



Ethical challenges in dealing with gender-based violence in the Primary Care Setting

Gender-based Violence and Primary Health Care Group
of the Catalan Society of Family and Community Medicine (CAMFiC)

Ethics Group
of the Catalan Society of Family and Community Medicine (CAMFiC)



Drafting Committee:

Joan Atmetlla Andreu
Pilar Babi Rourera
Clara Calleja Vega
Carme de Castro Vila
Esperanza Díez Fuentes
Montserrat Espuga Garcia
Aurora Rovira Fontanals

Gender-based Violence and Primary Health Care Group of the CAMFiC

Joan Atmetlla Andreu
Pilar Babi Rourera
Clara Calleja Vega

Noemi De Miguel Llorente
M. Esperanza Diez Fuentes
Margarita Español Garrigos
Montserrat Espuga Garcia
Maria Isabel Fernandez
Delgado
Hubert Foulon
Ana Gómez Saldaña
Núria Querol i Viñas
Manel Recasens Boada
Elisabet Martorell Sole
Cristina Muñoz Lopez
Gloria Ortiz Bordanova
Francesca Peñas Lopez

Anna Roig Campo
Aurora Rovira Fontanals
Isabel Villar

Ethics Group of the CAMFiC

Joan Atmetlla Andreu
Carme de Castro Vila
M. José Fernández de Sanmamed
Santos
Roser Marquet Palomer
Ramón Morera Castell
Eva Peguero Rodríguez
Albert Planes Magrinyà
Miquel Reguant Fosas
Marisa Rubio Montañés

Members of the group during the preparation of the paper:

Carmen Adalid Villar
Lluís Balagué Gea

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Ethics Group Experts

Noe Amorós
Carme Batalla
Isabel Buezo
Eva Comin
Carles Llor
Carme Prieto
Jesús Pujol
Aurora Rovira
Montserrat Soler
Pedro J. Subías
Ana Vall-Ilossera
Rosa Vila
Francesca Zapater

Reviewers of the paper

Núria Beitia Hernández

*Psychologist
Lecturer at Duoda (Women Center for
Research at the University of Barcelona)
Co-Chair of the Master's Degree Program in
Studies of Sexual Difference (Duoda - UB)*

María Casado

*Director of the "Bioethics and Law
Observatory" and Director of the UNESCO
Chair in Bioethics at the University of
Barcelona*

Heinrich Geldschläger

*Psychologist and psychotherapist, Conexus
Association*

Itziar de Lecuona

*Doctor of Laws
Prof. Dept. Public Health, School of Medicine
Researcher at the Bioethics and Law
Observatory
UNESCO Chair in Bioethics at the University
of Barcelona.*

Beatriu Macià

*Therapist Specializing in the Care of Battered
Women at Tamaia*

Francesca Puigpelat Martí

*Professor of the Philosophy of Law at the
Autonomous University of Barcelona*



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INTRODUCTION

The reason for this paper

In 2008, the symposium that the Gender-based Violence and Primary Health Care Group of the Catalan Society of Family and Community Medicine (CAMFiC) holds annually to commemorate the International Day for the Elimination of Violence against Women, on November 25th, was devoted to the ethical challenges to gender-based violence care. Two issues were discussed: what to do when the woman does not want to report the violence and the difficulties that arise when the aggressor and the victim are treated by the same person.

The idea for the paper we are presenting here originated during the discussions and from the impression that, although there has been much talk about this issue, it has not received much formal attention, therefore it was put together by the Gender-based Violence and Primary Health Care Group and the Ethics Group of the CAMFiC. In the document we deal with the two topics that came up during the symposium plus a third topic that deals with recording information on abuse, although it is not our intention to exhaust all of the possibilities of reflection generated by the issue of violence and related ethics.

The list of potential topics is very extensive. Among those that we could leave for discussion at another time are:

Specific ethical issues regarding gender-based violence against adolescent girls, older women and immigrant women:

Violence against minors raises specific ethical issues. For example, it is necessary to remember that in our country 16 is the age of legal capacity in health care matters and that for adolescents under that age there is the "mature minor" figure. With regard to elderly women and immigrant women, although some issues are touched upon in this paper, a deeper and more extensive analysis could be performed.

When female doctors are subjected to gender-violence or male doctors are abusers:

Theoretically speaking, these situations are frequent because the percentage of women who are mistreated and men who are abusive should in principle be representative of the general population to which the individuals belong, but there are no studies that document this issue. The implications of such situations in the

health care workplace and in the doctor-patient relationship have yet to be analyzed.

Institutions that do not incorporate gender perspectives:

Personal responsibility cannot substitute for institutional accountability, and institutional victimization can hardly be compensated by a practitioner's goodwill.

Treatment of gender-based violence requires a multi-disciplinary approach:

While a team-based approach is now necessary in just about every field, it is especially so in matters concerning gender-based violence; that raises ethical concerns with regard to records, coordination, confidentiality, etc.

This is a discussion paper, it does not document what resources are available, as these vary throughout our region, nor is it a procedural document: we aim to highlight and analyze the ethical conflicts that arise when providing care to women suffering from gender-based abuse and the men who mistreat them and, in particular, to propose ways to continue giving care rather than to try to propose solutions. To further explore the topic of gender-based violence, please refer to the CAMFiC 2012 book published by the Gender-based Violence and Primary Health Care Group, entitled "Violència de gènere i atenció primària de salut: una visió des de la consulta" [*Gender-based Violence and Primary Health Care: as seen from the doctor's perspective*].(1)

The structure of the paper

In addition to the three chapters mentioned above, we have included a glossary of the terms that are most commonly used when referring to gender-based violence. As the meanings we have chosen may influence the reading of this paper, the glossary appears immediately after this introduction.

At the end of the paper there are a number of key points that follow the structure of the text and can be used both as reading guide as well as a synthesizing summary after the longer document has been read.

In addition we have written a summary document, published as a separate text, which is intended to be self-explanatory and to give the keys to the longer document without being necessary to read it.



Final thoughts

It must be clear from the outset that caring for women who are victims of abuse takes time: the recollections and reflections on the decisions to be taken, among other things, require time. It is also necessary to take time for coordination with healthcare and non- healthcare services (e.g. with the courts). The process of getting out of an abusive relationship does not happen in a single visit, here too time is necessary.

It is our responsibility to organize the time assigned to the different duties we have in and out of the practice. Making sure that the organizational and human resources necessary to provide proper assistance are available is the management's responsibility.



GLOSSARY

Structural inequality: Our culture has shaped social and cultural differences between men and women to turn biological differences into hierarchies of power. This structural quality makes it difficult to visualize inequality and violence, including in the medical profession.

Empowerment: The deed of granting power to a group so that they may use their own means to improve their living circumstances. When dealing with cases of gender-based violence, it means enabling women to regain control over their own lives.

Ways of abusing women within a couple (1):

- Emotional abuse: hostile behavior, contempt, indifference, belittling, forcing the partner to do things that are humiliating or that go against their principles, and exhibiting controlling behavior (controlling friendships, way of dressing, where the partner is at all times, etc.). Emotional abuse is always present, so it must be kept in mind when dealing with any type of abuse. Its effects are more severe and longer lasting than most types physical abuse.
- Physical abuse: shoving, hitting, slapping, attempted strangulation, burning, assaults with objects or weapons, and so forth.
- Sexual abuse: spousal rape, non-consensual sex, lack of responsibility for birth control or for preventing transmission of STDs.
- Verbal abuse: insults and putdowns.
- Financial abuse: exclusive control over money, use of the family resources for personal gain, and preventing the woman to become financially independent (e.g., limiting access to work).
- Assault or threats to pets or damage to goods and property.
- Threat of harm and/or death to the woman herself or the children, or threatening to commit suicide (the abuser).



- Social isolation: any strategy to limit personal movement and relationships.

Abuser, aggressor, perpetrator: someone who inflicts any type of abuse. In the case of gender-based violence, the victim's partner or former partner.

Restraining Order: court ruling - or preliminary injunction - prohibiting the aggressor from going near the victim or to any of the places normally frequented by the woman.

Ethical guidelines: The four classical principles are: Beneficence, Non-maleficence, Autonomy and Justice. We have adapted the definitions contained in the CAMFiC's Ethics Group's paper called "L'autonomia, el dret a decidir" [*"Autonomy, the right to decide"*] (11): <http://www.camfic.cat/CAMFiC/Seccions/GrupsTreball/Docs/etica/autonomia.pdf>

- **Beneficence:** "Doing good", the moral obligation to act for the benefit of others. Heal the damage and promote good or well-being.
- **Non-maleficence:** This is the principle of "primum non nocere". Do no harm, and prevent it from happening. It includes not killing, not causing unnecessary pain or suffering, not causing any disabilities, not causing any damage.
- **Autonomy:** A person's ability to think and act freely, consciously and voluntarily, to achieve their goals and communicate them to others, accepting the consequences for their own actions. Autonomy is a dynamic characteristic, which changes in the degree (that may increase or decrease) at different times in a person's life. Total autonomy, like perfection, does not exist.
- **Justice or Fairness:** Equality in the distribution of burdens and benefits. It includes the rejection of discrimination on any grounds. Some of the specific issues covered by the principle of justice are the allocation of resources and also, the rights of others.



Victim: a person suffering from abuse, whether directly (battered women and their children) or indirectly (particularly children who witness the mistreatment of their mother). There have been some voices calling for alternative terms, such as "survivors", to describe battered women, to emphasize women's abilities.

Victimization: is the process that women suffering from gender-based violence undergo that causes them to not recognize the abuse, to feel guilty about what is happening, to lose their autonomy, their ability to make decisions and their social support system. It is not to be confused with the colloquial expression "playing the victim".

Secondary victimization: This occurs in the relationship between the victim and the health system, the police, the judicial system or society in general, which should be protecting her and fail to do so, whether actively or passively. For example, when the abuse is not recognized, the victim is blamed or the damage done is minimized, etc. It is also sometimes called revictimization.

Gender-based violence, male violence, violence against women: There are some conceptual distinctions between Spanish and international law, mainly with regard to the scope of the range of violence, which both in the UN declaration and under Catalan law refers to "any sort of discrimination against women in society", whereas the Organic Law of 2004 refers to "violence in the couple's relationship". In this paper we refer to gender-based violence in the latter sense: the violence that women experience in their relationship with their partner or former partner.

The 1993 United Nations General Assembly Resolution established that male violence "means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

Article 3 of Law 5/2008, of 24th April, of the Autonomous Community of Catalonia, on the right of women to eradicate male violence (20), states that: "With regard to this law, what is understood by *Male violence* [is] violence that is perpetrated against women as a manifestation of discrimination and the situation of inequality in the framework of a system of power relations of men over women and which, produced by physical, economic or psychological means, including threats,



intimidation and coercion, results in physical, sexual or psychological harm or suffering, whether it is produced in the public or private environment".

