Your Patient. My Client. Her Safety:
A Physician’s Guide to Avoiding the Courtroom while Helping Victims of Domestic Violence
By
Gael Strack, JD and Judge Eugene Hyman

About the Authors:

Gael Strack is currently the Director of the San Diego Family Justice Center which provides services to over 1000 victims of family violence (women, children and men) every month. The Family Justice Center was launched in 2002 by the City of San Diego as a public safety initiative to assist police and prosecutors respond to domestic violence. Under one roof are 25 agencies (government and non-profit) who have come together provide wrap-around services to victims of domestic violence and their children. Prior to this appointment, Gael was a prosecutor for over 17 years at the San Diego City Attorney’s Office. She joined the office in 1987 and served in many capacities including an Assistant City Attorney for the San Diego City Attorney’s Office and Head Deputy City Attorney overseeing the Child Abuse and Domestic Violence Unit. She has also worked as a deputy public defender and a deputy county counsel for the San Diego County Counsel’s office handling juvenile dependency matters. She graduated from Western State College of Law in December 1985.

Judge Eugene M. Hyman is a Judge of the Superior Court of California, County of Santa Clara (San Jose) where he has served for sixteen years. Judge Hyman has presided over cases in the criminal, civil, probate, family, and delinquency divisions of the court. He previously has presided over an adult domestic violence court and in 1999 presided over the first juvenile domestic violence and family violence court in the United States. Judge Hyman has lectured nationally and internationally and has written on issues surrounding domestic violence in the criminal and family courts especially with co-occurring issues of substance abuse and mental health. He has a special interest in domestic violence as it affects children, especially in the family court. His most recent projects include a speaking tour of Feiburg, Germany where he addressed judges, prosecutors, defense counsel, probation officers, police officers, advocates, intervention professionals, and custody evaluators. His most recent article, “Domestic Violence Cases Merit Greater Attention By CJA” appeared in the Fall issue of The Bench, California Judges Association Quarterly Journal. Prior to his appointment as a judge, Judge Hyman served as a Police Officer for the City of Santa Clara from 1972 to 1977 and was in private practice from 1979 to 1990.
Introduction:

Domestic violence is not only a health issue; it is also a crime. Domestic violence includes emotional, sexual and economic abuse as well as physical violence.\(^1\) Over the last 20 years, due to heightened awareness, both the health care and criminal justice systems have focused more attention on domestic violence issues. Both professions have stepped up their efforts in the fight against domestic violence. Despite our collective efforts, however, domestic violence continues to be a problem. People are still dying. People are still crying.

A missing ingredient is a strong partnership between the medical community and criminal justice system. Too often victims suffer incidents of domestic violence before either profession adequately identifies or responds to the abuse. Early detection and intervention can improve the quality of life and even save lives—those of your patient, those of our client. Ultimately it is her safety we are both concerned about.

Because victims will sometimes seek help from the medical community first, physicians need a basic overview of the law, legal issues and understanding of victim rights and resources. Because victims will sometimes seek help from the legal community first, attorneys need a basic overview of medical issues and understanding of domestic violence injuries. Victims need support and referrals from their physicians. They need advocacy from shelter providers and community based organization to help them stay safe and access legal assistance from attorneys to protect their rights. They also need abusers to be held accountable by the judicial system. Domestic violence is clearly everyone’s responsibility. One system cannot do it alone.

This article seeks to enlist the help of the medical community to improve collaboration among the medical, legal and domestic violence professionals and ultimately increase and improve referral and documentation once abuse is suspected and/or identified. This article is also written from the legal perspective and the collective experience of a former veteran prosecutor. The prosecutor is now Director of the San Diego Family Justice Center which provides direct services to over 1,000 victims per month. The judge, who is now sitting, is a former police officer and practicing civil attorney.


In 1985, former United States Surgeon General C. Everett Koop brought national attention to domestic violence as a public health problem.\(^2\) The Surgeon General stated:

> Identifying violence as a public health issue is a relatively new idea. Traditionally, when confronted by the circumstances of violence, the health professions have deferred to the criminal justice system … [Today] the

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Professions of medicine, nursing and the health related social services must come forward and recognize violence as their issue.”

As president of the American Medical Association, Robert McAfee made family violence his first priority and started a highly visible and effective initiative against family violence in 1992. The Family Violence Prevention Fund became the National Health Resource Center under the US Department of Health and Human Services in 1992 providing training and materials for health care professionals on domestic violence. In medicine, Ronald Chez and Robert Jones (1995) were instrumental in starting an American College of Obstetrics and Gynecology initiative for educating physicians to screen for and appropriately refer abused women. The American Nurses Association passed major resolutions on domestic violence in 1998 and 1999 calling for screening of women for domestic violence in all health care settings. The first nursing-social work hospital-based family violence intervention program was started in 1987 at Rush-Presbyterian St. Luke’s Medical Center in Chicago.

Similarly, the criminal justice system has been on a parallel track to improving it’s response to domestic violence. In 1984, at the direction of then United States Attorney William French Smith the first national task force on family violence was charged with the responsibility of identifying the scope of the problem of family violence in America and making suitable recommendations. For the first time, the federal government looked at the broad nature of family violence issues. Still today, the Task Force Report is an excellent primer on the complex history of family violence issues in America. It also yielded a set of recommendations that helped launch many initiatives in the mid-1980s. In the 1990s, the mainstreaming of a feminist view of domestic violence (violence as a power and control behavior exercised through male privilege) continued. Specially trained police officers, prosecutors and judges, all products of the feminist movement, began advocating their views within the criminal justice system itself. In 1991, the National College of District Attorneys held its first ever national conference on the prosecution of domestic violence. Judges, prosecutors, police officers and advocates from across the country came together for the first time. Prosecutors attending this and subsequent conferences of the National College of District Attorneys learned how to prosecute cases even if the victim did not want to “press charges.” Evidence-based prosecutions first advocated by Ellen Pence in Duluth, Minnesota were endorsed by the National College of District Attorneys as the best approach to promote victim safety and

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offender accountability. Jurisdictions such as San Diego, California; Quincy, Massachusetts; Baltimore, Maryland; and Dallas, Texas led the way in training prosecutors in the newly developed prosecution techniques. For the first time in America, the responsibility for law enforcement intervention in family violence cases was slowly removed from the shoulders of victims and placed squarely on the shoulders of the criminal justice system itself. Advocates, police officers, prosecutors and judges began working together to develop coordinated approaches to deal with the long-neglected crime of domestic violence and began treating domestic violence as a serious crime.  

Ultimately though, it is the influence, persistence and focus of the battered women’s movement that deserves most of the credit for these dramatic changes. For the last 20 years activists in the battered women’s movement urged the criminal justice system to take action against domestic violence and treat it as a crime. They have advocated for change in law enforcement policies and state laws. They even encouraged lawsuits when all else failed. Arrest was one type of intervention that advocates promoted as a fundamental underpinning of an effective response to violence.  

In 1985, a federal jury awarded Tracy Thurman $2.3 million and found that the city of Torrington, Connecticut and 24 of its police officers violated Mrs. Thurman’s 14th Amendment right to equal protection. For eight months, Mrs. Thurman had notified the police repeatedly of her husband’s threats on her life. She attempted unsuccessfully to file complaints against him. After one assault, he was convicted of breach of the peace and she obtained a protective order. Still, the police failed to arrest him after promising several times to do so. Finally, Charles Thurman brutally stabbed her. The court held that the police department’s policy of not arresting abusive men was based on an impermissible stereotype that husbands may beat their wives. The Court stated, “a man is not allowed to physically abuse or endanger a woman merely because he is her husband. Concomitantly, a police officer may not knowingly refrain from interference in such violence, and may not automatically decline to make an arrest simply because the assailant and his victim are married to each other. Such inaction on the part of the officer is a denial of equal protection of the laws.”

