Minichello et al., 2004).

Setting and Sample

A conjunction of purposeful and convenience sampling was used to recruit practising emergency nurses with at least one year of (full-time equivalent) experience. Recruited participants were enrolled in the emergency nursing post-graduate program at a metropolitan university in Sydney, New South Wales (NSW). Of the eight states in Australia, NSW has the highest concentration of trauma centres (large tertiary EDs) of any state. Convenience sampling was employed within the university nursing cohort to allow ethics to be sought internally, given the 12 month timeframe for this research. The eligible participant pool was 20 individuals, and the estimated final sample size was 10 participants. Eligibility for participation in this study was limited to nurses who were currently working within Australian EDs, to ensure currency of practice as reccomended by participatory action research.

To recruit participants, a ten minute presentation on the study was delivered during one of the nurses' theoretical lectures. Participants were then invited to join the study, and registered their interest through a signup sheet made available in their class.

Data Collection and Analysis

The study was approved by the University of Sydney's Human Research Ethics Committee. In order to obtain an unrehearsed, authentic, and organic understanding of nurses' understanding of IPV as recommended by participatory action research, two focus groups (FGs) held three weeks apart were the chosen mode of obtaining data with the underlying principles of postmodern feminism to guide the discussion and form the questions. The supportive environment of a group atmosphere can allow participants to explore their more intimate feelings through a positive group interaction (Minichllo et al., 2004). Additionally, FGs develop dynamic group discussions and yield interactive data. The primary researcher recruited and conducted the FGs to maintain continuity and trust and promote open discussion. Participants asked questions of each other and generated conversation and interactive data by creating and leading discussion as a discourse was built, consistent with the principles of participatory action research.

The purpose of the first FG (n=10) was to understand the participants' baseline attitudes towards IPV, achieved through asking a series of prompting questions (Table 1).

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Figure 1: *Top Things any Provider Can Do to Support Women Experiencing Violence.*

Table 1. Focus Group Prompts

Focus Group 1	Focus Group 2
What is Intimate Partner Violence?	Was the tool helpful?
Have you received training on Intimate Partner Violence?	Why/ Why not?
Who does Intimate Partner Violence effect?	
What/ Who is a "victim"?	
How does IPV usually start?	
How might a "victim" present to ED?	
How do we manage the "victim"?	
Who is responsible for management of the "victim"?	
Do you know the current protocol within NSW health of management of an IPV "victim" in ED?	
What role does the public health system play?	

At the conclusion of the first FG, participants were handed an intervention 'tool' designed for health practitioners, to prompt their awareness of ways to disuss violence with women who have experienced IPV (Varcoe, 2014). The tool, entitled 'Top 10 things any provider can do to support women experiencing violence' (Figure 1) highlights an individual's language and demeanour when addressing women and prompts practitioners to reflect on their assumptions and the assumptions of the organisation they work within towards womens who have experienced violence (Varcoe, 2014).

The purpose of the second FG (n=6) was to identify whether there were any shifts in discourse in relation to nurses' capacity to care for women who disclosed their experiences of IPV. Data were recorded and transcribed verbatim by the coresponding author. The transcripts were analysed using Willig's discourse analysis from a post-structural feminist perspective described further below. Analysis of the transcripts was undertaken by the primary author and then discussed and all interpretations agreed upon with all authors.

Willig's Method of Discourse Analysis

Willig's (1999) method of discourse analysis was utilized to understand the ways in which participants discursively constructed their capacity to care for women who have experienced IPV. These constructions of capacity were established by identifying discursive meanings attached to IPV,

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discursive meanings attached to women who experience IPV (referred to in the discourse as "victims"), discursive meanings attached to women and discursive meanings attached to nurses or EDs. The analysis of the data from the FGs broadly observed the process shown in Table 2.