Article 1 of Spain's Organic Law 1/2004 of 28 December on Measures for Comprehensive Protection against Gender-based Violence (24), states that: "The purpose of this Act is to combat the violence exercised against women by their present or former spouses or by men with whom they maintain or have maintained analogous affective relations, with or without cohabitation, as an expression of discrimination, the situation of inequality and the power relations prevailing between the sexes".

I. THE DIFFICULTIES OF REPORTING GENDER-BASED VIOLENCE TO THE JUDICIAL SYSTEM.

Before beginning this chapter we want to clarify that physicians who treat battered women often use the term "complaint" to mean the act of reporting the facts to the justice system through the injury report. In this chapter we will try to correct the misunderstanding and will use the terms "complaint or press charges" to designate the action whereby the battered woman or her relatives seek action from the justice system. We will call the filing of an injury report "notification" or "report to the law enforcement authorities".

CASE REPORT:

Maria is a 19 year old Ecuadorian woman who has been living in Barcelona for one year. Thirteen weeks pregnant, she lives with her partner in a shared flat.

She visits the Health Center for the first time for pregnancy-related discomfort. There she is given counseling on health and pregnancy: toxic substances, drugs, detection of abuse.

Two weeks later she visits her doctor again and gives her a report from the ER where she was treated a few days earlier for abdominal pain. She tells her doctor the injury was caused by an earlier assault by her partner, who threatens to take the baby away from her as soon as it is born. The physical examination shows she has a hematoma in the parietal region and several bruises and she is very anxious. The patient told the ER staff that the injuries were caused by an accidental fall.

She mentions some other less rough assaults and denies being sexually abused. She does not work outside the home. She has very little social support as she immigrated only recently, does not work and has no other relatives in our country.

She is afraid because of her illegal immigrant status: she's afraid she might be arrested, afraid of being expelled. As she does not perceive herself to be in imminent danger of suffering further attacks, she does not wish to press charges, despite her doctor's advice.

After assessing the risk, the doctor agrees to delay filing an Injury report, provided that the patient maintains contact, with the intention of allowing her to examine her goals and find the means necessary to carry them out: to protect the baby, acquire financial independence, a safe place to live, press charges, separate from her partner, etc.

With Maria's agreement, the doctor contacts the gynecologist and social worker to alert them to the risks of her pregnancy, the occurrence of new attacks and the need to improve her lack of social support. The Social Welfare services offer her specific programs for women who experience abuse.

A few days later the doctor sees the woman has no intention of making any lifestyle changes and, after considering her position of vulnerability in the coming months and the risk to the baby, talks to her, explains the legal obligations she has as a health care professional and tells her that she is going to file a report with the court.

Maria changes doctor and health center.

What to do if the woman does not want to file a complaint is the question that we continually ask ourselves, the first one that comes up in training courses. It is a question that causes anxiety in everyone who attends to women in abusive situations, and a bone of contention between institutions. From our health care perspective, we shall try to delve further into the subject by analyzing what we are afraid of, where the conflict between health care and law enforcement arises from, and at the end, propose alternatives that can be used to continue caring for these women without getting tied up in knots over whether or not we should file an Injury Report with the court. It is necessary to insist on the fact that filing an Injury Report does not terminate the health care process, which is aimed at getting the woman to set goals so she can remove herself from the abusive situation and receive whatever help she needs (1) (30).

WHAT ARE WE AFRAID OF WHEN A WOMAN DOES NOT WISH TO PRESS CHARGES AND ASKS US NOT TO NOTIFY THE COURTS?

The problem of disagreement with the law causes the physician to find him or herself in a difficult situation: complying with the law clashes with the health professional's obligation to seek the patient's welfare and minimize harm, while respecting her autonomy (29).

When faced with this situation, one of the emotions that arises is fear: fear of what may happen to the woman. or to us if we decide to obey the law or to act in



the interest of the patient's health if the two conflict. Rather than trying to justify ethical decision-making based on fear, let us instead try to discern what drives us to act and what holds us back, using fear to guide us through the various issues.

1. Fear of what could happen to the woman ¹

Notify the authorities and objectively cause the worsening of the woman's lifestyle circumstances: A typical case often seen in primary care is low grade emotional abuse of an older woman, often with little victimization, in which a kind of relational equilibrium has been achieved over the years, although there may be some physical violence lurking in the background. If we act in accordance with the law, we must file an Injury Report or notify the law enforcement authorities. In this case, giving priority to notifying the authorities will probably lead to loss of income, loneliness, alienation from children and grandchildren, etc. and is probably not in the woman's best interest. And let us not get started on what the situation would be like if the woman is the caregiver for an ill perpetrator. In such a case she will first want to have an adequate assistance program, sufficient income, time off for herself to compensate for the inevitable wear and tear of providing someone with care, etc.

From an ethical perspective, in such circumstances, it seems to us that not filing a report would be less maleficent, more beneficent and more respectful of the woman's autonomy.

There are however other situations in which we may also cause the worsening of the woman's living circumstances, and these have little to do with the woman's age or whether or not she is an immigrant, as for example, when the woman is subjected to forms of psychological, sexual or economic abuse but does not identify them as such. In these cases a report too hastily filed can be harmful.

Notify the authorities and endanger the woman: Gender-based violence often follows a cyclic pattern. We know that violence will increase in intensity,

¹ Further reflections from the point of view of beneficence can be found below in the section entitled "Do we have to notify the authorities of everything we record as abuse?" in the chapter on "Gender-based violence: The need for keeping records, the difficulties with records".



until it reaches a high point after which there is a truce and reconciliation stage ("honeymoon"), and the cycle begins anew. This is what is called the cycle of violence (2).

From a strategic standpoint, the abuser is not "losing it" when he attacks the woman, but rather is strengthening or regaining control of the relationship. Any incident that the aggressor interprets as a loss of control will make him try to regain it by increasing the violence. Incidents that involve a loss of control include talking about the mistreatment with a friend, going to the city council's help point, speaking to a doctor about the abuse, etc. And filing a complaint or the intention to press charges also represent a loss of power and control. In this regard, it should be remembered that many deaths occur after the woman has separated or has announced that she wants a separation. When filing an Injury Report or notifying the legal authorities, it is essential to aid the woman in taking safety precautions until the courts are able to protect her. This situation can be especially difficult if we notify the authorities without the woman's consent as she will probably not take safety measures to protect herself from the aggressor.

If upon seeing the situation in which the woman finds herself, we think that filing a complaint could somehow increase the risk of aggression, we should consider the possibility of not notifying the legal authorities immediately.

From a broader perspective, we may also put the woman at risk if we file a report without first seeking adequate protection for her and her children when the cycle of violence is at a high point. In this case, apart from the fact that the notification may lead to an outbreak of violence, we want to emphasize the obligation to ensure a safe environment, as required by the Code of Ethics. Article 72 states that: *"The physician must never be involved in any act that entails the use of, or threat to use, torture or any other cruel, inhuman, degrading, oppressive or humiliating treatment. On the contrary, the physician has a duty to report any such treatment if he or she has knowledge of it. A physician who has knowledge of abuse that is gender-based or against children or persons with disabilities, or in general against any other person, must provide them with the means necessary for their protection and has the duty to notify the authorities as soon as he or she has ensured that the victim is protected to the extent possible"*. (3)



Notify the authorities and cause the expulsion of the undocumented immigrant woman: Since notifying the authorities reveals the woman's irregular situation, up until recently she could have treated like any other immigrant and expelled. The special vulnerability of women in this situation has been recognized by the amendments enacted to the Immigration Act in 2011, which protects women who press charges against an aggressor from expulsion. The protection includes their children and persons in their environment who could be affected by the complaint.²

Notify the authorities and cause the aggressor to be expelled: Expelling the aggressor eliminates the risk of future attacks but it can also cause new problems for the woman: loss of financial support, loss of the intermediary with the outside world, having to give up or redefine the life goals that have been pursued up to then, etc. One must also consider that there may also be retaliation against the aggressor in the country of origin and repercussions on the children, both here and in their native country.

A woman who files a complaint may not always correctly foresee the legal consequences of pressing charges. There are times when a woman hopes the aggressor will receive a warning from the authorities but in no way expects a judicial process that may result in a prison term or expulsion. Even non-immigrant women may have this type of expectation, depending on their previous experience and knowledge of our country's legal system.

Notify the authorities and lose contact with the woman and thus, the chances of helping her: To file a report against the woman's wishes may cause the therapeutic relationship to break down and the patient to not to return to see us, as happened in the case mentioned above:

A few days later the doctor sees the woman has no intention of making any

² News agencies. No expulsion proceedings will be brought against foreign women who press charges for abuse. Madrid : El Pais; 28 July 2011. Available at: http://sociedad.elpais.com/sociedad/2011/07/28/actualidad/1311804005_850215.html



changes and, after considering her position of vulnerability in the coming months and the risk to the baby, talks to her, explains the legal obligations she has as a health professional and tells her that she is going to file a report with the court.

Maria changes doctors and health center.

By losing contact with the woman we risk losing all the work that has been done with her. Data in the patient's medical history may well be retained, but everything else that was achieved through the relationship with the physician may be thrown away, and so will the work performed by the support network to which we belong. However, there are two consequences that are especially harmful to the woman's recovery: in the first place, as she feels that we have betrayed her trust in us, it will be more difficult for her to address her situation of abuse later on. Finally, the loss of contact with the health system leads to increased risk, that is, it makes her more vulnerable.

We need to be aware that in recent years, in the health care system we have gone from secondary victimization by questioning a woman's story, to secondary victimization by going over their heads.

Looking at it in another way, the relationship is essential to helping the woman regain the autonomy that is becoming more and more eroded the longer she is victimized. Pushing the woman to take decisions when she has not really regained a genuine capacity for decision making (devictimization) further erodes the woman's autonomy instead of strengthening it. Not to take the woman's will into account harms her because empowerment becomes both the strategy and the end goal.

Thus, committing to autonomous decision making amounts to providing the conditions necessary for restoring autonomy and actively working for it. This conception of autonomy goes beyond the narrow conception that is prevalent in



the healthcare field, as it incorporates the relationship and the consideration of a process as essential ³.

Therefore, we should not unconditionally accept just any request to not file a report with the authorities, nor allow ourselves to be guided only by considerations of whether or not it will put the woman and her children into jeopardy, but we do have to consider whether it contributes to increasing the degree of autonomy for a decision. As we already know, the healing process for women is very long and is measured in years. That is why we insist on what the Framework Document on Male Violence and Immigration published by the Department of Health of the Generalitat of Catalonia (5) repeats over and over again, even for cases of serious, violent abuse: *"Avoid hasty action. It may take a woman some time before she can recognize male violence and it is especially important to respect this time for the sake of her life processes. There are times when the woman will seem to be myopic and impervious, so taking hasty action without her consent may be counterproductive and weaken or break the bond of trust that has been established"*.

After assessing the risk, the doctor agrees to delay filing an Injury report, provided that the patient maintains contact, with the intention of allowing her to examine her goals and find the means necessary to carry them out: to protect the baby, acquire financial independence, a safe place to live, press charges, separate from her partner, etc.

