Medical Records as Legal Evidence of Domestic Violence

Nancy E. Isaac, Sc.D.
Pualani Enos, J.D.

Domestic Violence Institute
Northeastern University School of Law

May 2000

FINAL REPORT

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Executive Summary

This study sought to describe, from a legal perspective, how domestic violence is being documented in abused women's medical charts. In total, 96 medical charts of 86 abused women covering 772 visits were reviewed. For 184 of these visits (24%), detailed information was abstracted on the medical record documentation because there was an indication of domestic violence, an injury of some type, or both.

The findings reveal some important shortcomings of current medical charts as legal evidence of domestic violence.

Based on the work of this practitioner-researcher partnership and the review of abused women's medical charts, we conclude the following:

- The legal and medical communities hold many misperceptions of one another's roles in responding to domestic violence. Many barriers to collaboration are based on these misperceptions and false assumptions.

- The work of the interdisciplinary partnership demonstrates that a common meaningful goal, respect for one another's professional expertise, and willingness to view a problem from a new perspective, can provide the context for productive medical/legal collaborations on the issue of domestic violence.

- Some legal advocates do not utilize medical records regularly in civil contexts or to their full potential in criminal contexts. Reasons for not using medical records include: difficulty and expense in obtaining them; their illegibility, incompleteness or inaccuracy; the possibility that the information in them, due to these flaws, may be more harmful than helpful.

- Many if not most health care providers are confused about whether, how and why to record information about domestic violence in medical charts.

- In an effort to be "neutral" regarding abuse situations, some health care providers are using language that is likely to harm an abused woman's legal case and aids her abuser (in a legal context).

- Though physicians' poor handwriting is often the subject of jokes, it can in fact prevent use of the medical chart in court. In this study, among medical visits that contained some indication of abuse or an injury, one-third of the notes from doctors or nurses contained vital information that was illegible.

- With minor modifications to documentation practices, many more abused women's medical charts would contain the elements necessary to allow their statements about abuse to be introduced in court as "excited utterances." Such evidence can allow a prosecution to proceed even when the woman is unwilling to testify against her abuser in court due to fear or for other reasons. The element needed for excited utterance exceptions that was most frequently missing from medical records was a description of the patient's demeanor.

- Many providers are recording significant details regarding injuries and health conditions in abused women's charts. If these practices were consistent, and symbols and abbreviations were standardized, this type of documentation could act as effective corroborative evidence in court.

- Emergency medical services (EMS) personnel may be an underutilized source of legal documentation of domestic violence. It appears that EMS providers may already be recording patient statements quite often; with additional training, the legal utility of these data could be greatly increased. This is especially true given the proximity of these providers (in time and space) to the actual violent events.

- Though many if not most protocols on healthcare response to domestic violence call for documenting injuries on body maps, this study found such maps or any types of drawing of injuries in only a handful of medical visits.

- Photographs, the "sine qua non" of evidence regarding abuse-related injuries, were almost never present in the charts reviewed in this study. Only one of the 93 visits involving an injury contained a photograph. The medical records also did not mention photographs stored in other locations, e.g., with local police.

- Although the partnership discussions and prior focus group research had both identified inappropriate, derogatory statements about abused patients as one current problem with medical documentation, such comments were found in physician or nurses' notes in only five instances, and in social work or psychiatry notes in four cases.

This research also identified some relatively minor changes in documentation practices that would be likely to improve the usefulness of abused women's medical records in legal contexts. Such changes may help health care providers to "work smarter, not harder" on behalf of their abused patients. Some recommended changes for clinicians include the following:

- Clinicians should, when at all feasible, take photographs of injuries that are known or suspected to have resulted from interpersonal violence. Optimally, there should be at least one photo each of the full body, the injury itself, and the patient's face.

- Clinicians should take care to write legible notes. Clinician training should emphasize that illegible notes may negatively impact health care and are likely to hinder a woman's ability to obtain legal remedies to address her abuse. The increased use of computerized systems is very helpful in addressing the common problem of illegible information.

- As often as possible, clinicians should use quotation marks or the phrases "patient states..." or "patient reports..." to indicate that the information being recorded is coming directly from the patient.

- Clinicians should stay away from words that imply doubt about the patient's reliability ("patient claims...", "patient alleges..."). Alleges is a legal term. It implies the statement following it is unproven and may not to have occurred. Providers should instead use quotes around statements made by the patient. If the clinician's direct observations are in conflict with the patient's description of events, the clinician's reasons for doubt should be stated explicitly.

- Clinicians should not use legal terms such as "alleged perpetrator," "assailant," "assault", etc. All legal terms are defined with great detail by federal or state statute and case law. Typically, such terms are used by lay persons to mean something more ambiguous or larger in scope. By using legal terms, providers may convey an unintended meaning. For example, assault is defined as an attempt to cause an unwanted touching, whether or not the touching actually occurred. Naming the person who has injured the patient as her "assailant" or "perpetrator" after the patient has identified the person who has hurt her as a husband, boyfriend, father of her child or by name, is likely to be interpreted in a legal setting as the provider's doubting the patient's credibility. These terms are used regularly by attorneys seeking to raise doubt as to who committed an act.

- Optimally, providers should describe and name the person who hurt the patient in quotes exactly as the patient has identified him. This prevents the abuser from obscuring his responsibility by accusing the victim of having multiple partners.

- Practitioners should avoid summarizing a patient's report of abuse in conclusory terms such as "patient is a battered woman", "assault and battery," or "rape" because conclusions without sufficient accompanying factual information are inadmissible in court. Instead, providers should document the factual information reported by the patient that leads them to conclude abuse occurred.

- Placing the term "domestic violence" or abbreviations such as "DV" in the diagnosis fields of medical records is of no benefit to the patient in legal contexts. This practice should be reconsidered unless there are other clear benefits with respect to medical treatment.

- Clinicians should include words that describe a patient's demeanor, such as: crying, shaking, upset, calm, angry, agitated, happy. Clinicians should describe what they observe, even if they find the demeanor to be confusing given statements of abuse.

- Clinicians should record the time of day in their record, and (ideally) some indication of how much time has passed since the incident (e.g., "patient states that *early this morning* her boyfriend, Robert Jones, hit her...")

Though these changes would go a long way to improve medical documentation of abuse, the research findings also imply that changes will be needed at the institutional level if the use of medical records in domestic violence cases is to improve. Specifically, it appears that:

- The importance of photographing traumatic injuries needs to be re-emphasized in training programs on medical response to domestic violence. Research should determine the most common barriers to taking photographs. Interventions that aim at increasing the frequency of taking photographs should be developed and evaluated.

- Medical units that handle abuse cases routinely (e.g., emergency medicine, social work) should have cameras stored in a secure but easy to access location. Resources should be allocated to buy cameras and film, and to train providers in their use. Each institution's policy on response to domestic violence should include details on where the camera can be found, how to photograph injuries, where to store photographs, and how to document the existence and location of these photographs in the medical record.

- Non-clinical health professionals (medical records managers, administrators, risk managers) should work with domestic violence legal and clinical experts to examine changes that might facilitate the accessibility of medical records for legal use without compromising patient confidentiality.

- Training regarding current health care response to domestic violence should be provided to judges who hear domestic violence cases regularly.

- Domestic violence training programs and materials for health care providers should clarify that a failure to *document* domestic violence completely when treating an abused patient does not constitute taking a "neutral" stance about the incident. It will almost always convey a legal advantage to the abuser. In medical terms, it constitutes poor preventive medicine.

Introduction

This grant supported a practitioner-researcher partnership bringing together individuals from the legal, medical, social services, victim advocacy and public health communities. The initial research undertaking of this partnership was a project that touches on the work of all of these sectors and required the expertise of all groups in its execution.

Over the past decade, considerable effort has been made to increase the responsiveness of the health care community to domestic violence. These efforts were initiated by and originally focused on healthcare practitioners and institutions, but have grown to include other sectors acting in collaboration with the healthcare community. This project sought to further expand these types of collaborations by focusing on a topic that would require the in-depth expertise of both the medical and legal professionals, as well as those who provide services to victims.

Much of the medical/legal literature on domestic violence focuses on legal issues upon which medical experts might testify: the battered women's syndrome; shielding the medical and counseling records of rape and domestic violence victims from examination by criminal defendants; the medical or psychiatric capacity of women or children to testify or the defendant to be held responsible for his acts. However, most litigation involving battered women relies primarily on testimony related to facts (i.e., evidence), not expert testimony.

With respect to medical facts as opposed to expert testimony, there has been little if any effort to describe in the literature how often medical records provide evidence of partner abuse in the context of court cases. Therefore, it was decided that the first empirical research undertaking of this practitioner-researcher partnership would be an assessment of the quality of documentation of abuse in battered women's medical records from a legal perspective. More specifically, the project aimed to enumerate the types of "flaws" contained in medical records, vis-à-vis the record's usefulness in legal settings.

Current efforts to improve medical documentation of battering, while widespread, are usually a relatively small component of training programs that focus on the universal screening of adolescent and adult female patients for abuse. This project brought together

a uniquely experienced team of researchers, medical personnel (including social workers), attorneys and judges, to consider what forms of potentially available medical documentation would be most useful in substantiating abuse in a variety of legal contexts. In addition, this project examined actual medical records to determine whether these records contain the necessary documentation, and if they do not, what further information might be included and in what form. Another goal of the project was to identify the extent to which documentation practices may increase the danger to victims. This research is intended to lay a foundation for the development and evaluation of strategies to improve domestic violence documentation in health care settings, particularly with regard to the usefulness of this documentation to victims who decide to seek remedies in legal settings.

Legal and Medical Responses to Domestic Violence

Domestic violence was a nearly invisible problem within the legal system until the early 1970s (Schechter, 1982; Pleck, 1987). A legal veil of privacy surrounded familial relationships, and virtually no efforts were made to inquire or otherwise investigate the existence of violence in the home. Although the criminal justice, family law and child protective arms of the legal system had mechanisms for dealing with the extreme cases of abuse when it was brought to their attention by the death, serious injury or (much less frequently) allegations of battered women or their advocates, the existence of this alleged domestic violence was largely denied, minimized or blamed on the victims in most of these legal cases. Thus, battered women were routinely discouraged from bringing criminal cases, decisions made with respect to divorce and related custody and visitation cases often placed them and their children in heightened danger, and if married to the abuser (alone among assault victims), they were prohibited from filing suit to recover damages for their injuries and related financial losses (Dalton, 1997).

Medical providers and the larger health care system turned a similar "blind eye" to the problem of domestic abuse. Virtually no effort was made to screen for domestic violence or even to consider such violence a health care problem. Unexplained or

suspicious injuries were treated without inquiring as to their source, and those infrequent admissions or complaints of abuse made to medical providers were, if addressed at all, referred to mental health professionals or spiritual advisors for intervention (Stark & Flitcraft, 1996; Warshaw, 1989).

Fortunately, changes in both the legal and medical systems' responses to domestic violence over the last twenty years--and particularly in the past five--have been dramatic. Largely influenced by the efforts of abuse survivors, legislation has been passed at both the state and federal levels to increase legal protection for battered women and to finance abuse prevention programs. Police, prosecutors and victim advocates are responding by implementing mandatory arrest, prosecution and incarceration policies, and the family law bench and bar is beginning to grapple with its role in protecting custodial parents and their children from abuse by a battering partner (Ferraro, 1989a,b).

Change in the medical response to domestic violence has been slower, but many hospitals, health centers and individual providers (including most of those in Greater Boston) have reviewed their policies and practices with respect to domestic violence and are training their staff in its complex dynamics. Numerous medical institutions and associations have developed protocols to guide clinicians in identifying, assessing and intervening in cases involving intimate partner violence.

Protocols for universal screening for intimate partner violence abound, and many include elaborate guidelines for intervention (Dorchester House Multi-Service Center, 1998; Conference of Boston Teaching Hospitals, 1997; Massachusetts Medical Society, 1997; Schornstein, 1997; Smock, 1997; Pediatric Family Violence Awareness Project, 1996; Whittier Street Neigborhood Health Center, 1996; Warsaw et al., 1995; Colorado Department of Health, 1994; American Medical Association, 1992; Advocacy for Women and Kids in Emergency, 1992). Unfortunately, these protocols often require the health care provider to perform assessments and take action outside his or her core area of expertise. Most problematic, however, is that exactly how one documents abuse in the patient's medical record -- a task that is squarely within the provider's core area of expertise -- has been given inadequate attention both in the majority of protocols and in the training programs that accompany their use. Only a fraction provide specific attention

to documentation (Smock, 1997; Warsaw et al., 1995; Chez, 1994). And even fewer are written from a legal perspective (Enos & McGuigen, 1998; Schornstein, 1997).

According to recent research, most primary care physicians are still not routinely screening patients for domestic violence unless the patient is injured (Rodriguez et al., 1999). A review of intentional injury records in an urban emergency department found that "basic surveillance data" such as the identity of the assailant, the object or force used, and the site of the assault are often missing from documentation (Houry et al., 1999). Several studies have found that even in cases where victims have been treated for a domestic violence injury, medical records may be inadequate to corroborate the existence of abuse, and may provide far less documentary evidence than they could (Smock, 1997; Covington, 1995; Abbott, 1995; Sugg and Inui, 1992). Two recent evaluations of interventions intended to improve clinician response to domestic violence found that while knowledge, attitudes, and some behaviors (e.g., screening) showed positive change, rates of documentation of abuse did not improve (Harwell et al., 1998; Kripke et al, 1998).

These findings are supported by anecdotal evidence that many health care providers remain confused about when and how to document abuse in medical charts (see Prior Work section below). Moreover, they appear to have many concerns regarding confidentiality and liability, are fearful of being asked to testify, and express confusion over which statements might inadvertently hurt the victim of abuse.

Law enforcement, legal and medical professionals and institutions are increasingly recognizing that they have much to learn from practitioners in other disciplines--and thus domestic violence specialists across diverse community agencies and institutions are beginning to share information and resources with one another. One focus of such efforts has been cross-training and the development of referral protocols. Local interdisciplinary coalitions to combat domestic violence are developing in many communities to strengthen and expand these collaborative efforts. Boston has been a pioneer in interdisciplinary collaboration, and with support from the Centers for Disease Control and Prevention, the activities of a Dorchester-based coalition (the Dorchester Community Roundtable) are being greatly enhanced.

Despite the importance of these community-wide partnerships, however, the core of our legal system's ability to use its particular resources to protect battered women lies in its ability to prove -- beyond a reasonable doubt in criminal cases, by clear and convincing evidence in child protective cases and by the preponderance of the evidence in family law and tort cases -- that the abuse being alleged (in whatever severity and over whatever period of time is relevant) did, in fact, occur. In this respect, domestic violence cases present very difficult and unique challenges that are often ignored in our more theoretical discussions of self-defense, battered women's syndrome, and batterer access to counseling records.

First, although popular support for abuse prevention efforts appears at an all-time high, there is an increasing backlash to holding batterers' accountable in today's legal system. Increasingly, battered women's activists hear judges, lawyers and other court personnel allege that vast numbers of women are fabricating or exaggerating claims of abuse just to "get back at" or "get something" from their present or former partners (Tifft, 1993). Second, as police and prosecutors have more aggressively held batterers accountable, the number of mutual restraining orders and criminal cross-complaints has increased dramatically, and the question of who is the victim and who is the perpetrator in any given encounter must often be decided in a series of related court actions. Third, as prosecution becomes more frequent and retaliatory actions are initiated by more defendants, an increasing number of victims are reluctant to testify against the defendant. While this reluctance can be based on many factors -- the victim's fear for her safety, fear of the consequences of retaliatory actions, mounting pressure from the batterer and his family or friends, or the threat of other negative consequences -- it can also be based on "positive" motivations such as love and commitment, a willingness to give the batterer another chance for his sake or the sake of his children, or a decision not to deprive oneself or the parties' children of his financial support.

Difficulties are not limited to the criminal system. As the criminal justice system more effectively shields victims from their abusers, custodial parents are more often confronted with aggressive custody and visitation actions designed to maintain a batterers' access to and power over his former partner and their children. In this scenario,

the children may be physically or sexually abused themselves, even if they have not been abused prior to the parental separation (Zorza, 1995). Many states are becoming increasingly aware of the impact of violence on children, and courts are beginning to recognize the need to address these issues in custody and visitation determinations (Quirion, 1998).

