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Domestic abuse and the duties of physicians: a case report

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Introduction Domestic violence against women is a global issue. An earlier report from the Centers for Disease Control and Prevention (CDC), USA, reported that injury caused by domestic violence was the second most common cause of death during pregnancy and in the postpartum period (1). The pregnancy-associated homicide ratio was found to be 1.7 per 100,000 deliveries and firearms were identified as the main source of injury. Domestic violence is more common in developing countries than in the developed world, and rural areas are worse affected than urban ones. The risk factors associated with intimate partner violence include husbands being unemloyed, belonging to a lower socioeconomic group, poor educational status, and alcohol and substance abuse. In a hospital-based study of 500 women, around 12.6% reported physical abuse by their spouses in index pregnancy (2). In another hospital-based study in which women were interviewed during the postpartum period, 23% reported physical abuse during index pregnancy (3). Death as a result of violence is not a new phenomenon. In 1994 the Human Rights Commission of Pakistan reported 372 cases of domestic violence, due to which around 274 women died during an 8-month period. According to a report for the year 2012-13 around 389 cases of domestic violence were reported in the Pakistani media that year. The same report states that in 2013, more than 800 women committed suicide due to domestic violence. In 2013, the Provincial Assembly of Sindh, Pakistan, passed The Domestic Violence (Prevention and Protection) Bill, 2013, which imposes a fine of Rs 20,000 for violent offences against women. Such bills have not been passed in other provincial assemblies of the country. Other countries in South Asia (India, Nepal, Bangladesh, the Maldives, Sri Lanka and Afghanistan) have national laws which make provision for extending medical assistance to women who have suffered domestic violence (4). However, a lot remains to be done to translate these laws into actual practice. In Nepal, special cells have been set up in police stations to offer services to women reporting domestic violence. Among those responsible for the implementation of these services, only a few were found to be aware of the fact that such services were supposed to be provided (5). Only 8% of women knew that such services were available (6). In Bangladesh, crisis centres have been established in tertiary care hospitals to deal with domestic abuse. Manuals have been designed for the attending doctors on how to provide assistance to the women and on the reporting of such events(6). In India, providers of medical care do not consider it their duty to report domestic violence(4).There is a need to sensitise the medical fraternity Indian Journal of Medical Ethics Vol XII No 4 October-December 2015 [248] to this issue, especially since many victims present to hospitals. Health providers also need to be given guidance on the steps they can take when confronted with cases of domestic violence. Around two decades ago, the

American Medical Association recommended universal screening for intimate partner violence. This led to a sharp increase of 30% in reporting of intimate partner violence among certain groups of the population (7). This report, based on personal experience, highlights the importance of reporting cases of domestic abuse, while also identifying some of the difficulties that physicians are liable to face in doing so within the prevailing social and legal contexts.

Case report

A 25-year-old woman, a primigravida who was 28 weeks pregnant, was referred from a secondary care hospital in a state of collapse. The woman, who had been married for five years, was physically examined, and her blood pressure and vital signs were not recordable. She was immediately moved to the operation theatre and intubated. Cardiopulmonary resuscitation was performed for 10 minutes. The physical examination had also revealed a bruised and oedematous left eye, bleeding from the mouth and gums, and bruise marks on the left hand, with gross evidence of a wrist fracture. Her abdomen was tense and tender, and she was also bleeding per vaginum. As the patient was intubated, and her signs and symptoms suggested internal bleeding, a provisional diagnosis of uterine rupture was made. The doctors decided to carry out a laparotomy. When the abdomen was explored, around 1.5 litres of blood was found in the peritoneal cavity. The uterine contours were intact. A stillborn male baby was delivered. The patient continued to bleed after the hysterotomy and the primary surgeon decided to perform a hysterectomy to save the woman's life. As the surgery proceeded, a sharp, vertical rent was identified in the left fornix of the vagina, involving the lower uterine segment, resulting in the rupture of the lower uterine segment. Haemostasis was achieved with difficulty. A total of 20 units of blood and blood products were transfused during surgery. After the surgery, the woman was transferred to the intensive care unit where, too, massive transfusion of blood and blood products continued. The patient expired after spending 24 hours in the intensive care unit. On questioning, the patient's attendants and husband firmly denied that there had been any physical abuse. They repeatedly claimed that they did not know how it had happened. According to them, she may have suffered trauma on account of the stretcher while being taken to the hospital. All the members of the family held fast to the same story. The doctors on duty noticed that none of the woman's relatives was present and asked to see them. They were told that they live in another province and had been informed. However, nobody from the woman's side turned up. All the findings mentioned above were suggestive of foul play. The ethical dilemma in this case consists of which person was supposed to report the potentially criminal case. Should it have been the medico-legal officer– a person who is responsible for maintaining a record of, and at times reporting, all police matters? Further, if it was his/her duty, was it a matter that he should have reported in the absence of a clear confession? In such a situation, what should have been the responsibility of the doctor in charge at that time? In a country where the legal system does not provide enough protection, what are the duties of doctors providing emergency services? These issues are not included in the postgraduate curriculum of obstetrics and gynaecology. Is there a

need to include cases of domestic violence in the curriculum to sensitise postgraduates and help them deal with it in their daily practice?

