Challenges of Violence and Ethical Foundations of Professional Nursing

Abstract

Clients who are a victim of violence can pose significant challenges in the medical setting. Challenges, and ethical difficulties can ensue for both the client, and the nurse. Clients who wish to report violent encounters to their clinician may experience apprehension, and when they do report, may not receive the proper care, and support they need. Nurses who are caring for a victim of abuse may not be aware that they are caring for one, or if abuse is suspected, may not know how to approach the situation. The nurse can have his or her own personal biases that effect care, and jeopardize the client's safety.

Keywords: violence, domestic violence, intimate partner violence, ethics

Violence, and abuse are a source of injury, physical, and mental anguish in people of all ages. The high incidence of violence has direct impact on health care, and crosses all cultural boundaries. Nurses are challenged to identify, and intervene when providing care for a victim of violence, and can even be a victim of violence themselves in the workplace from families, clients, and colleagues.

In meeting the challenge of providing care for victims of violence, nurses sometimes come into the profession with established values, and beliefs, which may be different from the clients. Beliefs may be so strong that it is difficult not to judge the client, and the nurse may react in a way that compromises care. Mandated reporting may discourage victims from seeking care, and create competing obligations for clinicians (a healthcare professional that works directly with the client). However, nurses have a role that enables them to recognize abuse, and have influence on reducing the effects of violence. Also, nurses have the opportunity to create a new workplace culture.

In 2019, according to the CDC, at least 1 in 7 children have experienced child abuse and/or neglect in the past year, which they determine as likely an underestimate. On average, more than 12 million women, and men over the course of a year are victims of rape, physical violence, or stalking by an intimate partner in the United States. Also, nearly half of all women and men in the United States have experienced psychological aggression by an intimate partner (Statistics, para.1). The American Medical Association Journal of Ethics reports that a 2014 study found that 88% of victims had contact with a health professional while being trafficked, but none were identified or offered help in getting out of their situation during the medical encounter (Henry, 2018, para. 2).

Related to the above statistics, it is of great important that violence is acknowledged as a prevalent problem in healthcare, by not just nurses, but all members of the medical team. Measures need to be taken to recognize, intervene, and bring safety to an abused client. However, those measures do not always come without challenges, and strain.

Violence often goes unreported, because victims fear blame, shame, embarrassment, fear of

not being believed, the batterer's retaliation, and unreliable legal action. Abused men specifically may be less likely to seek help because of the stigma. Clients have told Dr. Ravi, a family physician, that there were times they left a medical setting because they felt they were being judged. Dr. Revi states, clinicians, need to change the way they think about people who are deemed "frequent flyers" (para. 6). For example, a client who is coming in for frequent sexually transmitted infection (STI) testing, could be forced to be engaging in unprotected sex. Often, the nurse is the first one outside of a person's family to discover that the person is being abused. It is exceptionally important that clinicians are nonjudgmental to victims during the first visit, because that interaction can establish whether the physician's office, or emergency department is a safe place. The client may not disclose their abuse the first visit, but it opens the door for future disclosure.

The nurse may feel frustrated, and judge the client for continuing to stay in an abusive relationship. "A challenge for the clinician is to witness the woman's suffering and pain while understanding that only the woman can determine the right time to separate from the destructive relationship" (Valente, Jensen, ethical issues, para. 4). The cycle of violence plays a role in why the victim stays, and has 3 phases, which ultimately ends with the victim having difficulty deciding to leave. If the client decides to stay, which they often times do, the cycle repeats. "The majority of intimate partner violence survivors will leave an abusive partner 7-12 times before they leave for the last time" (cycle of violence).

Barriers related to domestic violence treatment exist for both the victim, and the nurse. Valente, and Jensen state that clinicians may lack domestic violence treatment training, and may experience denial regarding the client's problem. They may also believe that domestic violence occurs only in lower socioeconomic classes, or fear offending the victim by asking about abuse (Barriers to Treatment, para. 1). Victims of violence come from all socioeconomic, racial, occupational, educational, and religious backgrounds. To assist victims effectively, healthcare workers must examine their own biases, and reactions to domestic violence. Nurses who are unclear about their own feelings may deny violence exists, blame the victim in a crisis, or minimize its effects.