Table 2.0 Willig's Method of Discourse Analysis

Stage	Description
Discursive Constructions	Identification of the various ways in which the discursive object is constructed in the text of the focus groups, via recurrent formations of linguistic constructions and formulation of shared meanings. All references to victims of IPV and the interaction between ED nurses and IPV were isolated and sorted into overarching themes. Patterns were identified both in similarity in composition or content or in dissimilarity, contradiction or contrasting nature of what was said. These similarities in discourse contributed to the construction of shared ideas and definitions within the focus groups.
Discourses and Action Orientation	Placing various discursive constructions of IPV and ED nursing within wider discourses; e.g., ED is constructed as simultaneously 'the doorway to the hospital' or 'access to emergent healthcare' both of which are equally valid, based on the discourse subjects choose to take up.
Positionings	Meanings are established out of the links and networks within the focus group discussions, facilitating the identification of where participants positioned themselves in relation to the concepts of IPV and its effects. The discourses identified created the framework for the factors that affect nursing capacity to care for female victims of IPV, based on such positioning.
Practice & Subjectivity	Examination of the relationships between discourse and practice by considering the constructed limitations of action based on the individual's accounts of the world.

Results and Discussion

Discussion will be undertaken simultaneously with the exploration and development of the main discourses. It was found in FG1 (n=10) that all participants had received a varying amount of education on IPV from their respective EDs. Of the 10 participants, the majority were female (n=8). The mean years of nursing experience was 4.75 (range 3-14 years), and the mean years of ED experience was 3.5 (range 1.5-10 years). Analysis of the data identified two main discourses:

Constructions of Training and *Boundaries,* which are presented below.

Discourse One: Constructions of Training

Participants' discursive *constructions* of IPV reflected their workplace context and the training that they had received. The variations in participants' *constructions* of ED training on IPV and the associated relevance to their role as nurses allow an understanding of the *positioning* participants employ to deem IPV relevant or not within the context of EDs. Shown in Table 3 (below) are the main training discourses extracted from the FGs.

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Table 3.0 Constructions of Training Discourse

Discourse	Example from Focus Groups (FGs)
Requirement v. Responsibility	Female 2: *for the last 12 months they've been rolling it out. They started in a small area…* Female 1: - *It just started in a small area of the department, and the last… (looks to female 2)* Female 2: *ohh, two months?* Female 1: *three months? We've rolled it out to the entire department.* Researcher: *so, everyone is trained?* Female 1: *everyone has had training, yes- (Female 3 speaks over)- New staff, not so much* (Female 3: *on how to complete the forms*) Researcher: *sure* Female 2: *And there are champions as well that have had additional, like, the whole one day Saturday, where, um, [inaudible] social work would come and talk to them about completing the survey, and they're, like, the people that should be promoting it within the department.*
Governing Nurses	Female 3: *like, yeah, it's quite threatening now like, "you have to [use the screening tool]", (murmurs of agreement) like, [management are] not really asking us, the people implementing haven't really asked us "why isn't- why aren't you guys using it?"* Male 1: *yeah* Female 1: *"what are the factors preventing you from [using the screening tool]?"* Male 1: *but [management will] turn around and say things like "oh it was really great, 98% of women were asked" and then that's about the tool.* Female 3: *yeah, exactly.*
Expectations and outcomes of training	Female 3: *like we have champions in our ward… and she was like "it makes me cringe how some people [screen patients]", because they won't use the pre-amble, or they'll do it with all the family there, or they'll apologise profusely "I'm sorry these are really silly", "I'm sorry I don't want to ask you but blah blah blah" which is the opposite of what we've been taught to do.* Female 1: *Yep* Female 3: *so there is like a few different factors, and now it's like, what if you do get a positive screen? I've never had one! …but then it's like sometimes I get that sort of anxiety of like, is my response going to be adequate? Or…(cut off)* Female 1: *our friend the other day.* (female 2 and 3 agree) Female 2: *yeah, so I had asked one of my friends to do the screen on someone, and she knew off by heart all the beginning bits that you have to say, you know, up to the point where they usually say "no", and this person said "yes" and she was like, "oh! I have to go get my computer and read and figure out [what to do now]" because she had to tick boxes about what you have to do next and what support you offer and, um, basically we identified that it was happening and we offered support but, it was ultimately declined. There is only so much you can do.*

In relation to the *Requirement vs. Responsibility discourse,* the relevance of IPV training, education, and/or screening was constructed and contradicted repeatedly throughout the two FGs. There were varying levels of ownership of training for IPV and the screening tool displayed by participants. Female 2 stated that "they" implemented the tool, while Female 1 stated that "we've" been implementing it. Female 2 also furthers her positioning as one who perhaps opposes or is indifferent to the training when she shifts the responsibilities attached to her training to the "champions" who "should be promoting" the use of the tool. The atmosphere is quickly politicised, rather than around IPV, to the "us" and "them" discourse of nurses' relationships with management. The presence or lack of structural support for nurses screening or approaching patients was consistently defined as "difficult", "awkward", or "confronting", but also as "important". At times, participants explored management's responsibility to them as employees, and their responsibility to patients as nurses as two separate and opposing ideals.

