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ETHICAL AND LEGAL ASPECTS IN NURSING CARE FOR VICTIMS OF DOMESTIC VIOLENCE[1]

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ABSTRACT

Objective: analyze the knowledge of hospital nurses about the ethical and legal aspects in nursing care for domestic violence victims.

Method: qualitative research, involving 34 nurses at two hospital in the city of Rio Grande-RS (Brazil). The data were collected between May and August 2014 through semistructured interviews and analyzed by means of the software *Analyse Lexicale par Contexte d'un Ensemble de Segment de Texte*, which groups the lexicons with similar roots, constituting the classes according to the function of the words in the text.

Results: the class generated two subclasses: the nurses' (lack of) knowledge on the legal competences, in which the confusion between a police compliant and a mandatory report was observed; and (lack of) knowledge on the ethical competences, in which they mention the need for secrecy, advice and privacy in the care process. Continuing education empowers the professionals, which entails the visibility of the violence in the health area.

Conclusion: the attention of instutucional managers for training the professionals is necessary. The reified knowledge on the phenomenon, associated with the relational care, point towards humanized and emancipatory nursing care to the victims.

DESCRIPTORS: Domestic violence. Violence against women. Ethics, professional. Liability, legal. Nursing care. Professional training.

ASPECTOS ÉTICOS E LEGAIS NO CUIDADO DE ENFERMAGEM ÀS VÍTIMAS DE VIOLÊNCIA DOMÉSTICA

RESUMO

Objetivo: analisar o conhecimento de enfermeiras hospitalares sobre os aspectos éticos e legais no cuidado de enfermagem às vítimas de violência doméstica.

Método: pesquisa qualitativa, realizada com 34 enfermeiras de dois hospitais do município do Rio Grande-RS. Os dados foram colhidos, entre maio e agosto de 2014, por meio de entrevista semiestruturada e analisados através do *software Analyse Lexicale par Contexte d'un Ensemble de Segment de Texte*, que agrupa os lexicos, com raízes semelhantes, formando as classes, conforme a função das palavras no texto.

Resultados: a classe gerou duas subclasses: (des)conhecimento das enfermeiras acerca das competências legais; nela observou-se a confusão entre denúncia policial e notificação compulsória, e (des)conhecimento das enfermeiras acerca das competências éticas, em que mencionam a necessidade de sigilo, orientação e privacidade no processo de cuidar. A educação permanente empodera os profissionais refletindo na visibilidade da violência, no campo da saúde.

Conclusão: atenção dos gestores das instituições, para capacitação dos profissionais é necessária. O conhecimento reificado, sobre o fenômeno, associado ao cuidado relacional, sinalizam para um cuidado de enfermagem humanizado e emancipatório às vítimas.

DESCRITORES: Violência doméstica. Violência contra a mulher. Ética profissional. Responsabilidade legal. Cuidados de enfermagem. Capacitação profissional.

ASPECTOS ÉTICOS Y LEGALES EN EL CUIDADO DE ENFERMERÍA DE VÍCTIMAS DE VIOLENCIA DOMÉSTICA

RESUMEN

Objetivo: analizar el conocimiento de las enfermeras sobre los aspectos éticos y legales en la atención de enfermería a víctimas de violencia doméstica.

Método: investigación cualitativa con 34 enfermeros de dos hospitales de la ciudad de Rio Grande-RS (Brasil). Los datos se recolectaron entre mayo y agosto de 2014, por medio de entrevistas semiestructuradas y analizados utilizando el software Analyse *lexicale par Contexte d'un Ensemble Segmento de Texte*, que agrupa los léxicos, con raíces similares, formando clases de acuerdo a la función palabras en el texto.

Resultados: la clase generó dos subclases: (des)conocimiento de las enfermeras sobre las habilidades legales; se observó la confusión entre los denuncia ante la policía y la notificación obligatoria, y el conocimiento (falta de) de las enfermeras sobre competencias éticas, citando la necesidad de mantener el secreto, la orientación y la privacidad en el proceso de atención. La educación permanente permite a los profesionales que reflejan la visibilidad de la violencia en el campo de la salud.

