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Teixeira da Silva, J.A. (2018d). PubMed Commons closure: a step back in post-publication peer review. *AME Medical Journal* 3: 30. DOI: 10.21037/amj.2018.02.07

Teixeira da Silva, J.A. (2018e). Reflection on the Fazlul Sarkar vs. PubPeer ("John Doe") case. *Science and Engineering Ethics* 24(1): 323-325. DOI: 10.1007/s11948-016-9863-1

Teixeira da Silva, J.A., Dobránszki, J. (2018) Editors moving forward: stick to academic basics, maximize transparency and respect, and enforce the rules. *Recenti Progressi in Medicina* 109(5): 263-266. DOI: 10.1701/2902.29244

Teixeira da Silva, J.A., Dobránszki, J., Al-Khatib, A. (2016) Legends in science: from boom to bust. *Publishing Research Quarterly* 32(4): 313-318. DOI: 10.1007/s12109-016-9476-1

Teixeira da Silva, J.A., Shaughnessy, M.F. (2017) An interview with Jaime A. Teixeira da Silva: insight into improving the efficiency of the publication process. *North American Journal of Psychology* 19(2): 325-338.

Silence in Violence: A curse or a Goodwill?

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Abstract

Healthcare professionals face dilemmas regarding maintaining and breaching confidentiality while dealing with victims of sexual violence. The sensitivity of the cases of violence and the aim to prevent harm generates ambiguity for sound ethical and legal decision making. In Pakistan, maintaining silence is often preferred over breaking the silence. Thus, it is essential to view the risks and benefits of the conflicting positions keeping in mind the diverse perspectives and the bigger picture. Organizations, community and government can plan different strategies to put an end to this obscene game of "silence in violence".

Description of the issue

"Ssshhh… Don't talk about it! It is better to remain silent!" Sexual violence and intimate partner violence are always tagged as hush-hush phenomena in Pakistan (Ali & Khan, 2007). A survey by Human Rights identified that approximately 90% of females in Pakistan have faced some sort of abuse, among which 60% is related to physical abuse and almost 30% is reported as sexual abuse. However, due to the conservative and patriarchal societal system and lack of proper ethical-legal policies, the victims tend to keep the sexual violence confidential; therefore, it remains under-reported (Abugideiri, 2010; Pakeeza, 2015). Victims try to mask the occurrence of sexual violence through other vague reasons, and if a healthcare professional (HCP) identifies the case, patients force them to keep it confidential because of the fear of stigmatization and lack of socio-legal support (Andersson et al., 2010). However, few of the policies and laws like 'domestic violence bill and prevention of anti-women practices' encourage the citizens to report such events (Weiss, 2012). HCPs face dilemma regarding maintaining and breaching confidentiality of such sensitive events as reasonable ethical decision making is quite ambiguous in these situations. One of the clinical scenarios is described below.

A 20 year old female patient was admitted to a general surgery ward with rectal perforation. Further examination revealed multiple lacerations and cuts on her whole body especially on the breast and abdomen. Her husband said that few days ago patient fell down in the bathroom so these marks were due to the traumatic fall. However, on detailed interaction with the patient, the nurse identified that it was a case of intimate partner violence portraying physical as well as sexual abuse. Patient asked the nurse to keep this information confidential. The nurse was concerned about the patient so she shared this with higher authorities. The management paid no heed and insisted her to focus on nursing care. The nurse then tried to advocate for patient's right by talking with patient's mother about it. However, this created a chaos when patient's husband came to know about this situation. He filled the LAMA (Leave Against Medical Advice) form and discontinued his wife's treatment. Moreover, an observation was filled against that nurse by the management.

The ethical questions that arise from the above-mentioned scenario are: Does the duty to warn supersede the duty to maintain confidentiality of the victims? Does patient's safety override the principle of fidelity towards patient? Does breaching confidentiality rationalize beneficence or infringe on the principle of non-maleficence? Does one's job security outweigh one's responsibility of patient's advocacy? This paper will reflect on the scenario from diverse paradigms and find justifications based on ethical principles and theories.