Not notify the authorities and leave the woman and her children in the hands of the aggressor: Filing a complaint makes it possible for the authorities to act against the aggressor and in favor of the woman and children. This is the argument in support of the moral and legal obligation to file a report. Paying attention to the health issues, such as suspicious injuries or other signs of abuse

³ We also talk about care as a process in a chapter below on the topic of "When the abuser and the victim are patients at the same health care doctor's office". The idea of process is implicit in the interpretative and deliberative models in the physician-patient relationship proposed by Emanuel EJ and Emanuel LL in 1992. (4)



in the absence of physical signs, is not enough; we must also be aware that by notifying the authorities we can stop the aggressor.

Not notify the authorities and increase the woman's invisibility, especially if she is an immigrant: Mistreatment of women relies on a concept of privacy that makes a distinction between the public and private spheres, so intrafamily relationships are concealed from public interference, whether they are functional or dysfunctional, whether they are based on agreement or coercion. This has provoked that relationships based on the submission of women are regarded as a private matter.

Decades ago, the feminist movement claimed that "the personal is political". Since then, and along the same lines, our gaze has shifted and we have learned that structural inequality within the couple relationship makes women very vulnerable to abuse and it is necessary to limit the scope of privacy so it is not turned against women. A woman's freedom or her physical or psychological integrity cannot be put in jeopardy in the name of privacy. We should therefore strive to ensure that the home, in addition to being a shelter of privacy, is always a safe place for women. We note - as stated in Annex 2 of this paper: "Personal Stance With Regard to Violence: Structural Violence" - the need to modify the structure of relationships in order to build them under a code that does not include violence.

When dealing with immigrant women and, in general, whenever there are situations of inequality that cause greater dependence and vulnerability, there are several factors which together increase a woman's invisibility: financial dependence, limited opportunities for contact with the outside world (because the husband monopolizes the telephone or there are restrictions on movement outside the home), limited access to social and family relationships, less knowledge of "host" language than the husband, depending on the couple's country of origin, cultural values of the country of origin that are not always the same as those of the host country (related to maternity, hierarchy, family structure, loyalty to the group from the same country, etc.). On top of that, all these factors may hinder understanding and management of the violent situation from our part and limit our effectiveness.



Notification to the law enforcement authorities, which allows the violence in the relationship to become socially visible, can be especially beneficial in the immigration context.

2. Fear of what could happen to us

Up to this point we have discussed the risks of notifying the legal authorities when a woman asks us not to do so. However, we, the health professionals, what are we scared of?

Fear of being accused of not having filed a notification: Not to notify the authorities is risky. If there is an assault on the woman after we have decided to refrain from notifying the authorities, then we could be legally liable. Yet we will have taken that decision because we felt that the potential benefit for the patient was sufficient to justify taking that risk. The truth of the matter is that we are constantly making assessments of this type in our work: when we treat patients for asthenia or paresthesia or chest pain the decisions we make are either probably right or probably wrong, we do not have any certainty. Therefore, we encounter the same difficulties in assessing risk as we do in establishing a prognosis.

That is why it is essential to explain and justify our decisions in the medical records, particularly if we have decided not to notify the authorities or to postpone the notification because we believe it doesn't make sense from a healthcare point of view (1). We understand health care to mean the entire help process involved in the patient-physician relationship.

After all, when a notification of injury is filed following an assault on a woman, even if this is done only after much thought and careful consideration, we still have to ask ourselves if we have done the right thing, if we have done the best we could do for the patient. To have acted in accordance with the law does not



absolve us of moral responsibility. It seems to us that the analogy above between the difficulty of prognosis and the risk involved is equally relevant here.

Fear of seeing ourselves involved in a legal action: Imagining ourselves involved in legal proceedings and all that that entails (having to testify in court, the possibility of having to come face to face with the aggressor, of having to explain our professional actions, etc.) can get in the way of our obligation to notify or report. Nonetheless, fear of legal proceedings does not justify our turning a blind eye.

Fear of the aggressor: Although most abusive men are only violent towards their family, some are also abusive in other social relationships. The relationship with the perpetrator can be difficult, especially if the doctor is a woman, as the abuser may assume sexist attitudes towards her. After all, threats by the abuser to healthcare workers, both male and female, are not so rare.

Our name appears on reports, accounts of injuries, etc. that will be used by the victim against the aggressor if the case goes to court, and sooner or later he will know it. In addition, the fact is that very often nowadays we are the primary care physician for both the victim and the aggressor. Additionally, many healthcare and social service facilities do not have sufficient security measures in place.

BEYOND THE CONFLICT: THE PROCESS, THE INCREASE IN THE RELATIONSHIP BETWEEN INSTITUTIONS AND RESEARCH.

The conflict we have spoken of above, that we have an obligation to notify the authorities but reasons for not doing so, when considered dichotomously as we have done up to now, can be useful for analytical or educational purposes but does not allow us to go any further. Moreover, as is often the case with arguments that are antithetical, a hierarchy is formed: the law ends up by sucking up all the air and arguments from the health care provider are rendered helpless, seeming to be



written off as inconsequential. Annex 1 addresses this issue in the analysis of the reasons for conflict between health care providers and the legal system.

We therefore propose to widen our horizons on the issues that surround this matter, to leave behind the dichotomies and conflicting positions and consider the idea of a process.

1. The idea of process

Basis. The law requires us both to report the violence and to treat the woman: as often as not, the time required for care and that required by the law are not the same and we are supposed to comply with both.

The Framework Document of which we spoke of earlier (5) warns against making hasty decisions. And it does so repeatedly at every stage, thereby emphasizing the importance of respecting the time for care and the woman's time.

The aforementioned 2005 CCMA (Council of Catalanian Medical Associations) Code of Ethics goes along with the idea of process when it states that the duty to notify the authorities should be performed *"as soon as it is ensured that the victim is protected to the extent possible"* (3).

Health professionals and social workers pertaining to different health care levels and having different resources, who largely opt to apply caution when it comes to notifying the authorities without the woman's consent, do not do so because they are afraid of something, but from an understanding gained from experience.

Time. The law says we must report incidences of gender-based violence, but, except when physical injury is involved, does not say when precisely we must do so. Given that the same law asks us to not stop caring for the victim, we must understand that we are beginning a process with different types of objectives: some are clinical, some are social, others are legal or deal with providing assistance. In order to fulfill the objectives, time and a project are needed: a process.

Responsibility under the law and in caring for a woman in a violent situation is



not the yardstick by which a single heroic, solitary and urgent decision can be taken. It is the sum of many clinical and support services that define the physician's responsibility to a situation of gender-based violence.

When we say that responsibility under the law is a process, we do not mean to reduce this responsibility, nor to increase it either, but to have it adapt to the reality of our work and our helping relationship.

Many medical processes involve multidisciplinary teamwork. The biopsychosocial model helps us to be aware of that in our everyday medical practice. That said, if ever an issue required an interdisciplinary approach, that would be gender-based violence. We have insisted on the need to share information, define responsibilities, coordinate treatment, etc. The legal authorities are also grateful for multi-disciplinary reports that provide a comprehensive view of the problem. However, none of this is easy or quick. Teamwork requires time and dedication.

We need to be very careful in making sure the different services and programs that exist to help women who find themselves in violent situations do not become places where the woman is put through the wringer: working in a network has to mean that the different professionals act in a coordinated fashion and must not, as women who find themselves in abusive situations sometimes complain they do, force the women into making the rounds of the entire health support services network.

With Maria's agreement, the doctor contacts the gynecologist and social worker to alert them to the risks she faces of abuse during her pregnancy, the occurrence of new attacks and need to improve her lack of social support. The Social Welfare services offer her specific programs for women who experience abuse.

Process accelerators. Reasoned decision making conducted in collaboration with the woman takes time, but there are circumstances in which we may be forced to make quick decisions. We call them process accelerators. These circumstances may

have to do with the woman, the time of the violence taking place, the aggressor, people around the woman or even the support program itself.

Table 1: Accelerators of the decision-making process

Social isolation: All of the factors associated with social isolation increase the risk of serious violence.

Any mental dysfunction that prevents a woman from assessing or reporting on the severity of the situation (assessment of the patient's competence will be necessary).

Maltreatment with very significant victimization causing the woman to have great difficulty in identifying serious forms of violence.

Information from other institutions that furnish evidence of a serious problem (Social services, schools, other healthcare services, etc.).

Emergency room treatment: The risk-benefit assessment in these health care facilities make them opt for immediate report filing, as they usually lack the means to monitor the situation.

The presence of children or other dependents at risk. Gender-based violence statistics^a sadly remind us that too often the murders of women are accompanied by the murder of children and other members of the household.

Any situation that seems to warrant intervention following clinical evaluation: Unfavorable risk assessment, increase in the related ailment or its seriousness, etc. Indications of danger. Risk assessment in the doctor's office is very important. Various texts^b provide risk screening instruments that allow the assessment of danger in the situation we are dealing with.

(a) Centro Reina Sofía para el estudio de la violencia, Femicidios de pareja: [Centro Reina Sofía for the Study of Violence, Intimate partner femicides] Available at: <http://www.centroreinasofia.es/femicidios.asp>

(b) Ministerio de Sanidad y Consumo. Protocolo común para la actuación sanitaria ante la violencia de género. Madrid: Ministerio de Sanidad y Consumo; 2007. Disponible a: [Spanish Ministry of Health and Consumer Affairs. Common Protocol for a Healthcare Response to Gender Violence. Madrid: Ministry of Health and Consumer Affairs; 2007. Available at:

<http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/equidad/commonProtocol.pdf>

http://www.sergas.es/Docs/muller/protocoloComun_violenciagenero.pdf

Generalitat de Catalunya, Departament de Salut. Protocol per a l'abordatge de la violència masclista en l'àmbit de la salut a Catalunya. Barcelona: Generalitat de Catalunya, Departament de Salut; 2009. Disponible a:

[Generalitat de Catalunya, Department of Health. Protocol for Addressing Gender-Based Violence in the

Healthcare Environment in Catalonia. Barcelona: Generalitat of Catalonia, Department of Health; 2009]

Available at:

http://www20.gencat.cat/docs/canalsalut/Home%20Canal%20Salut/Professionals/Temes_de_salut/Violencia_i_maltractaments/pdf/abordatge.pdf

Álvarez Freijo M, Andrés-Pueyo A, Augé Gomà M, et al. Circuit Barcelona contra la violència vers les dones.

RVD-BCN: protocol de valoració del risc de violència contra la dona per part de la seva parella o exparella.

Barcelona: Circuit Barcelona contra la violència vers les dones; 2011. Disponible a: [The Barcelona Network to Fight Violence against Women. The RVD-BCN Risk Assessment Guide for Violence Against Women Perpetrated



by Their Partner or Former Partner. Barcelona: The Barcelona Network to Fight Violence; 2011. Available at: <http://w3.bcn.cat/fitxers/dona/rvdbcncatalaperinternetdefinitiu8febrer20121.421.pdf>

The idea of process that is being proposed here is in no way against the notification the authorities, but it is opposed to doing so too hastily without first obtaining the woman's consent and thus jeopardizing the health care intervention. Being held to account by the law while still caring for the woman should be possible to achieve within the health care system.