Participants agreed that their institution's method of enforcing training and screening resulted in direct resistance or "avoidance" of using the screening tool. This conscious or unconscious resistance to use of the screening tool was also demonstrated in the description of the "need" to approach all women being viewed as "unnecessary" and also "awkward", as participants were of the opinion that not all women presented with "obvious risk factors". While this evidence of screening tools acting to govern nurses is relevant and compelling, of

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equal consideration is the avoidance strategies that nurses employ, and the contradictions inherent in the nursing response to mandated screening. While participants voiced their responsibility to their patients and management's seemingly oppositional motives, many participants seemed to prefer conversations around sensitive subjects to be mandated by management, which removed them from responsibility. This contradiction is a direct example of a challenge to proposed subjectivities, leading to incoherence. While participants positioned themselves as responsible for caring for women who have experienced IPV, within the same discourse they denied care to the 'whole' of their patient. Participants proposed a subjectivity that restricts their agency to care for the entirety of their patient and paints ED nursing as seemingly separate from "other" kinds of nursing. The shared definition of nursing enabled participants to restrict their care, effectively rendering it inaccessible to women who experience IPV. Such an operation supports the idea that nurses avoid social-environmental and human rights aspects inherent in nursing practice (Kagan et al., 2010).

As outlined in the *Governing Nurses* discourse, inconsistencies between the intentions of the organisation and the voiced intention of the nurses left participants feeling "threatened" and "frustrated". Some researchers argue that screening tools such as these, which put the needs of the organisation above the clinical requirement of the tool, are designed for institutions to assess the nursing response, rather than for nurses to assess patient health, ultimately leading to nurses' incoherencies in their own subjective roles (Iankova, 2006; Green, 2011; Lowry, 1999). Concurrent with the evidence of screening tools acting to govern nurses, we considered the strategies that nurses employ to avoid accountability. The improper management of women who experience IPV is evidenced in the *expectations and outcomes of training*

discourse. The perceived "failure" of the tool was where it had been witnessed as inappropriately used "in front of family" or without its "preamble"; however, success does not point to proper management and respect given to a woman who may be experiencing violence. This incoherence between perceived success and failure of the tool exposes a weakness in the way that nurses are educated to understand their duty of care and scope of practice, removing nurses from accountability in a way that leaves women who experience IPV in a vulnerable position when seeking help in EDs. The socially specific construction of "IPV screening" or *training* between nurses has turned nursing attention to the impersonal outcomes central to a managerialist model of health care and is done at the patient's expense with disregard for their human experience. In this approach to caring for women who have experienced IPV, research participants' discourse notes a marked neglect of the issue of social power relations in the formation of women's experiences within the ED. Many participants seemed to either lack understanding, or deny the power they held in the exchange with patients when broaching sensitive topics. These incoherent ideologies play a part in the setting of boundaries that separate nurses from their clinical knowledge and restrict their duty of care to women.

Discourse Two: Boundaries

The term *boundaries* refers to the unspoken individual and group understandings of social, professional, ideological, and moral standards that influenced participants' positionings on the topic of IPV and on women who experience IPV, as opposed to a specific topic of construction and contention that *training* embodied. Put simply, the presence of *boundaries* was found to be participants' responses to IPV and the positionings that participants chose to take up and project together. Shown in Table 4 (below) are the main boundary discourses extracted from the FGs.

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Discourse	Example from Focus Groups
Disempowerment	*"There is only so much you can do"* Female 3: *Like, we're here to treat medical things… sometimes you can't fix everything... I- I felt almost ashamed of myself that I felt so awkward to ask, and if [my patient] had a bad experience [with IPV] …"*
Criteria for emergency care	Researcher: *do you feel like [caring for victims of IPV] is an emergency priority?* (silence) Female 1: *mmm. It's a priority, depending on the stage of the crisis. I don't know if it's an emergency priority. I mean the person who's arresting down the corridor would obviously take priority and you will always have a very sick patient in your care load. Um, even like [Male 1] said before, you need to change the way you think about it and go out there and find it, yet as an emergency nurse, you don't actively go out to find extra things ….* Female 2: *but there could be other stuff too… maybe next week it'll be "elder abuse" that's still very relevant and still harms a lot of people in the community so it's hard to be aware of all these other things and put the information to use.*
Patient redirection	Female 1: *…and even if they do present [to ED] … [we should refer victims to] GPs. But even if [GPs don't] have the same sort of screening tools… the next time it's sort of planted a seed [in the patient's mind] …they're a bit more, sort of, inclined or take other methods of help instead of going to the ED which is not helpful at all.*