Our position

We believe that in the aforementioned scenario and other similar circumstances remaining silent and maintaining confidentiality is ethically unjustified. The HCPs should breach the confidentiality in order to protect the patient from foreseeable preventable

harms and to put an end to this vicious cycle of "maintaining silence and promoting recurrent violence".

1) Confidentiality versus duty to warn

Privacy is the basic right of every individual that allows them to control their personal information, whereas confidentiality is a branch of informational privacy that highly demands non-disclosure of private information of patients by the HCPs (Burkhardt & Nathaniel, 2013). Liberalism theory also highlights that an individual is unique and is free to make decisions. Thus, the victims of violence can unrestrictedly make decisions and take choices regarding their privacy based on their values and beliefs, and it would be unethical to disclose patient's sensitive information without their consent. On the other hand, HCPs are obliged to warn individuals at risk. Thus, for the beneficence of vulnerable population, it is necessary to breach confidentiality (Burkhardt & Nathaniel, 2013). For instance, in this scenario, not warning the family members and the victims about the future risks could lead to more incidences of sexual violence, unstoppable harm and even the incidences of incest by the abuser. Duty to warn is based on two factors: (i) Potential threat (ii) Potential victims. In the scenario, both factors are foreseeable; therefore, breaching confidentiality is also justified.

The consequence of our position: Universal Declaration of Human Rights (1948) and the constitution of Pakistan (1973) clearly affirm that every individual's decision should be respected and they should be protected from undignified actions. Patient's ability to maintain privacy is an expression of autonomy, which safeguards their dignity (Beauchamp & Childress, 2013); breach in confidentiality of these victims may question the corresponding virtue of respectfulness. It may lead to stigmatization and loss of social relationships due to the taboo attached to sexual violence.

Counter argument for justification: In Pakistani culture, people live in extended families; thus the incidences of intimate partner violence not only affects the primary victim but also threatens the physical, social, emotional and mental state of other people in the family including children and elderly people (Ali, Asad, Mogren & Krantz, 2011; Widom & Wilson, 2015). Hence, dignities of all other family members' precious lives are under control of a single perpetrator. Utilitarianism theory asserts that maximum benefit (happiness) for maximum people is always at an upper hand than an individual's priority. It clearly justifies breaching confidentiality of a sexual violence case in order to warn a larger group of people at risk to prevent recurrent harm (Beauchamp & Childress, 2013).

2) Fidelity versus patients' safety

Confidentiality is one of the key aspects of patients' care mentioned in both the Hippocratic Oath and the Nightingale's pledge (Beauchamp & Childress, 2013). Thus, obligations of fidelity arise once an HCP builds a therapeutic relationship with a patient. Victims of violence are highly distressed; therefore, the role of HCPs is very crucial to rebuild their trust and to provide psychosocial support to them. This can be accomplished when the HCPs show trustworthiness by maintaining confidentiality. In contrary, HCPs are obliged to ensure patients' safety for patients' beneficence. The argument of maintaining strict confidentiality could be questioned based upon the probability and magnitude of a preventable harm. According to risk assessment criteria cited in Beauchamp and Childress (2013), if the probability of harm is high and the magnitude is major, then confidentiality could be breached (refer to appendix 1). In the case scenario, there was a high probability that patient could get abused physically and sexually after getting discharged from the hospital which could result in recurrent major psychological, physical and emotional harms, hence, confidentiality should be breached.

Consequence of our position: Breaching confidentiality could break the fiduciary relationship between HCP and a patient (Burkhardt & Nathaniel, 2013). Thus, the overall system of medical confidentiality and fidelity could get eroded. Hence, victims of sexual violence would never disclose sensitive information and would never opt for treatment despite the medical emergencies caused by violence (Ali & Khan, 2007). Furthermore, defying fidelity could also infringe on the principle of non-maleficence by creating an additional threat to the already compromised emotional and psychological well-being of the victim.