In Bruno v. Codd, twelve battered woman brought an action against the New York Police Department for failure to respond to requests for protection, “presumably because of reluctance on the part of the police to intervene in what they reflexively characterized as ‘domestic disputes’ rather than criminal offense.” A consent judgment was negotiated, resulting in a major revision in the department’s policy. The police agreed thereafter to arrest the husband whenever there was reasonable cause to believe a felony had been committed against the wife or the protective order had been violated; remain at the scene to prevent other offenses; and provide the wife other assistance.

13 Bruno v. Codd, 419 NYS 2d 901 (1979)  
Pursuing an agenda to criminalize domestic violence meant using individual cases to initiate the social change necessary to protect women. But criminalization was never intended to be the end all. Rather, activists have been calling for coordinated, comprehensive and specialized intervention by all components of the legal and human services systems.

The 1994 enactment of the Violence Against Women Act (VAWA) was a success of historic proportions on various political and social fronts. It has significantly furthered efforts to legitimize a feminist anti-violence agenda within the political mainstream by providing federal criminal and civil legal remedies for female survivors of violence.

While slow in coming, both the health care system and the criminal justice system are beginning to recognize the strong role each plays in responding to domestic violence, making victims safer and holding batterers accountable. In the 1990s, health and human services organizations and criminal justice agencies began to coordinate responses to victims of domestic violence through what has been described as “coordinated community responses” or CCRs. These CCRs took the form of coordinating councils, criminal justice center system reform and/or community intervention projects. One of the most well known CCRs is the Duluth Domestic Violence Intervention Project (DAIP) which has served as a model for many communities.

Today, more professionals not only work together but also co-locate under one roof in order to respond to family violence. In October 2002, the City of San Diego launched the San Diego Family Justice Center, under the leadership of then City Attorney Casey Gwinn, and Former Police Chief David Bejarano. It was launched as a public safety initiative to help victims of domestic violence and their children to promote victim safety, offender accountability, access to more services, avoid the run-around from having to go from place to place and reduce the trauma of having to tell their stories over and over again. The San Diego Family Justice Center is a strong partnership among 25 government and non-government agencies who are providing medical, legal, and social services from one centralized location. One of the key on-site community partners is the Forensic Medical Unit (FMU) sponsored by Sharp Grossmont Hospital under the leadership of Dr. George McClane. The FMU provides full time forensic documentation and limited medical services to victims of domestic violence and elder abuse. The Family Justice Center now serves over 1,000 victims per month and answers over 3,000 phone calls.

By October 2003, President George W. Bush, inspired by the San Diego Family Justice Center, launched the “President’s Family Justice Center Initiative.” It is now a bipartisan

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18 Townsend, M, Hunt, D, Rhodes W.  Evaluability Assessment of President’s Family Justice Center Initiative, DOJ, Grant No. GS-10F-00864, December 2005.
effort connecting newly developing Family Justice Centers across America. It is estimated that by the end of 2007, there will be 40 operating Centers in the United States, including the 15 created in the President’s Initiative. However, the current national family justice center movement was not created in San Diego. Not only has the movement toward this model evolved over many years, but the concept also borrows from the successful child advocacy center movement and the development of battered women’s shelters across the country and around the world. Battered women’s shelters have been providing co-located, multidisciplinary services for victims of family violence and their children for over 30 years. We have also been taught the lessons of organizing through the leadership of Rita Smith at the National Coalition Against Domestic Violence, Lynn Rosenthal (formerly) at the National Network to End Domestic Violence, Cheryl Cataes at the National Domestic Violence Hotline and Esta Soler at the Family Violence Prevention Fund.

The Prevalence of Domestic Violence

The research and statistics are compelling. These numbers tell us just how pervasive domestic violence still remains today and why our work is not done. More than 1.5 million physical or sexual assaults are committed by current or former intimate partners each year in the United States, and 1 in 4 women report having been harmed by an intimate partner during their lifetime. Fewer than half of abused women ever report domestic violence to law enforcement. Only about 20% of those who are injured seek medical treatment. Although domestic violence affects women about 85% of the time, men comprise about 15% of assault victims. Of the 1800 murders attributable to intimates in 1996, nearly three out of every four had a female victim. About 30% of murdered women were killed by intimates. These statistics also do not even touch upon the health care costs, cost to businesses, the pain and suffering associated with repeated victimization nor the impact to children who are exposed to domestic violence.

In recognition of the magnitude of the problem, much has been learned and written about domestic violence in the last 20 years—by both the legal and medical communities—leaving us with good news and bad news.

The Good News

The good news is that the medical and legal communities are now rich with information about domestic violence. In conducting the research for this article, we found an overwhelming amount of information about domestic violence for health care and legal professionals. There are domestic violence articles on the world wide web and published

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in prestigious journals. There are guidebooks, manuals, brochures and checklists written for and by physicians on how to identify abuse. There are books, text books, pages and pages of information on websites and a growing pool of research all addressing various aspects of domestic violence. Training is now available through Resources Centers, on the internet, at conferences, medical schools, law schools, grand rounds, at police regional academies, at police stations, hospitals, and much more. Awareness tools such as posters, buttons and fact sheets are now available in convenient kits for a nominal price. Training videos are also available to law enforcement, prosecutors and physicians for free or a small fee. There are also centers and teams specializing and providing services to victims of family abuse such as Sexual Assault Teams, Domestic Violence Response Teams, Child Advocacy Centers, and now Family Justice Centers.

The Bad News

The bad news is that neither the medical or legal communities are making good use of existing resources, available training or current laws. While most medical organizations and experts agree that it is good medicine to ask patients about domestic violence (and some even find it easy to ask), the value of screening is the subject of controversy. Although health professionals often treat abused patients, in the vast majority of treatment situations they fail to suspect abuse. Even when abuse is identified, there is resistance to validate, document, refer and follow up with victims of domestic violence. Often battered women treated in emergency rooms are released without any intervention or follow-up. The reported stumbling blocks include everything from time constraints; discomfort with the subject; fear of offending the patient; frustration with the patient’s denial, lack of skills and recourse to manage the abuse; and fear of opening Pandora’s box. Others have cited failure of a patient to volunteer information, lack of training, prejudice, misunderstanding on the part of medical personnel, uncertainty about the clinical evidence, misgivings about the actions of protective services and fear of involvement in court proceedings.

Interestingly enough this same resistance to change, training and laws exists within the legal community as well. In the past, law enforcement dispatchers have ignored domestic calls or assigned them low priority. Officers have failed to make arrests even when serious injuries were inflicted. Prosecutors have treated serious domestic violence cases as misdemeanors as opposed to felonies. Judges, too, have historically viewed domestic violence as a personal family issue and did not want to intervene or be seen as interfering. Domestic violence cases are emotionally exhausting.

Most judges come to the bench with little understanding of the social and psychological dynamics of domestic violence and, instead, bring with them a lifetime of exposure to the myths that have long shaped the public’s attitude toward the problem. The most persistent of these myths is the belief that battered women could leave their relationship if they simply chose to do so. This belief ignores the realities of why victims stay as well as the fact that many women make numerous unsuccessful attempts to leave before they actually are able to do so and are then punished with a more severe beating or even homicide.

