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The Veil of Silence around Family Violence: Is Protecting Patients' Privacy Bad for Health?

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INTRODUCTION

Privacy, a long held Hippocratic value, is fundamental to medical practice to assure that patients can trust healthcare professionals with what may be the most intimate information they share with anyone. Generally, privacy is held to be both an intrinsic and instrumental good, helpful in promoting trusting patient-clinician relationships and maximizing individuals' health. Yet privacy can also be harmful, functioning as an impediment to necessary care. In situations of family violence, the value placed on privacy may reinforce a non-intervention norm among healthcare professionals, perpetuating a detrimental veil of privacy around what might otherwise be a well recognized public health threat. Although ample research describes the gravity of the family violence pandemic, the issue receives insufficient practical attention in the healthcare setting. This article describes the historical value placed on privacy in American society and its impact on the healthcare environment, and questions the priority of the privacy principle in situations of family violence where it may be more harmful than helpful.

PRIVACY AS A MEDICAL VALUE

In medical practice, privacy is understood in concert with confidentiality. The former concept refers to an individual's ability to keep information from being known to others. In the healthcare setting, it is imperative and customary for patients to reveal such private information to their careproviders. Healthcare professionals, then, bear the responsibility for maintaining this information in confidence, protecting the private information of their patients from others. The physician's obligation of confidentiality is present in the earliest known codes of medical ethics and persists in more contemporary codes. The Hippocratic Oath requires the physician to swear, "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about."[1] The American Medical Association *Code of Medical Ethics* states, "The information disclosed to the physician during the course of the relationship between the physician and patient is confidential to the greatest possible degree."[2] International codes such as the *World Medical Association Declaration of Geneva*[3] and the *World Medical Association International Code of Medical Ethics*[4] require confidentiality, even after a patient's death. Such codes are reinforced in law. Regulations went into effect under HIPAA (the Health Insurance Portability and Accountability Act) in 2003 to protect all

forms of individually identifiable personal health information, and apply to all healthcare organizations, careproviders, and related services (for example, billing, insurers, information systems).[5]

The value placed on personal privacy and thus the physician's obligation of confidentiality can be explained in a number of ways. As a matter of inherent value, individual autonomy and the trust between healthcare professionals and patients would be compromised if the professionals inappropriately revealed patients' information. In terms of consequences, medical practice would likely be ineffective if patients felt uncomfortable and so withheld the details of their lives to those providing medical care. There is no question that privacy and confidentiality are important, even fundamental, to healthcare.

However, exceptions to confidentiality have been codified for the protection of the patient, for others, or for society generally. These exceptions recognize the tension between individuals' privacy and public health. Such exceptions, codified in state law, include required reporting of serious and imminent threats of harm to others, certain communicable diseases, and gunshot or knife wounds. Healthcare professionals are required to report child abuse in all 50 states under federal law, and are required to report elder abuse under most state laws.[6] As of late 2007, medical personnel are specifically required to report domestic violence in seven states (California, Colorado, Kentucky, New Hampshire, North Dakota, Oklahoma, and Rhode Island), although reporting is in effect mandated in most states under other statutes, such as those requiring the reporting of non-accidental or intentional injuries, injuries due to criminal activity, fire arm injuries, knife/sharp object injuries, burns, injuries likely to cause death, or other specific types of injuries.[7] Even when reporting is mandated, compliance and enforcement remain variable and controversial.[8]

THE VEIL OF PRIVACY IN FAMILY LIFE: A HISTORICAL PERSPECTIVE

Violence in the home has long been regarded as a "private" family matter, inappropriate for public intervention unless real, visible harm to body or property results. Screams and the sound of shattering glass may elicit only comments about the couple next door "going at it again," as the neighbor closes windows to dull the noise. Interfering with what goes on inside "a man's castle" has been perceived as taboo.[9] Further, in the United States, women, children, and the elderly, the frequent victims of family violence, are often politically and socially marginalized, powerless to seek protections until "real" (physical) harm is apparent.[10]