Conclusión: la atención de los administradores de las instituciones a la formación de profesionales os necesaria. El conocimiento objetivo sobre el fenómeno, asociado con la atención relacional, señal a un cuidado humanizado y emancipatorio de enfermería.

DESCRIPTORES: Violencia doméstica. Violencia contra mujeres. Ética profesional. Responsabilidad legal. Cuidados de enfermería. Formación profesional.

INTRODUCTION

Domestic violence against women (DVAW) has increasingly gained visibility in the past decade, in the Brazilian and international spheres. The discussions go beyond the problems for women's health, including the impact of the violence in the lives of the children[1] and in the family, addressing the credibility of the population in the Brazilian protective legislation[2] and focusing on spending on police, legal and health care in this context.[3]

This multifactorial problem is based on the hierarchical power relationships between men and women, due to the historically constructed and naturalized inequities.[4] The World Health Organization has characterized this form of violence as a global public health problem of epidemic proportions.[5] Nevertheless, in practice, few professionals have considered the phenomenon as something that deserves their attention.[4]

A mistaken perception exists that DVAW is restricted to the legal, social and public safety sphere,[6] limiting the health care to forwarding or medication treatment. According to call 180 (*Ligue 180*), the Call Center for Women, in the first semester of 2015 only, 179 cases of aggression against women were registered per day, 92 being related to physical, 55 to psychological and seven to sexual violence.[7] In many of these cases, besides being attended in hospital, the true cause of the illness is not investigated.

It is known that published data on DVAW are underestimated, as many women omit being a victim, even when they turn to health services.[8] Another factor that masks the actual data is the professionals' limited knowledge about the phenomenon, which can derive from gaps in the academic education or in continuing education.[4,8] The (lack of) knowledge about mandatory reporting is an example of this shortage, so that the professionals do not execute it.[9] Others are afraid the aggressor with retaliate,[9-10] indicate constraint to ask questions about the details of the violence or trivialize the facts, considering that they are part of daily life.[9]

In addition, there is insufficient clarity on the necessary conducts when the victim reveals the aggressions.[6,11] Deficient education, in combination with the burden of coping with histories of violence, entail dilemmas and contradictions, limiting the care actions in this context. Therefore, beyond repeating that the approach of this phenomenon is permeated by beliefs, judgments and stereotypes among the health professionals, inhibiting effective and humanized care for the female victims, problematizing their ethical and legal competences is fundamental.

In that sense, the Ministry of Health has issued technical standards and Codes of Ethics[12] exist that instruct the professionals and regulate the ethical and legal conducts towards the phenomenon. What the sexual violence is concerned, Law N.12.845 has recently been enacted, which makes comprehensive care to the victims within the Unified Health System (*Sistema Único de Saúde)* mandatory. The Law addresses immediate care, diagnosis, treatment of genital injuries, prophylaxis of diseases and pregnancy, as well as support by a multidisciplinary team.[13]

Therefore, in order to guarantee high-quality care for female victims of violence, the profession-

als need knowledge and training with a view to achieving problem-solving and effective actions. The women need to be heard and monitored at the reference services until they are prepared to recover their lives without feeling guilty for their exposure to the violent act.[14]

In view of the immediate consequences of the violence for the women's health, which make them use the emergency care services, and although nursing professionals are responsible for health education actions, having contact with the clients 24 hours per day, either during the hospital screening or at the services when hospitalization is needed, problematizing the ethical and legal competences that permeate the care process is unprecedented.

Hence, the objective in this study is to analyze the knowledge of hospital nurses about the ethical and legal aspects in nursing care for female victims of domestic violence.

METHOD

A qualitative and descriptive study was undertaken at two medium-sized hospital in the city of Rio Grande-RS (Brazil). One, a teaching hospital, was a reference for cases of sexual violence, and the other, a philanthropic hospital, had the only burns center in the city and receives victims of domestic violence.