A steady volume of this kind of case causes burn-out unlike any other assignment. Family matters, particularly disputes involving children and domestic violence cases, are often contested, murky, ambiguous and difficult to resolve. Finally, judges did not feel that they should be a part of the solution, let alone part of collaboration. Judges are not social workers. They complete a case and move on to the next, much like a “doc in the box” at the corner strip mall. Fortunately, this ideology is changing. Newer judges, who wish to effectuate change, realize that in order to do so will require greater involvement with batterers and victims. Judicial college, in California, now requires that all judges take a section on domestic violence. This is because domestic violence is viewed as pervasive in many different cases appearing in the different divisions of the court.

Most recently, the California Attorney General formed a task force to examine how the local criminal justice system responded to domestic violence across California. The task force considered close to 300 interviews with practitioners, hundreds of documents and testimony from 69 witnesses at six public hearings throughout the state. They focused on four areas: protective orders, prosecutors, batterer intervention programs (in particular how program providers and courts held batterers accountable), and finally reporting of domestic violence by health care practitioners. Their findings were disturbing. Repeatedly the task force found examples of agencies that failed to respond to domestic violence victims, enforce the law, comply with the law and to work in collaboration with other agencies.

Victims are Counting on us to Get it Right

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So what does this all mean? Should we just give up and stop trying to help victims of domestic violence given the poor state of affairs by both the medical and legal communities. Or should we step up our efforts and answer the call to action that Surgeon General Koop and the Attorney General William French Smith started back in 1984?

There is no doubt victims need our help. A study focusing on why women seek civil orders of protection revealed a desire among women to regain some measure of control in their lives by making the abuse public. These women discussed using the application for a protection order as a “loudspeaker” to notify the abuser that the law knew about his behavior. They viewed the legal system as having power over the abuser that they themselves had lost as a result of the abuse. They also felt a need to have the legal system both approve and reinforce their decision to leave the abuser. The protection order becomes an announcement that the abused women refuses to “take it” anymore. In a study focusing on criminal prosecution, “women were seven times less likely to be beaten or abused again if charges are filed and the batterer is prosecuted.”

Similarly in a study focusing on medical management of intimate partner violence, victims believed that physicians should screen women for abuse both on a routine basis and when symptoms indicate possible abuse are present even if the victim does not disclose the abuse. Physicians were also encouraged by participants in that study to affirm the abuse, know local resources, make appropriate referrals, educate victims and document.

One of “the most important contributions physicians can make to ending abuse and protecting the health of its victims is to identify and acknowledge the abuse” (Council on Ethical and Judicial Affairs, AMA, 1992). Both medical and legal professionals working with victims of domestic violence play a key role in breaking the cycle of violence, making victims safer and holding batterers accountable. We need to get over our own biases and attitudes towards domestic violence.

So ignoring the problem only allows for domestic violence to go undetected. Failing to report domestic violence injuries is tantamount to aiding and abetting a batterer and

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deprives the victim of the opportunity for the criminal justice system to work.\textsuperscript{38} Lack of coordination means that courts, victim advocacy groups, social service agencies and the medical community deal with domestic violence abuse in a fragmented and haphazard manner.\textsuperscript{39}.

It is universally understood that it is difficult for women (and men) to come forward and share their stories of abuse. When they do, we need to be ready to help. The challenge for the future is working toward a coordinated, comprehensive and specialized intervention (legal, medical and social) system. Victims are clearly counting on us to help them and to do our respective jobs well. Family Justice Centers will play a key role in our future.

She’s your patient, our client. It’s her safety that is at stake.

**Abuse Identified – Now what?**

“[I]dentification of domestic violence is the first stage of intervention.”\textsuperscript{40} When abuse is identified, physicians should validate the abuse, assess the victim’s safety, conduct safety planning [or at least make a referral for safety planning], make appropriate referrals to domestic violence agencies and document.\textsuperscript{41} Guidelines promulgated by the American Medical Association recognize the duty by physicians to diagnose and address domestic violence. They recommend that medical organizations implement policies and procedures that include: identification, assessment, documentation, treatment, information and referrals to appropriate agencies. They also state that risk management in domestic violence cases requires that health care professionals treat repeated and chronic injuries and learn to recognize the signs of domestic violence. Treatment should address not only the immediate symptoms, but also the underlying causes of the abuse.

- **Validate the Abuse**

Because victims are often isolated and cut off from friends and family it is important to be reminded that they are not alone, they do not deserve the abuse, and help is available.\textsuperscript{42} In a study of how physicians helped victims of domestic violence, UCSF

\textsuperscript{40} Warshaw, C., Ganley, A., Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers published by the Family Violence Prevention Fund, Chapter 2, Section 7, Identification of Abuse, p. 64.
researchers found that physicians who provided validation – acknowledged that the abuse had occurred and confirmed the patient’s worth – had a positive impact on patients. The study found validating messages such as “battering is wrong” and “you deserve better treatment” not only provided relief and comfort to women, but also helped them realize the seriousness of their situation and helped them move forward toward safety.\(^\text{43}\)

“Victims have reported that validation from a health care professional not only provided relief and comfort but also started the wheels turning toward realizing the seriousness of their situation and setting the stage for change.”\(^\text{44}\) Dr. Brigid McCaw suggests saying something like “I’m glad you told me about this, no one deserves to be hit. Unfortunately, this is a common problem, you are not alone. I can give you some information that may be helpful.”\(^\text{45}\)

- Refer Your Patients to Domestic Violence Experts

Physicians should refer patients who are victims of domestic violence to community based advocates, shelter workers, on-site trained professionals and/or other experts (including attorneys) in the field which may be located at domestic violence courts, Family Justice Centers and/or part of elder, sexual or domestic violence assault response teams. Several studies have shown the benefit of using specialized support services for women. According to one study, women who take advantage of victim service programs tend to have more positive outcomes and are more likely to report satisfaction.\(^\text{46}\) Researchers found that most positive outcomes occur when the staff at service agencies listen to women, carefully explain the options and then take action.

Another study evaluated an advocacy service for women experiencing domestic violence using a randomized design. Women were interviewed six times over two years and women in the intervention group reported a higher quality of life, decreased difficulty in obtaining community resources and less violence over time than women in the control group.\(^\text{47}\) Yet another study of 200 women who had used domestic violence outreach services found that 46% were living in situations of domestic violence when they first contacted the service. All of these women reported that the outreach services had helped them to leave the abusive relationship – a valued outcome for them.\(^\text{48}\)

\(^{43}\) www.ucsf.edu/today/.


Ideally, physicians would have access to trained advocates or dedicated staff, health educators, or social workers available on site or on call around the clock.\textsuperscript{49} These specialists would take complete histories of the abuse, thoroughly document additional disclosures of abuse, maintain the medical records, assess for safety and develop a safety plan if indicated, refer to community services, develop a follow-up plan, report to the police if required to by state law and inform the physician about all interventions.\textsuperscript{50}

- **Risk Assessment and Safety Planning**

Risk assessment simply means assessing the presence of violence or abuse in your patient’s life and assessing how safe she is before she leaves the medical setting.\textsuperscript{51} As Campbell has noted, injured women seeking medical care may represent the highest risk for lethality.\textsuperscript{52} Safety and Risk Assessment tools assist professionals in many settings to help assess a victim’s danger and also raise a victim’s awareness of the danger. Jackie Campbell’s Danger Assessment tool was specifically designed for health care system administration to increase battered women’s awareness of the potential for homicide. At the San Diego Family Justice Center, for example, every new client seeking services receives a service plan, a risk assessment (specifically using Jackie Campbell’s Danger Assessment Tool), safety planning and a follow up plan. The Danger Assessment tool has been validated in the literature and may be obtained from the author through nursing publications.\textsuperscript{53} It is also available on line at [www.dangerassessment.org](http://www.dangerassessment.org).