A few days later the doctor sees the woman has no intention of making any changes and, after considering her position of vulnerability in the coming months and the risk to the baby, talks to her, explains the legal obligations she has as a health professional and tells her that she is going to file a report with the court.

Maria changes doctor and health center.

2. Proposals for the future:

Increase the opportunities for inter-institutional exchanges.

Institutions often display an inbred nature. The lack of connection with others causes us to regard them with a distance that can easily turn into hostility. A lack of understanding of their discipline and procedures can make us feel alone within our own better-known and safer environment and our own specific languages, which are often cryptic.

We need places to connect with the various legal bodies (judiciary, prosecutor's office, victim assistance office, prison managers) to establish dialogues that go beyond mere information, to reach understanding. We need to move beyond difficulties and work together to find solutions.

We also need circuits to be established and feedback mechanisms with the prosecutor's office and the courts in general so that, among other things, we can learn what has happened to our patients, about restraining orders that affect us, to clarify which lines of communication are most effective for making sure the information reaches the authorities, etc.



It is true that very often there are individuals who are able to look beyond their specific roles and we must recognize the efforts some law professionals make to approach the realities of health care intervention, but there is also a larger institutional responsibility in making these encounters possible and attractive, from a professional perspective. Sadly, we must also be aware that up to now the lines of communication and protocols have failed to promote an effective dialogue among professionals.

Research. There is much we simply do not know. There are few data to determine what type of intervention, what professionals or what strategies are most effective in protecting women and dependent persons. This kind of research presents difficulties that can not be discussed in this paper, and yet, despite the difficulties, it is essential to allow us to prepare for and evaluate our work. We do not know whether the cases that are brought to justice differ from those that are not, or if legal and medical outcomes are comparable between one group and another, or whether there are services or types of care that vary greatly depending on what other measures are taken, in short, we need an analysis to be made of the variables related to filing a report with the law enforcement authorities and the consequences in the short, medium and long term.



II. WHEN THE ABUSER AND THE VICTIM ARE PATIENTS AT THE SAME HEALTH CARE DOCTOR'S OFFICE

As we first began to prepare this chapter, someone pointed out that in discussing the difficulty of treating both victim and aggressor at the same doctor's office, we were focusing almost exclusively on the abuser and ignoring the victim. That is, the woman is moved out of the scene⁴. On the other hand, treatment for the abuser is still underdeveloped. To the point that we could say that the abuser is practically off the radar in terms of care, as we have always approached the issue from the woman's standpoint. There is a tension between the risk of rendering the woman invisible if she is off the stage because the man has been brought in, and the risk of her being revictimized if we consider the man to be out of bounds in terms of care. How to include health care of the aggressor from the medical professional perspective, without causing revictimization of the woman, is one of the challenges of this paper.

CASE REPORT:

Rosa is a 59 year old woman, who has been treated at this center for the last 15 years. She is married and has two sons and a daughter between the ages of 20 and 30, who still live at home. She works as a cleaning lady. She has a history of migraine headaches and hip osteoarthritis. Her husband, Artur, is a 61 year old man who works as a taxi driver, is an ex-smoker with a history of high blood pressure, obesity and excessive alcohol consumption.

On a visit alone to see her doctor, Rosa asked her about vaginal dryness and told her that the truth of the matter was, "she didn't want to have sex". She spoke to her confidentially about her husband, a man with a gambling problem ("a year ago he spent all the money she had saved, and their children and the family found out") and who is also sexually promiscuous "since the first pregnancy". She described him as a man who is dirty and a slob, but "hardworking and a good father". She feels anger, loneliness and disgust, but she also feels sorry for her husband and does not consider leaving him. The doctor determined there was emotional, sexual and financial abuse by the

⁴ We thank Beatriu Macià for making this comment to us; it has been most useful to find an appropriate point of view from which to write not only this chapter but also the whole document.



husband, but she also realized that it was difficult for Rosa to identify the abuse. She also found the patient had high levels of emotional distress and was at risk for sexually transmitted diseases, and spoke to her about all of these things. Afterward, she reviewed Rosa's medical records and found she had been diagnosed with anxiety, which she had related work, and a visit 6 years earlier for perineal bleeding with injuries to the vaginal introitus, for which she had been referred to the gynecologist (the patient said she had not had sexual relations in the previous 15 days).

One month later, Artur went to the doctor for erectile dysfunction and asked if he could take Viagra® (sildenafil). Faced with this request, the doctor feels a conflict of loyalties; she is afraid there will be an increase in the abuse and risk for the wife, and hesitates over how to use the information she has for the benefit of the two, while duty-bound to maintain the confidentiality she owes to both patients. In the end, she prescribed the sildenafil and spoke with the husband about how sexual relationships change over time and the importance of having regard for women's desires.

Two months later, when Rosa goes to see her for another reason, the doctor brings up the subject of her relationship with her husband. The patient seems to be aware that she is being abused financially and sexually, claims they use condoms when they have sex and denies any physical abuse; they talk about her feeling guilty about her lack of desire and anxiety. The doctor tries to make her understand what it means to be the doctor both for her and her husband at the same time, and insists on the preservation of confidentiality and her aim of acting for the benefit of both of them.

INTRODUCTION

In the practice of family medicine it is very common to have information of the bio-psycho-social sphere of the various members of a family. This is frequently an advantage and helps to better treat the different family members. Sometimes, as in the example above, the doctor has information that generates emotions that make decision making difficult.

In the case presented here, the physician may have doubts about the appropriateness of prescribing sildenafil that could be summarized as follows:

- By giving him the prescription, will it contribute to hurting his wife, to facilitate a sexual assault or increase the risk of sexually transmitted disease?



- Not giving him the prescription, could it be bad for the patient? The information disclosed by the wife is confidential, how then can we justify our concerns to the abuser?

We have posed a very specific ethical conflict here - should I or should I not write the prescription? - and yet this is but one aspect among the many difficulties that may arise when both the victim and the man who abuses her are treated by the same doctor. To address these conflicts we will use the following scheme:

1. Rethinking the doctor-patient relationship.
2. Resorting to ethical principles.
3. Health care as a process. How to approach the abuser.
4. Other aspects.

RETHINKING THE DOCTOR-PATIENT RELATIONSHIP

It is well known that empathy is essential in a doctor-patient relationship. Empathy, in the technical sense⁵, allows us the capacity to understand and share the patient's vital objectives and, in this sense, support, for instance, their autonomy, an action guided by beneficence and respect for the value of loyalty to the patient.

That said, it is not easy to empathize with a man who assaults his partner. In the health care relationship with the abuser, one may have feelings of rejection, distaste, perhaps even a sense that somehow, by caring for him, the victim is being betrayed, or we feel that in some way our loyalty is being

⁵ Empathy, in its simplest form, is equivalent to "being in tune" and it is in this sense that it is most commonly used by health professionals not working in the field of mental health. This term is the one used in the "Diccionario terminológico de las ciencias médicas" (Terminological dictionary of medical sciences) (6): "Level of affective attunement with other people and the surrounding environment". In this paper, however, we will use empathy in the technical sense, according to the description of C. Rogers (7): "To sense the client's private world as if it were your own, but without ever losing the "as if" quality—this is empathy, and this seems essential to our field. To sense the client's anger, fear, or confusion as if it were your own, yet without your own anger, fear, or confusion getting bound up in it, is the condition we are endeavoring to describe".



questioned. We understand that taking into account both this aversion and the professional need to establish an empathic relationship with a patient, no matter who it is, contributes to the difficulty of treating the abusive man and his partner, both on ethical and emotional grounds:

The difficulty of empathizing with patients who commit criminal acts, especially if they are against people. This difficulty may pervade the relationship to varying degrees and be an obstacle only to issues related to the abuse or it may qualify the general quality of the physician's relationship with the abuser. We are not talking here about fear of the abuser by the physician, which is sometimes present and which was discussed in the previous chapter ⁶.

The difficulty of empathizing with patients who are abusive towards other patients of our office. We are doctors caring both for the abuser and the abused, and it is therefore very difficult to remain close to both the aggressor and the victim at the same time, to care for and understand the two of them without abandoning either one.

These difficulties also appear in various forms of family violence, in violence against children or adolescents and violence against old people. Although they can occur in other areas of care, such as treatment centers for drug addiction, they seem to us to be a glaring difficulty within the primary care environment.

The duty of confidentiality means we can not bring up the problem, namely that we have information about the patient that he has not given to us and about which we cannot speak with him, because the information comes from his partner who is also our patient. If we speak to the aggressor we would be violating the confidentiality of the information from the battered woman, and furthermore, we know that this could trigger an assault. It would therefore be a maleficent act.

⁶ We have discussed the health care staff's fear of the aggressor in the section entitled "Fear of what could happen to us" in the chapter on "What could we do when the woman does not wish to press charges".



With regard to the aggressor, if we were to think about not agreeing to his request, we would not be able to justify our decision and he would think it was arbitrary. We would be undermining his autonomy and, by not treating him like any other patient to whom we would give clear and understandable information for the denial, we would be unfair too.

The possibility of having the aggressor change doctors. Despite the strong obligation to not abandon the patient (8), the situation can be intolerable from the physician's viewpoint. He or she then has the possibility of requesting that the offender be cared for by another physician. A situation in which the physician feels he or she is incapable of providing adequate treatment to one of the members of the couple or that treating both members of the couple would harm one of them, could motivate a decision to request a change that originates with the physician without following the issuance of a restraining order.

We must do everything we possibly can so that the decision does not harm the aggressor.

We must do everything we possibly can so that the abused woman can decide whether she wants to continue to be cared for by the same person who treats her partner, and if she does not, we will also make it easy for her to change doctors.

Finally, we need to reflect on the fact that male violence within the couple is not well understood when it is considered just like any other crime, in which the perpetrator and the victim often have no personal relationship, let alone an intimate relationship. In the case of gender-based violence, the couple shares in common not only the violence but also many other things: house, children, life projects, doctors too, and all of that remains valid even as an abusive situation is occurring.

RESORTING TO ETHICAL PRINCIPLES

The ethical principles as applied to the prescription of sildenafil for a man who abuses his wife can be expressed schematically as follows:

Table 2: Effects of the prescription for sildenafil in relation to various ethical principles, according to whether they affect the man who is abusive or the woman who is abused

	On the abuser	On the victim
On Autonomy	Positive: Allows the patient to make an informed choice without coercion on how to improve his sexual performance.	Negative: <i>Could the woman be forced to have sex against her will due to the use of the drug?</i>
On Beneficence	Positive: Allows the patient to enjoy satisfactory sexual activity.	Negative * : <i>Can sex become less enjoyable for the woman?</i>
On Non-maleficence	Positive: Helps to avoid the harm repeated sexual dysfunction can cause.	Negative ** : <i>Could it lead to the infliction of physical and mental harm caused by sexual relations that we know are unwanted?</i>
On Justice	Positive: Treats the aggressor like any other patient in the same position.	<i>Given that this principle also protects the rights of others, it is the only one that allows the woman's interests to be considered when it comes to writing the prescription for her partner.</i>

* It is necessary to keep in mind that sexual relations in a violent context can constitute an instrument of abuse.