The medical clinic, surgical clinic, maternal-obstetric, intensive care, burns center and emergency center were selected, as the probability of female victims of violence being hospitalized is higher at those services. Up to three nurses were invited from each of these services to participate in the study, with at least two months of experience at the sector, considering that that period would have granted the informants the opportunity to deliver care to victims of violence.

The data were collected between May and August 2014 through individual interviews, held at the institution, inside a private room. A thematic script guided the interview, aiming to understand the attitudes and knowledge about the phenomenon, as well as the care practices for the victims of domestic violence. The script was applied to the members of the research group for testing and then adapted. The interviews were recorded and transcribed, with the informants' consent, for further analysis.

The corpus constructed based on the interviews was submitted to the software *Alceste* (*Analyse Lexicale par Contexte d'un Ensemble de Segment de Texte*), which divides the whole text into Elementary Context Units (ECUs), using cluster analysis. The higher the chi-square (x^2) coefficient the software attributes to these units, the greater their significance. They consist of the words that are meaningful, such as nouns, verbs, adjectives and adverbs. The ECUs are distributed into classes based on their semantic proximity, so that each class contains distinct aspects of the study object.[15]

In this study, the program produced eight classes, one of which was selected for a detailed analysis in this article, in view of the importance of the theme addressed. In the presentation of the results, the ECUs (statements) were identified using consecutive Arabic numerals, corresponding to the chronological order of the interviews, followed by the abbreviations UH – university hospital and PH – philanthropic hospital. Approval for the project was obtained from the Research Ethics Committee in Health under Opinion N. 80/2014 and CAAE registration N. CAAE 32033714.5.0000.5324.

RESULTS AND DISCUSSION

Among the 34 informants, 16 worked at the UH and 18 at the PH, and only one was male. The ages ranged between 25 and 59 years and the length of experience at the service ranged between two months and 20 years.

The class discussed in this text consists of 102 ECUs and is represented in the tree diagram in figure 1. The tree diagram displays the set of binary divisions within a specific class, showing the relation between groups of words and their meanings. In the diagram, the horizontal line originating in the first binary division divides the contents in two groups. In each of them, these divisions link the short forms with greater statistical significance, permitting the identification of their meanings. The x^2 coefficients of the short forms *notific* (102) and disease (93), located above the line; and compromiss (223) and legislation (200) located below the line stand out, permitting the identification of one category related to legal competences and another related to the nurses' ethical competences related to the DVAW, which produced the subclasses presented next.