A non-custodial parent may also withdraw essential financial support, often going to such lengths as quitting employment or hiding assets and income, so that the victim will be drawn into a protracted legal battle if she hopes to maintain a household separate from her batterer. Those who seek monetary compensatory or punitive damages against their abuser often fare even worse, for they typically face tort lawyers, third-party insurers and judicial decision-makers (whether juries or judges) who have no experience in these cases and are reluctant to get involved in these "newly created" tort suits.

Finally, and perhaps most significantly, ***as the consequences to batterers become more severe, we can expect the standard of proof that domestic violence has occurred to rise.*** While the legal standard of proof will probably remain the same, as a practical matter, it may be increasingly difficult to meet that standard in order to persuade concerned judges and/or jurors to impose such negative consequences on the batterer.

Accurate and comprehensive medical documentation of intimate partner abuse has the potential to corroborate or establish the occurrence of an incident of or pattern of abuse, providing abuse victims with reliable third party evidence. Typically, the only third party evidence available to victims are police reports, which vary in quality and completeness depending on the training and resources given to the responding police department. Medical records can be admissible for a variety of purposes in various legal proceedings, the scope and degree of their use dependent on the evidentiary laws of each state (see Creation of the Medical Record Data Abstraction Tool subsection below).

Medical documentation provides unbiased, factual information written at the time of or shortly after abusive events, often long before any legal proceedings occur. Additionally, information regarding the impact of the abuse, physically and emotionally, is included in the assessments made. In the best of records, photographs capture the moment in ways that no description can capture months later. Importantly, this type of

information can be admitted not only by a victim's lawyers, but also by a victim on her own behalf, in order to establish the requirements necessary to obtain a range of protective relief.

Given the importance of medical documentation to criminal, family law and tort litigation involving domestic violence, the question then becomes the one to which this research was addressed--are current medical records sufficient to provide evidence of partner abuse in legal contexts? Significantly, it does not appear that this question is being asked either by researchers or by practitioners, much less answered.

Medical Information as Legal Evidence

Medical documentation of domestic violence has the potential to be an advocate's most important tool in representing a victim. At the most basic level, it corroborates that an incident resulting in some type of health condition or injury occurred as indicated by the victim or other incident reports. Additionally, the person creating the documentation has a scientific background and is trained to make observations and conduct interviews solely for the purpose of responding to health care related issues. A provider's reliance on a patient's information to determine treatment demonstrates that the provider found the information to be credible. Likewise, when a health care provider takes actions such as helping a patient to seek shelter, police assistance or emergency court response, this demonstrates an objective third party's concern.

When a victim presents with injuries, an accurate and specific documentation that details the injuries can be used to prove that a batterer acted abusively. Even more importantly, these details can be used without the testimony of the victim or other witnesses to the event. There are two ways medical records, including photos, may become part of a court case. Either the victim provides written consent for her medical care institution to release her records or the court orders such release. The court may issue such an order, at either party's request, during the pre-trial phases of a civil or criminal trial or at the prosecutor's request prior to criminal charges for investigation purposes. When a victim is too intimidated or frightened to participate in a criminal

prosecution and refuses to sign a release of her medical records, prosecutors can obtain the relevant medical records through court order.

A court will almost always order institutions to release injury photographs because they are highly relevant and probative. Because there is an excellent chance that a jury or a judge will be persuaded by such evidence, the abusive partner may be encouraged to agree to a plea or settlement agreement. (Belknap et al., 1999; Cramer & Forte,1998). In the case of criminal prosecution, a defendant may plead guilty and be placed on lengthy supervised probation (possibly including attendance and completion of a certified batterer intervention program), providing some relief to a victim. A recent study found that arrest and conviction (not necessarily incarceration) decreased recidivism, while arrest without conviction increased recidivism. (Gross et al., 2000). Additionally, the defendant offering a plea, which includes supervised probation with conditions, may protect the victim without requiring her to endure the long and humiliating process of a criminal prosecution and the economic and emotional consequences of a batterer's incarceration.

Currently, medical documentation is an underutilized tool (Belknap et al., 1999). When it is used, it is usually by prosecutors in felony cases or by attorneys in tort litigation -- in cases involving permanent physical injury or death (Dalton, 1997). These are typically the cases in which an attorney has the time and the resources to obtain, review, prepare and submit the victim's medical records for use at trial. Improving the content and format of medical records would assist these attorneys in presenting this crucial factual evidence to the court.

However, records could provide a valuable source of information for attorneys representing victims in a variety of other contexts where they typically turn for help and where relief is often adjudicated prior to trial. These cases include contested custody and visitation cases, child protective services proceedings where the abused parent is charged with neglect, criminal cases where the victim is a defendant due to the abuser's retaliatory allegations or her own actions of self-defense.

While clinically accurate and comprehensive records provide a useful tool to attorneys working within settings where the rules of evidence are applied, they could

also prove useful to *pro se* litigants in a variety of the less formal legal contexts, where victims are often denied relief because of failure to present the existence of abuse. Thus, by presenting persuasive factual support that abuse in fact occurred, victims may qualify for specialized status or exemptions in the areas of public housing, welfare, immigration status, landlord/tenant disputes, health and life insurance, victim's compensation and employment.

Photographs are incredibly persuasive because they help to make the results of a partner's abusive behavior real to the fact-finder or decision-maker (Belknap et al., 1999; Cramer & Forte, 1998). Legal proceedings that determine the type of relief necessary for protection often take place months or even years after the abusive incident. During this time, the victim may have sought support and safety, and may currently appear to be both physically and emotionally healthy. Decision-makers may observe the results of a victim's effective coping skills and conclude that the abuser did little harm. Photographs of damage done on a particular day are a real reminder of what an abuser is capable of, the most important consideration for a fact finder. Photography has been emphasized in most health care protocols on domestic violence (Dorchester House Multi-Service Center, 1998; Conference of Boston Teaching Hospitals, 1997; Massachusetts Medical Society, 1997; Schornstein, 1997; Smock, 1997; Pediatric Family Violence Awareness Project, 1996; Whittier Street Neigborhood Health Center, 1996; Warsaw et al., 1995; Colorado Department of Health, 1994; American Medical Association, 1992).

Fortunately, in most states there are few admissibility requirements for photographs, as long as the patient or someone else can verify that the photograph accurately reflects the way the images contained therein looked on that day. While it is helpful to have an indication of the date, time, and place where the photograph was taken, it is not essential. Additionally, there are no chain-of-custody requirements (i.e., there is no need for written documentation of who has had the pictures).

Even before undertaking the research component of this project, the legal practitioners strongly believed that photographs are not used as often as they could be. Practitioners who work regularly in health care settings shared common experiences of not enough cameras, lack of access to cameras, little or no film refills and little training

among providers. While the Polaroid Corporation provides training for institutions that buy a number of their cameras, many budgets do not include resources for the purchase of cameras or film.

In a number of states, medical documentation may act as a substitute for live testimony by the provider, thereby relieving providers from the time and stress of testifying in court. Even when providers are required to testify, the provider can refer to records to refresh his or her memory and thereby improve testimony given. Unlike oral testimony based only on memory of the event, legible and accurate documentation written at the time of the event is safe-guarded against manipulation and distortion on cross-examination. Likewise, photographs and body maps provide the information in black and white or in color. Even where documentation may be limited in its scope, it can provide the missing piece of corroborative evidence that brings the other evidence together in a way that makes sense. The use of evidence other than the victim's testimony also prevents the victim from bearing the sole burden of making a case against her abuser.

Prior Work

Prior to this project, Pualani Enos, J.D. (the Project Director) had gathered information about different professionals' perceptions and knowledge regarding the use of medical records in legal contexts. Data were first collected from the legal community by conducting focus groups and individual interviews with attorneys (litigation focused), concentrating in areas that may address issues of domestic violence (e.g. abuse prevention orders, criminal proceedings, child protection, family law). Groups included attorneys who have represented all parties involved -- victims, perpetrators and children -- both by initiating actions and defending against them.

Next, focus groups were conducted with health care professionals, including physicians, nurses, social workers, and emergency medical technicians. These providers work in a variety of settings in developing their understanding of the use of medical documentation and testimony in cases of domestic violence. Selection of participants was geared to include professionals whose opinions would be broadly representative of

their respective groups, and did not target those practitioners experienced or interested in doing domestic violence work. Many of the groups were mandatory work training sessions. In addition to sharing their own opinions, practitioners were asked to share any opinions they had heard from others working in the field.

Attorney Focus Groups

Attorneys who specialize in battered women's advocacy make frequent use of their clients' medical records where such records exist. Attorneys use these records to corroborate that an incident of abuse occurred and frequently to demonstrate the impacts of the abuse on the victim through injury or diminished health condition. While more rare, attorneys may also use these records to corroborate statements made by a patient regarding abusive acts, especially when the acts do not result in an observable injury. Unfortunately, attorneys who are not specially trained in representing domestic violence victims, but who encounter victims in the course of practice, frequently do not utilize their clients' medical records to prove a theory of abuse.

A majority of attorneys who reported using medical records did so in conjunction with a health care provider's live testimony in those cases where the provider was identifiable and available to testify. Prosecutors, criminal defense, and legal services attorneys were most familiar with using medical records. Only a handful of the family law attorneys questioned had used medical records regularly in their practice, so there was no strong consensus of how reliably medical records could be used in place of live testimony by a provider.

Attorneys reported difficulty in obtaining a complete version of only those portions of a medical record that were specifically requested, especially given the significant time and resources typically required to access records. Private practitioners representing indigent or low-income clients were unable to afford the related copying costs. Prosecutors reported that when they sought medical treatment records to the exclusion of specially privileged records (i.e., psychological records), they had received

improperly redacted records or telephone calls from medical records departments refusing to release records without waiver of all privilege.

Another challenge in using medical records is the difficulty in interpreting medical terms, abbreviations and symbols. Attorneys believe that they could more effectively use medical records without needing the extensive time of health care providers if the records were written in plain English. Only a small number of attorneys mentioned using a medical dictionary to interpret the words or symbols.

Attorneys reported few experiences with health care providers willing to testify on behalf of their patients in court hearings. Additionally, poor handwriting rendered many documents unusable. Generally, health care providers were seen by the attorneys as unwilling to become involved with attorneys because they are too busy in their medical practices, unwilling to give up other paying client appointments and uninterested in the protective relief obtained by their patients.

Health Care Provider Focus Groups

Almost all of the health care providers identified domestic violence as an important health care issue that they respond to frequently within their practice. All providers reported that trauma and stress experienced within the home can negatively impact health in both short and long term ways. For this reason, most providers reported feeling responsible for identification and intervention. However, they also reported being unable to provide effective intervention services and being limited by time and resources available in their institutions.

Most providers reported that they had received multiple trainings about the importance of identifying domestic violence, but little specific direction regarding how to document in ways that will most effectively protect the patient. Several providers discussed the large amounts of time they had spent with a few patients to help them find shelter, access police services and obtain assistance in seeking abuse prevention orders. Many feel they have had some successful interactions with other systems and expect their patients will obtain the relief they need from the legal system. However, most indicated

that they do not have the time, resources or expertise to carry out extensive interventions with all clients.

Most health care professionals expressed a general distrust of the legal system. This distrust seemed to stem from their expressed needs to safeguard against liability and to protect their clients' best interest and safety, and from their personal fear of testifying in legal settings. A large number of providers felt that once a patient presented domestic violence as a problem, their own risk of liability increased substantially. The ever-increasing fear of a civil action for medical malpractice or libel appeared to discourage many doctors who are concerned and interested in supporting their abused patients from becoming involved with their patients' legal representatives.

A large number of providers indicated that risk managers and general counsel for their institutions warned them against "getting too involved" in domestic violence cases and thereby "creating a liability." These two phrases came up repeatedly in the focus groups when providers were expressing their fear and confusion over how to assist abused patients. Many providers were afraid of being sued for libel or defamation for documenting their observations and patients' statements in the medical record. Medical malpractice liability as a result of failure to diagnose domestic violence was not discussed explicitly. A number of providers said they "did not feel right" about writing things down if they had not seen the abuse themselves, while others remarked that that type of documentation constituted "defamation" and "hearsay."

Many providers were uncertain about what aspects of the examination and treatment to document. Providers discussed writing what seems "safest" for patients, but since they did not have objective criteria for determining what was "safe" to write, it was clear that the application of this standard varied widely from provider to provider. Many providers reported that they do not explicitly document anything about abuse in the chart, under the assumption that writing nothing will ensure ultimate safety and privacy. These providers did not express concern about any clinical repercussions of a lack of documentation.

Other providers have been trained to summarize (patient was beaten, patient in argument with husband, patient fighting with father of baby, hit in face with rubber ball,

kicked in stomach, hit in face with fist), to use labels (battered woman, domestic violence case, patient is abused), or to use abbreviations (dv, dom vio, bw, batt w) to alert the next provider that the problem exists. They report that they were trained to leave out more specific information that might later be used by the batterer or other outsiders to punish or stigmatize the patient.

Many providers believe that criminal prosecution of the patient's partner against her wishes may put her in increased danger or damage her chances of obtaining the relief she needs. Also, some providers feared that by documenting domestic violence, they would draw the woman to the attention of child protective services. No providers mentioned the possible use of medical records in family law cases or other civil matters involving the victim and perpetrator. Most providers were of the opinion that abuse prevention orders were "easy enough" for victims to get without needing medical documentation of their abuse.

Some clinicians also expressed frustration that effective legal relief was not being provided to their patients. They had heard stories from their patients about how long the criminal justice process takes and how often a batterer is "let off" by an acquittal or a conviction with no jail time. Additionally, clinicians expressed frustration from seeing patients return to violent and abusive homes even after lengthy intervention services had been provided.

Most providers who had testified in court reported that the attorney who called them to testify did not prepare them prior to the day of testimony. As a result, providers who are accomplished and well-respected in their field felt they were not able to effectively support the patient's case. They have lasting memories of court appearances as a source of undue humiliation and embarrassment.

While some providers understood conceptually how a patient might use medical documentation in legal contexts, many questioned the real need and whether the need outweighs the risk. Most assumed that police reports and victim testimony regarding events were adequate to secure the relief needed by a victim and her children. The importance of medical reports from all stages of treatment, in addition to police reports, was surprising to most. Most providers were also very surprised to be told that

photographs of injuries were often needed to convince various fact finders of an abusive episode's impact. A large number of the providers were unaware that batterers sometimes file retaliatory actions to discredit and disempower their partners.

Focus Groups with Social Workers and Mental Health Clinicians

For many years, the general approach of social workers toward documenting abuse was to document as little as possible. This approach was based on fears that information would get into the wrong hands and ultimately hurt the patient. However, social workers who participated in focus groups reported that, having observed clients attempting to get relief from the legal system, they are now rethinking this approach. Providers are developing a new appreciation for the importance of a comprehensive record of the events that occurred during the abusive relationship.

The social workers noted that they are in a position to document over time what the abuser is telling his victim, his manipulative/coercive tactics and what she is doing in response. Also, the focus in social work documentation is shifting from primarily identifying and describing problems, to also highlighting the client's strengths and help-seeking efforts. One problem identified by the social workers was a lack of both resources and time. They also felt it was important to include only "pertinent facts," not anything and everything the client might mention. Some participants felt that documentation "checklists" could trivialize the complexity of the work being done, to the disadvantage of the client.

Social workers expressed great concern about victims' records being accessed inappropriately by others in the hospital. Partly due to this concern, there was disagreement among participants about the wisdom of placing labels or other identifiers on medical charts signifying that the person is affected by domestic violence. Some social workers reported giving the client a choice about whether social service interaction would be documented comprehensively. Others stated that documentation was not negotiable, and if the client didn't want documentation she would have to decline service.

Overall, it was clear that the social workers had put a great deal of thought into documentation issues, but remained confused about the best practices. Since there is no single professional standard, documentation practices continue to vary substantially from individual to individual.

Development and Lessons of the Practitioner-Researcher Partnership

Building the Partnership

This partnership grew out of existing relationships among some of its members. Both the principal investigator and the project director had already worked with many individuals from the legal, medical and social work communities, and were able to bring together a diverse group committed to interdisciplinary work addressing domestic violence.

While the practitioners within each community knew each other well, there were only a few prior working relationships between the two communities. Practitioners from the different communities were eager to learn about one other's work setting, resources and limitations.