** The effects on the victim are assumptions that cause a conflict for the physician but for which we have no certainty (e.g., we do not know with whom he will use the sildenafil). It would therefore be necessary for the evaluation of the risk of aggression to be very unfavorable for this principle to enter into play and in that case, it would also be necessary to consider the advisability of notifying the authorities.

HEALTH CARE TREATMENT AS A PROCESS. ADDRESSING THE ABUSER



Up to now, family medicine had not contemplated the idea of treatment for the man who is abusive and indeed, it is not often that a patient who is an abuser will recognize that he is. However, more and more frequently, we are seeing men who, whether motivated by themselves or persuaded to do so by their spouses, are seeking help in a roundabout sort of way (because of nerves, arguments, etc.) for an uneasiness that is related to their violent behavior towards their partners⁷.

With regard to how to establish an empathic relationship with a man who is abusive, there is a proposal based on violence's structural nature in ANNEX 2.

Addressing the man⁸, not avoiding the issue, trying to get him to "loosen his tongue", talking to him, looking into his request to see where he wants to go and trying to find out from what he has to say whether he really is being abusive is, at present, a challenge that has become more and more necessary to take on in primary health care. We must do all of this, with an awareness of our own limitations and poor training in the helping relationship with the man who is abusive, trying to treat him and/or refer him to specialist programs.

In this area and within the framework of a reflection on the need to approach the man who is abusive, we need to consider the initiatives directed towards getting the abuser to question his stance ("I deny my partner the same rights that I have"), or at least to not allow it to harden. And we need to do it in such a way that we do not betray the victim's trust or put her in danger.

We know it is not easy to acknowledge one's own violence. It is necessary to take advantage of other reasons for seeing the doctor, together with the uneasiness described above, in order to suggest long term treatment. The patient may very well insist on the immediate difficulties that motivate his plea and therefore the doctor's attempts to dissociate care from the strictly immediate plea may come to nothing. That is why it is necessary to insist on detection without being afraid, as was done initially in detecting the abuse in the woman. The same persistence and

⁷ Geldschlager H, Ginés, O . Abordaje terapéutico de hombres que ejercen violencia de género. [Therapeutic approach to men who commit gender-based violence] FMC. 2013;20(2):89-99.

⁸ Although no reference is made to healthcare matters, the case for focusing on the male aggressor so as to stop talking about "the issue of women who suffer violence", may be found at Montero Gómez A. Reenfocar la antiviolencia de género. El Correo: 18 de Julio 2007; opinión. Disponible a: [Refocusing anti-gender based violence. El Correo: 18 July 2007; opinion. Available at:] http://www.observatorioviolencia.org/upload_images/File/DOC1188469885_antiviolenciadegenero.pdf



the same tact must be used and, when all is said and done, we need more studies to confirm the effectiveness of this approach.



OTHER ASPECTS

When restraining orders involve health centers. When a restraining order is issued, the authorities have to do whatever is required to ensure that the protective distance maintained. The case may arise that the Health Center is within the established perimeter of compliance, and that the aggressor is able to get close to the victim simply by going to the Center he is assigned to. In this case, it will be necessary to officially assign him to another Health Center.⁹ Nevertheless the aggressor's choice will be respected if he chooses a Center that is outside of the established safe distance. If the aggressor shows up at the Center, he should be treated only in case of an emergency, otherwise it is best to call the appropriate police force (in Catalonia, the Mossos d'Esquadra).

There are other scenarios that have not yet been resolved: if the man who is abusive is the father of underage children whom he must accompany on a visit to the doctor at the corresponding Health Center, his obligations as a father conflict with obedience to the court order and it is not up to the Health Center to decide which of the two duties gets top priority. It is also worth pointing out that the Health Center usually finds out about the existence of a restraining order informally, often through the victim or the people around her.

Difficulties in recording the abuser's status. This issue is dealt with in the section on "Problems arising from cross-references in the medical records of the victim, the aggressor, their children and other household members" in the chapter on "Gender-based violence: the need for keeping records, the difficulties with records".

⁹ According to an inquiry made to the legal services of the Catalan Institute of Health (4 December 2009).



III. GENDER-BASED VIOLENCE: THE NEED FOR KEEPING RECORDS, THE DIFFICULTIES WITH RECORDS

CASE REPORT:

Paula, 32 years of age, goes to see her family doctor. She begins by complaining of insomnia and fatigue-related health problems that she ascribes to her job as an executive secretary. During the course of the conversation with the doctor, she reveals a recent breakdown of a relationship in which there was psychological abuse that continues although they are no longer living together: the ex-partner threatens to take her child away, to hurt her, continuously puts her down, refuses to provide financial support for the child, etc. By the end of the visit they have agreed that it is this situation that is causing her health problems and that there may be no need to take any drugs or for any referrals to specialists. The physician informs her about various services where she can find help and which, in part, the patient already knows about.

Two years later the patient returns to see the doctor with a man. During the conversation the doctor sees the woman looking at the computer screen, first with amazement and then with concern. Emotional abuse is conspicuously identified as a determinant of health. The man also looks at the screen.

The doctor is worried for a moment as she doesn't know whether or not the companion is also the abuser. The patient openly asks why that information is there. The doctor explains the reasons why it is important to make a record of health problems. She understands but asks that the information not be so conspicuous.

The man, who is a new partner, listens in astonishment to the conversation.

INTRODUCTION

In this chapter we will mostly deal with recording everything that refers to the victim, as we are only just beginning to learn about how to address the man who is abusive.

In the healthcare environment, we tend to speak about abuse as a diagnosis. To think of it in that way makes it easier to keep records on it besides making the act itself and the woman who suffers from it visible. Nevertheless, although abuse can lead to symptoms, severe distress and in the end, can make a woman sick, it is not



in itself a disease. Speaking of abuse as a diagnosis turns the woman who suffers from mistreatment into a sick person. It medicalizes suffering and, in the case of gender-based violence, is a form of victimization. That is why we have tried to talk about the abuse as a determinant of health.

It has also been argued that it would be more appropriate to record the consequences of abuse to health rather than as a determinant of health: we would record major depression or irritable bowel, for example, instead of recording abuse. However, to do so would on the one hand, invisibilize a situation that affects the woman's health and on the other, make it difficult to understand ailments and diseases that have a common origin but which do not always seem to be related. It is for these reasons and also because of the legal and administrative implications for the woman, that some coding systems recommend recording the abuse as a major determinant of health, as detailed in "The coding of abuse as a determinant of health", later in this chapter.

With regard to health data, as a whole they are considered to be sensitive data. That said, if certain health information loses its quality of confidentiality, that can especially harm the person to whom it belongs. Examples include sexually transmitted diseases, and AIDS in particular, psychiatric illnesses, certain bad habits, and so forth. It is also true of the mistreatment of women. What these health conditions have in common is that:

- They contain even more sensitive privacy-related factors than most health data.
- In different ways and to varying degrees they can affect third parties.
- Any breach of confidentiality that occurs in handling the data may entail varying degrees of stigma.

These consequences need to be kept in mind when this information is recorded in the medical records and when it is or is not passed on to other health professionals. This is not a matter of letting the guard down when dealing with health issues that carry no stigma, but rather to consider the possibility of stigmatization as a red flag so that on the one hand, we take greater precautions to preserve confidentiality and on the other, that we discuss the issue with the patient, as we will see later.



As for abuse as a determinant of health, the importance of discussing when, how and where to keep records resides in large part in the fact that this determinant is associated with a crime, and that this crime is made visible by its impact on the health of the woman who suffers from it. Keeping a record of this determinant of health may affect the woman's safety because, depending on how it is performed, it can become known to the perpetrator and of itself, facilitate, aggravate or trigger an assault¹⁰.

Furthermore, this is a crime that is perpetrated within the family setting, where members often share information regarding health. What is more, in our environment, both professionally and socially, it is considered "normal" to share this information within the family, unlike what happens in other cultural environments.

The issue of confidentiality in relation to abuse takes place against a background in which scant attention is paid to the confidentiality of health records in general. These and other common topics have already been addressed in the following papers published by the Ethics Group of the Catalan Society of Family and Community Medicine (CAMFiC):

- *Medical records in the electronic age.* (9)
- *Confidentiality: The right to privacy.* (10)
- *Autonomy, the right to decide.* (11)

In addition there is a document by the Bioethics Working Group of the Spanish Society of Family and Community Medicine entitled *Medical records, use of information technology and confidentiality.* (12)

We have grouped specific aspects of record keeping into five areas for consideration:

1.- The tension between the need to keep records, the visibility given to abuse as a determinant of health and the confidentiality of the data.

¹⁰ We need to remember that attacks often occur when the abusive man loses control over certain areas, such as when the woman talks about her situation, when she sees the doctor for health problems related to the abuse, when she files a complaint, etc

- 2.- The difficulty with cross references.
- 3.- Mandatory information sharing between government agencies under Catalan law.
- 4.- Do we have to notify the authorities of everything we record as abuse?
- 5.- Print-outs of patients subjected to abuse.

1. THE TENSION BETWEEN THE NEED TO KEEP RECORDS, THE VISIBILITY GIVEN TO ABUSE AS A DETERMINANT OF HEALTH AND THE CONFIDENTIALITY OF THE DATA.

The **record** of what takes place in the doctor-patient relationship is of fundamental importance in the health care process, as it also is in cases of abuse. To refrain from recording abuse is not to act neutrally but instead gives an advantage to the man who is abusive, at least from a legal standpoint (13), because it assumes that anything that has not been recorded does not exist: if there are no records, there is no abuse.

The benefits of recording in cases of abuse have already been studied by other authors and are listed in Table 3. As for the disadvantages, recording abuse involves the same difficulties as those involved in the use of electronic media in general healthcare practice. That is why the amount and type of information to be recorded are relevant issues to consider. In Table 4 we have summarized the four ethical principles that specifically apply to electronic recording of health information. They have been discussed at length in the paper on *Medical records, use of information technology and* (12) mentioned above.

On top of that, recording abuse involves some difficulties and consequences of its own, as discussed below.

Table 3: Arguments in support of keeping accurate records of abuse in the medical history

To ensure the continuity of health care.
Make communication between the various professionals involved in caring for the woman easier.
Legal value of the medical records.
Improve our understanding of the impact of violence on the woman (create new

knowledge).
The data collected provide justification for evidence-based clinical recommendations
Legal protection for health care providers
Allows collection of data to justify investment in detection, intervention and support services.