Counter argument for justification: Overriding fidelity may serve as a short-term source of maleficence for the patient; however, taking actions for beneficence may prevent harm and promote good for a long run. Females in Pakistan are financially and physically dependent on their husbands; therefore, the probability of recurrent violence is very high (Chatha, Ahmad & Sheikh, 2014). Islam also refers to sexual violence and intimate partner violence as "*Zina* and infliction of harm" respectively, and guides us to take actions to save one's life (Abugideiri, 2010). Hence, breaching confidentiality for the victim's beneficence may prevent the victim from life-long recurrent physical, psycho-social and emotional harms caused by

intimate partner violence, and it could also reduce the burden of hospital re-admissions. Thus, the principle of beneficence outweighs the duty to keep promises in this situation.

3) Job security versus patient's advocacy

Moral standards are of two types. Ordinary moral standards are the obligations of common morality that pertain to every HCP working in an organization, whereas extraordinary moral standards are the supererogatory acts that are performed by the HCPs who aspire to achieve moral ideals altruistically (Beauchamp & Childress, 2013). Unfortunately, the institutes and the healthcare systems in Pakistan are not flourished enough to demarcate the fine line between obligations, ordinary moral standards and moral ideals (Syed,2012). The hospital-based policies and top management force HCPs to just stick to their obligations and criticize them to perform supererogatory acts at times and vice versa. In our healthcare system, job description confines nurses to routine care activities and prohibits them from indulging in legal and personal matters like sexual violence. In the case scenario, although the nurse was criticized by the management, she altruistically advocated for the patient by going against the policies of the organization. Consequently, an observation was filled against her. Thus, these types of repercussions compel HCP to think about their job security and associated personal consequences rather than performing supererogatory tasks for patients' benefit.

In contrast, Kantianism theory emphasizes on rationales and reasons of an act rather than relying purely on consequences. Kant believes that an HCP's actions depend on his/her maxims that can be justified through categorical imperatives (Beauchamp & Childress, 2013). If HCPs do not advocate for their patient in order to save their job, then, do those HCPs believe that someone would advocate or care for them when they are in need? Will those HCPs presume that somebody would act to prevent them from foreseeable harm? Obviously not! Hence, advocacy should be given priority over personal means.

Consequence of our position: There is a threat to job security of HCPs because of unclear job descriptions and obligations. Due to the repercussions faced by the nurse in the scenario, nobody would take charge to talk about such issues in healthcare when faced with similar situations. Moreover, due to lack of ethical and medico-legal policies in an institution as in the mentioned case scenario, the abuser may deny the truth and may show his/her dominancy over the victim. As in this scenario, the husband discontinued his wife's treatment. Likewise, the abuser may threaten the HCP who reported the incidence of sexual abuse. Therefore, safety of the HCP is equally important as of the patient.

Counterargument for justification: It can be deduced that HCPs prefer to remain silent due to organizational constraints and lack of policies. Hence, it is an organizational issue rather than HCP's fault. However, advocacy for the victims of sexual violence is one of the fundamental duties which lie within the holistic care model of nurse-patient therapeutic relationship and it is an act that can easily become a universal imperative as per Kant (Burkhardt & Nathaniel, 2013). Thus, in this case advocating for the patient is justified as it is embedded in nursing and medical ethics. Hence, the application of Kantian ethics vindicates that it is unethical to remain silent over preventable harmful conditions for patients.

Recommendations for implementation

According to WHO's world report on sexual violence (n.d.), the following interventions could be strategized at organizational, community and governmental levels. Organizations must work in a coherent way so that patients and HCPs both can trust the system; therefore, hospitals must develop an ethics committee that should solve medico-legal and ethical issues. All HCPs should be trained to identify the potential cases of violence, to assess the victims and to handle these situations in a sensitive yet effective manner. This should be included in the nursing and medical curriculum as well. Besides, hospitals should have "sexual violence evidence kits" that include instructions for collecting medico-legal evidence and legal forms for proper documentation. Furthermore, a trio approach should be considered when dealing with victims. This includes emergency care nurse/doctor, hospital ethics committee and psychologist. Victims must be counseled regarding potential harm and the ways to deal with a situation. Moreover, hospitals must collaborate with legal authorities so that legal proceedings could be done against the perpetrator. Additionally, rather than criticizing, the institution must appreciate the HCPs who advocate for victims of abuse and organizations should provide job security and safety to its employees too.