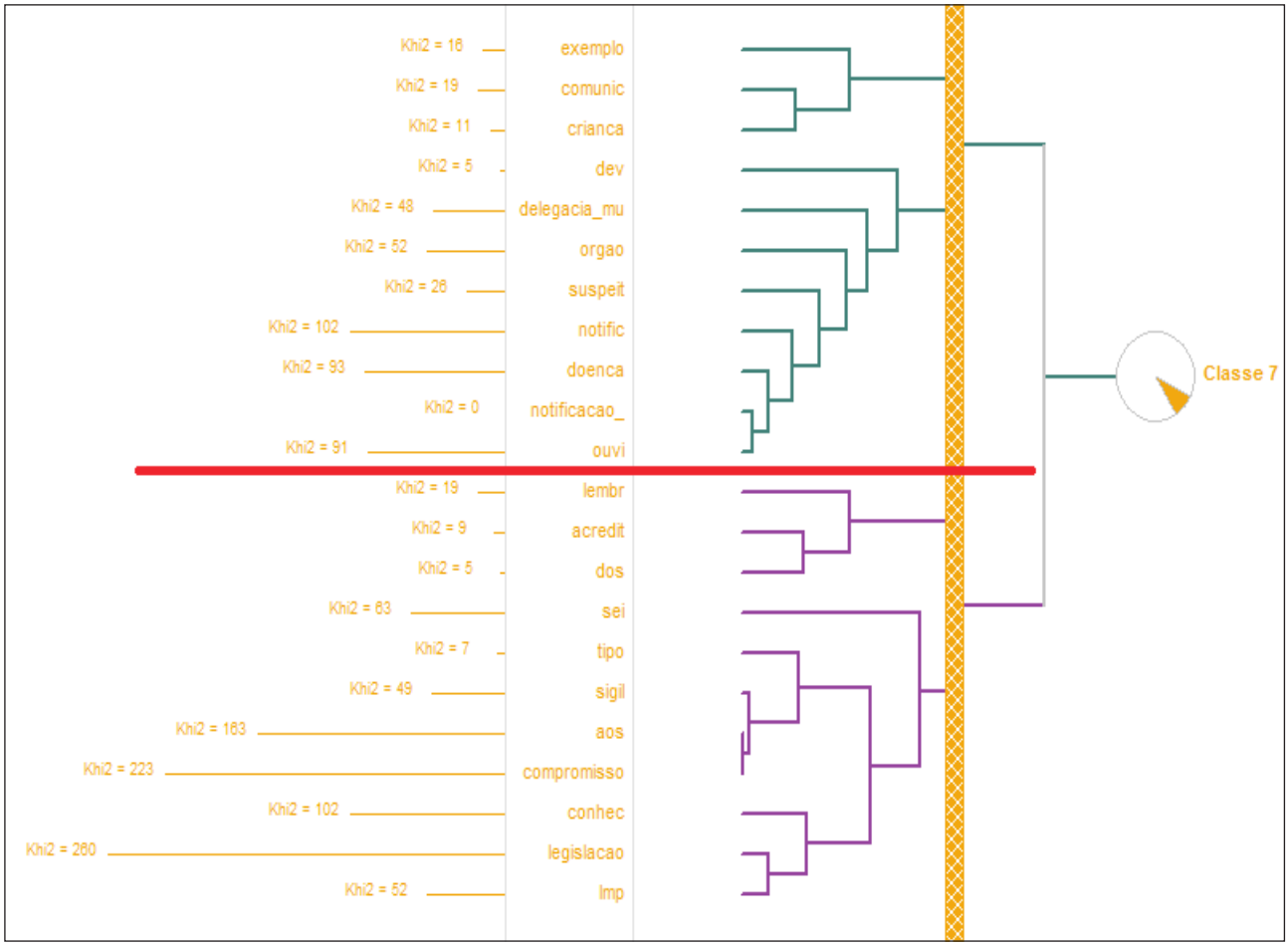

Figure 1 – Ascending hierarchical ranking of the selected class – Ethical-legal competences of the nurses in care for victims of domestic violence. 2015

Nurses' (lack of) knowledge on the legal competences

This subclass refers to the legal aspects involved in care for victims of violence. The interviewees affirmed knowing the mandatory reporting, but limited it to the registration of infectious-contagious diseases. This revealed that they did not know about the need to notify domestic and sexual violence. The professionals mixed up the reporting of this kind of violence with the police complaint, admitting that they should visit the women's police station to file a complaint.

On the other hand, some nurses demonstrated partial knowledge, mentioning that statistical data exist about the phenomenon, but they believed that the police dimensions these data based on the victims' complaints. The following ECUs express this meaning.

The professional needs to file the complaint at the women's police station and register it in the nursing book, which is the only register that supports us. I have heard of mandatory reporting in case of illnesses, but never in cases of violence against women (Nurse 20, PH).

The problem is that I have never seen a reporting form, because there is mandatory reporting for transmissible conditions, but not for violence against women. There is no such form here, but I know it exists, because there are rates. It is a global target, I know that even the IBGE has rates, but I thought it were police data, because I've never had any access, and we've never been instructed to do the mandatory reporting (Nurse 24, UH).

I have heard about mandatory reporting, but I've never looked into what it is more closely. Are you talking about mandatory reporting to the civil police? I've kind of heard about it, but I've never tried to look into what it is more in depth (Nurse 6, PH).

The literature has attributed the underreporting of DVAW to the health professionals' lack of knowledge on their legal responsibility. Law N. 10.778 from 2003 establishes that the reporting of cases of violence against women who are attended at public or private health services is mandatory

across the Brazilian territory. This report is confidential and should be executed in suspected as well as confirmed cases.[16]

To justify the lack of knowledge on this legal competence, some argue that they do not work "*in this area*", and others that their professional experience is limited.[9] As the report is frequently considered as a denunciation, one can presuppose that the underreporting is due to the fear of exposure to a police entity as well as to retaliation by the aggressor.[10] These perceptions distance the professional from practicing this legal competence.