Modified from: William J. Rudman. Coding and documentation of domestic violence. Family Violence Prevention Fund, 2000

<http://endabuse.org/userfiles/file/HealthCare/codingpaper.pdf>

Table 4: Ethical principles that specifically apply to electronic recording of health information

Principle of restraint (relevance):
Under this principle, health care practitioners need to limit themselves to collecting and recording only what is strictly necessary to ensure quality medical care.
Principle of openness:
Acting appropriately is important, but so is allowing it to be known, (...) Therefore, it is best for the patients to know what type of information is being collected about themselves, as well as who may have or has access to it and under what circumstances.
Principle of responsibility:
For one thing, it means that the practitioners need to be careful and responsible in handling the data, being mindful of the consequences that minor flaws or omissions may have on patients. For another, it is necessary to remember that teamwork can not be used as an excuse for blurring responsibilities.
Principle of security:
This refers to the fact that security measures to protect health information must be implemented at all times, in all centers and for all users (including for health care professionals when they are the patients, for example).

Modified and translated from: Semfyc Bioethics Working Group. Informatización y confidencialidad de la historia clínica. Aten Primaria. Julio-Agosto 2004; 34(3): 140-2. [Maintaining the confidentiality of electronic medical records. Primary Care. July-August 2004; 34(3): 140-2.]



Visibility of the determinant of health refers to how diagnoses and determinants of health can be displayed on electronic media to people who have no connection with the health care process.

From the perspective of a proper therapeutic relationship, in order to maximize the benefit to the patient and avoid doing her any harm, abuse as a determinant of health must be clearly visible. That said, if it is too visible it has the following serious shortcomings:

- The computer screen may be visible to the relatives or persons accompanying the patient, as well as the patient herself.
- Referral notes, which are often passed along from one desk to another and will end up in the home where the abuser lives, may unnecessarily make reference to abuse as a determinant of health.
- Other medical specialists will be able to learn about the abuse as a determinant of health through shared medical records, although it may be irrelevant to the type of care they need to provide, etc.

With regard to the **confidentiality of the data**, the especially sensitive nature of abuse as a determinant of health makes it difficult to simultaneously protect the patient's privacy and provide the best possible care.

Nonetheless, as health care providers our actions should be guided by what will benefit the patient, avoid harming her and, for all these reasons, we should take her wishes into account. (14)

1.1. About abuse as a determinant of health

Abuse has an intensity gradient that is such that it is possible to describe similar situations in very different ways. For example, where one person just sees brusqueness or stinginess, another may see emotional abuse or financial control. We need to work toward a consensus as that is essential to communication between professionals, for teamwork and so forth.

It seems to us that this issue carries much weight in ethical reflections on abuse and, even more so, in a general reflection on abuse (as concerns diagnosis, classification, etc.), because we often do not know if we are all talking about the



same thing. Now then, the challenge of making an accurate diagnosis is something that is shared with, for instance, the majority of psychiatric diagnoses.

1.2. About the decision to make an entry in the records

It is recommended in the literature that the woman be informed about what level of confidentiality she can expect the entry in the record to have (where it will be placed, who will see it, how it will be used) so that the woman can decide whether or not she wants it to be recorded. She should also be informed about our legal obligations with regard to confidentiality (lists, shared medical records, documents on comprehensive care for the woman, etc.). (14,15)

For our part, we submit the following considerations:

- To record or not to record abuse as a determinant of health:

To record: There is the possibility that making an entry in the record will harm the patient. A breach of confidentiality is in and of itself harmful even if there are no consequences, as this is information that belongs to the patient and is private. Furthermore, this is a deed that can lead to stigmatization of the woman as much as an assault by her partner.

Not to record: It may happen that the continuity of care will be broken, if the woman sees a different doctor than the one who usually cares for her. There is also the possibility that her regular doctor will forget.

- Record abuse as a determinant of health prematurely or too late:

To record the abuse as a determinant of health from the outset is supported by the effort to maximize beneficence. However, rushing to make a record of abuse as a determinant of health without the consent of the patient, when the abuse has barely been detected, can be perceived as an imposition by the patient and thereby become an instrument of victimization. This could happen especially in two types of situations:

- The patient knows that we are making entries into the record and does not feel it is necessary to do so.



- The patient knows that we are making entries into the record but is not aware that she is being abused.

Waiting until the relationship has progressed, and making the entry with the woman's agreement may be advisable as it is based on the notion of the patient's autonomy.

- The woman does not want the information to be recorded:

What do we do if the woman requests that the information provided not be recorded anywhere? On one hand, we must respect her autonomy, that is to say, that any decisions must be respected insofar as possible because of the fact that she is the owner of the health information that concerns her. On the other hand though, not recording the abuse as a determinant of health could lead to her not receiving the best possible care and even endanger her. For this reason the patient should be informed in detail of the possible consequences, while being mindful of the conditions designed to assess the degree of autonomy in a decision. These conditions are "...an absence of coercion, the ability to distinguish between several possible actions, an ability to choose and the capacity to defend a choice in accordance with individually chosen values". (11)

If we agree that a patient's decision making capacity should be directly proportional to the risk involved in the decision to be made, so that the higher the potential risk, the higher the level of competence required¹¹, we will need to ask ourselves whether the patient has the capacity to make such a serious decision.¹² It may

¹¹ This is the idea behind Drane's sliding scale for competency assessment. The author proposed that the greater the level of risk in the decision to be made, the higher the required standard of competency should be for the patient. Thus, in low-risk decisions (for example, consenting to antibiotic treatment for uncomplicated pneumonia on an outpatient basis) a minimal level of competency is sufficient. On the other hand, for decisions with a high level of risk (rejecting treatment for a malignant solitary pulmonary nodule with no invasion of surrounding tissues and no metastasis), the patient must have a high level of competency for it to be able to be considered an autonomous decision. Drane's sliding scale is presented and discussed by Simón Lorda, P. El Consentimiento Informado [Informed Consent], pp. 289-295. For the meanings of capacity and competency, *Ibid.* 277 and subsequent pages. (16)

¹² We want to emphasize that we are referring to the patient's *competency* in a technical sense, and are using it as a term established by custom. We do not underestimate the possibility of its being used inappropriately as an instrument for gender discrimination or victimization, by being applied to every woman who is mistreated or in other ways.



have important consequences for the woman's physical safety. For example, if there are no entries in the medical records, any future report to the court will carry a lot less force than if there are, and this may have an influence on the judge's decision to issue a restraining order on the aggressor.

It should be noted how difficult it is to treat a battered woman who comes to see us, in the first place because of the shortage of time available to deal with a matter, the abuse, which requires much time. If on top of that we want to make sure that decisions will be taken with adequate information, a certain feeling of being overwhelmed is inevitable.

We also need to be aware of the fact that the notion of informed consent has brought about a perverse change; it has gone from being an instrument that provides the patient with the right to receive information prior to making a decision to becoming an obligation for the patient prior to receiving some type of health treatment (typically invasive diagnostic tests or surgery). This is especially relevant in cases of abuse, because it would turn informed consent into an instrument for the victimization of women by the health system.

A slightly different matter is the question of how to record abuse as a determinant of health if the woman expresses that she does not feel herself to be a victim of abuse. It is obvious that we shall have to weigh the relationship between beneficence-nonmaleficence and autonomy, and if we are dealing with a problem that is current and clinically relevant, we will probably have to record it. In any case, the question is not whether or not to record the abuse, but rather when should we do so: as we have already said before, postponing the decision, despite the risks, may be a suitable option. Another alternative would be to use the section for subjective notes in the computer program.

Also keep in mind the possibility of writing in the patient's clinical record that "the patient refuses to allow the recording of personal information", without being specific.

The relevance of abuse as a determinant of health may vary over time depending on a number of circumstances. We have to try and make sure that we do not turn a determinant of health that may already be out of date into something chronic, as in the example above, for instance. We still need to reach a sufficiently large



consensus on this issue, especially as to when to consider the violence and its effects on health have ended.

To conclude, we think that all we have reflected on regarding the difficulties in taking a decision before making an entry in the records, would benefit from considering that abuse, as a determinant of health, is not just an isolated event or as a decision to be taken at a given moment, but as a process that develops over time.

1.3. Various technical methods of record keeping:

We need to be aware that referral sheets on paper are on their way out. Also that the trend is toward shared medical records, with the serious problems of maintaining confidentiality that entails: every healthcare professional will have access to the entire contents of the medical records.

We propose several possibilities:

- Encrypting abuse as a determinant of health would be a good solution, since it would prevent uncontrolled "leakage" of information but, on the other hand, the entire team could know the code. Obviously though, if abuse is the only determinant of health that is encrypted, it will not be necessary to read about it to know that it is abuse, and so would have the opposite effect to what was intended.
- View all the information on the computer screen and just have it encrypted when printed out (so only the code for abuse as a determinant of health is printed but not the text, or something to that effect), also it would be made possible for it to be decrypted by clicking on the code. The disadvantage to this is that the encryption could be negative for a woman if the doctor treating her (e.g. in an emergency room) did not know the code and this information were relevant to her treatment. In some cases encryption may not be sufficient, in cases of women who are health professionals, for instance.
- Option of selecting the sections of the medical records that must remain confidential, just by asking the patient what she prefers during the conversation with her.



- It will probably be necessary to prevent access to any descriptions, actions, agreements with the woman, etc. that are of no interest to anyone outside the doctor's office.

1.4. The coding of abuse as a determinant of health

Annex 3 shows the codes for the mistreatment of women in the two classification systems that are most commonly used in primary care health systems: the International Classification of Diseases, 10th Edition (ICD-10) and the International Classification of Primary Care, 2nd Edition (ICPC-2). (17,18)

It is necessary to remember that coding guidelines developed for ICD-9 recommend that abuse always be coded as the principal diagnosis for an admission to the hospital or an episode, and all others as secondary diagnoses regardless of severity (19). At present, this especially affects visits to the emergency room and hospital admissions. We must also underline that there are implications to coding violence as the primary condition:

- the primary condition is responsible causing the admission, and if it is for violence, it will result in treatment, scientific, economic and political implications.
- scientific research often considers only the primary or principal condition, so this guarantees it will show up in data collection.

2. PROBLEMS ARISING FROM CROSS-REFERENCES IN THE MEDICAL RECORDS OF THE VICTIM, THE AGGRESSOR, THEIR CHILDREN AND OTHER HOUSEHOLD MEMBERS

Other publications have highlighted the contradictory nature of the recommendations for recording information relating to abuse in the medical records of children (15). It is important for a child's medical records to show the abuse of



the mother, but we have to remember that if the aggressor is the father, he will be able to have access to them.¹³

Entering information in the medical records of an abusive man also calls for reflection:

- It is debatable whether a crime, with or without a sentence, should be recorded in a patient's medical record: in the coding systems that are commonly used there are no codes for designating an abuser. Moreover, that is also not a fact that he has communicated himself.
- The decision to include the label of abuser only in cases resulting in a sentence, as some experts advise, although it may ensure the legality of the entry, does not solve the issues that are raised concerning the ethical problems, the woman's safety or non-discriminatory medical treatment for her husband¹⁴.
- Although recording the status of the abuser may benefit both the victim (for instance, by preventing the giving of information to the aggressor) and the man who is abusive (by alerting to the possibility of providing him with specific professional help), we believe it is not a sufficiently strong argument to justify the desirability of recording this fact¹⁵.