Table 4.0 Boundary Discourses

The establishment of an emotional boundary by nurses is asserted as a symptom of a greater systematic failure of how nursing empowerment is promoted and maintained (Campbell et al., 2001; Loughlin et al., 2000). The phrase "there is only so much you can do", voiced multiple times within focus groups, represents a powerlessness and a perceived inability of nurses to care for their patients any more than they are subjectively capable of doing within their organisation, or from their training. Lawler (1991) asserts that nursing is a discipline that primarily focusses on individuals' embodied existence, emphasising that nursing knowledge is integrative of the objective and subjective experiences that comprise human life, which are then channelled into care. This intimate and powerful knowledge that makes the discipline of nursing among the most trustworthy of professions (Roy Morgan, 2017) is historically found to be subjugated to medical knowledge, as nursing is relegated to "dirty work" or "women's work" (Ashley, 1976; Porter, 1992; Miers, 2000). Kagan and colleagues (2010) stress the intertwining of power and knowledge being demonstrated by dominant groups determining the legitimacy of knowledge, which poses a significant problem to traditionally disempowered groups such as nurses even when knowledge held by these groups is arguably equally important. Nursing and feminist values are allligned in aiming to provide holistic care and integration of all parts of the human as equally valid for consideration (Cheek & Rudge, 1994; Brooks, 1997). For structurally supressed groups such as nurses, disempowering forces must be addressed to allow empowerment of the knowledge embedded in caring to become available, and in facilitating this empowerment, individuals can change the very social structures that construct their subjectivities (Cheek & Rudge, 1994; Code, 1991; Weedon, 1987). Participants' reliance on accessing their empowerment, or the selected skills that were empowered by their organisations, to maintain positionality within the FG became apparent in their discursive construction of emergency nursing and, in effect, their positions as providers of care to a specific "type" of patient (and exclusively to that type).

The quality of ED care is defined by economic and political factors shaped by business values that nurses strain to uphold for those in power whose interests are hidden and often separate from nursing interests (Melon et al., 2013; Murray et al., 2007). ED nurses' inability to perform the social justice components of their profession due to the positions afforded by economic rationalism creates stress on nursing values, which in turn disenfranchises nurses, and effectively hides knowledge (which cannot be commoditised) that nurses are not empowered to use (Melon et al., 2013). The

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"there's only so much you can do" discourse can be seen to enable nurses to take up positionalities within the discourse of active disempowerment. Subjectivities are afforded that remove nurses from accountability toward their patients, invariably shifting risk away from nurses to women seeking help for IPV. This power dynamic poses a significant challenge given the statistics that see women who have experienced IPV largely presenting to EDs, and by extension nurses, when exhibiting help seeking behaviours.

Participants explored their prioritisation by likening "other" or implicitly lesser patients, as anything other than the medically unwell; for example, people who experience "elder abuse". In distancing themselves from arguably equally legitimate emergency patients due to the structurally enforced disempowerment of their knowledge, nurses create and police professional boundaries between themselves and their patient. In taking ownership of this available subjectivity that nursing only cares for the medically unwell, nurses ignore the other positions available to them within their profession; their entrenchment into the objectivity of their role obscures other subjectivities that are on offer (Murray et al., 2007). The ideology of 'medicalised' nursing shifts the role, and subsequent power, of caring for 'non-emergency' patients to other services, such as a "General Practitioner" (GP) or "outpatient services". The sentiment in the *patient redirection* discourse highlights the key insight that nurses do not make themselves available as the 'right kind of help'. In choosing not to acknowledge their capacity to challenge the construction of the very structures that govern them, nurses further allow themselves to be governed by, and exist within, a system that dictates their knowledge and their capacity as nurses to care for their patients. In effect, nurses' creation or acceptance of boundaries between the knowledge they wish to take ownership of, and the knowledge they are permitted to take ownership of, subsequently disempowers nurses and the culture that nurses practice within. In erecting boundaries, nurses *hide* within the confines of the structures that govern them, restricting their own professional capacity to care for women who have experienced IPV.