American society has demonstrated complicity in, and even tacit approval of, family violence, particularly when perpetrated by men against their wives and children. This complicity is apparent in our legal (non)interventions.[11] Since early in this country's history, American courts have affirmed a husband's right of "domestic chastisement." For example, in 1824, the Mississippi Supreme Court ruled that this allowed a husband to "use salutary restraints in every case of a wife's misbehavior, without being subjected to vexatious prosecutions resulting in the mutual discredit and shame of all parties concerned."[12] In the mid- to late nineteenth century, state courts appeared to begin to move away from recognizing violence as an accepted part of marriage. The first law against wife beating was enacted in Tennessee in 1850, although enforcement may not have been realized for another century.[13] In 1871 the Alabama Supreme Court concluded that the privilege to chastise one's wife, "ancient though it may be, to beat her with a stick, to pull her hair, choke her, spit in her face or kick her about the floor, or to inflict upon her like indignities, is not now acknowledged by our law."[14] The same year, the Massachusetts Supreme Court similarly decided that "beating or striking a wife violently . . . is not one of the rights conferred on a husband by the marriage, even if the wife was drunk or insolent";[15] and, in 1875, the Texas Supreme Court decided that a husband's right of control over his wife does not extend to punishment and correction, but is limited to protection and self-defense.[16]

Legal attention to domestic violence illustrates the veil of privacy behind which family violence has existed. Courts similarly have historically allowed parents to "discipline" their children as a matter of family privacy. For example, in 1886, the North Carolina Supreme Court reviewed a case in which the defendant whipped his daughter 35 times with a switch, choked her, and threw her to the ground, dislocating her thumb. The court noted that this "punishment" may have been "needlessly severe," but held that "we refuse to take cognizance of it as a criminal act, because it belongs to the domestic rather than legal power, to a domain into

which the penal law is reluctant to enter, unless induced by an imperious necessity." The Court specifically recognized privacy within the home, explaining:

> If, whenever parental authority is used in chastising [children], it could be a subject of judicial inquiry whether the punishment was cruel and excessive . . . and the father himself exposed to a criminal prosecution . . . in defending himself from which he would be compelled to lift the curtain from the scenes of home life, and exhibit a long series of acts of insubordination, disobedience and ill-doing — it would open the door to a flood of irreparable evils far transcending that to be remedied by a public prosecution.[17]

Although the issue of spanking and other corporeal punishment remains controversial, many states continue to exempt parents from punishment for what otherwise would constitute criminal assaultive conduct,[18] despite federal legislation enacted in the 1960s that mandates reporting and intervention to protect children from child abuse and neglect.

In addition to changes in the legal response to family violence, research, public attention, and advocacy for victims has also increased. The harmful effects of observing violence, as a child might observe one parent abusing another, have also been recognized.[19] The veil of privacy seems to have become more transparent. Yet social norms that limit (if not prohibit) intervention in "private" family matters persist in the general public and the medical community. Seeing the problem has not translated well into action generally, and in healthcare practice specifically.

THE VEIL OF PRIVACY IN THE U.S. HEALTHCARE SETTING

Health professionals practice in a societal microcosm that reflects entrenched values related to private life. What may be described as a norm of non-intervention affects not only neighbors, but health practitioners who see the victims of violent or neglectful activities that society may deem to be private. Even when violence is suspected or recognized as the root cause of presenting complaints, it may be a common perception that the healthcare professional's job is to "fix the broken bones, not the broken homes."[20] In the hospital, the source of injury or illness may not be sought; rather, the focus is on repairing the damage done. The value on privacy that interferes with addressing family violence in the population at large also appears to operate as a barrier to medical intervention and prevention.

The effects of family violence are far from veiled, although the underlying cause of injury and illness may not be openly acknowledged. Victims of family violence suffer serious injury and illness and regularly present in the healthcare setting. Despite the prevalence of violent victimization, and the high incidence of serious medical and mental health sequelae from abuse and neglect, abuse remains under-diagnosed and under-addressed. Consider, for example, the current situation with domestic violence, defined as abuse or neglect between intimate partners. It is a significant problem in the U.S. both in terms of health effects and cost. According to the National Violence Against Women Survey, almost 25 percent of the women and 7.5 percent of the surveyed men claim to have experienced sexual or physical violence by a current or former intimate partner at some time in their life.[21] In other studies, 40 percent or more women reported that they had experienced domestic violence at some time in their life.[22] Women also experienced the highest rate of serious injury,[23] and more than half who experienced domestic violence reported that they experienced repeated episodes.[24] Rates of injury increased substantially, as much as threefold, when psychological and emotional injuries were included in addition to physical injury.[25] Regardless of their cultural background, violence against women may cause long-term physical and mental health problems such as difficulties with daily activities, memory loss, and pain.[26]