Mandated reporting may cause an ethical dilemma, because clinicians want to protect their client from harm, but they also want to respect the client's confidentiality and autonomy. "It is difficult for the clinician to accurately predict when reporting abuse will help protect the client, and when it will prompt the abuser to increase violence" (Valente, Jensen, Ethical Issues, para. 1). All states require reporting child abuse, but only a few states require reporting domestic violence against a victim who is not a child or elder, which could lead to difficult decision-making for the clinician.

Supporters of mandatory reporting believe it helps prevent domestic violence by holding the perpetrator accountable and keeps the client safe. However, others think mandatory reporting violates clients' rights, can lead to more violence, and deters victims from seeking medical treatment. From a study conducted based on survivors' opinions of mandated reporting, 60 out of 61 participants (whom are all women) did not support mandated reporting by health care professionals, until a number of system-level changes have occurred (Sullivan, Hagan, 2005, p. 5). The majority of the participants indicated that they had sought medical attention for at least one injury that was related to the violence. Through this experience, they either lied to the treating physician and/or nurses about how they became injured related to feelings of humiliation, or fear of the authorities being called and their abuser retaliating. In other cases, the

abuser remained in the treatment room, and would not let the victim speak for herself. Participants who experienced this reported that no member of the healthcare team had asked the abuser to leave the room. Some of the women had a desire to report, however were unable to, because the abuser lingered. Of words from a participant “once he jabbed me with a fork, imbedding it in my hand. The doctors had to remove it for me. They never asked me what happened and believed my husband’s reason that the injury was another accident. Doctors should learn how to identify abuse of women. For 7 years, the abuse was hidden. No one gave a shit or provided me with any assistance” (Sullivan, Hagan, 2005, p. 6).

Regarding sexual abuse specifically, the participants intensely believe that it should be a woman’s choice whether the police are contacted from a medical facility. The only time the partakers were hesitant in this opinion, was if the victim was a child. Some of the women studied had been sexually abused as children, and had wished that a clinician had done something to stop the abuse. Some participants received good medical treatment following their sexual assault, however some reported that the treatment they received by physicians, and nurses made them feel worse about what had happened to them. They described a variety of victim-blaming questions, and comments made by the health care professionals.

Furthermore, “participants who obtained medical treatment reported being left not only with the physical and emotional scars of the assault, but also with the bills for the treatment” (Sullivan, Hagan, 2005, p. 9). Several women had unpaid bills with hospitals that used rape kits on them, some had to pay for medications from contracting an STI, and many women experienced damaged credit because their cases were referred to collection agencies. The women reported that hospitals did not inform them that it would be their responsibility to pay for the forensic examinations, or the medical treatment. “The women felt revictimized by the system” (Sullivan, Hagan, 2005, p. 9). Lets also not forget, that mental health treatment seeked by these clients is common, and can be costly.

With all of these challenges for victims, and nurses brought to the forefront, clinicians have the opportunity to make a change. The participants in this study discussed the urgency for health care providers to receive better training. It was also mentioned that instead of calling the police for rape victims, they should call the rape crisis center. Screening for domestic violence should be routine in healthcare, regardless of the chief complaint. “Clinicians must ask direct questions about violence, and detect subtle, and overt clues” (Valente, Jensen, 2000, Headnote, p. 1). Detection of victims of violence requires high levels of skill in communication and assessment.

Assessing safety, recognizing risk factors, and recognizing physical, and emotional signs of abuse are important step in screening. The nurse should do a head-to-toe assessment with emphasis on the head, integument, musculoskeletal, abdomen, and neurologic system. When the client is alone, and after building rapport, nurses can use screening tools. If abuse is suspected, the clinician should emphasize that the client did not deserve to be abused, that it is not their fault, and should stress the desire to want to help. When asking questions regarding abuse, clinicians should be frank, and based on the client’s response, ask for further details. The nurse can offer the option of answering “sometimes” instead of only “yes” or “no”; this may encourage the client in making the first step to acknowledge the abuse (Blais, Hayes, p. 449). “There are numerous such accounts from abused women saying that direct inquiry from a caring health care professional helped them disclose their abuse and find the appropriate intervention services” (Asking about domestic violence, 2014, para. 1).