Safety planning means helping the victim prepare to leave. When a victim of domestic violence tries to leave an abusive relationship, makes a police report or seeks an order of protection, the batterer feels that he is losing power and control. Consequently, the violence may escalate. Safety plans must be put in place to ensure her safety. Only the battered women fully understands her own particular situation, knows when and how she can be safe and can decide when it is the right time to leave the relationship.\textsuperscript{54} According to the Family Violence Prevention Fund (FVPF) the goals of safety planning are threefold: Increase the victim’s and children’s safety; respect the authority or autonomy of the adult victim to direct her own life, and hold the perpetrator, not the victim, responsible for his abusive behavior and for stopping the abuse. Dr. Ellen Taliaferro points out that “one of the most important questions you can ask as a part of the process

\begin{itemize}
  \item \textsuperscript{53} Campbell J, Boyd D. Violence Against Women: Synthesis of Research for Health Care professionals. NIJ, NCJ 1999761, December 2000.
\end{itemize}
is if she thinks it is safe to go home. She knows her situation better than anyone. The decision about going home or not is ultimately hers.” For a sample copy of a safety plan go to www.endabuse.org or http://www.sandiegofamilyjusticecenter.org/get-help/learn-more/victim-what-to-do-now.

You’ve Been Subpoenaded – Now what?

It’s Saturday morning and there are patients to visit at the hospital. You promised your family that you would reduce your hours and spend more time with them. You are reviewing the chart of your last patient when you are approached by a woman who asks if you are Dr. Ted Smith. As soon as you answer “yes” she gives you a piece of paper and says “you have been served.”

After thinking “what else can go wrong today”, you discover that you have been served with a criminal summons. The name on the summons is foreign to you and the date listed for your appearance is Thursday of the coming week. There is a name and number to call, but since it is the weekend, no one will be there to talk to you.

You call the director of the hospital who immediately puts you in contact with their attorney, John Law. You need his help and feel reasonably certain that lawyers can answer any legal question, after all, doctors can answer any medical question.

John happens to be home and invites you over to talk about your upcoming adventure. Fortunately, John’s practice is in the nature of criminal defense. John carefully reviews the summons and then gives you the following information.

- It is important to make contact with the person listed on the summons. You need to first be informed of the role you will play, to understand why you were summoned. Are you an expert witness or just a percipient witness? A percipient witness can be anyone who has made observations and is asked to testify about what they saw. It requires no expertise.

- An expert witness is used to explain to a jury or to fact finder information that the average person knows little or nothing about. For example, that an injury is consistent or inconsistent with being hit with a bottle. An expert witness may also be a percipient witness.

- Know who has issued the summons: the district attorney or the defense attorney? This information is helpful as an aid in understanding your role in the case. You also need to know the name of the patient, date of birth and date of treatment in order to obtain the medical records.

John is helpful in determining that the subject matter of the case is domestic violence as the courthouse address and courtroom number is a domestic violence department. You have treated a number of patients injured by domestic violence. It is difficult enough
obtaining a helpful history from the patient and providing treatment. You have a concern that testifying during the trial will harm your doctor-patient relationship.

In domestic violence prosecution, it is very rare that a physician will be called to testify. Your necessity as a witness suggests the possibility that the victim may have disappeared, moved or is avoiding service. She may also be afraid to testify. The prosecutor probably needs your help to fill in information that may otherwise not be admissible in the trial. Perhaps the nature of the injury is very serious and you are needed to discuss cause and effect. More likely, the prosecutor’s case contains a number of inconsistencies between the victim’s prior statements to the police and what her expected testimony will be during the trial. The victim likely has returned to the abuser and has changed her story. [Briefly explain why a victim might change her story: Abuser is source of income, father of children, or the abuser has directly coerced the victim into changing her story.]

John is willing to meet with you after you have obtained the medical records. He suggests also making contact with the person named on the subpoena to obtain additional information. You subsequently learn that you are needed to give both percipient and expert witness testimony and that it is now clear that the victim will be recanting what she previously has told the police and others. After obtaining information about the victim you are able to obtain the medical records.

The first thing John does is to study the medical records. When he is finished, he informs you that the victim made several statements to you about the events that caused her injuries that you recorded and that the prosecutor may want to introduce them in trial to corroborate the victim’s initial story given to the police and to discredit any new statements she makes in trial.

John tries to give a class lecture about hearsay and its exceptions, but he can see how difficult this is to grasp. Understandable, since most attorneys find medical intricacies rather opaque.

John gives you a number of helpful suggestions to prepare yourself for testifying in court. The first is to schedule a time to meet with the prosecutor to review the information that you may be questioned about. Specifically, ask the prosecutor to tell you what are the likely questions the prosecutor will ask of you and what are the likely questions the defense attorney will ask you.

At that time also ask the prosecutor if any additional witnesses and/or records from your hospital have been subpoenaed. If so, you will likely need to bring the original of all those records with you to trial and may be expected to testify concerning all those records, such as any additional medical reports that may have been completed by an ambulance crew from your hospital. The prosecutor will likely be interested in any and all statements that the victim made at the scene of the crime and how they compare with the statements that you have recorded in your medical records. The prosecutor will also be interested in the victim’s injuries, how they were caused and who did it.
You are not required to meet with the prosecutor, defense attorney, or an investigator. You can only be forced to show up at court and answer questions under oath. However, if you refuse to meet with the defense attorney or the defense attorney’s hired investigator, you may be asked under oath why you refused to meet. The defense is trying to demonstrate bias.

In the event that the prosecutor cannot meet with you, be sure to obtain all the information previously suggested.

John expresses the concern that some expected information is not in your medical records. There are no quotes to distinguish the victim’s actual statements from your summary of what the victim said. The body map of the victim has not been completed with the usual indication of where the injuries were located or where she complained of pain. No photographs were taken. The records do not include your opinion as to the causation of the injuries and whether or not they are consistent with what you were told by the victim. You have not adequately described the injuries except to say that they were minor or serious. John indicates that if your medical report was more complete that it is more likely that you would not have been needed to testify since the defense would know what you were expected to say when asked certain questions.

John encourages you to do the following preparation: Read the victim’s medical records carefully in order to refresh your recollection. Then draw a large diagram of both sides of the female human body and note the locations where injuries were received and/or complaint of pain. The jury will be impressed with your preparedness, likely find you credible (experience shows that wearing your white coat helps) and the diagram is likely to be more accurate and professional looking. [Is it permissible, after the fact, to add the diagram to the victim’s official medical records or is the drawing strictly for use at trial? Not clear from the discussion here.]

The criminal defense attorney will attempt to impeach your testimony for accuracy as a result of your failure to include important information in the original medical records. All is not lost as reading the reports of others may refresh your memory as to forgotten details. All details are not equally important. The purpose of a medical report is to record medical treatment provided, not all aspects of background information. Recording everything the victim told you may not aid you in providing treatment besides taking a great deal of time.