A brief description of the background of the partnership members is provided here in order to convey the depth of experience in domestic violence work that was brought to the table.

Legal Community

The legal professionals in this partnership were chosen because of their exceptional work in the area of domestic violence, and also because they had experience in using abused women's medical records in many legal contexts. The legal members were:

- A judge who has practiced in the criminal and civil session of the district court; who has experience with abuse prevention order sessions; has dealt with same sex domestic violence; and is active on statewide training panels. This judge is also active in the domestic violence roundtable that meets monthly in her courthouse. It

was important to the research undertaking of the partnership to have a judge who is used to making discretionary determinations regarding what evidence will be admissible in court.

- Two prosecutors with extensive experience in prosecuting misdemeanor and felony cases involving domestic violence. These individuals have made frequent use of medical records, both in cases where the victim was testifying and when she was not. They are experienced in the process of retrieving medical records in the types of cases where all evidence that may help the defendant must also be turned over to defense counsel. They have worked with hospital-based domestic violence advocates and health care providers as witnesses.

- Two civil attorneys in small private practices. These individuals specialize in legal matters involving domestic violence in the contexts of family law, tort law, and abuse prevention orders. Each of these participants had from 10-20 years of litigation experience, primarily in representing moderate- to low-income clients. They helped to pioneer the state's Abuse Prevention Law and continue to be active in domestic violence policy development. They are familiar with the particular issues facing battered mothers with children and the coercive tactics used by fathers who are batterers.

- A legal services attorney with 20 years of legal service work who is very active in the Boston Bar Association and Women's Bar Association. This individual has written practice manuals, pro se materials, and articles for legal journals. She is an active appellate attorney and has been involved in training family court judges.

- Clinical Director of the Domestic Violence Institute at Northeastern University School of Law, an attorney with many years experience training students to act as *pro bono* advocates to women seeking assistance in the local district court. This attorney also helped to found an extensive interdisciplinary community coalition to address domestic violence (the Dorchester Community Roundtable).

- Supervising Attorney of the Domestic Violence Institute at Northeastern University School of Law, who has assisted numerous abused women in both civil and criminal proceedings and who has previously collaborated with other researchers in the domestic violence field.

[An anonymous reviewer of this project report suggested that the partnership could have been improved by the addition of one or more members of the defense bar. We concur with this view and recommend that future projects include such individuals.]

Healthcare/Public Health Community

Partnership members from the healthcare and public health sectors included:

- Two social workers affiliated with hospital-based domestic violence programs. Both of these individuals were responsible for developing and managing these programs and have also been involved in the development of other nationally-recognized advocacy programs. These individuals are involved in regular direct service to hospital patients and employees affected by domestic violence. They have provided numerous in-service trainings for health care professionals, and have been involved in interdisciplinary policy development within a teaching hospital coalition addressing domestic violence.

- Two physicians, one an internist and the other an emergency physician, both of whom were directly responsible for interdisciplinary domestic violence programs within their hospitals. These individuals have published journal articles and training manuals, have performed statewide training, and have been active in the domestic violence work of the state medical society.

- A nurse practitioner affiliated with another domestic violence research project, where she was responsible for accessing medical records in numerous hospitals and reviewing the contents of the records for information on domestic violence.

- An epidemiologist with a decade of experience in domestic violence research involving the medical, legal, education and corporate sectors. This individual has also been involved in interdisciplinary policy development as a member of the Governor's Commission on Domestic Violence (Mass.) since 1993.

Interdisciplinary Perspectives on Response to Domestic Violence

The meetings of the practitioner-researcher partnership revealed significant misperceptions by the legal and health communities regarding one another's beliefs and approaches in responding to domestic violence. Generally speaking, the discussions echoed many of the findings from the focus groups the Project Director had previously performed to examine these professions' perceptions of one another (see Prior Work).

Legal Professionals' Misperceptions of Health Care Issues

The major misperceptions that many of the legal professionals held about health care providers and institutions were:

- Legal professionals tended to underestimate the quality and scope of the relationship that health care providers frequently establish with individual patients.
- The legal participants were uninformed about the efforts made by health care professionals to identify abuse and access resources for patients. They were not aware of requirements by the JCAHO that call for identification of abuse cases and training of staff in appropriate responses. They also underestimated the extent to which many health providers wish to assist patients in achieving safety as a means of improving their future health and reducing the likelihood of future injury.
- Many attorneys tended to believe that the primary reason health care providers refuse to testify in court is due to the loss of income during time spent in court.
- Legal professionals felt it would be a big improvement (and relatively easy) for medical providers to write more neatly, to refrain from using abbreviations, and to use language that can be readily interpreted by those outside the medical profession. Most legal professionals are unaware of the limited time each provider has to devote to the care and documentation related to each patient. (The health care providers made clear that use of medical abbreviations and labels such as "domestic violence" were a time saving strategies and standard in medical practice. They feel that providers are more likely to document abuse if doing so requires little time and effort. Many agree that an brief notation is better than none.)
- The legal community is largely unaware of the advice that physicians receive from risk managers and general counsel within health care institutions regarding the documentation of domestic violence. (According to the physicians, they are often advised to write "as little as possible" in order not to create "liability.")

Health Care Professionals' Misperceptions of Legal Issues

Similarly, the health care professionals held quite a few misinformed opinions regarding the legal handling of domestic violence cases and the legal uses of medical information.

- Health care providers tended to underestimate the need for evidence to corroborate claims of abuse made in legal settings. There is a tendency to assume that police evidence is generally sufficient, and medical information is seldom needed.
- Health care providers have some inaccurate assumptions about what type of information is helpful to abused women in legal settings. For instance, they tend to believe (and have often been trained) that they should avoid using the term "hysterical" or other demeanor terms that imply that the patient is upset and therefore not credible.
- Many providers believe that the term "domestic violence" in a diagnosis field constitutes sufficient documentation of the issue for both medical and legal purposes. While such notation provides general notice to the next provider that some issue related to abuse has been previously identified, it omits the underlying facts critical to the subsequent provider effectively and efficiently discussing the issue with the patient. (Additionally, legal professionals identified this information to be inadmissible in court proceedings.)
- Labels such as "battered woman" or "abused woman", and abbreviations such as "dom. vio." or "dv" are often used by health care providers to leave a "paper trail" when time is limited. (Again, however, these are of little or no use as legal evidence because they either draw unwarranted conclusions or are ambiguous or non-standard terms.)
- Some providers believe they should use euphemisms such as "problems at home," "fighting with husband," or "husband lost temper" as more neutral and less dangerous ways of indicating domestic violence. However, this mischaracterization of the husband's deliberate act against the patient's will undermines her attempts to prove her partner's abusive behaviors in court.
- Health care providers often believe that using terms such as "alleged", "assailant" and "perpetrator" demonstrates that the provider is being objective and neutral. However, a medical professional's use of such terms may be interpreted in court as indicating skepticism about the patient's version of events.

- The health care community is for the most part distrustful of the competency and intentions of the legal community. Providers see attorneys as insensitive to providers' concerns, unwilling to prepare providers for testimony in court, and ineffective in providing relief to victims.
- Many health care providers are concerned that responding to domestic violence entails increased liability. Many fear that an abuser may file a defamation suit if the provider documents the facts relating to an incident of abuse. It appears that attorneys who are internal to health care institutions may sometimes be providing information to health care providers that is incomplete or contradictory to other domestic violence training received from outside experts.

Finally, it appears that both legal and health care providers often believe they do not need specialized training in domestic violence because the social workers they call upon for assistance will be specially trained. Because they view domestic violence as a "social" problem rather than an explicitly medical or legal one, they believe that social workers are the most qualified to respond. Unfortunately, the social work participants indicated that many social workers have actually had little training in the dynamics or appropriate responses to domestic violence unless they have sought out special "elective" courses on domestic violence, so these assumptions about social workers' backgrounds are often unwarranted.

Perspectives of Social Work Participants

The partnership members with social work backgrounds had a good understanding of the misperceptions and fears of health care providers regarding intervening in domestic violence cases. This is due to their work in hospital-based domestic violence programs, which has included many hours of clinician training.

For the social workers themselves, a major concern about clinicians documenting abuse is uncertainty about the health care institution's ability to protect patient confidentiality both within and outside the institution. Concerns included the possibility of insurers dropping coverage for patients and their children due to domestic violence, or

insurance forms indicating abuse being sent to the policy holder (often the abusive partner), thus revealing that the woman sought assistance.

Additionally, social workers have similar fears regarding their own documentation of service. Licensed social workers face the same types of malpractice risks, and privacy and mandatory reporting requirements that physicians and nurses do. Because social workers have such intimate relationships with clients, they are likely to know more personal details about them. While some of this information might be helpful to the client in a legal context, other details might be damaging.

Social workers with special training in domestic violence are often particularly concerned about empowerment issues and are highly sensitive to clients' safety needs. While these concerns can improve the quality of service a client receives, they may also affect the degree to which the social worker feels safe documenting details of the case. For instance, a social worker may not document the client's help-seeking efforts in order to protect the client's strategizing and the location of safe places. A social worker may also avoid describing a client's demeanor as "upset, hysterical, despondent" for fear that this description could be used in the future to discredit her, for instance in child-custody hearings. In most legal contexts, however, this type of demeanor description is exactly what will allow the evidence from medical records (including social work notes) to be included as part of her case.

Translating the Lessons from the Partnership into Research Ideas

In order to translate the lessons from the partnership into a research undertaking that examined medical charts as legal evidence, it was necessary to lay out for all partnership members the legal background relating to evidentiary issues.

The necessary legal research was conducted primarily by legal staff from the Domestic Violence Institute (NUSL) with review and input from the legal members of the partnership. The research scope was quite broad at first, including every evidentiary issue that could possible apply to the use of medical documentation in legal settings, both in form and content. There were two goals involved in presenting this summary to the

partnership. One goal was to establish consensus among the legal partners regarding how to describe the evidentiary rules and how they are practically applied in a variety of legal settings. The second goal was to provide the non-legal partners with a basic understanding of the evidentiary rules for the purpose of clarifying what a medical record needs to look like in order to be useful in court.

The evidentiary rules acted as a springboard for lively interdisciplinary discussions. It was clear from these discussions that the evidentiary rules were often counterintuitive to what the health care providers and social service workers expected.

This discussion also made clear how difficult a task it would be to quantify a given medical record's status as "good" or "bad" with respect to the quality and admissibility of evidence about abuse. Numerous factors can influence the usefulness of a given medical chart, including the record's content and legibility, the experience and creativity of the attorney introducing the record, and the opinions of the presiding judge (given their wide discretion to apply the rules to the facts when determining admissibility).

For the sake of clarity, the "steps" that were followed in deciding how to go forward with the research are outlined below. Though this outline implies that the process was linear and highly structured, it was in fact often discursive. There were numerous debates among the partners, and time spent explaining in greater detail the perspectives and experiences of the various participants. These sidebars did not at all detract from the process, but were a necessary and useful part of grappling with complex issues. However, it is not possible or useful to recreate the entirety of these complex discussions in this report. The following outline provides the backbone of the process as an overview and as a guide to those who may wish to undertake similar collaborative efforts.

Step 1: The following subject areas were identified as legal contexts in which medical documentation could be used to corroborate abuse:

- abuse prevention order petitions
- criminal proceedings
- probation surrender and parole revocation
- family law proceedings, particularly those addressing custody, visitation and property division

- self-petitioning for U.S. citizenship under the Violence Against Women Act (VAWA)
- child protective services interventions
- achieving priority status to receiving housing, welfare and disability benefits
- tort litigation

Step 2: Rather than structuring our analysis by subject matter, we placed the variety of legal contexts identified into three categories:

Category I: Settings when the rules of evidence do not apply. These include: administrative hearings, child protective services investigations, self-petitions for citizenship under VAWA, pre-complaint magistrate hearings.

Cateogory II: Settings where the rules of evidence do not apply, but the fact finder has discretion as to whether to consider the records or not. These include: abuse prevention order hearings, detention based on dangerousness hearings, probation and parole revocation, GAL investigations, family services negotiations, mental health evaluations. Probate and Family Court judges often allow in evidence that might be excluded in other hearings in order to address more comprehensively and adequately the best interest of the children involved.

Cateogory III: Settings where the rules of evidence are strictly applied: civil and criminal trials.

Step 3: Next we identified generally how records may be used:

- by the survivor of abuse to initiate an action or defend against false retaliatory claims by the perpetrator
- by the abuser to defend himself or initiate action against his partner
- by a state agency in the area of prosecution and child protection services

Step 4: We needed to define the focus of our inquiry in order to establish a way to quantify the contents of the medical records using abstraction tools:

- What contents are helpful to survivor's case
- What contents are damaging to survivor's case
- What contents would be helpful to the abuser

Step 5: Identifying the types of information most relevant to our inquiry:

- identification of present abuse by partner
- corroboration of an incident
- descriptions of injury or health condition
- photographs of injury

- description of acts of abuse
- identification of perpetrator
- concerns of health care provider
- observations of perpetrator and children

Step 6: Identifying the most relevant evidentiary issues in order to limit the scope of inquiry to a manageable research undertaking:

- All information documented in the medical record and all statements made by any person documented herein fall within the hearsay rule (described in Creating the Abstraction tool section.) To be admissible as evidence, any information contained therein, whether delivered through live testimony or by submitting the document itself into evidence, must fall within an exemption to the hearsay rule. We prioritized the following exceptions to the hearsay rule:
  - Information relating to diagnosis and treatment
  - Medical Records
  - Excited Utterances
  - Refreshing Witnesses Recollection
  - Declaration of Physical Condition
  - Prior Inconsistent and Consistent Statements

- Photographs and Body Maps

- Privilege and Confidentiality Issues: Identifying the patient privilege and confidentiality rules that attach to various portions of the record.

These discussions lead to the development, review and refinement of the data abstraction tools, which are described in greater detail below. The tools themselves are in the appendix to this report.

In its entirety, this process impressed upon all partners the potential for medical charts to provide important evidence in legal settings. However, it also clarified the many difficulties, from both legal and medical perspectives, in creating, accessing and presenting such records. It became clear that the most common barrier to the use of records in legal settings is accessing the records. This process can be *time consuming* -- so much so that the window of opportunity for using a record in a legal setting may pass while awaiting its arrival. The increasing complexity of health care networks may mean that physically locating a patient's records is not a simple task. Retrieving medical

records can also be *costly* -- unless fees can be waived for an indigent client, copying costs can easily run into the hundreds of dollars. Finally, the process can be *complex* -- in order to benefit and also protect a client, it may be necessary to request only certain portions of the medical chart and to have more highly privileged information redacted. Health care institutions may balk at such requests because they are seen as too complicated, too time consuming, and too risky given the possible liabilities involved in releasing the wrong information. The end result can be an institution's failure to send any records at all, or its forwarding portions of the chart it was asked not to release.

Research Undertaking: The Current Status of Medical Records as Legal Evidence of Domestic Violence

Overview

In order to describe, from a legal perspective, how domestic violence is being documented in abused women's medical charts, the researcher-practitioner partnership developed a Medical Records Data Abstraction Tool. This task was one of the major undertakings of the study, and involved all medical and legal partners.

Originally, the project anticipated obtaining medical records of and performing semi-structured clinical interviews with a total of 100 new clients assisted through the law clinics at Northeastern University School of Law. The clinics assist battered women in a variety of legal matters, and in the context of legal advocacy, often retrieve clients' medical records from hospitals, neighborhood health centers and private physicians' offices. Due to several major barriers, the existence but not the extent of which had been anticipated, the project could recruit only 31 women from the court setting during the time period of the grant. This sub-section of the project is referred to as the In-Court Study.

In order to supplement this sample, the project added a second sub-study (the In-Hospital Study) in which medical charts of abused women were reviewed on site at two Boston-area hospitals.

The development of the data abstraction tool and the two sub-studies are described in further detail below.

Creating the Medical Records Data Abstraction Tool

Assigning Value to Characteristics of the Record

Assigning an overall value to a medical record is impossible given that it may be used in a variety of legal settings for different purposes. We decided instead to identify particular characteristics of a medical record that would make the record useful to the survivor, or potentially damaging to the survivor (which would also tend to make it helpful to the perpetrator). Additionally, we recognized that each type of health care provider has different information and varying documentation responsibilities. To accommodate these differences we developed separate tools. Three of the tools relate to information from different sections of the medical record: Emergency Medical Services, Physician and Nurses Notes, Social Work & Psychiatry Notes (which included the notes of domestic violence advocates). A separate tool was also developed to collect information on statements written by any of the above providers (the purpose of this tool is described more thoroughly below). All abstraction tools are included in the appendix of this report.