Finally, the reflection we have made regarding the children can also be applied to other members of the household, for example, elderly relatives who live in the home.

3. MANDATORY INFORMATION SHARING BETWEEN GOVERNMENT AGENCIES UNDER CATALAN LAW

¹³ Keep in mind that a significant proportion of children of battered women experience abuse directly. Witnessing violence against the mother has consequences on the child's health. If abuse to the mother is documented in the child's medical records, it may provide the pediatrician with some clues to interpret the child's condition.

¹⁴ Perhaps some practitioners will reject the possibility of less conscientious care, however remote it may be, if they believe that it is viable to treat patients on a strictly objective basis, with no emotional interference, for example. We have dealt with this issue in the section about "Rethinking the doctor-patient relationship" in the chapter on "When the abuser and the victim are patients at the same health care doctor's office".

¹⁵ Having to treat the abuse through the victim creates an imbalance between that which hope to know and what we have a duty to do in each case: with regard to the woman, we record, we refer, we ask her to file a complaint, we ask her to understand, to accept the decision and so forth, but no comparable demands are placed upon the man who is the abuser. We can not deal in any depth on this issue, as that could yet force us to rewrite this text.



Under the heading "Data Transfer", Article 78 of Catalan Law 5/2008, of 24th April, on the right of women to eradicate sexist violence establishes that:

"The competent public bodies must share the data of a personal nature required to be able to manage the services of the Health Care and Recovery Network and the financial provisions made under this law, as well as others established by law and related to sexist violence in an appropriate way. To this effect a specific registry must be created, and which must be controlled by regulation". (20)

The law states that there must be a mutual sharing of information, but what tends to happen is that certain areas do the providing of information (e.g. the healthcare services) and others do the receiving (e.g., the justice system or the police). In this way, information flows are clearly asymmetric and often entirely unidirectional.

In the event that, in our capacity as health professionals, we are requested to turn over this information, from an ethics standpoint we need to consider:

- o The mandatory nature of the data transfer.
- o The indeterminacy of the data. The law only states explicitly that the "required" data must be shared without specifying what that means.
- o The scope of "*the services of the Health Care and Recovery Network and the financial provisions*" that are indicated.
- o The existence of a specific database (a subject we will deal with in the last point).

Beyond the legal imperative, there is the matter of the network of institutions, which is perhaps not very extensive but which is being driven at different levels and which offers clear advantages in many ways, such as, for example, getting information to flow smoothly so that the victim does not have to repeat her story every time someone at another professional level or at a different agency interviews her, and can also decrease her being forced to make the rounds of the different services. However, the chances of information leaking and the stigma that



could result is a risk that needs to be limited. This risk is especially great in smaller communities and when the battered woman works in the health care field.

Controlling information is therefore one challenge. Another is to provide adequate information to the woman and obtain her consent. The conflict will arise if the patient objects to allowing the information to flow through this network. As mentioned above, we need to consider the possibility of writing in the patient's clinical record that the patient refuses to allow the recording of personal information, without going into specifics.

4. DO WE HAVE TO NOTIFY THE AUTHORITIES OF EVERYTHING WE RECORD AS ABUSE?

We know that as professionals we have a legal obligation to report any abusive situation we are aware of. Moreover, the report has positive consequences for the woman: it allows legal action to be taken to protect her from further attacks, aid and assistance to be obtained to break the cycle of violence, support so she can keep her job or attain financial independence, etc. Even if charges are not pressed, filing a complaint will set a precedent so that if there is another assault the authorities will be compelled to act more forcefully.

Nevertheless, there are a number of situations in which, from the medical point of view, we see that notifying the authorities is not in the interest of our patient or that it will do more harm than good. Therefore, reflection on this point should not be based on the principle of autonomy, as in the case described above in the chapter entitled *Do we have to notify the authorities of everything we record as abuse?*, but on the principle of beneficence.

For example, take the case of an elderly couple living on the husband's pension, where the abuse has lasted for years but where the physical violence ended long ago, where at present the man has a domineering attitude, which could be considered emotional abuse, and the wife shows signs of victimization, but where their relationship has reached an equilibrium and the wife enjoys taking care of the grandchildren, states that she loves her husband and under no



circumstances does she want to file a complaint. Does it make sense to bring the law into this situation?

In many relationships where the emotional abuse doesn't appear to be severe, we may have doubts about whether initiating legal proceedings is best for the patient. Not because we believe that to some degree violence is acceptable, indeed it is certainly not, and furthermore, let us not forget, it also has health consequences. The thing is, that these incidents occur in private, often without any witnesses. Unless the physician has an extraordinarily close relationship with the woman, she is likely to back off.

From the legal point of view it is clear that one has done what was supposed to be done, but from the health care perspective the treatment process will have been interrupted by the woman's withdrawal, and therefore it will have to start all over again, if the true goal is to help the patient break the cycle of abuse. In other words, the intent of the law has been complied with but nothing else. And, from the health care standpoint, the work that has been done thus far has been lost and nothing has been gained.

Furthermore, and in relation to the intensity gradient of abuse as a determinant of health mentioned above, many men have very subtle but identifiable sexist attitudes (Luis Bonino speaks of "micro-sexism", discussed in Annex 2) that cause discomfort and dysfunction, but where one can hardly speak of abuse unless it is meant in the structural sense set forth by this author. So, does it benefit the patient in these circumstances to file a report with the authorities?

At the root of this disagreement, among other things, there is a question of semantics: we use the same words to talk about concepts - for example, violence against women - that do not have an identical meaning in the legal and medical contexts. That is because the law and medicine are not only different fields of knowledge, but are also removed from each other¹⁶. This means that, for example, the detection of maltreatment in a relationship that has ended with the death of the man who was the abuser probably has no legal significance, but that the health consequences may persist and they need to be addressed.

Finally, we wish to stress that the conflict is between acting according to the law and acting in the patient's best interests, not in obeying or disobeying the law.

¹⁶ See Appendix 1: Why is there conflict between the areas of health care and law enforcement?



5. PRINT-OUTS OF PATIENTS SUBJECTED TO ABUSE.

Health care providers and government agencies often consider lists of patients who are victims of gender-based violence as a useful tool to gauge the extent of the problem, to achieve more comprehensive monitoring of the cases, as an aid in research, as a tool for teaching, etc.

We have to be very clear that under Organic Law 15/1999 of 13 December on the Protection of Personal Data (21), any list of this kind may be considered to be a data file and to create them legally, data files must meet a number of conditions.

From an ethical point of view these print-outs pose difficulties with regard to privacy and non-discrimination, even if they are made in accordance with the law (22). Specifically speaking, since they deal with women who are victims of violence, we need to think about the possibility of their being victimized by the healthcare system.

For research on violence against women, WHO has developed guidelines for the protection of privacy and safety of participating women (23).

KEY POINTS

Introduction.

- Health care for women who are victims of gender-based violence very often raises ethical dilemmas.
- Care for women who are victims of violence and reflection on the decisions that need to be taken require continuity, longitudinality in the care and time for the visits.



I. What to do when a woman does not wish to press charges

What are we afraid of when a woman does not wish to press charges?

- When a woman who is subjected to abuse does not want to file a complaint there is an ethical dilemma between the professional obligation to respect the woman's autonomy and the legal duty to report the abuse to the authorities.
- Notification to the authorities allows the violence to become visible, for measures to protect the women to be taken and to act against the aggressor. Not to notify may have negative consequences for a woman who is a victim of violence.
- Notification to the authorities does not end the health care process, which is aimed at helping the woman to set goals so she can get out of the abusive situation with whatever help she may need.
- We need to consider what negative consequences our filing a report with the authorities may have for the woman: objectively worsen her living circumstances, increase the danger, not foresee what consequences legal action may have.
- Not respecting the woman's autonomy can lead to greater victimization, cause the therapeutic relationship to break down and make the violence invisible again.
- Other factors that may have an influence on our professional decisions do not justify our reticence: fear of incurring legal responsibilities or finding ourselves involved in a trial, difficulties in the assessment of risk or fear of the perpetrator.
- It is necessary to record our assessment and justify our decisions in the medical records.

Beyond the conflict: the process.



- Care for a woman in an abusive situation initiates a process that has clinical, social and legal objectives that extends over several visits.
- We must avoid hasty action, work to help the woman to recover and regain her autonomy, ensure her safety conditions are adequate, allow time to seek her agreement and facilitate a multidisciplinary approach.
- There are circumstances that may force us to accelerate the process: children at risk, danger indicators, very significant victimization, the woman is mentally incompetent, social isolation, lack of continuity of care, or other serious situations.
- We present two proposals for the future: increase the opportunities for inter-institutional exchanges and promote research on the ways of addressing gender-based violence and their results.

II. When the abuser and the victim are patients at the same health care doctor's office

- Having knowledge of the situation of abuse through the woman and the duty of confidentiality condition the professional treatment of the man who is abusive.
- Negative emotions and loyalty conflicts may arise in the professional treatment of the man who is abusive that make care difficult. It is not always possible or it may not be best to resort to changing doctors.
- Ethical analysis using the classic principles is not enough because only the principle of justice considers the rights of others.
- It is becoming more and more frequent for men to seek help for conditions that are related to the violence they exert against their partners. Treatment for the abuser is not very developed in primary care and poses an unavoidable challenge.
- Knowledge and understanding of the structural quality of male violence allows us to find the context in which to treat the man who is abusive.



- The existence of a restraining order poses complex organizational issues and decisions with regard to the man under the order if both he and his wife have been assigned the same health facility.

III. Gender-based violence: the need for keeping records, the difficulties with records

- To refrain from recording abuse as a determinant of health is not to act neutrally but instead gives an advantage to the man who is abusive. An entry in the medical record is important both from the health care and legal standpoints.
- Recording a situation of abuse may stigmatize a woman and put her safety at risk if there is any breach of confidentiality.
- The ethical dilemma arises from the need to make entries in the medical records that are sufficiently visible while simultaneously ensuring the confidentiality of the data, explaining to the woman what the limits are and taking her wishes into account.
- The decision to record, what to record and when to do so has implications for care and ethics. We need to integrate the matter of recordkeeping in the process of caring for the woman, seeking her agreement.
- Shared electronic medical records, multidisciplinary networking and legal imperatives pose privacy risks.
- Recording abuse of the mother in the medical records of her children and recording the designation of the abuser in the abusive man's medical records raises specific ethical problems.
- For research on violence against women, WHO has developed ethical guidelines that refer to the privacy and safety of participating women.



ANNEXES

Annex 1: why is there conflict between the areas of health care and law enforcement?