The second purpose of a medical report is to assist future medical treatment by recording what treatment has previously been provided.

The goal of a defense attorney is to discredit your testimony by demonstrating that you have a bias or prejudice, poor memory, or poor perception. That is why John has requested that you review all reports. Generally speaking, the jury will perceive you as having greater competence if you refer to your reports on an occasional basis rather than continually during the course of the trial.
John tells you to use caution when answering questions where the answer is either “yes” or “no”. If the answer cannot be answered in that fashion, say so. Answer only the question asked and do not volunteer any information. If you do not understand the question, ask for clarification.

Be cautious of questions that begin with “isn’t it possible.” These questions seek to elicit and encourage speculation which will discredit your testimony. “Is it medically probable” is a permissible question which should usually be answered, unless again it would be speculation.

John stated that he was almost finished and had just a few more suggestions before he concluded. John cautions you to be careful of questions that ask information about time, distance, or whether it is easier for the examiner to have the witness adopt the suggested information which will later be used against a party to the case. It is permissible to use examples, stories and analogies. It is very important to explain technical terms immediately, least the jury not understand the point being made.

John also cautioned about using overstatement and understatement words like very, certainly, and definitely, as well as always or never which may cause the jury to give less creditability to the testimony. Jurors understand that absolute certainty is an illusive quality in most real-world situations and will be suspicious of testimony that is overly definitive.

Ted thanks John for his advice. He knows that there is a lot of work that needs to be finished before he is adequately prepared for trial.

**Document it or tell it to the Judge**

The above scenario is common. Prosecutors and judges see situations all the time where unsuspecting physicians’ testimony—due to inadequate training and/or knowledge about the criminal justice system—is undermined by experienced defense attorneys.

Prosecutors often say that good cases plead out (settle before trial) and bad cases go to trial. Good cases are generally described as those cases with served witnesses, strong evidence and considerable documentation. Bad cases are generally described as those cases that are hard to prove due to the unavailability of witness, unwillingness of witnesses to testify, issues with the credibility of a witness, lack of corroborating evidence, lack of cooperation from medical witnesses, poor medical documentation, illegible medical records, and other deficiencies.

From our collective experience, physicians rarely are required to testify when their medical records are clear, legible, detailed and complete. More often than not, the more a physician documents in the medical record, the less likely they will be required to testify in court. A medical report that is not clear regarding causation, nature and extent of injuries, does not list questions asked by the physician and answers given by the victim increases the likelihood that the physician will be needed for the trial and decreases the
likelihood of a pre-trial settlement of the case. A poorly written medical report also increases the likelihood of embarrassment to the physician witness when questions are asked and the physician is unable to give a reliable answer. A conviction is also less likely, placing a victim in greater harm and also increasing the likelihood that the victim will not seek medical treatment if injured again.

More importantly, when attorneys know the medical record is solid, they usually stipulate to the introduction of the medical record without the physician’s testimony. They know that there is an excellent chance that a judge or jury will be persuaded by such evidence.55

Medical records also provide potentially invaluable sources of evidence and may be admitted into evidence without the testimony of an attending physician, provided certain elements are met.56 Fact finders, such as judges and juries, often view disclosures made to health care providers in the context of treatment with less suspicion than a report lodged with law enforcement, particularly if the disclosure and corresponding documentation is prepared prior to the initiation of litigation57. The physician’s questions are asked of the victim in order to assist the physician in making a determination as to the causation of the injuries. This is necessary for a proper diagnosis which is of great importance in determining a proper treatment plan. Answers made by the patient to the treating doctor’s questions may be admissible in court in place of the victim’s testimony for the truth of the statements made which may eliminate the need of the victim for the prosecution’s case.

Assistant District Attorney Cindy Dyer said it best: “If you have your records and good documentation, why would I risk bringing you to court? Many witnesses freeze on the stand. You might be a good doctor but turn out to be a bad witness. If I have medical records with good documentation, I will simply introduce them into evidence rather than give the defense attorney an opportunity to cross examine you.”58

To help you avoid having to go to court to “tell it to the judge”, please read on:

- **Legal and Medical Benefits for Documentation:**

Documentation is key to a successful intervention. When accurately and objectively documented, documentation of domestic violence incidents can be useful for criminal prosecution, civil cases, legal proceedings and obtaining legal and financial remedies, including but not limited to: applications for protective orders, child custody, child visitation, small claims court, restitution, victim witness funds which include funds for collateral victims like children, child protective services, housing, welfare, citizenship application for battered immigrant women, unemployment insurance, life insurance,

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56 California Evidence Code Section 1370.


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landlord/tenant disputes and/or lawsuits against her abuser for the abuse or employers for wrongful termination. Documentation of domestic violence in the medical record can be used not only by a victim’s attorney but also by the victim herself and on her own behalf in order to corroborate the abuse and obtain a range of protective, legal and financial relief.\textsuperscript{59}

Victims of domestic violence are known to recant. Even if victims are initially reluctant to report, victims may later want or need to pursue legal remedies. Documentation of past incidents will help either a criminal or civil case,\textsuperscript{60} especially if that documentation is absent of bias. As stated by Isaac and Enos, “Failure to document domestic violence completely when treating an abused patient does not constitute 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.”\textsuperscript{61} The problem is many attorneys and victims are prevented from using medical records to assist them. Reasons for not using the records include: a) difficulty and expense in obtaining records, b) illegibility, incompleteness or inaccuracy of documentation, c) the possibility that the information in the records, due to these flaws, may be more harmful than helpful.\textsuperscript{62}

Important to Remember: The window of opportunity to intervene in domestic violence cases is short. Depending on the victim, her willingness to tell the truth may last only minutes and often no more than a few days. She may also be experiencing guilt, denial, enlightenment or responsibility, characteristics of the Battered Woman Syndrome.\textsuperscript{63} For this reason, a physician who suspects domestic violence needs to act quickly. Recognize that by the time a woman seeks medical care for her injuries, she may be having second thoughts, have had further contact with the batterer who is now remorseful and begging for forgiveness. Your patient may already be entering the “honeymoon phase.” Accordingly, a physician should not be surprised if the patient refuses to admit to any violence and describes her injuries as the result of an accident.

- Knowing A little More about Prosecution May Help

Over the past twenty years, law enforcement and prosecutors have recognized that intimate partner violence is a crime against society at large as well as against the individual. The feminist movement is credited for the heightened awareness of intimate partner violence and the movement toward aggressive police and prosecution policies.\textsuperscript{64} The purpose of pro-prosecution policies in intimate partner violence cases is to hold the batterer accountable for their actions while trying to protect the victim. Taking the responsibility for the prosecution away from the victim, and placing it at the prosecution

\textsuperscript{59} Isaac N, Enos P. Medical Records as Legal Evidence of Domestic Violence, NIJ, May 2000.
\textsuperscript{60} Hyman, A., Mandatory reporting of domestic violence, prepared for the Family Violence Prevention Fund.
\textsuperscript{61} Isaac N, Enos P. Medical Records as Legal Evidence of Domestic Violence, NIJ, May 2000.
\textsuperscript{63} The relevance of battered women’s syndrome evidence and the common experiences of battered women was initially defined by the criteria set out in People v. Bledsoe, 36 Cal. 3d 236, 249-51 (1984).
\textsuperscript{64} Attorney General’s Task Force on Family Violence, Final Report, September 1984.
agency, insulates the victim from the batterer’s anger and retaliation. Because it is the prosecutor that is pursuing criminal charges against the batterer, the batterer has no basis for coercing the victim to “drop” charges or blaming the victim for prosecution. Prosecution policies also recognize that victims face a multitude of competing survival necessities, including the desire to have the criminal case dismissed in order to avoid retaliation by her batterer.