These tools, taken as a whole, are referred to as the "DV tool." The DV tool was applied to any medical visit that contained any of the following: a mention of domestic violence, a screen for domestic violence, a referral to domestic violence services, an indication of relationship problems, or an injury of any type.

For each medical record that was reviewed, the research staff first completed a Visit Summary tool (see appendix). This enumerated basic information on all visits in the chart, such as the location of service (e.g., emergency department), chief complaint, diagnoses, and which criteria, if any, were met for completing a DV tool. Those visits that qualified for a DV tool were then reviewed and the appropriate additional tools completed. The following lists summarize the types of information abstracted from the medical records in the course of completing a DV tool.

Generally Useful Characteristics:

- legibility of provider's handwriting; clear xerox copies
- accuracy and consistency
- identification of patient by name, age/birth date, or description
- consistent identification of relationship to abusive partner (e.g., husband, boyfriend, father of baby)
- patient's statements regarding incident and immediate and future safety (potential of abuser coming to hospital; weapons)
- documentation of answers to screening questions
- presence of abusive partner during visit; observations of abusive, threatening or intimidating behavior by partner which impacted medical treatment
- identification and documentation of concern and active intervention by medical staff
- name and contact number for all providers involved in treatment and all referrals made

Potentially Damaging Information:

- victim blaming notations; attributing abuse to the patient's current intoxication substance abuse or mental health issues
- inclusion of irrelevant information regarding her employment, education, dress, etiquette
- using ambiguous, unclear and confusing statements, ie., leaving abuser out of description (e.g., patient was thrown across table, patient broke her arm, bruised from being punched by fist)
- notes indicating suspicion of domestic violence despite patient's denial of abuse (e.g., believe patient is lying about abuse; patient is not willing to end relationship even though it may kill her)
- information that is afforded heightened privilege noted in a variety of places throughout the record, making it more difficult to detect and redact prior to release of medical records
- failing to review notes from previous visits
- incomplete or inaccurate medical history
- failing to conduct and document findings from a comprehensive exam (ie., examining a fractured wrist without performing a full body exam)
- use of legal terms (e.g., allegedly, purported, assault, attempted assault, perpetrator)
- summarizing events as relationship problems/mutual aggression
- failing to document observations or concerns
- unnecessary inclusion of privileged or irrelevant information about the patient (ie., childhood experience of sexual abuse)

Information Deemed Useful in EMS records:

- name of the EMS company (many cities contract out to private companies)
- name of EMS workers and badge numbers
- identification of patient by name and date of birth
- identification and contact number of all persons involved in pick up
- patient's statements, demeanor, time of response
- description of injuries as described above
- observations of home, abuser, children
- consistency between patient statement of events and injuries/condition observed

Information Deemed Useful in Physician and Nurses Notes:

- name of institution and department
- notation regarding results of screen
- date of treatment
- identification of abusive partner by relationship and name, history of relationship; onset and regularity of abuse; presence of partner during visit
- detailed description of symptoms/injury, ie., #, size, type, location, shape, color, degree of healing
- body maps indicating location, size and shape of injuries; degree of healing
- photographs which accurately represent injuries, especially a set of photos which represent a full body, facial and injury view
- indication of consistency between patient's statements and providers observations and assessment of injuries/health condition
- notation of where any real evidence collected during treatment has been kept.

Information Deemed Useful in Social Service and Psychiatric Notes

- source of referral
- identification of domestic violence as the problem, rather than "relationship problem"
- accurate diagnosis of depression/anxiety and its relationship to abuse
- identification of other social stressors and amount and type of support available to client
- safety assessment; protective resources available
- help-seeking behaviors, access to resources, strengths of patient, reasons for not using services
- intervention strategies used by providers
- DSM diagnosis, particularly Axis V
- quantity and quality of services offered and follow up plan
- patient's statements when accompanied by demeanor and indication of time between the statement and incident
- detailed description of injuries
- observations of partner's behaviors and statements

-- Evidentiary Considerations --

Having identified the substance of the documentation needed to corroborate abusive incidents the legal practitioners turned their attention to the *presentation* of valuable information. Before facts may be considered by a judge or jury, they must be offered and accepted into evidence by the presiding judge. Oral or written statements must comport with the applicable "rules of evidence" before a judge will allow the statements to be "admitted" into evidence.

Evidentiary rules vary from state to state. Federal Rules of Evidence do exist but govern state proceedings only if adopted by the state. Presently, most states have adopted some version of the federal rules through statutes or case law. Statutes typically define the scope of each rule in detail. Case law defines the rules through a piecemeal interpretive process, as attorneys litigate ambiguous issues before the appellate courts.

At the first working group meeting, legal practitioners noted the complexity and difficulty of identifying all the evidentiary pitfalls surrounding the use of information from medical records in legal contexts. Additionally, they felt strongly that the analysis of evidentiary issues should be limited to Massachusetts law for the following reasons: they practice in Massachusetts; the records would most likely to be used in Massachusetts courts; and analysis of an additional state's law would increase the information sought exponentially. Legal practitioners summarized a number of the evidentiary rules for the non-legal practitioners so that a joint decision about the scope of analysis could be made. After lengthy discussions regarding the number of factors to be considered, and recognition that there would be variability in each judge's interpretation, the group unanimously decided to focus its attention on only a portion of Massachusetts' evidentiary rules. The practitioners prioritized a handful of rules, weighing the predicted persuasiveness of information, the relative difficulty of meeting the rules' requirements and the frequency with which providers identify and record such information.

Using these criteria, the group agreed to limit the analysis to three areas:

Hearsay Exceptions Related to Admissibility of Information in Medical Records

- Information relating to diagnosis and treatment
- Medical Records (portions related to diagnosis and treatment)
- Excited Utterances
- Prior Consistent Statements
- Prior Inconsistent Statements

Photographs and Body Maps

- Photographs
- Body Maps
- Drawings

Issues Relating to Privilege and Confidentiality

- Types of information that have heightened privilege
- Frequency of information in each type of provider record
- Location of information in record (relevant when redaction is required)
- Requirements for release of records

-- The Hearsay Rule and Related Exceptions --

All states have adopted the hearsay rule. The hearsay rule prohibits admitting into evidence any out-of-court statements -- even if testimony is provided by the speaker, writer or actor of the offered out-of-court statement. Fortunately, all states have a number of exceptions to this rule, allowing certain out-of-court statements to be considered by a judge or jury. Judges decide whether a statement falls within the hearsay rule and if so, whether there are any applicable exceptions.

-- Information Related to Diagnosis and Treatment & The Medical Record Exception --

One exception to hearsay is "Information related to Diagnosis and Treatment." This exception permits health care providers to testify to matters related to care and treatment of a patient.

Another exception is the "Medical Record Exception". A handful of states; Massachusetts, Maryland, Michigan, Maine and Utah, allow written records to "speak" in

the place of providers in order to save providers the time, inconvenience and stress of testifying in court. The "medical records" exception provides that any portions of a certified medical record that are "related to diagnosis and treatment" may be included in the evidentiary record without requiring that a physician testify to the contents. Thus, a provider who writes comprehensive, specific, legible notes may be spared the burden of testifying in court.

A practical limitation of the medical record exception is that only the portions of the record that can be *read and easily understood by lay persons* will be admitted. Thus, only a provider who writes legible records, containing terms defined by a medical dictionary and symbols relied upon by a medical treatise, will be relieved of the duty of having to interpret the records in court.

The primary consideration related to the admissibility of statements by a health care provider or patient that are contained in medical records is whether such information is related to diagnosis and treatment. In 1995, the Washington Court of Appeals in State of Washington v. Sims, 890 P.2d 521, explicitly held that statements identifying a patient's abusive partner and his abusive behavior are admissible pursuant to a hearsay exception for statements made for the purposes of medical diagnosis or treatment. The court found that the physician must know who the abuser is to render proper care. In Sims, the hospital had implemented a policy of routinely referring assault or domestic violence victims to the social work department or to counseling programs. In Sims, the provider documented that he referred the patient to the social work department and suggested ways to avoid threatening situations to the patient. Also, the provider admitted the patient for an additional day in order to further social work interaction. The court concluded that the provider's awareness of the abuser's identity and behavior was useful to the patient's care.

Sims is the first case to acknowledge domestic violence intervention and similar information as relevant to "diagnosis and treatment". Massachusetts' courts have yet to interpret the scope of the medical record exception as broadly; however they consistently look to medical practice to guide their understanding of what is related to "diagnosis and treatment."

According to a recent study performed jointly by NIJ and the CDC, approximately 1.9 million women are physically assaulted annually in the U.S. (Tjaden & Thoennes, 1998). Over one million women seek medical treatment for abuse-related injury each year (Stets and Straus, 1990). Data from several studies suggests that 22%-25% of women presenting to emergency departments, for any health problem, are experiencing and presenting symptoms related to abuse, and that as many as 37% of patients seen in the obstetrics department are physically abused during pregnancy (Council on Scientific Affairs, 1992). These studies, in addition to the implementation of domestic violence protocols at most institutions, provide ample evidence that the medical community considers information related to domestic violence pertinent to diagnosis and treatment.

Even if statements are determined to fall outside the medical record exception, they may satisfy the requirements of other exceptions, such as the excited utterance exception, the prior inconsistent statement exception or the prior consistent statement exception. Also, even if not admissible as evidence, the statement may be used simply to refresh a witness's memory.

-- Excited Utterances --

A somewhat complex but particularly relevant exception to the use of medical records in legal contexts is the "excited utterance" or "spontaneous exclamations" exception. Massachusetts Law allows such statements to be admitted if the, "utterance was spontaneous to a degree which reasonably negated premeditation or possible fabrication and if it tended to qualify, characterize, and explain the underlying event" (Commonwealth v. Crawford, 417 Mass. 358, 1994). While some states require a showing that the speaker of the statement is unavailable, Massachusetts does not. Statements made during or soon after a stimulating event are considered to be reliable under the theory that a person who is reeling with emotion and stress from a shocking event is less capable of fabricating a description of the event. The partnership members agreed that this exception was a priority for research given the likelihood that a battered woman being seen for abuse-related medical conditions may share statements about an abusive episode soon after the incident.

Three factors are relevant in determining whether a statement meets the excited utterance exception: (1) an identifiable statement, (2) the duration of time between the incident and the statement being made, and (3) the patient's demeanor when the statement is made. In some states, these statements may be used even in cases where the victim's testimony in court contradicts the excited utterance. The court's reliance on such statements, as recorded by police or health care providers, acts to relieve victims of the responsibility of "prosecuting" the state's case. The admissibility of the statements allows a victim to support the prosecution of her abusive partner without requiring her to testify in person against her abusive partner. The risk to the victim of retaliatory acts against her and her children is thereby decreased.

To accommodate the number of elements that need to be satisfied for the excited utterance exception, a specific "Statements" tool was developed (see appendix). As other portions of the DV tool were completed (such as the tools for Doctors and Nurses notes), each "statement" in the record was separately abstracted using the "Statements" tool.

Photographs and Body Maps

Photographs are highly persuasive. In most states, photographs are not subject to chain of custody restrictions. In Massachusetts, a photograph may be admitted based on witness testimony that the photograph is a fair and accurate description of the object it purports to represent. Training for providers is minimal. Once trained, providers can do an efficient intervention that requires relatively little effort and decision-making from a traumatized patient. As part of the medical record, photographs are privileged. Another benefit to taking photographs is that the provider can give a set of the photographs to the patient for her to use on her own behalf.

Body maps are described in most domestic violence intervention protocols. Generally, body maps are outlines of the front and back view of a human body, providing clinicians an opportunity to diagram a patient's injuries rather than describing them in a narrative. Body maps vary in size and some include a legend of symbols to use when drawing. Body maps are intended to save providers time by allowing them to draw what

they see. Even if a body diagram is not contained within the paper work provided to physicians, providers may draw their own picture of the injury with notations regarding color, size, texture etc. Detailed drawings, whether in the form of a body map or hand written, effectively portray specific characteristics about a patient's injury that can later be used to corroborate abuse.

Privilege and Confidentiality

In all states, a patient's medical records are protected from release to anyone other than the patient. In many states, including Massachusetts, certain types of information contained in the medical record, including information related to sexually transmitted disease, AIDS/HIV, substance abuse treatment and psychiatric treatment have special privilege. Additionally, any information shared with a therapist, social worker, or domestic violence advocate is specifically privileged. No similar federal protection exists. Evidentiary privileges represent the states' attempt to balance a patient's right to obtain confidential health care against a defendant's right to a fair trial which includes admission of all relevant evidence.

Health care institutions are legally responsible for protecting patients' privileged relationship with providers. As part of this responsibility, institutions may only release information in the medical record when a patient consents through written release or upon court order. Frequently, only parts of the record are authorized for release. Under these circumstances, the institution is responsible for redacting those portions of the records that have not been authorized for release. The resources required to perform such redaction are dependent on the quantity and location of such information.

Attorneys may request medical records without providing the patient's consent for release or court order, either by telephone communications with the treating provider or by sending a letter or subpoena to the medical records department within the institution. Occasionally, information confirming that a patient has been treated within a particular institution or related information is released by that institution before privilege requirements are met. Similarly, information with special protection, such a counseling

records, may be released when consent or court order has only authorized that information related to health care treatment be released. Institutions that fail to protect patient privilege may be liable to the patient for any harm resulting in unauthorized release.

Some of the mostly hotly contested evidentiary battles before the court occur in domestic violence cases involving medical documentation of abuse, where the abuser seeks to obtain specially privileged information in an attempt to discredit and humiliate the victim. In Massachusetts, as in many other states, the abuser's attorney must submit a written request to the court, detailing a good faith, specific and reasonable basis that the privileged material contains evidence which tends to justify, excuse or clear any allegations of fault or guilt. If the abuser can make this showing, the judge will review the record to determine whether it includes relevant material to be admitted into evidence.

IN-COURT STUDY

This portion of the project sought to review the medical charts of a group of identified abused women who were seeking legal assistance. All of the women were recruited at Dorchester District Court (Dorchester, MA), where they had come to request a restraining order against a current or former intimate partner. The aim was to retrieve the medical records in a manner as similar as possible to that used by an attorney seeking to represent this woman in a legal context.

-- Subject Recruitment and Interviewing --

The Law Clinics at NUSL routinely train groups of law students to provide legal advocacy to abused women at Dorchester District Court. The students receive rigorous training on a wide range of issues related to domestic violence (e.g., the dynamics of abuse, reasons why women stay in abusive relationships, control tactics used by abusers, issues for children exposed to violence), as well as legal responses to domestic violence.

All clients of the NUSL Law Clinics who are assisted by the law student advocates routinely discuss the details of their cases with their advocate. With the assistance of attorney Lois Kanter, who is Clinical Director of the Domestic Violence Institute at NUSL, all law student advocates were trained to administer a semi-structured interview intended to serve the purposes of both legal advocacy and this research undertaking. The students received ongoing support and assistance from the supervising attorney of the Law Clinics, Pualani Enos, who was also Project Director for this research.

During the client interview, information was collected on demographics, the client's abuse history, her history of seeking medical assistance, and her opinions regarding previous encounters with health care personnel. Interviews were performed after the interviewer had obtained informed consent for both components of the study (clinical interview and medical record collection/abstraction). When women chose not to participate in the study, they were interviewed under the existing guidelines of the Law Clinic's advocacy program.

In addition to the semi-structured interview tool, the law students also assisted the women in filling out waivers that would allow us to retrieve their medical charts for periods of time during which they were experiencing abuse. Some of these waivers were from specific Boston-area institutions, while others were "generic" forms for use with institutions outside the Boston area.

-- Description of the Court-based Sample --

A total of 90 women seen by the law student advocates were asked screening questions regarding prior use of health care providers (these questions were posed *before* the woman was asked about enrollment in the study). Of these women, 81% had received either routine or other medical care in the past year; and 86% had received some kind of health care in the past five years. These women were also asked whether they had seen any health care provider for treatment of injuries related to abuse in the current or any prior relationship. Nearly one-fourth (23%) had received treatment for abuse-related injuries in the past year; 29% in the past five years; and 33% over an indefinite period of time.