These aspects demand further reflection, also based on the professionals' discourse: "*we have never been instructed to do the reporting*", "*are you talking about mandatory reporting to the civil police?*", "*I have never seen a reporting form*". The mandatory reporting is actually a systematic and organized registration on a specific form, used in suspected cases or when violence against women has been proven. The professional does not need to know the aggressor to complete it. Next, the document is forwarded to the municipal Epidemiological Surveillance department for input in the National Disease Notification System.[17]

Nevertheless, the professionals need to be familiar with the form. A study has evidenced 101 professionals' difficulty to complete this form; 53.5% attributed this to the victim's constraints, such as fear and shame to answer the questions; 33.7% referred to the characteristics of the form; and 29.7% mentioned constraints to ask about the violent act.[18-19]

Training is reflected in the visibility of this form of violence in the health area, as evidenced in research.[20-21] Therefore, the professionals need to be heard about the limitations and needs deriving from the professional practices, with a view to problematizing relevant inquiries, anxieties and conducts in situations that can strongly affect the victims' health and influence the professionals' quality of life, such as DVAW, cancer and AIDS.

The nurses' (lack of) knowledge on the mandatory reporting of the violence is not restricted to the problems for the woman. Weaknesses are also observed concerning the conducts related to the cases of violence against children and elderly, according to the following ECUs.

What the legislation is concerned, I know that for children we call the Tutelage Council; for elderly, the statute of the elderly; for women, I think that, due to the violence, you call the women's precinct directly (Nurse 2, PH).

The reporting for children is with the police, I know that you have to call the policy. The professional has to identify in order to protect the child, because I know that protection for children has existed for a long time, I know that you are obliged to report, it seems that you call the police and the policy calls the Tutelage Council (Nurse 031, UH).

The same mistake is evidenced in the reporting of violence against children, associating it with the police complaint. It is highlighted that legal documents like the Child and Adolescent Statute and the Elderly Statute also mention the mandatory reporting of these violence cases.[20] The Tutelage Council should be activated whenever situations of risk or violence against children and adolescents are perceived, as it is intended to apply measures in protection of this population's rights.[22]

A study to characterize the occurrence of domestic and sexual violence based on the reporting forms in the city of Belém revealed 3,267 cases of violence between January 2009 and December 2011. Physical violence against female victims older than 19 years of age stood out (n=663). Among the children, sexual violence prevailed.[20]

Based on the records, the profile of the victims can be outlined, as well as of the aggressor, the type of violence and the place where the violence took place, among others. This dimensioning permits the implementation of policies on a national and local scale, according to the epidemiological profile of the violence found.

Nurses' (lack of) knowledge on the ethical competences

This subclass refers to the ethical aspects of nursing in care for victims of violence. Reflecting on these aspects is one way to cope with the challenges that emerge in the health work area. According to Bioethics, four principles should guide the practices, decisions and actions in health: beneficence, which refers to the moral obligation to act for the benefit of others, assessing the risks; the principle of non-maleficence, which is intended not to cause harm and avoid harming people; the principle of justice, which seeks a balance between the duties and social benefits; and the autonomy principle, as a condition to promote the independence, to allow people to make choices without any kind of control.[23]

What the care for the victims of domestic violence is concerned, the nurses mentioned the need for secrecy and private, protection and orientation on these women's rights. Nevertheless, many un-

certainties existed and, again, the police complaint is mentioned as an ethical competence.

Concerning the ethical commitments, I think that preserving this patient's privacy is one, advising this patient another, protecting this patient is also ethical. People tend to come here very weakened by this kind of attitude, of suffering. I think that's basically it, I don't know if there is something that turns the reporting mandatory, or that kind of things (Nurse 18, UH).

As for the commitments, I think the first thing is to preserve the confidentiality of what she trusted you with, preserving the confidentiality among coworkers and professionals (Nurse 34, UH).

