The author(s) shown below used Federal funds provided by the U.S. Department of Justice and prepared the following final report:

Document Title: Medical Records as Legal Evidence of Domestic Violence, Summary Report

Author(s): Nancy E. Issac Sc.D. ; Pualani Enos J.D.

Document No.: 184528

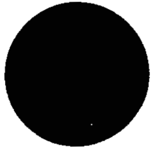
Date Received: September 25, 2000

Award Number: 97-WT-VX-0008

This report has not been published by the U.S. Department of Justice. To provide better customer service, NCJRS has made this Federally-funded grant final report available electronically in addition to traditional paper copies.

Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

184528



Medical Records as Legal Evidence of Domestic Violence

-- Summary Report --

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

Domestic Violence Institute
Northeastern University School of Law

May 2000

FINAL REPORT Archive

Approved By: [signature]

Date: 9/20/00

PROPERTY OF
National Criminal Justice Reference Service (NCJRS)
Box 6000
Rockville, MD 20849-6000

This is the final summary report of Grant No. 97-WT-VX-0008 from the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position of the U.S. Department of Justice. The text of this summary report and the full report can be viewed and downloaded at the website of the Domestic Violence Institute, Northeastern University School of Law: http://www.dvi.neu.edu/ers/med_doc.

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Introduction

Over the past decade, considerable effort has been made to increase the responsiveness of the healthcare 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. The importance of documenting abuse is mentioned in many healthcare protocols and training programs. However, it is often given little emphasis relative to topics such as the dynamics of abusive relationships and the importance of universal screening of adolescent and adult female patients for domestic violence.

There are many potential barriers to good documentation of domestic violence in healthcare settings. Focus groups with various types of healthcare providers that were conducted as groundwork for this research indicated that providers have many concerns regarding confidentiality and liability, are fearful of being asked to testify in court, and are uncertain which statements might inadvertently hurt the victim of abuse. The potential risks of documentation (to the clinician or the patient) appear to be more salient to clinicians than the potential benefits. This is not surprising given that they have received little information about why and how medical records can assist abuse survivors in legal settings.

Accurate and comprehensive medical documentation of domestic violence 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.

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

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

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.

Medical records may also be useful to *pro se* litigants in a variety of less formal legal contexts, where victims are often denied relief because of failure to show the existence of abuse. 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.

Thus, given the potential usefulness of medical documentation to abuse survivors, the question then becomes the one to which this research was addressed -- are current medical records sufficient to provide evidence of domestic violence in legal contexts?

Methods

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. (See end of document for list of partnership members.) Based on extensive discussions of the uses of medical charts, the rules of evidence and current medical practices, this multidisciplinary team developed a set of data abstraction forms (collectively referred to as the "DV tool") that were used to glean information from medical charts.

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 document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

In order to increase the number of charts included in the study, permission was obtained from two Boston-area hospitals to review charts on site. The charts that were reviewed belonged to women who had been identified as abuse survivors by hospital-affiliated domestic violence programs. Thirty charts were reviewed at each hospital.

In total, the study reviewed 96 medical charts belonging to 86 abused women. The 96 charts contained 772 separate visits for care. The visits involved health care received in recent years; 70% of the visits were made in 1997 or later, only 15% were made before 1995.

Each of the 772 visits was reviewed to determine whether there was any indication of domestic violence that would call for more detailed data abstraction using the "DV tool." A full abstraction was completed if any of the following indicators of abuse was present: a completed screen for domestic violence (whether positive or negative); mention of domestic violence; referral to domestic violence services; mention of relationship problems; an injury of any type.

Selected Findings

Table 1 shows the types of visits that were reviewed and how often a DV tool was completed for each type of visit. As can be seen, half of the emergency department visits called for a full data abstraction, compared to about 15 percent of ob/gyn visits. In total, 184 of the 772 visits (23.8%) were abstracted using the DV tool.

Table 2 shows how often the various criteria for a DV tool abstraction were met. The most common reason for the completion of a tool was presence of an injury. Although all of the charts reviewed belonged to women who had already been identified as abused (either in court or by an in-hospital domestic violence program), only 5 percent of the visits contained a completed screen for domestic violence. It is possible that some of the other visits involved screening by a provider that wasn't documented in the medical record.

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Table 1. How Often DV Tool was Completed for Different Visit Types

Type of Visit	n	Percent
Emergency	142	50.7
Admission	12	66.7
Primary care / Clinic	198	17.2
OB/GYN	231	14.7
Specialty	68	30.9
OR/Pre-op	18	5.6
Other	89	14.6
Total	772	23.8

Note: (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 2. Reasons for Completion of DV Tool

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.

Many different aspects of medical documentation by doctors, nurses, social workers, psychiatrists, and emergency medical technicians (EMTs) were examined in this study. A few of the quantitative findings are provided below; other more qualitative results are described in the Conclusions section.

- It was very difficult to obtain medical records in a timely fashion. Of the 42 charts requested using signed patient waivers, 38% were received within one month, 26% required more than one month but less than 2 months, 21% of charts did not come for 2 months or more, and 14% were never received. Retrieval times would have been much longer if research assistants had not made repeated follow-up phone calls.

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

- Among the health care visits reviewed, 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.

- Only 3 out of 93 injury visits contained documentation of the injuries on a body map, 1 contained past injuries on a body map, and 8 contained drawings of injuries.