The study recruited a total of 31 women from court. The sample was primarily African-American or Caribbean women (81%), most of low income. The age distribution of the sample is shown in Table 1. Eighty-seven percent of the women reported that one or more minor children resided in their home.

Table 1. Age Distribution of Court Sample (n=31)

Age category	N	%
18-19	4	13.0
20-29	9	29.0
30-39	8	25.8
40-50	6	19.4
Unknown	4	12.9

The women reported serious and extensive abuse histories during the semi-structured interviews. Overall, 84% of the women reported that they had been physically abused, 90% reported emotional abuse, 39% had been sexually abused, and 36% had been stalked. Table 2 gives more specific detail regarding the types of abuse that had been perpetrated by the "index" partner. The index partner is the individual against whom the client was requesting a restraining order when she was recruited into this study.

A total of 36 charts were retrieved from 16 different institutions for 26 of the women recruited in the court (charts were requested but never received for 5 women). The findings of the detailed chart review are described in the Results section below.

Table 2. Forms of Abuse Experienced by Court Sample (n=31)

Type of Abuse	n	%
Threatened to hit	23	74.2
Pushed, shoved	25	80.6
Slapped	17	54.5
Hit with fist, punched	19	61.3
Hit with object(s)	10	32.3
Kicked	16	51.6
Choked	14	45.2
Beaten up	14	45.2
Sexually assaulted	9	29.0
Threatened with knife/sharp objects	11	35.5
Stabbed	3	9.7
Threatened with gun	5	16.1
Shot	0	--
Threats to children, relatives, pets	9	29.0

-- Medical Records Retrieval --

A research assistant sent the medical waivers to all institutions from which we were requesting medical records, accompanied by a letter on law clinic stationery stating that the client was indigent and therefore any charge for medical chart copying should be waived. (All clients of the Law Clinic must be indigent to qualify for services.) Massachusetts requires that all institutions provide indigent clients with medical records free of charge. Otherwise, most institutions charge between $1 and $2.50 per page. The form indicated the relevant dates of medical records to be sent (i.e., the period during which abuse had been occurring). The form also emphasized that the information should be sent ONLY to the Law Clinic, and not to the patient directly. We were concerned that medical chart information sent to the patient could be intercepted by others, possibly jeopardizing her confidentiality and/or her safety.

Though many institutions sent back medical charts in reasonable time and with little prompting, others required numerous follow-up calls despite the fact that the cover letter stated that charts were needed expeditiously for legal matters. Of the total of 42 charts requested, 6 (14%) were never received (these 6 charts involved 5 different

subjects). More than one-third of the charts (38%) were received within one month, 26% required more than one month but less than 2 months, and 21% of charts took more than 2 months. It is important to emphasize that these return times would probably have been much longer without the numerous telephone follow-ups made by research assistants.

Many initial requests for records were met with resistance from personnel who insisted that records would not be released without payment because the copying was done by outside contractors who needed to be paid. The Project Director contacted the general counsel, the public relations office and medical records superiors, but still records were not released. At two institutions, it was not until domestic violence researchers from within the institution made the request that records were delivered without charge. Other institutions, while sending the records promptly, also included a bill to the patient. The researchers had to negotiate with these institutions to ensure that patients would not be held responsible for payment.

The major obstacle to receiving charts expeditiously was hospital bureaucracy. It sometimes required many calls to different departments or hospital affiliates to determine exactly who had the charts and where they had to be sent in the system for copying. In many instances, it appeared that if routine follow-up calls had not been made by the research staff, the request would have been sidetracked for many additional weeks or not filled at all.

A second problem was the existence in the charts of highly sensitive information, particularly regarding HIV or other sexually transmitted diseases (STDs). Several times, hospital personnel alluded to HIV/STDs as the reason a chart was not being forwarded. In several other instances, charts were forwarded to the Law Clinics without such information having been adequately redacted. For instance, one chart did not contain information on HIV testing or HIV+ status, but did refer to the fact that the patient was receiving the drug AZT (used to treat AIDS).

-- Abstracting Information on Domestic Violence from Medical Charts --

The Project Director and research assistants trained by the Project Director performed the medical chart abstractions using the tools that are in the Appendix. The original study protocol had called for two abstractions per chart with different abstraction teams, in order to enhance the accuracy and consistency of the abstraction process. However, given the barriers encountered by the study, there was insufficient time to undertake the duplicate abstraction. Future studies may want to streamline the data collection process in order to allow time for such duplicate abstraction.

-- Barriers to the In-Court Study --

Several barriers were encountered in the course of the in-court study, each of which had significantly more impact than originally anticipated and which cumulatively put the project at great jeopardy.

First, we found that regardless of intensive training the law student advocates were usually ambivalent at best or resistant at worst with respect to carrying out the "research" aspects of their interactions with clients. The advocates had trouble being consistent in both recruitment of subjects and administration of the semi-structured interview. They expressed concern that their time with clients was limited and the research seemed to take up too much of that time. However, the semi-structured tool was designed to collect much of the same information that the advocates would collect with any client, except for some of the opinions on prior medical care. Although the importance of medical charts in legal settings was covered in the clinic/research training, many of the students remained ambivalent about the research component of their work.. Their concerns had to be addressed in additional training in order to continue with the study.

A second barrier to the research was that a higher proportion of women refused participation in the study than was originally anticipated. We anticipated an acceptance rate of about two-thirds of those offered participation in the study, but had an actual estimated participation rate of about 35 percent.

Early in the study we found that many women were telling the advocates that they had not received any medical attention at all for many years (and hence had no medical charts for us to retrieve). Since we wanted to quantify the proportion of women making this statement, we asked the law student advocates to complete a screening questionnaire with all women who were being given advocacy before asking them about participation in the study. What we found was that in fact the large majority of the women coming to court (86% of the 90 women interviewed) had actually received some type of health care in the past five years. We believe that some women who had been indicating that they didn't have any health care in the past five years may have been passively resisting participation in the study. For whatever reasons, it was easier for them to say that they had no medical charts than to refuse directly to be in the study.

It also became clear from some of the charts that we did review that a subset of women may have refused participation in the study because their charts contained information on prior substance abuse, sexually transmitted diseases, or other highly sensitive issues. Though the advocates explained to each woman that retrieving and reviewing the medical charts might help her in future court cases (since, with their permission, this information would be added to their file at the Legal Clinic), some women may have seen more risk than benefit in having such records retrieved. The women were not offered any direct remuneration (cash, coupons, or otherwise) for their participation in the study.

The study was also complicated by actions taken by court personnel. Some court personnel insisted that the law student advocates could not perform their interviews in the room where restraining order petitioners wait. Women were reluctant to leave this room to be interviewed for fear that they would miss their opportunity to be heard in court. The law student advocates also encountered an increased amount of court "red tape" that decreased the amount of time they had with clients and thus made the advocates reluctant to use this time for subject recruitment.

Finally, the number of eligible subjects appears to have been lower than originally estimated due to an apparent increase in the proportion of restraining orders being taken out against individuals other than intimate partners.

IN-HOSPITAL STUDY

When it became apparent that the court recruitment was hindered by numerous barriers, especially a very low participation rate, it was decided that the number of abused women's charts being reviewed should be increased by reviewing charts directly in two area hospitals. These two institutions will be referred to as Hospital A and Hospital B. The demographics of these two hospitals' patient populations are considerably different. Hospital A sees a predominantly white, middle class population, while Hospital B treats more low-income minorities.

Each of these hospitals had domestic violence advocacy programs in place that could be used to identify abused women. At each hospital, 30 women were identified through these programs, and all visits in their medical charts since 1991 were reviewed. This allowed the selection of charts without actually reviewing the charts themselves to determine whether they appeared to belong to someone who had been identified as abused. It should be noted that the records from these hospitals may be biased toward more completeness regarding information on domestic violence, since the institutions are responsive enough to this issue to have developed on-site advocacy. Also, the women seen by the on-site advocates have either self-identified or been identified by hospital staff as abused, increasing the likelihood that there will be at least some information on domestic violence in their charts. However, the focus of this project is on the quality and specifics of this information, not its mere presence. Thus, as part of a pilot study, these charts allow us to describe many of the positive and negative aspects of documentation from a legal perspective.

Description and Discussion of Findings from Chart Reviews

Numerous data points were collected in this study, as can be seen by even a cursory review of the data abstraction tools in the appendix. Presented here are findings on some of the medical chart characteristics that are considered most basic to improving their legal utility, good candidates for documentation interventions, or most "comprehensible" to non-legal audiences. It is hoped that these findings will inspire others to undertake similar (though perhaps more streamlined) chart review studies, and that they will also encourage practice-based discussions of the legal aspects of domestic violence documentation.

Across the in-court and hospital studies combined, a total of 772 visits were reviewed from 96 medical charts. Close to half of these visits (n=361, 46.8%) came from the court sample; the rest were about equally divided between Hospital A (n=190, 24.6%) and Hospital B (n=221, 28.6%). In general, the "unit" of interest in this study is the health care visit, since each visit represents an opportunity for a health care provider to have observed and recorded information relevant to abuse.

The visits involved healthcare that was received in recent years. Eighty-five percent of all visits were made in 1995 or later; 70% were made in 1997 or later. Thus, these charts reflect current documentation practices. Table 3 shows the years in which all visits were made, by subsample.

When visits are made to any healthcare provider, they may generate documentation in various parts of a chart (e.g., doctor's notes, social work notes, etc.). Table 4 shows the types of notes that were present in the reviewed visits.

As can be seen from Table 4, it was unusual for emergency medical service (EMS) run sheets to be included in visits. This is probably because relatively few of the visits involved ambulances (this can not be determined independently without great effort if at all). However, it is also possible or even likely that run sheets may not always have been filed in the chart. Doctors and nurses notes were common across all three subsamples. Social work and psychiatric notes were more common in the hospital samples because of the presence of the domestic violence advocacy programs (and the selection of the samples through these programs).

Table 3. Year of Visits Abstracted from Abused Women's Medical Charts

	Court		Hospital A		Hospital B		Total	
Year of Visit	N	%	N	%	N	%	N	%
1990	1	0.2	0	--	0	--	1	0.1
1991	11	3.0	7	3.7	0	--	18	2.3
1992	6	1.7	9	4.7	1	0.5	16	2.1
1993	28	7.8	9	4.7	1	0.5	38	4.9
1994	29	8.0	7	3.7	2	0.9	38	4.9
1995	39	10.8	3	1.6	10	4.5	52	6.7
1996	45	12.5	12	6.3	6	2.7	63	8.2
1997	66	18.3	39	20.5	35	15.8	140	18.1
1998	112	31.0	66	34.7	82	37.1	260	33.7
1999	19	5.3	38	20.0	83	37.6	140	18.1
missing	5	1.4	0	--	1	0.5	6	0.8
Total	361	100	190	100	221	100	772	100

Note: Total percents may not add to exactly 100 due to rounding.

Table 4. Types of Notes Present in Charts (for 772 visits total)

	Court		Hospital A		Hospital B		Total	
Type of Notes Present	N	%	N	%	N	%	N	%
EMS run sheets	8	2.2	21	11.1	6	2.7	35	4.5
Doctors notes	250	69.3	146	76.8	106	48.0	502	65.0
Nurses notes	214	59.3	124	65.3	117	52.9	455	58.9
Social work notes	9	2.5	17	8.9	29	13.1	55	7.1
Psych. notes	4	1.1	5	2.6	8	3.6	17	2.2

Note: Percents are percent of all visits in the sample that contained this type of notes. More than one type of notes may be present for any single visit.

Three types of visit (emergency, ob/gyn, and primary care) made up about three-quarters of all of the visits reviewed. Table 5 shows the types of care for which all 772 visits were made, both in total and by sample subgroup.

Table 5. Types of Visits in Medical Charts

	Court		Hospital A		Hospital B		Total	
Type of Visit	N	%	N	%	N	%	N	%
Emergency	47	13.0	75	39.5	20	9.0	142	18.4
Admission	1	0.3	0	0	11	5.0	12	1.6
Primary care / Clinic	142	39.3	25	13.2	31	14.0	198	25.6
OB/GYN	112	31.0	46	24.2	73	33.0	231	29.9
Specialty	26	7.2	14	7.4	28	12.7	68	8.8
OR/Pre-op	0	0	3	1.6	15	6.8	18	2.3
Other	25	6.9	21	11.1	43	19.5	89	11.5
Unknown	8	2.2	6	3.2	0	0	14	1.8
Total	**361**	100	**190**	100	**221**	100	**772**	100

Note: Total percents may not add to exactly 100 due to rounding.

Proportion of Visits Reviewed for Information on Domestic Violence

A "DV tool" was completed when any of the following criteria were met for a given healthcare visit: a screen for domestic violence was completed; domestic violence was mentioned; a referral was made to domestic violence services; relationship problems were mentioned; or the visit involved an injury of any type. "DV tool" was the short-hand used for the sum of any and all data abstraction forms that were necessary for the given visit (EMS, Physician/Nurses Notes, Social Work/Psychiatry Notes, Statement tools).

A "DV tool" was completed for 184 (23.8%) of the visits, but this percentage varied across the subsamples. For visits made by the court sample, only 16.3% resulted in completion of a DV tool; for Hospital A, this percent was 34.7%, and for Hospital B, 26.7%. Table 6 shows the percent of time that a DV tool was completed for different visit types across the subsamples. For instance, in Hospital A, over half (57.3%) of the 75 emergency visits contained some information potentially indicative of domestic violence that triggered completion of the DV tool. By comparison, only 15.2% of the 46 ob/gyn visits triggered completion of a DV tool.

Table 6. How Often DV Tool was Completed for Different Visit Types

	Court		Hospital A		Hospital B		Total	
Type of Visit	N	%	N	%	N	%	N	%
Emergency	47	48.9	75	57.3	20	30.0	142	50.7
Admission	1	100	0	--	11	63.6	12	66.7
Primary care / Clinic	142	12.7	25	20.0	31	35.5	198	17.2
OB/GYN	112	7.1	46	15.2	73	26.0	231	14.7
Specialty	26	26.9	14	71.4	28	14.3	68	30.9
OR/Pre-op	0	--	3	0	15	6.7	18	5.6
Other	25	4.0	21	4.8	43	25.6	89	14.6
Total	361	16.3	190	34.7	221	26.7	772	23.8

Note: The number (N) is the total number of visits of this type; the percent is the percent of these visits that were abstracted using the DV tool.

Table 7 shows how often each of the different criteria for a DV tool were met. The most common reason that a medical visit triggered the completion of a DV tool was because an injury was involved. Of the 184 DV tools that were done, 93 (50.5%) involved an injury; and among all 772 visits reviewed, 12 percent involved an injury. A single visit could trigger the completion of a DV tool for more than one reason (e.g., a woman with an injury who was also screened for domestic violence).

Table 7. Reasons for Completion of DV Tool (full sample)

Reason for Tool	n	% of all tools	% of all visits
DV screen completed	41	22.3	5.3
DV mentioned	59	32.1	7.6
Referral to DV services	23	12.5	3.0
Relationship problems	46	25.0	6.0
Injury	93	50.5	12.0

Note: More than one reason can be present for a single visit.

Information from Ambulance (EMS) Runsheets

There were only 18 visits involving DV tools that contained some information from emergency medical services (EMS) runsheets. Thus, these findings must be considered very preliminary.

One interesting finding was that the name of the EMS company was not apparent for 15 out of the 18 visits (83%). Without this information, it would be harder for legal representatives to locate EMS staff who might be able to recall information regarding circumstances of the event such as the victim's demeanor or the appearance of the household (e.g., smashed furniture). However, in 15 instances an EMS worker's name was legible on the records, and for 10 visits there was also a phone number -- both of which would facilitate contact. According to the runsheets, the police were involved in 13 of the EMS calls, but there was an officer's name in only 1 visit, and a phone number for only 2 visits. There were few problems with illegibility of key information in the EMS run sheets, with only 1 visit out of 18 having a problem (due to poor photocopying).