Limitations and Recommendations for Future Research

Understanding nurses' capacity to care for women who have experienced IPV requires a comprehensive understanding of nursing subjectivities that the scope of this research was limited in its ability to investigate. While this study has opened a discussion on the idea that the capacity of nurses to care largely relies on the importance their institutions place on the problem of IPV, the subjectivities of nurses that contribute to this capacity would warrant further research such as long-term studies, or follow-up evaluations. Past history of IPV and/or trauma in the lives of nurses themselves, which have complex interctions with their undestandings of violence, has the potential to influence the findings of this paper. This is an important avenue for future research but was not within the scope of this study.

The training that participants received on IPV was unable to be reviewed in this study. A review of participants' training (whether training was intended only for screening tool implementation) within the FGs may have provided additional verification of the training programs that were described and discussed by participants. Understanding relevant organisations' purpose for training nurses and the sufficiency of this training in preparing nurses for practice would provide further insight into the structural violence healthcare systems enact on nurses. Although we focused on two prevalent overarching discourses for the purposes of this paper (training and boundaries), it must be noted that there were multiple intersectional discourses that occurred within the FGs that were excluded from this paper, which would certainly warrant further analysis and interpretation within a separate body of work, such as a continuations of this discourse analysis, or the inclusion of perspectives from a larger cohort of nurses with diverse experiences on IPV.

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Recommendations for Practice

Findings suggest a need to address/amend the current approach to training nurses to appropriately care for women who have experienced IPV. The capacity of nurses to care for women who have experienced IPV is bound by the institutionally recognised role of nurses and the subjectivities they are permitted to assert within this role. The factors that contribute to the formation of nursing subjectivities that remove nurses from accountability are required to be reconsidered if nurses are to be professionally equipped to care for women who have experienced IPV, and instead replaced with innovative strategies that challenge nurses and allow the formation of new subjectivities. In empowering nurses to break down the contradictions between their subjectivities as nurses, and the structures that govern them, nurses and women who have experienced IPV can share a mutually beneficial approach to IPV, thereby improving attitudes and knowledge rather than questioning their nature or source.

A system change model of training nurses that focusses on enabling and facilitating nursing knowledge rather than designating or ranking this knowledge has shown merit within the textual data (see Male 1). Changing the training on IPV in EDs and, by extension, the discourse within EDs that empower nurses to think critically, use clinical skill, and take accountability for their patients may contribute to a shift in the management of women who experience IPV at a systemic level (i.e. training that focuses on help-seeking behaviour patterns within the context of the statistics of IPV within Australia; positive reinforcement and feedback for providing a care pathways for women rather than feedback on rates of screening; EDs continuing to establish working relationships with women's shelters and ensuring understanding of appropriateness in referring patients).

Consciousness raising education and training of nurses on IPV can work to allow nurses to understand the context of violence and position nurses to be active members in creating social change, framing their care as an ethical responsibility rather than merely clinical load. This has the potential to be achieved through values clarification education, where nurses have the opportunity to establish their values on IPV and are prompted to challenge any contradictions that may exist within their values. This model of values clarification education is offered in Figure 1 by Varcoe and Wathen (2017). In discouraging nurses from hiding behind their constructed inability to care, nurses may be facilitated to take up positions of power within discourse that bring forward the injustices that women face to an arena where social accountability is a value of nurses' practice.

Conclusion

Findings of this study suggest that current methods of IPV training not only remove the needs of women from sight, but the needs of nurses. Future training is recommended to focus on the needs and requirements of nurses who are asserted to be the most influential providers of care to women who have experienced IPV as they effect the direction a woman's care could take.

The health system's duty of care to women who have experienced IPV lies with ensuring that frontline clinicians, particularly nurses, are readied to care for these women. Education and awareness is the starting point to facilitating this change; however, it becomes problematic when nurses' values and consciousness are left out of the conversation and remain unchallenged. Bringing such consciousness into the core of nursing education on IPV, and the positions this education hopes to develop, is essential in bringing issues hidden in plain sight to innovations in nursing practice and the discipline.

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