The publication of laws, in many respects pioneering, against gender-based violence by the Spanish national parliament (24) and the Catalan regional parliament (20) have been an important step for the care of women in situations of violence. Different protocols, such as the Common Protocol for a Health Care Response to Gender-Based Violence (31) and the Protocol for Dealing with Sexist Violence in the Healthcare Field in Catalonia (32), have also set the standards for care. As legislation and protocols have encountered practice issues, some difficulties, such as the ones we review in this paper, have raised. In this annex we address a very specific issue: the reasons why we believe that the areas of health care and law enforcement enter into conflict.

The areas of health care and law enforcement enter into conflict because, although they share a common interest (to end violence against women), they have different missions. We try to analyze this difference by thinking on concepts, objectives, organizational models and inter-institutional exchanges.

Definition

The diversity of names and definitions given to violence against women has been discussed elsewhere. This probably reflects the fact (among other important issues that we will not address here) that we are not facing a unique situation that is well defined and easily limited. Far from it, behind the term "spousal abuse" there is a wide range of situations, some of which can be understood from a criminal law perspective but not others, as for instance, when a patient tells of the difficulty of caring for an elderly husband who had been a violent man at another time in life, or how to grieve for a man who abused his wife and children, or the effect of the so-called "micro-sexism" (Annex 2) on the emotional and social health of women, among other things.

Objective

The objectives, which are the same generally speaking, i.e. prevent gender-based violence, are not quite parallel when it comes to the specifics. The law's purpose is



predominantly punitive and retributive, whereas the fundamental purpose of health services is to improve the woman's situation and, in the specific case of health care, to improve her health.

Organization

Because the law *is a power of the state* and health care is not, the relationship between them is not symmetric: the professionals who work in different areas of health care, whether medical, social, psychological or other types, occupy the same place in society: service to the public. The legal world occupies a different social space: it is a power of the state, and the relationship is not symmetric. This causes, at least on occasion, unease. It is unpleasant when, for example, we send information regarding a woman and we are not provided any feedback, or when we do not receive information about a restraining order that affects us as a health center, just to show two everyday situations.

Indeed, sometimes more than just troubled, we feel, let's be clear, fear of the legal system: fear that we will be cited as experts or witnesses, and fear, especially in relation to violence against women, of being incriminated for failing to act in accordance with the law, despite having done everything correctly from the clinical and ethical perspective. We are often afraid.

There is a dual reality: judges and prosecutors say we have the obligation to report all kinds of abuse. The health care services, including the ones that are most focused and committed, claim that this is impossible and act differently. Whenever this has been brought up in seminars or courses with legal professionals, it always ends up by their invoking the law and the duty to enforce it, without any real discussion of the issues and experience, so weight of the law suffocates all other considerations. This, the silence, heightens the feeling of fear.

There is also a paradoxical situation that may help to better understand the disagreements:

The law acts with knowledge of the facts: without the participation of either the victim or the witnesses (we are privileged witnesses), the law must remain on the sidelines. Regarded in this way, it is understandable that they should consider our reticence to communicate facts to the law system as being obstructionist. We must



remember that violence against women is a problem that has consequences on health and also a crime that we witness through the victim who, let us not forget, frequently does not want to file a complaint. This fact, which characterizes situations of violence in the domestic setting, causes health care professionals to play an especially relevant role that is contained in the law itself.

Interestingly enough, the opposite happens in the clinical context: if we file a report with the law enforcement agencies without the woman's consent, we often lose her as a patient and we are the ones who are sidelined. Obviously, this is not about being "the center of attention" but rather that all the work that may have been done by way of detection, raising of awareness, motivation to change, etc. falls into the void when we notify the authorities without having the woman's consent. At that point, more often than not, the therapeutic assistance falls through. Some have also called this "revictimization", and it has already been discussed in the section on "What are we afraid of when a woman does not wish to press charges?" in the chapter on "The Difficulties of Reporting Gender-Based Violence to the Judicial System".

Needless to say, in this paper we emphasize the difficulties we find, while very often concurrences occur much more frequently than disagreements and it is not our intention to create a dichotomy of "us and them"; far from it, what we are trying to do is to analyze different aspects of the difficulties for the sake of overcoming them.

The need for places of encounter

The lack of places where we can come together to work and reflect makes it hard to express our difficulties in a clear way or enrich our perspectives by learning about the perspective of the other (in this case, judges, prosecutors, police, etc.) and stop viewing each other from a distorting distance.

We need to have non-hierarchical places of encounter with the legal world to help us understand different points of view, be better able to comply with the law and lobby for it to be qualified or changed where appropriate.

If many professionals are afraid about filing Injury Reports, another emotion that is generated is confusion: we sometimes do not fully understand the difference



between sending the report to the prosecutor or the court, whether it should be sent by fax or through our superiors, who will see it, what will happen next, how long it will take, etc.

The purpose of this annex is not to call for constraint of the legal point of view, but it does want the difficulties to be clarified and a space that will lead to the formulation of proposals be created.



Annex 2: personal stance with regard to violence: structural violence.

The abuser and his doctor share the circumstance of belonging to a society in which violence is structural. It must be said from the outset that the structural quality of gender-based violence is explicitly recognized¹⁷ in *Catalan Law 5/2008, of 24th April, on the right of women to eradicate sexist violence* (20).

We say that violence is structural because, besides being used as a method of dealing with conflict, it permeates and structures the relationships that are established by individuals and societies. We realize that it is the relationships that are based on a code of violence, regardless of whether or not any identifiable origins can be found for it in the past. Relationships are established in a violent "mode" (25) and then the difference leads to inequality, the inequality leads to hierarchization and hierarchization leads to submission. The incorporation of violence into the structure of relationships makes each of these steps necessary and natural (26).

That is why it is not enough to simply exclude violent behaviors and attitudes from our relationships if in the long term we want the effects to be lasting, but rather we would have to radically modify these relationships, rebuild them using another code, constitute them in such a way that violence can not determine the exchanges. Therefore, if the physician and the man who is an abuser belong to a society in which violence is structural, it means that they share stereotypes, patterns of behavior, that are structurally violent.¹⁸

¹⁷ Article 7: *Guiding principles in the actions of public powers: b) Due consideration of the structural and multi-dimensional nature of sexist violence, especially with regard to the involvement of all the support and compensation systems.*

¹⁸ We can see the danger involved in asserting that violence is structural, as it can encourage passive attitudes with considerations such as: "It is structural, there is nothing we can do, the problem is that everything is very bad." We are also aware of how risky attempting to establish a common ground between the doctor and the aggressor is, and in this sense we want to clarify that we are not proposing that any doctors should be thought about as though they were abusers (although some may be as, in theory, there should be as many men who are abusive among doctors as there are in the social class to which they belong). We also believe that we cannot consider the abusive man as an individual who is disconnected from his world, as a sort of monster with no context nor, on the contrary, can we lay most of the blame on structural violence on account of its explanatory power, thereby de-responsibilizing the aggressor.



Micro-sexism

So far, our discussion regarding structural violence has not gone into specifics. Now let's look at how an analysis from the perspective of the kind of relationship a couple has helps us to understand how violence structures relationships.

According to Luis Bonino, micro-sexism or microaggressions are those *"tiny, almost imperceptible, quasi-standard controls and abuses of power that men continuously use. They are practiced in the arts of command, using small maneuvers that, without being very noticeable, insidiously and repeatedly restrict and violate women's personal power, autonomy and mental equilibrium, and also attempt against the democratization of relationships"* (27). When they are detected, it is because of the effect that they have on the woman and then, since the microaggressions remain undetected, we call them the woman's oddities and peculiarities. The effectiveness of micro-sexism lies in that it modifies the relationship, adjusting it to serve the interests of the man, and quite often not even the man himself is aware of it. What's more, as micro-sexism is at the same time a tool that shapes the male identity, there is usually remarkable resistance by men to recognize that they are behaving in this way. Abusive use of space, the maternalization of women and the pseudo support¹⁹ are examples of behaviors that can hardly be considered violent in the conventional sense but have the same goals and cause the same effects that macroaggressions do.

If microaggressions are so widespread that the issue of structural violence becomes a detectable feature of a couple's relationship, we can assume that the physician and the aggressor share common ground with structural violence. As a second step,

¹⁹ On *The expansive use of physical space* ["This practice is based on the idea that space belongs to men and that women have little need for it. Thus, in the home, the man takes over the house by leaving his clothes strewn about, taking naps on the living room couch thereby preventing the use of the common space, monopolizing the television or occupying all the space at the table by spreading his legs, among other tricks"]. On *The maternalization of the woman* ["Request, promote or create conditions so that the woman modifies her behavior to give priority to unconditional caring (especially for the man himself), cause her to put aside her own career development, acquiesce to her desire to have a child, by him promising to be a "good father" and then refusing to have anything to do with the child's care"]. On *Pseudo support*: ["Making statements of support but failing to back them up with cooperative actions, to women who improve their access to the public space"]. (28)



we may consider this common ground as the basis for a potential relationship between the physician and the abuser, which will have to be configured in each case. It seems to us that this professional link that includes the emotional factor is sound, and also allows an appropriate relational distance to be maintained in order to avoid any improper identification.

Although it might seem more appropriate for a male doctor to use this resource, we suggest that recognizing the microaggressions that men and women commit in every field, and not just within intimate relationships, will provide the necessary empathy with the abuser.

Annex 3: International Classification of Diseases, 10th Edition (ICD-10) and the International Classification of Primary Care, 2nd Edition (ICPC-2), domestic violence related codes (17,18)

	ICD-10 (e-CAP) *	ICPC-2 (OMIAP) *
<p>In the Primary Care health records of the WOMAN:</p> <p>To indicate the setting and author of the abuse</p> <p>To specify the type of abuse without specifying the perpetrator (also includes abuse to children and the elderly)</p> <p>To indicate some of the consequences of the abuse</p> <p>When we have not confirmed the abuse or do not want to be too specific</p>	<p>Y07.0 Maltreatment of spouse or partner by perpetrator</p> <p>T74 Maltreatment syndromes:</p> <p>T74.0 Neglect or abandonment T74.1 Physical abuse (wife/husband/child/infant) T74.2 Sexual abuse</p> <p>T74.3 Psychological abuse T74.8 Other maltreatment syndromes (mixed forms) T74.9 Maltreatment syndrome, unspecified (adult and child)</p> <p>F43.1 Post-traumatic stress disorder</p> <p>Z63.0 Problems in relationship with spouse or partner</p>	<p>Z12 Relationship problem with partner (includes psychological or emotional abuse)</p> <p>Z25 Assault/harmful event problem (includes physical or sexual abuse of child or partner)</p>
<p>In the Primary Care health records of the CHILDREN:</p>	<p>Z61 Problems related to negative life events in childhood (excludes maltreatment syndrome)</p> <p>Z63.0 Problems in relationship with spouse or partner</p>	<p>Z16 Relationship problem with child (includes emotional abuse)</p>

*e-Cap and OMI-AP: electronic medical record systems in Primary Care



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