For 11 of the 18 visits (61%) the EMS staff had recorded a patient statement, and in 9 instances they had paraphrased or summarized a patient's statement. (See section on Content of Statements below for information on the importance of statements). The numbers are too small to draw conclusions about what sort of statement information is "typically" present in EMS run sheets. However, it appears to be feasible for EMS personnel to collect this sort of information. To the extent that it is already a part of practice for many EMS responders to record patient statements, there is an opportunity to provide training so that these statements are recorded in ways that make them useful in legal settings. For instance, for only 2 visits was there mention of the patient's demeanor -- an important element for admitting a patient's statement as an excited utterance. With minimal extra effort, EMS personnel could record patient demeanor.

In one instance, EMS personnel had noted that the patient's statement about her condition was inconsistent with the provider's observations. And in another instance, the EMS provider had explicitly identified a connection between an intimate relationship and the woman's injury.

It was uncommon for physical evidence to have been collected by EMS staff -- there was one instance where blood was collected, and one instance of damaged clothing; no hair or weapons were retrieved.

Information from Physician & Nurses Notes

There were 160 visits involving DV tools where physician and/or nurse notes were present.

In 39 (24%) of these visits, a screen for domestic violence was indicated; 22 of the 39 (56%) had screened positive. (Note: More patients may have been screened without the act of screening or the result being recorded in the chart.) In 30 visits (19%), the chart indicated a perpetrator by relationship status (e.g., husband, boyfriend, etc.), but in only 5 instances was an individual named. The length of a relationship was recorded in 12 visits (8%), and information on the time period of abuse (e.g., "past 2 years") was present for 4 visits. In 36 of the visits (23%), a referral was made to domestic violence services. In 25 visits (16%), the patient had been previously identified as a victim of abuse.

Although 93 of the visits (58%) involved injuries, only one chart contained a photograph. It may be that a social worker or advocate took pictures and stored them in private files but did not note the existence of the photographs in the main medical record. Even if they do exist, they remained inaccessible to us, even after a relatively rigorous record retrieval effort. While it may be that a patient would remember that pictures were taken, it is highly unlikely that a patient would remember who to call and how to track down those records for later use. One way to protect photographs, but flag their existence, is to note in the chart that photographs were taken and where they are being stored (e.g., specific police department). Only 3 visits contained current injuries drawn on a body map, 1 contained past injuries on a body map, and 8 contained drawings. None of the charts contained or made reference to physical evidence of abuse (e.g., bloody clothing).

Though maps and photographs were seldom used, it appears that injuries were often described in significant detail. Almost three-quarters (73%) of injury visits had 3 or more descriptive terms; 81 percent had one or more patient symptoms.

Twenty percent of the visits included some description of the patient's demeanor. Patient statements were recorded in 84 visits (53%), and the clinician paraphrased or summarized patient statements in 93 visits. Some sort of conclusion or summary was made regarding domestic violence in 25 visits (15.6%); "relationship problems" were referred to in 15 visits (9%); and 12 visits (8%) mentioned a protective order. All of these instances represent opportunities for clinicians to record information that could be legally helpful to clients. [The section on Statements below provides more detail on the actual content of the documented statements.]

Only four visits indicated the consistency or inconsistency between a patient's statement and the provider's assessment of her condition.

Some clinicians place "domestic violence" under the list of diagnoses, though this does not constitute admissible evidence in court. In this study, domestic violence or a related term was present in the diagnosis field for 23 visits (14%). In legal settings the abbreviation "DV," sometimes used by clinicians, is problematic because of its ambiguity. Fortunately, this abbreviation appeared in only 2 visits. Labels that denote domestic violence (e.g., "abused woman") appeared in 13 visits.

Only a small number of visits contained documentation about the woman or her situation that appeared to be explicitly negative. For instance, 4 visits contained references to the woman's education, social class or appearance that had no relevance to her medical condition or care. In one visit, a provider had made assumptions about the patient's circumstances or motives. These types of statements can harm a woman's case in court by, for instance, undermining the credibility of the statements she made to the provider.

A small but important subset of visits contained privileged information that should have been redacted by the institution that sent the records (in the case of the court study), or was being kept in an inappropriate section of the chart. For instance, mental health was noted in the main record for 24 visits (15%). Notes from psychiatry were in

the main record in 8 instances, and, perhaps most disturbing, AIDS/HIV status was indicated in the main record in 3 instances.

Abused women sometimes state that they are reluctant to discuss abuse with healthcare providers because of concern that intimate partners will see their medical records. Apropos this concern, we found that in 12 visits (7.5%) there were consultation notes from a domestic violence advocate in the medical record itself.

Finally, information from a medical chart cannot be introduced into court if it is illegible. There was vital information that was illegible for 55 visits (34%), mostly due to problems with handwriting as opposed to photocopying.

Information from Social Work & Psychiatry Notes

Among the visits that involved a DV tool, there were 75 visits that contained social work or psychiatry notes (sw/psych). It was not possible to determine the exact source of all of these notes, but a substantial portion of them were written by individuals who are not only social workers but domestic violence specialists.

These notes identified the perpetrator by relationship (boyfriend, estranged husband, etc.) in 71% of the cases, but only named a specific individual in 13%. The length of the relationship was noted for 20% of visits.

Nearly three-quarters of the sw/psych visits (54, or 72%) contained a patient statement or similar information. (See "Content of Statements" below.)

A very small proportion of visits (4, or 5.3%) contained negative statements about the client's dress, appearance or manner. Nearly a quarter (18, or 24%) of the visit notes described the woman's help seeking behaviors. Over one-third of the sw/psych visits (28, or 37%) identified one or more of the patient's strengths, such as:

"remains optimistic and future oriented"

"goal directed, organized and using available resources"

"significant gains in her capacity to assert self in relationship"

"taking more active steps on behalf of self/kids in decreasing isolation thru talk with family/friends"

Table 8 shows how often various problems were mentioned in the sw/psych assessments. In a total of 15 visits (20%), the client was assigned one or more psychiatric diagnoses.

Table 8. Problems Noted in Social Work or Psychiatry Notes (total n=75)

Problem	N	%
Domestic violence	54	72.0
Marital/relationship issues	24	32.0
Depression/anxiety	29	38.7
Suicidal/homicidal	17	22.7
Major mental illness	8	10.7
Chemical dependency	9	12.0
Child protective issues	19	25.3
Caregiver/parenting issues	8	10.7
Sexual assault	7	9.3
Homelessness	4	5.3

Table 9 indicates some of the most common forms of assistance, resources or referrals provided to the clients. A small number of visits (6, or 8%) indicated that the client refused or was unwilling to use resources. In 5 visits (6.7%) there was mention of a 51A (child protection) filing.

Table 9. Assistance Mentioned in Social Work or Psychiatry Notes (total n=75)

Assistance/Resource	N	%
Individual counseling	26	34.7
Restraining order	21	28.0
Shelter	20	26.7
Police	17	22.7
Safe places to stay	16	21.3
Identified family support	16	21.3
Children's services	12	16.0
Legal services/court advocacy	12	16.0

Content of Statements

Some of the most important pieces of information in abused women's medical charts are contained in the statements that are made by the patient or others about the abuse, injury, or the circumstances that brought the patient in for medical care. During the process of completing a DV tool, each time a statement was encountered in the medical record, a separate form was completed in order to collect details on these statements.

Over the course of the 184 visits that triggered completion of a DV Tool, a total of 831 statements were abstracted.

Beginning on the next page are some examples of actual statements that were made in medical records, with some commentary on how the statements are or are not useful in legal settings and how the documentation might be improved. Some of the suggestions for improvement go beyond the issues that were the primary focus of this research project, but are included for informational purposes.

EXAMPLES OF STATEMENTS AND THEIR USEFULNESS AS EVIDENCE

Example 1

Patient states that her husband hit her in the face with the phone receiver and then threw the phone at her back after she tried to call the police. Last time, she did not press charges because she had discussed with her husband that he needed to change his behavior. This time she called the police and they arrested him. She will go to court to get a RO on Monday. The assailant is in custody. No known psychiatric history, substance abuse or weapons.

From a legal standpoint, it is best to describe exactly how, how many times and where the patient has been attacked. The information about the phone being thrown "after she tried to call the police" may support a charge of intimidating a witness, which may or may not have been included in other
accounts of the event given to police. The inclusion of documentation regarding the involvement of police is important to future safety planning. Legal terms (e.g., "the assailant") are inappropriate to include in medical charts and will only be a source of confusion in legal contexts. It is possible that a judge may infer from the use of the term "assailant" that the provider has doubts about the patient's report that it was her husband who hit her. The provider notes the patient identifying the husband but then refers to the person in custody as assailant, leaving room for the possibility that the assailant is someone other than the husband. The last sentence of the note is confusing because it is unclear whether the provider is referring to the patient or the husband.

An improvement on this documentation might be:

Patient states that her husband hit her in the face with phone receiver 3 or 4 times on the right cheekbone and eyebrow after she had tried to call the police because he was abusing her. She states, he hit her with so much force the last time that she flew into the corner. He has threatened to kill her before. She reports he pulled the phone out of the wall and threw it at her, it hit her in the middle of her back, as she was walking out of the room. She is very afraid of what he might do if he gets out of jail. She says she is afraid he will kill her. Police report that husband is in custody and will not be released until tomorrow morning arraignment. Patient states she will meet with an advocate to talk about applying for an abuse prevention order to protect herself and her children.

Example 2

Father of the child is difficult, father did not want child, relationship very difficult, denies physical abuse, father emotionally abusive, expressed concern about father wanting to be involved with baby, sounded tentative when denied safety concerns.

Without any other information from the record regarding injuries or condition, this note indicates there is no physical danger to the patient at the hands of the father of her baby. The source of the information is not made clear by quotations or use of the phrase "patient states". Information relating to the patient's concerns about the father of the child seeing his baby are open to a number of interpretations. The mother may have reasonable fears for her child's safety and wellbeing based on the father's past behavior and threats. The note could also be interpreted to support father's argument's that patient is a vengeful, angry woman who wants to keep him away from his child because of past difficulties between them. Ambiguous descriptions of abusive incidents are easy to characterize as arguments and relationship difficulties in a legal setting. Careful and accurate factual notations about who has done what and specific reasons for concern safeguard against minimization, justification or denial of abusive acts.

While patient is noted as denying physical abuse by the father of the child and safety concerns, the fact that the provider asked about these two issues demonstrates the provider's concern that the father is a danger to the patient and possibly the child. The note that patient 'sounded tentative' further indicates that the provider is unsure that the patient revealed her actual beliefs regarding safety. Here the provider could have asked follow up questions to learn more about the patient's relationship to the baby's father and concerns about his contact with the baby, what behaviors he exhibits when he is being "difficult" and what leads her to believe the father doesn't want the child. The provider could also ask what the patient means by "emotionally abusive" or ask the patient about the father's behavior when he is upset or difficult. Sometimes, asking the patient about her fears and if there is a chance he could harm her or the baby is more effective than asking if she feels safe. By asking these questions, the provider will have factual information to document in the record. Answers to these questions not only provide the clinician with detailed factual information to document but also more information upon which to make an assessment and tailor an intervention. The provider can also document his/her own concerns for the patient's safety based on observations and information learned.

An improvement on this documentation might be:

Patient stated the following: She dated father for 9 months before she got pregnant with his baby. After she got pregnant he was always yelling at her, accusing her of sleeping with other men and keeping her from leaving the house. She left him one month before the baby was born and has been living with her mother. He calls her and follows her when she leaves the house to see what she's doing. He warned her that if found her with someone else she would be sorry. He has also said that it would be too bad if her baby had to grow up without a mother. She's afraid of what he might do. I gave her a number to call to learn more about services.

With additional information from follow up questions it might look like this:

Patient states "he is afraid that I am going to go after him for child support, and said that if I did, he'd take the baby away from me and I'd never see him again." "He wanted me to get an abortion but I wouldn't." I talked to patient about my concern for her and the baby's safety once she leaves the hospital. Patient agreed to talk to the social work advocate about services available to her.

Example 3

Patient fell on Friday, hit upper and lower back on stairs.

If a patient indicates that she was injured in a fall, a provider may want to ask where, when, and how the patient fell, what exactly happened and who was there. If the patient doesn't disclose a trauma inflicted by her partner, careful examination of the injuries and a full body exam may still lead to other questions about the circumstances behind the injury. If the findings upon examination are not consistent with her explanation of the mechanism, this should be documented.

An improvement on this documentation might be:

Patient states she fell down stairs on Friday, October 1, 1999. She cannot remember what time. She does not remember where on the stairs she fell or what caused her to fall. Patient states that no one else was present. Contusions on the back and lower leg are possibly consistent with a fall, but bruising in these areas appears old. A fresh laceration to the lower right arm, requiring 12 stitches, is inconsistent with patient's explanation of fall. Patient states she does not know how the laceration occurred. Patient appears upset.

Example 4

Patient states she awoke with significant swelling of right eye, She says she has clots after delivery. First she reported she is not in contact with FOB but then reported upon closer questioning that he plans to move `down south' and has threatened to take son. She denied wanted to be pregnant again but giggled during discussion.

The provider should note all possibilities for eye swelling and, whenever possible, rule out those which are inapplicable. This way, even if the patient does not disclose the injury was caused by abuse, she could use these records in a later context to dispel alternative explanations.

Does the patient feel safe? When was delivery? Is clotting a common occurrence given her delivery date? The provider could inquire further about the patient's concerns that the father of the baby has threatened to take him; such probing might reveal an abuse history. The provider does not clarify the relevance of her wanting to be pregnant again.

Example 5

5D ago was thrown out into the wall, head banged the wall. Complains had pain in stomach. C/o R elbow pain. Was seen at XXX Med. Ct. for radial head fx.
[c/o=complains of]

There is no indication here of who was pushed, who did the pushing, or where the wall was located. The record does not reflect how hard the patient's head banged the wall, or what part of her head hit the wall. The record contained no description of the injuries or pain around the head. There is no indication of whether the previous radial head fracture was a result of trauma inflicted by the same person. There was also no indication that this provider contacted the previous provider for further information on the prior head fracture.

[Same patient five days later in the same institution] :
c/o scratched chest and right jaw pain. Right elbow injury worse per patient. c/o right elbow pain.

This note came from an emergency department visit. There was no indication in the record that the patient had been seen just 5 days earlier in the same institution's primary care clinic.

Example 6

Claims her ear feels weird where she was punched. She claims to have noticed clotting blood at times between periods. Claims she spoke to aunt about incident and aunt gives support. She informed her health center but claims they haven't helped.

This provider's use of the word "claims" to describe every statement made by the patient leaves a strong impression that the provider doubts the patient's credibility. The provider omits from the note who punched the patient or any factual information describing the "incident." Further, the provider does not indicate any follow up questions to explain what the patient meant by "weird."

All of the above examples of documentation demonstrate how shorthand summaries, without clear subjects in the sentences, result in records that are both clinically incomplete and of limited use in legal contexts. Also, the use of legal or ambiguous terms such as "assailant" and "claims" can be interpreted as the provider doubting the credibility of the patient's statements regarding the identity of the person who hurt her or the factual explanation of the cause of her injury, condition or fear.

The sterility of these summaries is more likely than not to be used to support an abuser's claim that the injury was an accident, or due to some fault of the patient. Improved documentation requires that providers make a fuller inquiry through follow up questions, in order to get a more complete story of what happened and who was involved. Comprehensive questioning not only provides a complete and accurate record for future use in legal contexts, but is likely to lead to more efficient and comprehensive medical service.

Documentation of Specific Acts Relevant to Abuse

Statements may contain information on current or prior acts relevant to abuse. Table 10 indicates how often certain actions were mentioned in the statements. It is important to note, however, that the specific usefulness of documenting these types of acts depends a great deal on the many issues already discussed (i.e., exactly what language is used and whether there is a clear indication of who inflicted an injury, what the injury looked like, the patient's demeanor, etc.).

Table 10. Content of Statements in Medical Records of Abused Women

Action Mentioned	Current Acts		Prior Acts	
	N	%	N	%
Assault	135	16.2	44	5.3
Forced sexual contact	40	4.8	11	1.3
Accident	34	4.1	0	--
Verbal threat	24	2.9	6	0.7
Weapon or object	22	2.6	2	0.2

Note: Percent is percent of all statements (n=831).

Excited Utterances

[See page 41 above for a complete description of the excited utterance exception.]

Only 28 of the 831 statement tools (3.4%) included all elements necessary to satisfy the excited utterance exception; 19.3% (n=160) satisfied two elements and 55.3% (n=459) satisfied at least one element. Somewhat surprisingly, 22 percent of the statement tools contained none of the required elements. The element that was most frequently missing in the statements was a description of the patient's demeanor (e.g., "upset," "crying," "hysterical").