The San Diego City Attorney's Office, like many other prosecuting agencies throughout the nation, has initiated “Vertical Prosecution” and “Pro-Prosecution” Policies. Vertical prosecution means one prosecutor will be assigned to handle a domestic violence case from the time it is submitted for prosecution, until the probationary periods ends—sometimes as long as three to five years after conviction. Prior to vertical prosecution, victims of domestic violence would rarely see the same prosecutor twice and inevitably have to tell their story over and over again while her abuser might have the same defense attorney for all hearings—a clear legal advantage for the abuser. “Evidence-Based Prosecution” or a “Pro-prosecution Policy” means prosecutors will seek criminal charges against batterers where there is sufficient evidence to do so and will not dismiss cases simply because a victim recants or minimizes. “No drop” prosecution has substantially improved the circumstances for domestic violence victims, including increased conviction rates, more effective sentences for abusers as well as enhanced access to social services for victims. Many specialized domestic violence prosecutors work closely with social service agencies in order to provide long-term support for victims who need to interface with the criminal justice system. However, not all prosecution offices are alike. There are still many jurisdictions in America that do not have specially trained prosecutors handling domestic violence cases. Most offices may even assign their most junior prosecutors to handle these very complicated cases. To find out more about local prosecuting offices, you may contact the National District Attorney’s Association or your statewide Prosecutor’s Association.

Furthermore, as a result of a recent United States Supreme Court case known as Crawford vs. Washington, prosecutors are now having difficulty proving cases without the victim’s testimony and evidence-based prosecutions are being put to the test. Consequently, medical records will likely become increasing more important and sought after by more prosecutors. A more detailed discussion about the Crawford case is provided below.

Medical Records and the Testimony of Health Care Providers After Crawford

65 Domestic Violence on Trial, Daniel Sonkin Editor, Chapter 2, Domestic Violence is a Crime: A Case Study – San Francisco Family Violence Project by Esta Soler.
Traditionally, under federal rules of evidence, statements by a victim during a medical examination were allowed into evidence for the reason that statements made to a health care provider are presumed inherently truthful. A patient is expected to be honest with a health care provider in order to receive an accurate diagnosis and appropriate treatment. Under Federal Rules of Evidence 803 (4), these statements were allowed into evidence regardless of whether the patient testifies. In another words, if a domestic violence victim is unavailable to testify (death, fear, avoiding service), prosecutors were still permitted to introduce statements made by the victim to the attending health care provider provided those statements were obtained during the health care provider’s primary duties.

When the U.S. Supreme Court announced the new rule under Crawford that testimonial statements are no longer admissible in court unless the witness testifies and there is an opportunity to cross-examine the defendant, “confusion and concern swept through the nation’s prosecutorial community” because the Crawford Court did not define “testimonial”. At first prosecutors feared that medical records may not survive Crawford. Since Crawford, over 2,000 post-Crawford cases have addressed what is testimonial by asking two questions in determining whether a statement is testimonial: (1) Was a governmental agent involved in creating the testimony or taking a formalized statement from the witness? And (2) Would an objective person in the declarant/witness’s position reasonably believe that the statement may later be used in court.

Fortunately, courts have overwhelmingly agreed that physicians and nurses who conduct a medical examination of a victim can still testify to statements of the victim that pertain to the medical diagnosis and treatment. In order to accurately diagnose a patient, physicians and nurses will ask questions like: “Why are you here?” “What happened?” “When did it happen? And “Who did this to you?”. Doctors and nurses do not possess the “government agent” label as law enforcement does and if allowed to perform their medical duties without direction or interference from law enforcement, this agency status


State v. Vaught, 268 Neb. 316 (2004) [A statement given to a doctor by a child who was a victim of sexual abuse, and who identified the perpetrator of the assault, was admissible under Crawford, because it was given for the purposes of promoting diagnosis and treatment and was therefore not testimonial in nature.], in accord, State v. Scacchetti, 690 N.W.2d 393 (Minn. App. 2005) [Statements made by three-year-old child victim to a nurse practitioner in the hospital during a medical examination are not testimonial.]

Ohio v. Stahl, 2005 WL 602687 (Ohio App. 9 Dist. 2005) [Where a victim made incriminating statements to a police officer and later to a nurse at the hospital, the court distinguished between the circumstances. The court found that statements to the officer for the purpose of filing a police report were “indisputably testimonial” and inadmissible. On the other hand, victim’s statements to the nurse were not prosecutorial, but rather meant to encourage aid, comfort, and medical treatment. In addition, the court noted that the victim had already made her statement to police and it is reasonable that she would perceive the role of the nurse differently. As a result of this distinction, statements made to the nurse were non-testimonial hearsay and admissible under a Crawford analysis.]
will not transfer to the health care provider. Therefore statements of the victim relevant to the diagnosis and treatment, under these circumstances, will be admissible through the health care provider’s testimony.  

Similarly, statements made to emergency medical technicians (EMTs), sexual assault nurse, a neighbor who was a surgical medical assistant have also been permitted into evidence through the medical hearsay exception.

However, the law is still developing when it comes to sexual assault nurse examiners and other health care providers who are primarily or exclusively working with a multi-disciplinary team for purposes of child abuse, sexual assault, elder abuse and/or domestic violence investigations. From existing court cases, it appears statements by victims to forensic teams will be admissible if they relate to medical diagnosis, treatment and/or laboratory tests and not admissible if the sole purpose was to take a statement from the victim-patient and collect evidence. In order words, if you are health care provider who is primarily or exclusively working with a governmental multi-disciplinary team or with law enforcement for purposes of gathering evidence of criminal activity, and if the health care provider does not engage in diagnosis or treatment of the victim, then the statements made by the victim during the examination will likely be deemed testimonial and will not properly fit under the medical diagnosis/treatment hearsay exception.

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75 State v. Castilla, 87 P.3d 1211, 1214 (Wash. App. Div. 1 2004) [State declined to call complainant, who suffered from significant developmental delays and schizophrenia, as a witness at rape trial of her nursing assistant because the complainant’s mental condition had deteriorated to the point where she would not be found competent to testify. Certain of the complainant’s statements to nurse who performed sexual assault exam were admitted under hearsay exception for statements made for purposes of obtaining medical treatment. The statements did not go to any disputed issue as defendant conceded that he had intercourse with the victim–patient and collect evidence. “Further, these statements were not testimonial in nature. They were not elicited by a governmental official and were not given with an eye toward a trial. As such, they do not raise the same concerns under the Sixth Amendment as does testimonial hearsay.”]

76 People v. Cervantes, 12 Cal. Rptr.3d 774, 781 (Cal. App. 2 Dist. 2004) [Statement made by co-defendant to neighbor, a surgical medical assistant, regarding the underlying incident was properly admitted at murder trial against non-declarant co-defendants. Declarant-codefendant-accomplice did not testify at trial. The appellate court found that the statement was not testimonial. The statement was made when declarant sought medical assistance for cuts and bruises from a friend of long standing who had come to visit his home. The statement appeared to have been made without any reasonable expectation it would be used at a later trial. The court found it far more likely that the declarant thought that the neighbor would not repeat anything he told her to the police. The neighbor admitted that she knew appellants were gang members and indicated that she was afraid to testify in the case.]