- Though photographs and body maps were rare, injuries were otherwise described in detail. Three-quarters of injuries were documented with 3 or more descriptive terms and 81% of the injury visits contained one or more patient symptoms.

- Among health care 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.

- Negative statements about patient appearance, manner or motives were present in less than one percent of the reviewed notes made by doctors, nurses, social workers or psychiatrists.

- All 3 elements considered in order to use a patient's statement in court as an "excited utterance" were present in only 3.4% of the 831 statements reviewed in the medical visits. (See next section for more detail.)

Medical Records, Hearsay & the Excited Utterance Exception

All states have adopted the hearsay rule, which 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.

One exception to the hearsay rule is "information related to diagnosis and treatment." This exception permits health care providers to testify to matters related to the care and treatment of a patient. In some states there is also a "medical record exception," which 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 somewhat complex but particularly relevant exception to the use of medical records in legal contexts is the "excited utterance" or "spontaneous exclamations"

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

exception. An "excited utterance" is a statement made by a person in the midst of or soon after an event, when the person is in an "excited" or agitated state of mind. The proximity in time to the event, and the excited state of mind add credibility to the statement because it is unlikely to have been premeditated. 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.

In order for something a patient said to qualify for an excited utterance exception, three things are considered: 1) whether it is clear that the statement came from the patient; 2) whether there is an indication of the time between the event and the statement; and 3) whether there is a description of the patient's demeanor at the time of the statement.

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 her. 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."

Within the 184 medical visits that were reviewed using the DV tool, 831 separate "statements" were evaluated. Only 28 of the 831 statements (3.4%) included all three considerations related to the excited utterance exception; 19.3% satisfied two considerations; 55.3% satisfied at least one consideration; and 22% of the statements satisfied none. The element that was most frequently missing in the statements was a description of the patient's demeanor (e.g., "upset," "crying," "hysterical"). Another common problem was that the patient was not clearly indicated as the source of the information (e.g., "patient was kicked in abdomen by husband" versus "*patient states* that she was kicked …"). This is the kind of subtle difference in medical documentation that makes a significant difference in the information's usefulness in a legal context.

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Conclusions & Recommendations

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 multidisciplinary 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).

- Poor handwriting by clinicians, though often a subject of jokes, may be a common barrier to the use of medical documentation in legal settings since illegible information is inadmissible in court. In this study there were many instances where crucial information was illegible in physicians' and nurses' notes.

- With minor modifications to documentation practices, many more abused women's medical charts would contain characteristics that would enable their statements about abuse to be introduced in court as "excited utterances." Such evidence can allow a

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

prosecution to proceed even when the woman is unwilling to testify against her abuser in court due to fear or for other reasons.

- 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 abusive 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 1 of 93 injury visits contained a photograph.)

- 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 less than one percent of clinician notes.

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

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

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 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," after the patient has identified the person who has hurt her as a husband or boyfriend, 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 by using quotation marks and recording the identifying information as it is provided by the patient (e.g., *The patient stated "My boyfriend John Smith kicked and punched me."*). 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.

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

- 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 the medical documentation of abuse, the research findings also imply that changes will be needed at the institutional level. 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.

- Attorneys need further training on how to access health care records and how to introduce medical documentation into evidence. In addition, attorneys need to work more collaboratively with medical professionals on the use of such documentation in legal contexts.

- 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.

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.

Practitioner-Researcher Partnership Members
(listed alphabetically)

Mary Louise C. Ashur, M.D.
Community-oriented Primary Care
Carney Hospital
Dorchester, MA

Christine L. Butler, J.D.
Butler & Monks
Cambridge, MA

Thomas P. Campbell, J.D.
Suffolk Country District Attorney's Office
Boston, MA

Jeanmarie Carroll, J.D.
Chief, Domestic Violence & Sexual Assault Unit
Office of the District Attorney
for Norfolk County
Dedham, MA

Pualani Enos, J.D.
(Project Director)
Supervising Attorney
Domestic Violence Institute
Northeastern University School of Law

Judge Linda Giles
Justice
Plymouth County Superior Court
Brockton, MA

Nancy E. Isaac, Sc.D. *
(Principal Investigator)
Research Director
Domestic Violence Institute
Northeastern University School of Law

Lois Kanter
Clinical Director
Domestic Violence Institute
Northeastern University School of Law

Alyce Kuklinski, R.N.
W.A.T.C.H. Project
Massachusetts Department of Public Health
Boston, MA

Judith A. Linden, M.D.
Assistant Professor & Attending Physician
Department of Emergency Medicine
Boston University School of Medicine

Sandra E. Lundy, J.D., Ph.D.
Attorney at Law
Brookline, MA

Jane Oldfield, M.S.W.
Department of Social Work
New England Medical Center
Boston, MA

Ian Polumbaum, J.D.
Assistant District Attorney
Domestic Violence Unit
Suffolk County District Attorney's Office
Boston, MA

Pauline Quirion, J.D.
Senior Attorney, Family Law Unit and
Battered Women's Legal Assistance Project
Greater Boston Legal Services
Boston, MA

Lisa Tieszen, LICSW
Director, Safe Transitions
Beth Israel Deaconess Medical Center
Boston, MA

*currently Senior Research Scientist, Harvard Injury Control Research Center, Harvard School of Public Health

This document is a research report submitted to the U.S. Department of Justice. This report has not been published by the Department. Opinions or points of view expressed are those of the author(s) and do not necessarily reflect the official position or policies of the U.S. Department of Justice.