In order for the event description contained in a statement to be characterized as a patient's "statement" under the excited utterance exception, it must be clear that the patient was the source of the information being attributed to them. This is clearest in those medical records where patient statements are indicated as such by the use of quotation marks, or the phrases "patient reports" or "patient states". Sometimes providers write "patient indicated," "complains of" or "discloses," but these forms of documenting a patient's statement are less clear and less likely to meet legal standards.

In total, slightly less than half of the statement tools (45.1%) recorded event descriptions that could be characterized, in a legal sense, as patient statements. The rest of the statement tools included *descriptions* of abusive events but did not explicitly identify that the patient was the source of any of the information. Accordingly, there is no statement to be introduced in court, only a summary of events as related through the physician. A simple modification of using quotes, or writing "patient states..." or "patient reports..." at the beginning of the documentation note is more accurate and provides the patient with a record of her presentation closer to the time of the result.

The time between the abusive event and the patient's statement is considered an important factor in determining the reliability of the statement. A statement tool was scored as including "time" if there was a note of the time of the event, a description of the stage of healing of an injury, or mention of the time between the incident and treatment. At least one of these measures of time was present in half of the statement tools.

A description of patient demeanor, the third element needed to admit a statement under the excited utterance exception, was the element that was most often missing in the statement tools. Only 10.3% of the tools contained statements indicating demeanor or conclusions that may have resulted from the provider's assumptions based on the patient's demeanor. Terms that were considered to accurately describe demeanor included: anxious, agitated, hysterical, upset, tearful, awake/alert, calm, scared, despondent, sad, angry, flat affect, frightened, hyper, unable/reluctant to speak, pressured speech, worried, concerned, writhing in pain, tired, pleasant, happy, laughing, smiling, and confused.

Some terms or phrases that may be used in response to interaction with the patient but that do not describe demeanor include: good/bad, shy, ambivalent, inappropriate, doesn't want to give information, low self-esteem, afraid of not being believed, unhappy but stable. These terms do not describe the demeanor exhibited by the patient, rather they are conclusions about the patient's state of mind, feelings or opinions. These terms are not helpful descriptions of the patient because they are dependent not only on the provider's observation skills but also on his or her judgments or interpretations of the client's response to a stimulating event.

If they were given a brief training on the importance of the three types of information involved in the excited utterance exception, providers could make small modifications to their documentation routines that would be likely to help survivors and also save time during intervention. These small changes might also reduce the chances of a provider being called to make a live court appearance.

One of the most important components of such a training would be attention to the inclusion of words that describe patient demeanor. The relative scarcity of demeanor terms in the medical records may indicate that providers are concerned about creating harm to the patient by describing her when she is hurt and afraid. Providers should be assured that describing demeanor can only help a patient. Even if the patient's demeanor does not help to get a statement into evidence as an excited utterance, it may serve other purposes. For instance, it might help to corroborate statements given to others such as the police. At worst, a statement that might have been helpful won't be admitted into evidence. On the other hand, failing to describe a patient's demeanor might turn out to be

helpful to the abuser. If the medical record describes a woman who is very badly hurt, but does not appear "appropriately" upset or afraid, a defense attorney may claim or insinuate that she was not actually the victim of an assault, was on drugs, or was seriously mentally impaired. Any of these assertions might damage her court case. Obviously clinicians should only include those demeanor words that they feel accurately reflect the patient's emotional state as observed.

CONCLUSIONS

This study sought to describe, from a legal perspective, how domestic violence is being documented in abused women's medical charts. In total, we reviewed 96 medical charts of 86 abused women covering 772 visits. For 184 of these visits (24%), we abstracted detailed information on documentation because there was an indication of domestic violence, an injury of some type, or both.

We believe that this study, though performed on a limited sample representing patients and documentation practices from one major metropolitan area only, nonetheless has revealed some important shortcomings of current medical charts as legal evidence of domestic violence. The research has also identified some relatively minor changes that could significantly improve the potential legal utility of medical records. We believe that such changes could help healthcare providers to "work smarter, not harder" on behalf of their abused patients.

Based on the work of this practitioner-researcher partnership and the review of abused women's medical charts, we conclude the following:

- The legal and medical communities hold many misperceptions of one another's roles in responding to domestic violence. Many barriers to collaboration are based on these misperceptions and false assumptions.
- The work of the interdisciplinary partnership demonstrates that a common meaningful goal, respect for one another's professional expertise, and willingness to view a problem from a new perspective, can provide the context for productive medical/legal collaborations on the issue of domestic violence.

- Some legal advocates do not utilize medical records regularly in civil contexts or to their full potential in criminal contexts. Reasons for not using medical records include: difficulty and expense in obtaining them; their illegibility, incompleteness or inaccuracy; the possibility that the information in them, due to these flaws, may be more harmful than helpful.

- Many if not most health care providers are confused about whether, how and why to record information about domestic violence in medical charts.

- In an effort to be "neutral" regarding abuse situations, some health care providers are using language that is likely to harm an abused woman's legal case and aids her abuser (in a legal context).

- Though physicians' poor handwriting is often the subject of jokes, it can in fact prevent use of the medical chart in court. In this study, among medical visits that contained some indication of abuse or an injury, one-third of the notes from doctors or nurses contained vital information that was illegible.

- With minor modifications to documentation practices, many more abused women's medical charts would contain the elements necessary to allow their statements about abuse to be introduced in court as "excited utterances." Such evidence can allow a prosecution to proceed even when the woman is unwilling to testify against her abuser in court due to fear or for other reasons. The element needed for excited utterance exceptions that was most frequently missing from medical records was a description of the patient's demeanor.

- Many providers are recording significant details regarding injuries and health conditions in abused women's charts. If these practices were consistent, and symbols and abbreviations were standardized, this type of documentation could act as effective corroborative evidence in court.

- Emergency medical services (EMS) personnel may be an underutilized source of legal documentation of domestic violence. It appears that EMS providers may already be recording patient statements quite often; with additional training, the legal utility of these data could be greatly increased. This is especially true given the proximity of these providers (in time and space) to the actual violent events.

- Though many if not most protocols on healthcare response to domestic violence call for documenting injuries on body maps, this study found such maps or any types of drawing of injuries in only a handful of medical visits.

- Photographs, the "sine qua non" of evidence regarding abuse-related injuries, were almost never present in the charts reviewed in this study. Only one of the 93 visits involving an injury contained a photograph. The medical records also did not mention photographs stored in other locations, e.g., with local police.

- Although the partnership discussions and prior focus group research had both identified inappropriate, derogatory statements about abused patients as one current problem with medical documentation, such comments were found in physician or nurses' notes in only five instances, and in social work or psychiatry notes in four cases.

RECOMMENDATIONS

The recommendations stemming from this research cover two related but distinct topics: improving the interdisciplinary cooperation of the legal and health communities in addressing domestic violence documentation; and improving specific documentation practices that may make medical records more useful to abused women who are seeking legal assistance. Also provided are some suggestions for future research.

Improving Cross-disciplinary Understanding and Cooperation

Improving the legal usefulness of medical records will require close cooperation among individuals from both professions.

First, lawyers experienced with using medical evidence in domestic violence cases need to train other attorneys in how to obtain medical records and how to use them in legal settings. Lawyers also need to create better alliances with health care providers in order to obtain the help they need in interpreting records. The participation of health care professionals in legal training related to medical issues may facilitate such alliances.

The legal community needs to provide more information and training to medical professionals on how medical records can assist abused clients in legal settings. They should also address health care providers' concerns about liability, confidentiality and

privilege issues as related to documenting domestic violence. All such presentations should to be geared to an audience that is not used to hearing legal terminology. Attorneys should be careful not to expect *radical* changes in medical documentation practices, and should emphasize changes that also represent improvements in medical care.

Further, lawyers need to do a more thorough job of preparing medical professionals for court testimony. Such efforts may pay off in several ways: they have the potential to decrease medical professionals' concerns about testifying (and may thus make them more willing to document abuse clearly); they may decrease some of the common hostility between the two professions; and they may result in more effective court presentations on behalf of abused patients.

Health care professionals will need to be open to education from legal experts on certain aspects of documenting domestic violence. Clinicians should guard against a possible tendency to dismiss any recommendations from legal professionals as "irrelevant" to good medical practice.

Health care providers are used to encountering the legal community in very adversarial contexts (e.g., medical malpractice suits), and will need to set aside old grievances and preconceived notions in order to work cooperatively on improving documentation.

Improving Medical Record Documentation

Though protocols to improve response to domestic violence have proliferated, and often contain information on documenting abuse (including body maps), there is still much confusion among health care providers regarding whether, how and why to document abuse. Data collected from the discussions of this practitioner-researcher partnership, from prior focus group research, and from the medical records review, indicate that the primary reasons records are not used in legal settings are: illegibility, incompleteness, and confusing or ambiguous statements.

Below are some preliminary suggestions that might improve the legal utility of medical records as evidence of domestic violence. They are divided into

recommendations that primarily involve the practices of individual clinicians, and those related to broader systems response. Future studies should continue to explore whether these changes are feasible and also whether they lead to documentation that assists women in obtaining legal remedies.

Suggested Changes in Clinician Practices

- Clinicians should, when at all feasible, take photographs of injuries that are known or suspected to have resulted from interpersonal violence. Optimally, there should be at least one photo each of the full body, the injury itself, and the patient's face.

- Clinicians should take care to write legible notes. Clinician training should emphasize that illegible notes may negatively impact health care and are likely to hinder a woman's ability to obtain legal remedies to address her abuse. The increased use of computerized systems is very helpful in addressing the common problem of illegible information.

- As often as possible, clinicians should use quotation marks or the phrases "patient states..." or "patient reports..." to indicate that the information being recorded is coming directly from the patient.

- Clinicians should stay away from words that imply doubt about the patient's reliability ("patient claims...", "patient alleges..."). Alleges is a legal term. It implies the statement following it is unproven and may not to have occurred. Providers should instead use quotes around statements made by the patient. If the clinician's direct observations are in conflict with the patient's description of events, the clinician's reasons for doubt should be stated explicitly.

- Clinicians should not use legal terms such as "alleged perpetrator," "assailant," "assault", etc. All legal terms are defined with great detail by federal or state statute and case law. Typically, such terms are used by lay persons to mean something more ambiguous or larger in scope. By using legal terms, providers may convey an unintended meaning. For example, assault is defined as an attempt to cause an unwanted touching, whether or not the touching actually occurred. Naming the person who has injured the patient as her "assailant" or "perpetrator" after the patient has identified the person who has hurt her as a husband, boyfriend, father of her child or by name, is likely to be interpreted in a legal setting as the provider's doubting the patient's credibility. These terms are used regularly by attorneys seeking to raise doubt as to who committed an act.

- Optimally, providers should describe and name the person who hurt the patient in quotes exactly as the patient has identified him. This prevents the abuser from obscuring his responsibility by accusing the victim of having multiple partners.

- Practitioners should avoid summarizing a patient's report of abuse in conclusory terms such as "patient is a battered woman", "assault and battery," or "rape" because conclusions without sufficient accompanying factual information are inadmissible in court. Instead, providers should document the factual information reported by the patient that leads them to conclude abuse occurred.

- Placing the term "domestic violence" or abbreviations such as "DV" in the diagnosis fields of medical records is of no benefit to the patient in legal contexts. This practice should be reconsidered unless there are other clear benefits with respect to medical treatment.

- Clinicians should include words that describe a patient's demeanor, such as: crying, shaking, upset, calm, angry, agitated, happy. Clinicians should describe what they observe, even if they find the demeanor to be confusing given statements of abuse.

- Clinicians should record the time of day in their record, and (ideally) some indication of how much time has passed since the incident (e.g., "patient states that *early this morning* her boyfriend, Robert Jones, hit her...")

Suggested Changes in System Approaches

- The importance of photographing traumatic injuries needs to be re-emphasized in training programs on medical response to domestic violence. Research should determine the most common barriers to taking photographs. Interventions that aim at increasing the frequency of taking photographs should be developed and evaluated.

- Medical units that handle abuse cases routinely (e.g., emergency medicine, social work) should have cameras stored in a secure but easy to access location. Resources should be allocated to buy cameras and film, and to train providers in their use. Each institution's policy on response to domestic violence should include details on where the camera can be found, how to photograph injuries, where to store photographs, and how to document the existence and location of these photographs in the medical record.

- Non-clinical health professionals (medical records managers, administrators, risk managers) should work with domestic violence legal and clinical experts to examine changes that might facilitate the accessibility of medical records for legal use without compromising patient confidentiality.

- Training regarding current health care response to domestic violence should be provided to judges who hear domestic violence cases regularly.

- Domestic violence training programs and materials for health care providers should clarify that a failure to *document* domestic violence completely when treating an abused patient does not constitute taking a "neutral" stance about the incident. It will almost always convey a legal advantage to the abuser. In medical terms, it constitutes poor preventive medicine.

Possible Directions for Future Research

This research looked at an issue that has received little attention amidst the past decade's increases in medical and legal response to domestic violence. The project was intended as a starting point in examining issues surrounding the status of medical records as legal evidence of domestic violence. The findings should be confirmed, modified, or refuted by future studies. In addition, this research undertaking and the discussions of the practitioner-researcher partnership spawned other related questions deserving of further research. These include:

- What are the views of a larger and more representative group of attorneys toward the use of medical records in domestic violence cases? A larger interview or survey study would determine whether the findings of this study are generalizable, and would shed further light on possible modifications that could improve the legal utility of medical charts.

- What do health care providers in various subspecialties perceive as the major barriers to documenting domestic violence in the chart? What are the major misperceptions (especially regarding legal issues) that may be hindering improvements to documentation? What, if any, potential liability exists?

- What are the attitudes and beliefs of abused women regarding the medical documentation of domestic violence? What are their specific concerns? Which concerns are valid and which are based on misinformation or misperceptions?

- How should sexual assault in the context of intimate partner abuse be documented in medical records? (Sexual assault documentation was not examined at all by this study.) How should documentation practices differ from sexual assaults perpetrated by strangers?

- What do documentation issues imply about any possible downside of universal screening for domestic violence in medical settings? If, for instance, women are sometimes asked about abuse in contexts that aren't perceived by them as safe, private or useful, and therefore deny abuse even though it exists, screening (where followed by documentation) can lead to a medical chart that reflects "no abuse" when abuse is actually present. What are the legal implications of such documentation? Does it inadvertently benefit the abuser? Is the possibility of such "inaccurate" documentation outweighed by any measurable benefits from universal screening?

Further research work of this type presents other opportunities to bring together the medical, legal and advocacy communities in focused efforts that may lead to improving the access of abused women to legal remedies.

References

Abbott, J., Johnston, R., Koziol-McLain, J., Lowonstein, S. (1992) Domestic Violence against Women: Incidence and Prevalence in an Emergency Department Population. *JAMA,* 273, 22.

American Medical Association (1992) Council on Scientific Affairs. Violence against women: Relevance for medical practitioners. *JAMA*, 267, 3184.

American Medical Association (1994) *Domestic Violence: Diagnostic and Treatment Guidelines.*

Belknap, J, Graham, D.L.R., Allen, P.G, Harman, J., Lippen, V. and Sutherland, J. (1999) 5 DVR 1, October/November.

Chez, N. (1994). Helping the victim of domestic violence. *American Journal of Nursing,* 94, 32.

Children's Safety Network (1992) *Domestic Violence: A Directory of Protocols for Health Care Providers*. Newton, MA: Education Development Center, Inc.

Colorado Department of Health with the Colorado Domestic Violence Coalition (1994) *Domestic Violence: A Guide for Health Care Providers,* 5th Edition.

Conference of Boston Teaching Hospitals (1997) *Train the Trainers Manual, Domestic Violence Advisory Council.* Boston, MA.

Covington, DL, Maxwell G., Clancy, T. et al. (1995) Poor hospital documentation of violence against women, *J. Trauma,* 38, 3.

Cramer, E. and Forte, J,. (1998) 3 DVR 81, August/September.

Dalton, C. (1997) *Domestic Violence, Domestic Torts and Divorce: Constraints and Possibilities.* New England Law Review, 31, 321-394.

Dobash, R.E. and Dobash, R.P. (1979) *Violence Against Wives: A Case Against Patriarchy*. New York: Free Press.