When seeking to introduce a victim’s statement to a health care provider through the medical hearsay exception, the American Prosecutors Institute recommends that prosecutors ask medical witnesses these questions:

- What was the purpose of seeing the victim?
- Did the health care provider follow a standard protocol of questions and procedures regardless of law enforcement involvement?
- When a health care provider questions the victim (e.g. who was the perpetrator?) be prepared to answer why the health care provider must know that information in order to properly treat the victim.
- Did the health care provider document answers from the patient and observations made regarding the patient’s demeanor and physical injuries, in a medical report under a protocol regardless of the possibility of criminal prosecution?
- The health care provider should not advise or inform the patient-victim regarding the possibility of court testimony or court appearance.
- Is the health care provider employed in a jurisdiction where victims of sexual assault are required to file a police report and/or cooperate with law enforcement in order for the sexual assault examination to be paid for with state dollars?
- How is the health care provider paid? How is the hospital or program funded?

The American Prosecutors Research Institute also recommends that law enforcement officers remain out of the medical examination room in order to avoid any Crawford issues with the examination. “The goal is to provide the best service to crime victims, as well as to allow for each victim to be heard in court even if that victim is unable to testify during trial. Allowing our health care providers to perform their duties on behalf of child and adult victims will aid in this effort and keep the courtrooms open to our most vulnerable victims.”

**Getting the Medical Records and Admitting the Records (are Two Different Things)**

Generally, prosecutors will seek copies of medical records through a subpoena duces tecum (a court order that requires the health care provider to bring the records to court or to deliver them to the prosecutor’s office), a search warrant or voluntary production (especially when there is the victim’s consent). The admission of medical records into trial is subject to state and/or federal rules of evidence. The judge will ultimately decide whether or not a medical record will be admitted into evidence based on the rules of evidence, arguments of the attorneys and the evidence itself.

For medical documentation to be properly admissible in court, under the business records exceptions, health care professionals or the custodian of records need to be prepared to testify or provide an affidavit that the records were made during the regular course of

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80 Phillips, A. “I have an ‘owie’” Health Care Providers’ Roles after Drawford, Davis & Hammon, National Center for Prosecution of Child Abuse, American Prosecutors Research Institute, Vol. 19, No. 4 & 5, 2006, Special Double Issue,
examination or interview, that they were made in accord with routinely followed procedures, that they have been properly stored and access limited to professional staff, and they were made at or near the time of the act or event recorded on them.

**Identification of ALL Domestic Violence Injuries:**

When battered women are severely injured, they seek help. They seek help from police officers and their health care professionals, including their dentist. They also suffer a wide range of injuries, ranging from bruises, cuts and scrapes to sprains, burns, broken teeth and bones, dislocations, internal injuries, wounds from knives or guns and permanent disfigurement or brain damage.\(^{81}\) Victims of domestic violence may present with various and confusing complaints such as headaches, insomnia, choking sensations, hyperventilation, gastrointestinal pain, chest pain, pelvic and back pain.\(^{82}\) Abused women may also present with anxiety, neurosis, depression, suicidal ideation and substance abuse and may not comply with drug therapy.\(^{83}\) Between 22% and 35% of women’s visits to hospital emergency departments are prompted by injuries or illness related to ongoing abuse or stress from such abuse.\(^{84}\) The literature reports, 36-95% of battered women are suffering injuries to the face, neck or head.\(^{85}\) Abused women are more likely than accident victims to sustain multiple injuries.\(^{86}\) The pattern of injuries in abuse cases typically involves injury to the head, face, neck, breast and abdomen.\(^{87}\) Forced sex can lead to higher prevalence of gynecological problems. Battered women have described sexually abusive and controlling acts such as verbal sexual degradation, refusal to use condoms or refusal to use contraception, obvious links to sexually transmitted diseases, HIV and unintended pregnancy.\(^{88}\)

While detection of domestic violence injuries is generally not difficult, it does require the healthcare professionals to be perceptive. There is a tendency of abused patients to minimize domestic violence and/or hide their injuries. There is also evidence to suggest that male attackers may tend to avoid striking the face so that injuries will not be apparent to onlookers; instead, blow to the back of the head may be more common. To help health practitioners, identify domestic violence, attached as an appendix for “What to Look For

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83 Add cites from 21-23.

84 Randlaa, T., Domestic violence intervention calls for more than treating injuries. JAMA 1990; 264:939-940.


Abused victims may also be strangled and may not have visible injuries and the detection of subtler signs and symptoms of strangulation will be critical. A physician’s failure to properly diagnose domestic violence may result in inappropriate treatment, including prescription of sedatives or antidepressants, which include the risk of suicide or place the woman at greater risk of injury from escalating violence.89

- **The Signs and Symptoms of Attempted Strangulation**

Strangulation has only been identified in recent years as one of the most lethal forms of domestic violence: unconsciousness may occur within seconds and death within minutes. It is known that victims may have no visible injuries whatsoever—yet because of underlying brain damage by a lack of oxygen from being strangled—victims may have many serious internal injuries or die days or several weeks later. Strangulation is often indicative of a high level of domestic violence in a relationship that can escalate quickly to death. In a study conducted by the San Diego City Attorney’s Office of 300 domestic violence cases, visible injuries such as tiny red spots on the face, bloody red eyes, red marks, scratches and bruising on the neck, were only visible 16% of the time. Often, when visible injuries were present, the injuries were subtle and hard to find. The study disclosed other symptoms such as voice changes and difficulty swallowing. To understand the medical significance of the findings from the study, the City Attorney’s Office enlisted the help of Dr. George McClane, an Emergency Physician, and Dr. Dean Hawley, a specialist in Forensic Pathology, for their medical perspective.90

**What to Document:**

- Detailed explanation of the cause of injury
- Detailed description of the injury
- Description of the victim’s condition and demeanor
- Identity of all witnesses – Ask who else was present at the time this happened to you?
- Identify who caused the injury and their current location – Are s/he in the hospital? Waiting outside in the parking lot?
- History of domestic violence and/or sexual abuse (reported or unreported to police)
- History of threats to kill or further violence
- Date/Time of Incident
- Date/Time of your examination

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- Results of all tests (with their relevance to the injuries)
- Medical Treatment provided and required
- Any written or verbal information provided to the patient
- Collection and storage of any physical evidence such as photographs
- Consent to take photography
- Referrals and follow-up plans (medical appointment)

How to Document

Language is critical. The process of documenting abuse can serve to validate the patient if accompanied by genuine, nonjudgmental statements of concerns. Personal beliefs, biases or prejudices should never appear in a medical record. As an example, the following phrase casts doubt on the victim’s credibility: “the patient claims that her boyfriend hit her” as opposed to “the patient stated “I was hit by my boyfriend John Smith.”

The victim’s direct words should be denoted with quotation marks. A patient’s own words, especially those that contain names, places and specific behaviors, carry more weight in legal cases than physician’s summary statements. When victims speak a different language or are possibly deaf, consider the use of an interpreter. The person who is used as an interpreter should be independent and a professional interpreter. Do not use family members or friends in this role. Prosecutors and Judges have learned that when victims recant so do their friends and family members who have been used as interpreters. Victims may also need a support person to help them through the court process.