The National Violence Against Women Survey also found that in about one-third of all rapes and physical assaults perpetrated against women, the victim sustained a physical injury and in about one-third of those cases, the victim received some type of medical care (for example, paramedic care, emergency department treatment, dental care, or physical therapy).[27] Of the estimated 6.8 million rapes and physical assaults perpe-

trated against U.S. women annually, 2.6 million result in an injury to the victim and 792,200 result in the victim receiving some type of medical care.[28]

Domestic violence is associated with an increase in psychological, psychosomatic, and physical conditions including headache, chronic pain, gastrointestinal and gynecological symptoms, depression and anxiety, and acute and chronic injuries.[29] For example, women who reported sexual abuse had significantly more irritable bowel symptoms,[30] acute pelvic inflammatory disease (PID),[31] and chronic non-PID pain[32] than women who did not report abuse. About one-third of battered women suffer from anxiety and depression and over one-quarter of females attempting suicide are victims of domestic violence.[33]

Physical and psychological sequelae contribute to increased costs and utilization of medical and other services.[34] Studies indicate that the rates of overall hospital use and hospitalization for domestic violence victims are up to 3.5 times higher than for non-domestic-violence victims.[35] Domestic violence appears to be a significant predictor of hospitalizations, general clinic use, mental-health services use, and out-of-plan referrals, with net costs of $1,775 more annually for each victim of domestic violence than for comparison patients.[36] National annual cost estimates for partner abuse range from $5 billion to $67 billion.[37] Direct medical costs of care for battered women are estimated at $1.8 billion per year.[38]

Despite the growing evidence of the impact on healthcare utilization and costs, the health professions have historically considered family violence primarily as a social or legal issue, rather than a medical issue. In 1991, then-Surgeon General C. Everett Koop framed family violence as a health issue, convening the first workshop linking violence and public health. He wrote:

> Identifying violence as a public health issue is a relatively new idea. Traditionally, when confronted by the circumstances of violence, the health professionals have deferred to the criminal justice system. . . . [Now], the professionals of medicine, nursing, and the health related social services must come forward and recognize violence as their issue.[39]

That year the American Nurses Association published guidelines for identifying and treating intimate partner violence.[40] The American Medical Association did the same in 1992.[41]

Studies suggest that healthcare professionals do recognize some obligation to victims of domestic violence. For example, healthcare professionals, including dentists, dental hygienists, physicians, nurses, psychologists, and social workers, were asked to respond to the statement: "Professionals in my discipline have as much responsibility to deal with problems of family violence as they do to deal with other clinical problems." Of the 1,521 careproviders who responded, 98 percent of psychologists, 97 percent of social workers, 87 percent of nurses, 85 percent of physicians, 53 percent of dentists, and 54 percent of dental hygienists agreed with this statement.[42] In a survey of 6,568 ob-gyn physicians, 86 percent reported their belief that domestic violence is a medical problem.[43] Another survey of 275 nurses in perinatal practice reported that fewer than 4 percent of private office nurses, 5 percent of public health nurses, and 3 percent of hospital nurses agreed with the statement that domestic violence is "not a medical problem."[44]

Such attitudes, however, do not necessarily result in action, and concern about privacy and confidentiality appears to be a significant barrier. In one study of emergency service staff at four hospitals, where 90 percent of staff members stated that they should try to identify abused women and 82 percent felt this was "part of their job,"[45] those surveyed did not respond to instances of domestic violence at all in 40 percent of cases, and responded inadequately in 49 percent. This was due, in part, to the belief that to help would be "an invasion into 'personal affairs'."[46] In interviews, primary care physicians identified privacy concerns as among the most common barriers to identifying and intervening in DV. A fear of offending the victim "often originated in the physician's discomfort with areas that are culturally defined as private. . . . The uncertainty of whether patients would consider domestic violence a legitimate area to probe was distressing. . . . Physicians felt that by even broaching the subject of violence, the patient would take offense. . . ." Reluctance to "overstep the bounds of what is private . . . leaves the physician wary of how to approach the issue."[47] In another study of pediatric emergency medicine fellows, approximately 40 percent labeled a reluctance to invade family privacy as either a major (7.7 percent) or minor (32.8 percent) obstacle to identifying and

reporting suspected abuse of a child-patient's mother.[48] In another survey, 63 percent of physicians, nurses, and social workers cited personal discomfort and 57 percent cited concern about family privacy when asked about barriers to their own effective responses in domestic violence and sexual assault cases.[49]