Enos, V.P. and McGuigan, K. (1998) *Domestic Violence Education, Identification, and Intervention Protoco.* Boston, MA: Dorchester House Multi-Service Center.

Ferris, L.E., McMain-Klein, M. and Silver, L. (1997) Documenting wife abuse: A guide for physicians. Can. Med. Assoc. J.,156,1015-1022.

Gross, M., Cramer, E., Forte, J., Gordon, J., Kunkel, T, and Moriarty, L. (2000) 5 DVR 49 April/May.

Ferraro, K.J. (1989a) The legal response to battering in the United States. In: J. Hanmer, J. Radford, & E.A. Stanko (Eds.). *Women, Policing, and Male Violence*. London: Routledge.

Ferraro, K.J. (1989b) Policing woman battering. *Social Problems*, 36, 61-74.

Harwell, T.S., Casten, R.J., Armstrong ,K.A., Dempsey, S., Coons, H.L. and Davis, M. (1998) Results of a domestic violence training program offered to the staff of urban community health centers. *Am J Prev Med*, 15, 235-42.

Houry, D., Feldhaus, K.M., Nyquist, S.R., Abbott, J. and Pons, P.T. (1999) Emergency department documentation in cases of intentional assault. *Ann Emerg Med*, 34, 715-19.

Kripke, E.N., Steele, G., O'Brien, M.K. and Novack ,D.H. (1998) Domestic violence training program for residents. *J Gen Intern Med*, 13, 839-41.

Massachusetts Department of Public Health (1992) *Identifying and Treating Battered Adult and Adolescent Women and Their Children: A Guide for Health Care Providers*. Commonwealth of Massachusetts.

Massachusetts Medical Society (1997) *Identifying and Treating Battered Adult and Adolescent Women and Their Children*. Seminar Series on Domestic Violence, Wellesley, MA.

Pleck, E. (1987) *Domestic Tyranny: The Making of American Sound Policy Against Family Violence From Colonial Times to Present*. New York: Oxford University Press.

Quirion, P. (1998) *Increased Protection for Children from Violent Homes. The Presumption Against Awarding Child Custody to the Batterer,* Massachusetts Family Law Journal, 67-82.

Rodriguez, MA, Bauer, HM, McLoughlin, E., Grumbach, K. (1999) Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians. *JAMA*, 282, 468-474.

Schechter, Susan. (1982) *Women and Male Violence: The Visions and Struggles of the Battered Women's Movement*. Boston, MA: South End.

Schornstein, S. (1997) *Domestic Violence in Health Care: What Every Professional Needs to Know*. Thousand Oaks, CA: Sage, 75-166.

Smock, W. (1997) *The Forensic Aspects of Caring for Victims of Domestic Assault -- Identification of Pattern Injuries.* Physicians for a Violence Free Society. Action Notes, October, 1-3.

Stets, J.E. and Straus, M.A. (1990) Gender Differences in Reporting Marital Violence and its Medical consequences. In: Straus, M.A. and Gelles, R.J., eds. *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,415 Families,* New Brunswick, NJ:Transaction Publishers.

Sugg A.M and Inui, T., (1992) Primary care physicians' response to domestic violence. JAMA, 267, 3157-3160.

Tjaden, P. & Thoennes, N. (1998) *Prevalence, Incidence, and Consequences of Violence against Women: Findings from the National Violence against Women Survey.* Research in Brief. Washington, DC: National Institute of Justice, U.S. Department of Justice.

Stark, E. and Flitcraft, A. (1996) *Women at Risk. Domestic Violence and Women's Health.* Thousand Oaks, CA: Sage.

Tifft, L.L. (1993) *Battering of Women: The Failure of Intervention and the Case for Prevention.* Boulder, CO: Westview Press.

Warshaw, C. (1989) Limitations of the medical model in the care of battered women. *Gender and Society,* 3, 506-517.

Warshaw, C. (1995) Identification, assessment, and intervention with victims of domestic Violence. In: C. Warshaw, A.L. Ganley, et al. *Improving the Health Care System's Response to Domestic Violence: A Resource Manual for Health Care Providers.* San Francisco: Family Prevention Fund.

Whittier Street Neighborhood Health Center (1996) *Protocol for Domestic Violence.* Roxbury, MA.

Zorza, J.(1991) *Woman Battering: A Major Cause of Homelessness.* Clearinghouse Review, 24, 421-423.

APPENDIX

Data Abstraction Tools

Visit Summary Form

NIJ Medical Records Project

Visit Summary Form

Study Subject ID_____

Medical Institute_____

Visit No._____	Visit No._____
Page Nos._____	Page Nos._____
Date_____	Date_____
Military Time_____	Military Time_____
EMS Y N **SW Notes** Y N	**EMS** Y N **SW Notes** Y N
MD Notes Y N **Psych Notes** Y N	**MD Notes** Y N **Psych Notes** Y N
RN Notes Y N	**RN Notes** Y N
Chief Complaint _____	Chief Complaint _____
_____	_____
_____	_____
Diagnoses _____	Diagnoses _____
_____	_____
_____	_____
Visit Type*_____	Visit Type*_____
DV Screen Done? Y N	DV Screen Done? Y N
If YES, what result? Pos Neg	If YES, what result? Pos Neg
Should DV Tool be done? Y N	SHould DV Tool be done? Y N
Reason for tool**_____	Reason for tool**_____

* Use codes: 1=Emergency; 2=Admission; 3=Primary care/clinic; 4=OB/GYN; 5=Specialty; 6=OR/Pre-op, 7=other

** Use codes: 1=DV screen done (positive or negative); 2=DV mentioned; 3=DV referral; 4=relationship problems, 5=traumatic injury

Tool for abstracting information from

Emergency Medical Service (EMS) notes

Study ID # _____

EMERGENCY MEDICAL STAFF RUN SHEETS

Response

date _____

time _____

___ EMS company name apparent

Patient's Demographic Information

___ birth date

___ name

___ address ___ shelter address ___ patient indicates address is confidential

Persons Involved in Response	**Name**	**Contact #**
___ EMS worker	___	___
___ police	___	___
___ children	___	___
___ patient's family/friends	___	___
___ partner's family/friends	___	___
_____ other	___	___

Treatment

___ emergency treatment - no need for transport

___ stabilize for hospital treatment

___ refused transport

___ risk assessment/safety plan

___ dv referral to ___ person ___ resources/info given

Provider's Assessment and Observations

___ chief complaint/presenting problem (narrative not dispatch)

___ physical exam

- ___ full body exam
- ___ refusal of exam

___ patient's statements [COMPLETE DESCRIPTION TOOL]

___ EMT paraphrasing or summarizing patient's statement [COMPLETE DESCRIPT. TOOL]

___ patient's demeanor

___ partner or child's demeanor

Physical evidence

___ hair ___ blood

___ weapons ___ damaged clothing

Consistency Between Patient's Statements and Provider's Assessment and Observations

___ consistency explicitly noted

___ inconsistency explicitly noted

___ identifies connection between relationship and injury

___ **Illegibility of Vital Information**

___ xerox problem pg.#s _____

___ handwriting pg.#s _____

Tool for abstracting information from

Physician's and/or Nurse's notes

Study ID # _____

PHYSICIAN'S AND/OR NURSE'S NOTES

Type of Institution
___ hospital
___ health center

Department
___ emergency
___ admission
___ primary care/clinic
___ OB/GYN
___ specialty
___ OR/pre-op

Visit
date _____
time _____

____ **Mode of Arrival**
____ ambulance
____ police

____ **Screen for Domestic Violence** performed by provider
___ negative response noted
___ positive response noted
___ incident indicated
___ perpetrator indicated
___ by relationship status (husband, boyfriend, girlfriend)
___ by name
___ services offered
___ referral made
___ referral completed or services provided

____ Presence of Others
___ partner
___ name
___ contact information

Patient's Demographic Information
___ name
___ address
___ shelter address
___ patient indicates address is confidential
___ birth date

Provider's Assessment and Observations

___ patient's demeanor
___ physical exam
    ___ full body exam
    ___ pelvic exam
    ___ refusal of exam
___ health related problems/condition
    # symptoms _____
    ___ complications or problems with pregnancy
    ___ routine physical/annual exam
___ injury
    # descriptive terms used regarding injury ___ 1 ___ 2 ___ 3 ___ > 4
    # symptoms ____
___ diagnostic tests
___ blood alcohol test
___ intoxication
    ___ level
    ___ self-admission
    ___ appearance
    ___ impacted treatment
    ___ impacted credibility
    ___ became sober - had interactions
___ patient's statements [COMPLETE DESCRIPTION TOOL]
___ paraphrasing or summarizing patient's statements [COMPLETE DESCRIPTION TOOL]
___ conclusion or summary re dv/abused/battered/violent [COMPLETE DESCRIPTION TOOL]
___ relationship problems
___ legal term

Body Map

___ current injuries drawn in detail on body map
___ past injuries drawn in detail on body map
___ drawing ___ xray/radiology

Diagnosis

___ domestic violence or other domestic-violence related term _____
___ legal term
___ "trauma"/ injury ___ medical diagnosis (non-injury)

Relationship Information

length of relationship (years) _____(months) _____
time period of abuse history _____

Relevant Social History

# of social history facts ____
___ sexual orientation
___ conclusion or summary regarding dv/abused/battered/violent with current partner
___ conclusion or summary regarding dv/abused/battered/violent with former partner
___ relationship problems
___ protective order

Relevant Medical History

___ previously identified as victim of abuse
___ primary care provider identified
___ untreated illnesses or injuries
___ complications during pregnancy
___ mental health issues (depression, suicide)
    ___ previous hospitalization

Treatment

___ treatment
___ refused treatment
___ referral to medical specialist
___ dv referral ___ person ___ resources/info given

Consistency Between Patient's Statements and Provider's Assessment and Observations

___ consistency explicitly noted
___ inconsistency explicitly noted
___ identifies connection between relationship and injury

Persons Involved in Visit

___ treating providers #___ legible names #____ signatures

	Name	Contact #
___ advocate	___	____
___ mental health	___	____
___ social service	___	____
___ interpreter	___	____
___ security	___	____
___ police	___	____
___ other	___	____

Privileged Information

Type of Information	Main Record	Consultation Notes in Medical Record	Records Kept by Department
psychiatry/psychology			
social services			
DV advocate			
venereal disease		XXXXXXXXX	XXXXXXXXX
AIDS/HIV			
mental health noted		XXXXXXXXX	XXXXXXXXX
substance abuse			

Photographs

___ photograph taken

Real Evidence ___ reference to real evidence

___ discarded
___ kept by hospital
___ given to police
___ given to patient
___ given to advocate/social service/psych nurse

Other Information

# of contradictions within Physician's/Nurse's Notes ____
# of contradictions between department records ____

___ illegibility of vital information
    ___ xerox problem pg. #s _____
    ___ handwriting pg. #s _____

___ summarizing or paraphrasing incidents of abuse
___ subjective conclusory statements which demonstrate provider suspects abuse
___ provider indicates that patient is falsely denying abuse
___ provider's editorializing about patient's choice to remain in abusive relationship
___ using labels that denote domestic violence
___ using abbreviations that denote domestic violence
___ labeling patient: prostitute, drug addict, "crazy"
___ notes patient's level education, appearance, economic class, presentation, etc.
___ using sarcasm
___ making assumptions about the patient's circumstances or motives; predicting future behavior of the patient
___ ambiguous, unclear, confusing statements
___ victim-blaming statements

Tool for abstracting information from

Social Services or Psychiatry records

Study ID # _____

SOCIAL SERVICES OR PSYCHIATRY RECORDS

Type of Record

___ psych/social assessment/diagnostic assessment (circle)
___ progress notes
___ department specific record (phantom notes)

General Information

___ date of interaction
___ name of patient in upper right corner
___ clinic/unit
___ legible clinician name ___ signature
___ professional title ___ contact number
___ illegibility of vital information
____ xerox problem ____pg.#s
____ handwriting ____pg#s
# of contradictions ___

Referral Information

____ staff made referral ___ name of person who made referral
____ reason specified

____ **Patient Statements** [COMPLETE DESCRIPTION TOOL]

Identification of Abusive Partner

___ identifies current/estranged abusive partner
___ name of partner provided

ASSESSMENT

Problem List:

___ depression/anxiety
___ suicidal/homicidal
___ adjustment reaction to illness
___ PTSD
___ major mental illness
___ cognitive/developmental impairment
___ community violence
___ sexual assault
___ child protective issues
___ elder protective issues
___ domestic violence
___ Battered Woman's Syndr.
___ Rape Trauma Syndrome
___ environmental issues
___ need for continuing care
___ marital/relationship issues
___ caregiver/parenting issues
___ language barrier
___ homelessness
___ chemical dependency
___ adolescent pregnancy
___ somatic complaints
___ vague conclusion w/out factual basis
___ predicting future behavior
___ other

dress, appearance, manner: + -- Ø (circle one)
identifies strengths _____ pg #s ____
_____ pg #s ____

___ help seeking behaviors
___ positive help seeking experience
___ negative help seeking experience

____ Date of separation ____ Length of relationship ____ Psych history not taken

HISTORY

___ failure to follow through
___ substance abuse
___ mental health problems
___ suicidal/homicidal
___ depression/anxiety (bipolar, dysthemia)
___ psychosis (delusions, thought processing disturbance)
___ psychiatric hospitalization

Childhood Trauma:
___ experienced abuse by parents/caregiver
___ witnessed dv as a child
___ substance abuse by parent/caregiver
___ parents died as child

Child Abuse (Current)

___ recognizes dv has negative impact on parenting ___ mother ___ father ____ child
___ identifies current child abuse ___ mother ___ father
___ DSS involvement

Diagnosis YES NO (circle one)

___ domestic violence
___ DSM
Axis I _____ Axis IV _____
Axis II _____ Axis V _____
Axis III _____

INTERVENTION

Risk Assessment
___ fear
___ prior physical violence / sexual
___ threats to cause physical injury / sexual
___ threat to cause death
___ threats regarding accessing help
___ threat of loss (kids, $, house, friends)
___ threat of suicide by partner
___ weapons
___ hurting animals or destroying property
___ current support network
___ disparity in economic/social status
___ stressors of partner
___ partner's history of drug or alcohol abuse
___ partner's mental health issues
___ outstanding orders/parole probation
___ violent criminal history
___ arrest/custody

Safety Planning/Resources/Referrals(discussed)
___ individual counseling
___ medical care
___ children's services
___ public assistance/housing
___ batterers' treatment
___ couples counseling
___ anger management
___ legal services/court advocacy
___ pros & cons of staying & leaving
___ obstacles to leaving
___ police involvement
___ safe places to stay
___ shelter
___ rape counseling
___ restraining order
___ case management
___ support group
___ identified family support

Safety Planning/Resources/Referrals
(unspecific)

___ safety plan
___ hotline resource phone #s
___ counseling
___ legal options
___ resources or options

___ denied, refused, unwilling to use resources
___ declined, unable to use resources
___ 51A filing

Statement Tool

Study ID # _____

PATIENT'S DESCRIPTION RELATIVE TO ABUSIVE RELATIONSHIP OR EVENT THAT BROUGHT HER IN

Visit Date _____ Type of Provider _____
Statement # ___ Page or Tab # _____
Declarant: ___ patient ___ other
___ quotation marks used
___ patient reports, states, told me
___ complains of, discloses, indicates , other _____
Declarant Inexplicit:
___ in response to questionnaire (indicates from patient but not explicit)
___ provider description of precipitating causes

Fact	Current	Prior	Bad Acts Against Child	Bad Acts Against a 3rd Party
assault				
weapon or object				
verbal threat				
threat through behavior				
verbal harassment				
control or harm through perp. behavior				
forced sexual contact				
homicide				
self-inflicted injury				
accident				
other _____				

Time (complete only if related to incident that led to present visit)
___ time indicated _____
___ explicitly states no activities between event and admittance
___ stage of healing indicates time that injury was inflicted
Demeanor (complete only if related to incident that led to present visit)
___ crying, sad, frightened, scared, upset, stressed
___ uncooperative/reluctant/refusing to answer questions
___ avoidant/distracted/unable to answer questions
___ hostile, angry
___ disheveled appearance, flat affect, confused
___ excited, hysterical, hypervigilant, anxious
___ behavior noted _____
___ tone of voice noted _____
___ other demeanor _____