I believe there should be something in the ethics code of nursing professionals. There should be in our code because I've read it, I've seen it with regard to omitting the suspicion, which is improper (Nurse 12, UF).

The nurses' discourse revealed that they demonstrated greater knowledge on the ethical competences, as these actions permeate the care practices. In the Nursing context, ethics comprises attitudes and conducts that involve knowledge, values and skills to favor the potentials of human beings and the coping with the health and disease process.[24]

In that sense, the privacy the nurse mentions is an action intended to preserve the female victim, in line with the principles of beneficence and non-maleficence. They commonly arrive at the service weakened, in need of welcoming, of a reciprocal relationship: these actions are translated through the discourse, touch, active listening. Nevertheless, it does not depend on the processional only, but on the physical structure and the material resources available, which often leave room for appropriate counseling and a physical examination.[14, 25]

According to the Ministry of Health, the female victims of sexual violence should be prioritized in care, and unjustified refusal to provide care can be ethical and legally characterized as omission. In addition, to preserve their intimacy, spaces that cause constraint or stigma should be avoided, such as the identification of a "*care for rape victims*" room for example.[17]

The women's revictimization at the health services should be avoided, valuing light technology in care practice. It is known that the professionals' conduct can influence both the victims' decision to reveal the violence and their future decisions. Hence, these women's instruction and protection, according to the nurses, represent the principle of beneficence, established through the relational sphere of care.

In a study to identify physicians and last-year students' knowledge on the epidemiological, ethical and legal aspects of gender violence, the majority's correct positioning was identified: 99% agreed that signs of violence should not be ignored, even when the patient does not mention the topic; 72.8% mentioned scheduling return appointments at short intervals; almost 69% referred that it is correct to ask about the possible existence of violence; 85.4% of the participants reported offering the telephone of the women's precinct and the address of a shelter house for patients; and only 22.3% would advise the woman to leave her violent partner immediately.[11]

The literature suggests not to encourage the woman to leave her home without means to provide the victim with minimal safety conditions; not even summoning the aggressor to the service for a conversation.[11] Nevertheless, remaining inert goes against the ethical-legal duty, which defends aiming for health. To help the women to break with the violent cycle, they need to be equipped to be able to make their own decisions, respecting the principle of autonomy.

The responsibilities, duties and prohibitions related to the nursing professionals' ethical conduct are listed in the Ethics Code,[12] which only one interviewee mentioned. What the study theme is concerned, the expression "domestic violence" does not figure explicitly in the text, but article 52 considers that "provoking, cooperating or colluding with maltreatment" represents an ethical infringement, punished with penalties ranging from a simple alert to the nullification of the right to practice the profession,[12] which strengthens the nurses' commitment to the mandatory reporting as an ethical duty as well.

Women exist who omit the situation of violence,[4,14] while others end up self-medicating in the attempt to solve their problems and support the context of violence.[26] Others turn to the health services, but are afraid that the reason for the consultation will be revealed to the relatives. Abstaining from the revelation of confidential information they know about to people or entities who are not bound by secrecy is considered a professional right.[12] Thus, the secrecy the interviewee mentions is in accordance with the ethical competences.

The situations in which the rupture of professional secrecy should be highlighted, like in cases of a court order, or with the stakeholder's written consent. In a multiprofessional activity, the confidential fact can be revealed when the need is observed to support the care practice, thus contradicting the interviewee's discourse.[12]

As observed, the nurses' professional code contains instructions that, although not exclusive to the female victims, support the care conducts and the professionals for their care practices. The (lack of) knowledge on these responsibilities and duties can cause ethical dilemmas, making effective activities for these clients more difficult.

The health professionals, including nurses, face many difficulties to approach the victim, identify the cases of violence, adopt conducts and forward the women to the other services,[8,19,21] as observed in the ECUs below.

You have to try to register, denounce, register the police complaint. I believe that's it, forward to some service, in this case file this complaint, register everything that was done in a nursing book and try to forward her. I'm not sure, because that was not discussed in the undergraduate program, nor here (Nurse 14, PH).