At the community level, community-based projects should be run to empower victims. Life skills and other educational programmes should be initiated and men should be involved in such activities to support women. The stigma attached to the victims can be erased via community-based theatres, debates, public meetings and media. Community health nurses could propose psycho-social support programs and referrals for the

patients. Additionally, centers for providing comprehensive care to the victims could be established. Also, a helpline number could be initiated, where a victim can anonymously ask for help and opt for further guidance. Besides, exploratory researches should be done to dig out culturally sensitive solutions and to plan interventions accordingly.

Government must make strict laws and reforms for reporting abuse and must provide assistance and support to the victims. The sensitivity and speed of processing of sexual violence cases should be improved in the courts. Moreover, government based legal authorities should be linked with each and every hospital and it should consist of men and women both, so that victims could approach them according to their comfort and feasibility. Additionally, media should be discouraged to disclose the confidentiality of the victims for the sake of generating breaking news; however, perpetrators should be exposed. Furthermore, media should raise awareness regarding existing policies formed by the government such as "law for protection of women and a domestic violence bill". Last but not the least, the government should ensure the rigorous implementation of these policies and programs.

Conclusion

Various ethical, legal, and sociocultural perspectives create a dilemma for HCPs dealing with victims of sexual violence. The sensitivity of the cases of violence and the aim to prevent harm generates ambiguity for sound ethical and legal decision making. Thus, it is essential to view the risks and benefits of conflicting situations keeping in mind the diverse perspectives and the bigger picture. Organizations, community and government play an important role in providing social, financial, psychological and legal support to the victims, erasing the stigma of being a victim and providing job security to the HCPs in order to put an end to this obscene game of "silence in violence".

References

Abugideiri, S. (2014). A perspective on domestic violence in the Muslim community. *Faith Trust Institute*, *6*(11), 2014.

Ali, T. S., Asad, N., Mogren, I., & Krantz, G. (2011). Intimate partner violence in urban Pakistan: prevalence, frequency, and risk factors. *International Journal of Women's Health*, *3*(1), 105.

Ali, T. S., & Khan, N. (2007). Strategies and recommendations for prevention and control of domestic violence against women in Pakistan. *Journal of Pakistan Medical Association, 57*(1), 27-32.

Andersson, N., Cockcroft, A., Ansari, U., Omer, K., Ansari, N. M., Khan, A., & Chaudhry, U. U. (2010). Barriers to disclosing and reporting violence among women in Pakistan: findings from a national household survey and focus group discussions. *Journal of Interpersonal Violence*, *25*(11), 1965-1985.

Aumir, Z. (2016). Domestic violence In Pakistan: Is legislation available? *The Law*, *1*(1), 347-349.

Beauchamp, T., & Childress, J. (2013). *Principles of biomedical ethics,* (7th ed.). New York, NY: Oxford University Press.

Burkhardt, M. A., & Nathaniel, A. (2013). *Ethics and issues in contemporary nursing,* (4th ed.). Delmar, Austrailia: Nelson Education.

Chatha, S. A., Ahmad, K., & Sheikh, K. S. (2014). Socio-economic status and domestic violence: A Study on Married Women in Urban Lahore, Pakistan. *South Asian Studies*, *29*(1), 229.

Pakeeza, S. (2015). Domestic violence laws and practices in Pakistan. *Transactions on Education and Social Sciences*, *6*(1), 17-20.

Syed, A. (2012). Decline of moral values. *Daily Times*. Retrieved from https://dailytimes.com.pk/109500/decline-of-moral-values/

United Nations (1948). *Universal* https://dailytimes.com.pk/109500/decline-of-moral-values/*declaration of human rights* (pp.1-4). United States: UN General Assembly.

Weiss, A. M. (2012). *Moving forward with the legal empowerment of women in Pakistan* (pp. 1-12). United States: US Institute of Peace.

WHO. (n.d.). *World report on violence and health: Sexual violence* (pp. 149-173). Geneva, Switzerland: World Health Organization.

Widom, C. S., & Wilson, H. W. (2015). Intergenerational transmission of violence. In J. Lindert & I. Levav, *Violence and mental health* (2nd ed., pp. 27-45). Switzerland, Dordrecht: Springer Link.