To successful intervene, it's important that clinicians refer clients to resources that best suit their needs. Let the victim know that health, housing, legal, and social services are available to them, because some victims have economic dependence on their abuser. "Because severely battered women are a risk for homicide, the nurse needs to teach the client about associated risk factors, and how to determine the immediacy of danger" (Blais, Hayes, 2016, p. 450). Information should also be given about protective services. There is evidence that women who use a shelter for protection, experience a reduced rate of re-abuse, and further value life when they also receive advocacy, and counseling (Blais, Hayes, p 450.)

Most victims feel trapped, and as mentioned, rarely leave the abusive situation at first. The nurse must respect victims' decisions, and experiences, and understand their perspectives. "The clinician should recognize the system is imperfect, encourage the woman to keep an open mind on available legal options, and if available, recommend advocacy programs that help women navigate the legal system" (Valente, Jensen, Resources and Referrals para. 3). Interviewing the client alone is an extremely vital piece in detecting violence. Dr. Ravi urges that it is also important to establish a policy, that states a client needs to be seen one-on-one for part of the visit because often, trafficked patients will come in with a man or woman who is trafficking them (para. 8). Clinicians can create safety plans with their clients, and they can place victim safety cards in the bathrooms for clients who need information but may not be ready to disclose.

When considering the term nursing management, nurses often think only of those nurses who are in designated administrative positions, when in reality, registered nurses often are guiding, or managing other support personnel (Blais, Hayes, p. 177). Staff nurses are nurse managers even when they don't have an official management title. With being a manager, comes leadership, and with being a leader comes advocacy, integrity, courage, initiation, and self-awareness. However, when it comes to initiating a course of action, and making an ethical decision, it is not always simple. For example, "an ethical argument arises as to whether healthcare is a right, or a privilege" (Blais, Hayes, 2016, p. 68).

Nurses have the responsibility for considering the financial impact of healthcare decisions for clients. Finances have their fair share of challenges in healthcare, especially when it in involves violence. Resource management, which is using cost-effective approaches to high-quality health care, and prevention, can both be used as cost-containment methods. There has been a change in focus from treatment, and cure to prevention, and promotion of wellbeing (Blais, Hayes, p. 318-319).

According to the CDC, all forms of intimate partner violence are preventable (2019). The CDC works to prevent injuries, and death from violence through its Division of Violence Prevention (DVP). The DVP monitors and tracks trends, conducts research, develops prevention strategies, and promotes evidence-based prevention. "Strategies to promote healthy, respectful, and nonviolent relationships are important part of prevention. Programs teaching young people healthy relationship skills such as communication, effectively managing feelings, and problem-solving can prevent violence" (CDC, 2019, para. 4). Likewise, strategies that provide support to parents, and teach acceptable parenting skills will help prevent child abuse. These are just a few examples to prevent violence.

An advocate supports clients and their autonomy. "Advocacy is an ethical concept for nursing practice, and refers to providing support for a client's rights, or best interests" (Blais, Hayes, p.70). Through advocacy, nurses act as the client's defender, and acknowledge the client's

entitlement to respect. Putting their own biases aside, nurses also help the client reach decisions consistent with their values, and lifestyle. Today's healthcare crises of abuse, and increasing health care costs all demand that the nurse fulfill the role of advocate.

Nursing professionals are known to be caring, compassionate, and trustworthy. The nursing profession has been recognized as the most honest occupation 18 years in a row. Therefore, nurses can help clients regain attributes, such as trust and safety, and the element of self-worth, that might have been lost from the violence they experienced. Clinicians can help clients release the burden of violence from their lives. Although violence does not go without its challenges and ethical dilemmas, the validation a clinician can provide to a victim is extremely important. It communicates that nurses, physicians, and unlicensed assistive personnel are there to listen.

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