I cannot recall specifically, I know there's the women's statute, the Maria da Penha Law, which is discussed in the media, but I haven't heard anything for nursing or health (Nurse 23, UH).

These weaknesses can derive from the lack of training by the institution where they worked, besides the lack of a standardized manual that contains information on the management and structure of the local support service network. One exception is the Technical Standard for the Prevention and Treatment of problems resulting from sexual violence against women and adolescents, elaborated and updated by the Ministry of Health, which offers guidelines to the professionals.[17] The Standard appoints aspects related to care for the victim and to the institutional organization.

In cases of sexual violence with penetration, the Ministry of Health recommends that the start of treatment with anti-retroviral drugs and emergency contraceptives occurs within 72 hours after the violence since, after this period, the efficacy of the medication drops significantly, granting less protection.[17] In that sense, nursing is responsible for guidance on the side effects of the drugs, the importance of following the medication scheme, associating technical with relational care.

As observed in the ECU, the standard recommends that the details obtained during the interview, the physical and gynecological examination and the results of complementary tests be registered in detail. In addition, drawings, pictures of the injuries and descriptions of the women's signs and symptoms can be included.[17] If the woman postpones the expert examination at the Medico-Legal Institute (MLI), the experts can elaborate the report based on the patient's history, in those cases in which she visited a health service after the violent act. Therefore, the criminal evidence is not restricted to the MLI, as the patient histories can also be demanded as legal evidence for the woman.

Violence against women is a condition that demands an intersectoral and interdisciplinary approach, with an important interface with human rights, police, public safety and justice issues. In that sense, the Law Maria da Penha, which the interviewee superficially mentioned, needs to be discussed among the professionals, as it states the attributions of the multidisciplinary team, including the psychosocial and the health area. It should be highlighted that the requirement of a police complaint at the primary care or hospital service in order to deliver care to the victims is incorrect.[17]

Therefore, the nursing professionals need to get to know the support network for victims in the city with a view to forwarding and advising the victims on the services concerning the support offered by the *lei Maria da Penha*, helping them to cope with and overcome the physical and psychological traumas. The pain of the "soul" associated with the disqualification of the female physique[26] often causes the greatest suffering,[14] with nursing serving as the "remedy" to treat the invisible marks through holistic and humanized care.

Nursing's ethical competences mainly aim for respect for the female victims, through an empathetic and welcoming approach that can minimize the suffering and guarantee the rights of the person receiving care. These are measures, postures and conducts that seek to attend to these women's biopsychospiritual demands, prioritizing the health care before any other police or legal measure.

CONCLUSION

Based on the analysis of the ethical and legal aspects that permeate the care for female victims of domestic violence, it could be concluded that there are gaps in the nurses' knowledge on these competences. As the hospitals receive the most severe cases of violence, which cause physical injuries, besides hospitalizations due to the problems, discussing the conducts, forwarding, rights and duties of nursing in this context is fundamental.

It is inferred that the underreporting of this form of violence is directly related to the lack of distinction between mandatory reporting and police complaints. In addition, the lack of knowledge

was also evidenced concerning the legal obligation to report in cases of violence against children and elderly. On the other hand, greater knowledge was observed about the ethical competences, although these are general practices that are not restricted to victims of violence. The confidentiality, advice and privacy are actions that permeate the nursing care.

None of the interviewees mentioned the laws and standards of the Ministry of Health that guide the specific care practices for victims of sexual violence. In this sense, the professionals, particularly the nurse, need to be prepared and mobilized to assist women in situations of domestic violence. Therefore, they need to work based on scientific knowledge; face the challenge of detecting, notifying, delivering care, minimizing and preventing the situations of domestic violence.

Hence, considerations are raised about the role of health institution managers, who are responsible for training the professionals. Not only the professionals who work with the clients directly, but also the service managers should commit to the Unified Health System and the health indicators. Continuing education is fundamental in professional qualification, granting knowledge on the specific legislation and the interpretation of violence as a public health problem, contributing to humanized and emancipatory nursing care for the victims.

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