Discussion

This case report highlights the problems faced by attending doctors in routine practice in the developing world. A case is termed a medico-legal case if the police is involved. A medico-legal case need not necessarily be filed by the victim's family members. A doctor who has examined the woman and suspects foul play or assault can report his/her findings to the medico-legal officer, who can then proceed further. All major public sector hospitals in the provinces have a medico-legal section. In the case described here, the residents on duty were interviewed thoroughly to ascertain why they had not reported the case to the medico-legal officer (MLO). Among the reasons cited by them was that the MLO would want the complaint to be lodged by the family members, who were denying physical abuse to begin with. They were also unclear about whose name the FIR should be registered in. Who would be responsible for appearing before the police or court later on? One of the junior residents said, "Who will help me when I am asked to appear in the court?"A resident, who had also worked as a medico-legal officer in a peripheral hospital, narrated a friend's experience in support of her colleague. It was about a certain medico-legal case that had been running for a couple of years and the doctor concerned was asked to appear in court each time there was a hearing. The resident then asked the pertinent question: "Who is going to provide me and my family security when I request the MLO to register the case?" She argued that the next time she is on duty, the aggrieved party may come back and harm her, and who would protect her then? Senior doctors vehemently opposed the idea of reporting such matters to a police officer, citing personal examples of how they were threatened by the accused and speaking of the lack of security measures available to them. They said that they wanted to report cases of domestic violence, but were afraid of doing so. One of the senior faculty members said, "Why is it my duty to register the case? Why is it not the duty of the administration to register the case? Once I have informed the administration about suspected foul play, it is for them to register the case." The attitude of the senior faculty members towards the woman was clearly not one of beneficence. Their attitude also denied the woman her last chance of receiving justice. There was unshakeable evidence that she had been assaulted, presumably by her husband and in-laws. Such cases require clear justification Indian Journal of Medical Ethics Vol XII No 4 October-December 2015 [249] as to their medico-legal nature on the part of the attending physician, and it is his/her moral duty to report the matter to the department concerned. The Pakistan Medical and Dental Council does have a code of ethics on such matters, but it is silent on the duties of doctors confronted with situations such as that described above. The interviews with the residents and faculty members brought out a few points. The majority of doctors were unaware of the fact that the country's laws do require that they register a case with the police when they suspect foul play. It is not true that the case must be registered only by a family member of the victim. It was also noted that the doctors were not willing to take responsibility as they considered such cases an administrative issue. The third

problem was related to the system – having to make repeated appearances in court and the lack of security prevented doctors from registering cases. The subject of domestic violence leading to the deaths of women is not a part of the regular postgraduate curriculum of obstetrics and gynaecology. Whatever the students learn is from their own experience. Regular textbooks do not deal with the subject in detail; those which do fail to consider the subject in the context of the developing countries. One needs to view the matter in a different perspective in the case of developing countries because of the weak legal systems there. Postgraduate students receive no formal training on what to document and how to document it so that all the evidence can be saved to make matters easier from the legal point of view. The traditional teaching of the postgraduate curriculum is borrowed from countries like the UK and the USA, where the legal system is strong enough to provide assistance. Genderbased violence should be considered one of the important topics in undergraduate medical education as well, to increase awareness among the students and sensitise them to the issue. Both at the undergraduate and postgraduate levels, students should be taught to look for signs of domestic violence. They should be made aware that it is their responsibility to report these cases to the authorities concerned, and also, to provide support to the woman. Emphasis should be laid on the providers' own attitude to gender roles in the context of the provision of support to the affected women. It is also important for them to recognise the fact that violence against women is a violation of the Human Rights Act(7). The curricula for specialists and other service providers should include a course on the country's laws on domestic abuse, as well as their responsibilities under the law for the provision of support services and for reporting of violence against women.

Conclusion

The healthcare systems in the South Asian countries should be more responsive and proactive in providing support to women suffering domestic abuse. Most of the time, it is the healthcare provider whose help is sought for physical injuries. Healthcare providers should, among other things, help to link the victims with support services and provide further help in the future. Providers at all levels – from community health workers to specialists – need to be trained to detect signs of domestic violence. Finally, it is important to make them aware of the relevant laws in their country and of their legal duty to report the matter to the concerned authorities.

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