Further, research reports both clinician resistance to reporting and problems arising from mandatory reporting requirements.[50] Among these are concerns about breaching confidentiality and so undermining patients' autonomy.[51] Such concerns are further complicated by the increased attention on privacy and confidentiality since HIPAA regulations went into effect. The American Medical Association (AMA) exhorts its constituents to inquire routinely and to treat domestic violence, but hedges on reporting: "When a jurisdiction mandates reporting suspicion of violence and abuse, physicians should comply. However, physicians should only disclose minimal information in order to safeguard patients' privacy. Moreover, if available evidence suggests that mandatory reporting requirements are not in the best interests of patients, physicians should advocate for changes in such laws."[52] The American College of Emergency Physicians (ACEP) similarly encourages assessment and treatment of all forms of family violence, but "opposes mandatory reporting of domestic violence to the criminal justice system. Instead, ACEP encourages reporting of domestic violence to local social services, victims' services, the criminal justice system, or any other appropriate resource agency to provide confidential counseling and assistance, in accordance with the patient's wishes."[53] Both the AMA and the ACEP cite patients' autonomy, patients' best interests, and privacy protections as reasons for opposing reporting requirements.

Legal reporting requirements remain controversial and certainly are no panacea. Concerns regarding patients' safety and autonomy may reflect good intentions to protect the patient; patients whose abusers discover the disclosure may be at greater jeopardy for further violence or retaliation.[54] Reporting may seem ineffective or even counterproductive given insufficient social structures to address the problem of family violence. However, among the goals underlying the reporting requirements is making a private problem publicly visible. Reporting requirements may be considered a clumsy tool for encouraging intervention by health professionals in a problem with horrific health implications. But no reporting means no visibility, and no opportunity for public response. Therein lies the problem. In the name of supporting individual privacy, healthcare professionals may ignore — purposely or by omission — the social context of the illness and injury they treat, or they may neglect to report their suspicions. Naming "privacy" and "confidentiality" as justifications for ignoring or failing to address a situation of family violence inappropriately prioritizes privacy over other values — such as individual and societal beneficence, as well as regard for the law — and perpetuates a potentially harmful veil of privacy that obscures an issue in need of much social, medical, and political attention. While recognizing a problem does not guarantee that it will be addressed, not acknowledging it assures that it will not be addressed.

CONCLUSION

The concept of privacy can create a conundrum for addressing family violence: "Is too much privacy bad for your health?"[55] Privacy is a helpful and necessary concept in the practice of medicine, but one that can become harmful when patients present with symptoms that are rooted in social ills, perceived to be private family matters with which clinicians should not interfere. The obligation to protect patients' information may disguise an underlying sense of non-interference that ultimately neglects patients' protection and may facilitate harm. The private information remains private, to the detriment rather than to the benefit of the patient. This is not to suggest that a patient's situation of family violence should be broadcast. There are very real needs for maintaining confidence throughout the reporting and treatment process. Disclosure must be undertaken carefully in the context of safety planning. But taking refuge in the value of privacy and confidentiality may increase the danger for patients and allow a significant public ill to persist unattended. In balancing values, health professionals are obligated to weigh competing interpretations of privacy and confidentiality to determine how best to serve their patients. The privacy of patient-victims must be protected,

but if family violence is treated solely as a private matter beyond the purview of healthcare, the likely result may be a consequence far worse than a breach of privacy.

The ethical and practical dilemma over the proper role of privacy in situations of family violence will persist at least until the importance of intervention by health professionals is regularly recognized, and evidence-based treatment and intervention protocols are developed and routinely implemented. This presupposes that family violence is a medical, as well as social, ill that requires healthcare response, among other societal interventions. As healthcare professionals are often best situated to identify the existence of family violence, medical protocols are needed that will account for the trade-off between individual privacy protections and health benefits, lifting the veil of privacy to allow healthcare professionals in. Certainly attention from healthcare professionals will not be sufficient to resolve the problem of family violence, but such attention is a necessary step in shedding the veil altogether. There is no ethical justification for allowing such violence to persist, and healthcare professionals, as members of the greater society, have an important role to play in moving beyond the norm of non-intervention.

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