Tools to Document the Injuries:

The authors recognize that the typical medical office may not be equipped with special domestic violence forms, body maps and/or a camera to document additional information about domestic violence. The good news is today there are many resources for medical professionals to improve their documentation. There is no need to reinvent the wheel. The Family Violence Prevention Fund has developed Health Kits which may be easily obtained via their website at www.endabuse.org to address the issue of domestic violence in your office.

Most trauma centers have specialized domestic violence report forms which are a template to assist the medical provider in the documentation of the patient’s medical

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Even most law enforcement agencies have developed specialized domestic violence reporting forms to help gather the evidence at the scene, such as documenting the existence, location, demeanor and statements of witness, evidence of injuries and/or pain, history of document and undocumented violence, use of weapons, presence of drugs and/or alcohol, existence of restraining orders, threats of future violence and some even contain risk assessment tools embodied in their report. The San Diego Police Reporting form is attached. It’s been called “a revolutionary sheet of paper” as its use by police in collecting evidence has resulted in prosecutions winning 90% of their cases and a 62% decline in domestic violence homicides.

Recently, medical and legal professionals have started using specialized reporting forms for attempted strangulation cases. This form was developed at the Forensic Medical Unit located at the San Diego Family Justice Center by Dr. George McClane. All professionals working with victims of domestic violence are encouraged to use this form, or an equivalent, if they suspect or know a patient has been subjected to attempted strangulation. Dr. McClane also uses a wig head to help victims describe the manner in which they were struck to the face, head and neck. Included in this article is a copy of various reporting forms. (Add to Appendix).

Important Tools for your Medical bag on Domestic Violence.

Health care professionals play an important role in helping victims of domestic violence stay safe and also recover from the short term and long term effects of domestic violence. “While good medical care in the traditional sense allows a doctor to sleep well at night, it is often the small things – the kind words and gestures that are offered to the battered woman – that start her vital healing from within.” To help physicians deal with the complex issues related to domestic violence and become a more effective advocate for your patient, a few suggestions are offered below. Doing any one or all of these things could make a huge difference in someone’s life.

- Learn more about domestic violence dynamics.

The National Domestic Violence Hotline’s website offers significant resources for all professionals. As defined on their website, domestic violence can be defined as a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound someone. Domestic violence can happen to anyone of any race, age, sexual orientation, religion or gender. It can happen to couples who are married, living together or who are

95 Kit Gruelle, Domestic Violence Prevention, Intervention and Education Specialist.
96 www.ndvh.org
dating. Domestic violence affects people of all socioeconomic backgrounds and education levels.  

Two leading experts, Dr. Patricia Salber and Dr. Ellen Taliaferro, have a new book out called The Physician’s Guide to Intimate Partner Violence and Abuse, A Guide for all Health Care Professionals, published by Volcano Press. Buy it. An excellent discussion on domestic violence dynamics fears for health care professionals in provided in Chapter 4.  

The American Medical Association has produced comprehensive diagnostic and treatment guidelines for domestic violence, child abuse, child sexual abuse and elder abuse.  

Understand what laws apply to you and your patients.

Significant changes in the law and improvements to the legal system have occurred in just the last 10 to 15 years to help and protect battered women and their children. While victims of domestic violence may often contact the medical system first, they will often have contact with the legal system at some point. When health care providers have a basic understanding of the domestic violence laws that apply to them and their patients, victims will ultimately benefit from that information.

Laws that apply to health care professionals may include medical mandated reporting laws, a duty to warn others about credible threats and dangerous patients (under the 1976 case Tarasoff v. Regents of University of California) and, of course, there is the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Victims of domestic violence need to know about their legal rights and remedies including the right to file criminal charges, seek civil protection orders, kick out orders, visitation and child custody orders, child support, spousal support, legal separation and/or divorce. Victims may also file a lawsuit against her abuser and be awarded damages for assault and battery, intentional infliction of emotional distress or may seek other civil tort actions for intentional interference with custody, parental kidnap, defamation, tortuous infliction of a sexually transmitted disease and/or marital rape.

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97 www.ndvh.org  
98 Published by Volcano Press in 2006. For online ordering: www.volcannopress.com.  
101 17 Cal. 3d 425, 551  
• Find out how your state has been graded.


• Develop partnerships with your domestic violence advocacy, sexual assault nurses and advocates as well as the legal community.

Although domestic violence shelters and advocacy services must remain the cornerstone and first priority of efforts to address violence against women, the reality is that the majority of abused women never go to shelters and usually do not call police before the violence has become severe\textsuperscript{104}. Consequently when victims knock on the door of any system (medical or legal) it is necessary to be knowledgeable about available resources and be ready provide those referrals to victims. Armed with information and resources, victims can make intelligent and informed decisions about their next step. Information to empower victims and victim empowerment is the guiding philosophy behind most domestic violence programs. The empowerment model is based on the belief that a battered woman will know how to keep herself safe given her unique ability to predict the abuse, to use techniques to minimize the violence and to assess when it is safe to leave.\textsuperscript{105} Today, there are more advocates, resources and specially trained professionals available to help victims of domestic violence than there were just 10 years ago.

Knowledge is also power for medical and legal professionals. Knowing all the possible resources available on a national and local level will make it easier for you to not only help victims of domestic violence but also victims of other crimes such as sexual assault, child abuse and elder abuse. And the more you reach out to others for education, resources and training, the more other organizations will be interested in partnering with you. With just a little bit of effort, attorneys and domestic violence professionals can quickly become your allies and your backup system for any intervention in the health care system.

National Domestic Violence Organizations include: The National Coalition Against Domestic Violence, the National Network to End Domestic Violence, the Family Violence Prevention Fund, the National Resource Center on Domestic Violence, the Battered Women’s Justice Project and the National Domestic Violence Hotline. The


\textsuperscript{105} Goodmark L, Law is the Answer? Do we kNow that For Sure? Questioning the Efficacy of Legal Interventions for Battered Women, 23(1) St. Louis U. Pub. L. Rev 7, 2004.
National Hotline in particular can assist you in contacting your local and statewide domestic violences, sexual assault and legal organizations.

SANE (Sexual Assault Nurse Examiner) nurses and advocate companions should be available for all victims of sexual assault to provide appropriate examination and intervention. Nurses are being trained in increasing numbers to provide appropriate examination, preservation of evidence and sensitive assessment of victims of sexual assault. Their practice is performed in conjunction with volunteer sexual assault advocates and all victims of sexual assault who desire these services should have access to them.106

National Legal Organizations addressing Domestic Violence include: The American Bar Association, the Commission on Domestic Violence; the National College of District Attorney’s, the American Prosecutors Research Institute, and the National Family Justice Center Alliance.

Consider partnering with your Family Justice Center, Child Advocacy Center and/or Domestic Violence Council near you. To find out more about Family Justice Centers, visit www.familyjusticecenter.org.

- Find out More about Victim Advocacy Programs Near You

Most prosecutors today have developed victim advocacy programs within their offices and/or work closely with outside victim advocacy programs to assist victims of domestic violence navigate the criminal justice system. An advocate is “anyone who responds directly to help abused women in an institutional context.”107 Prosecutors, especially those working in specialized domestic violence units, recognize the need for advocates to address the unique needs of victims of domestic violence. Among other things, advocates may help victims understand the court process, answer questions, provide updates on the status of the case against the victim’s abuser, obtain restitution, accompany victims to court, assist with victim impact statements, provide counseling, offer support and referrals, and may even testify as an expert witness on the battered spouse experience or syndrome.108 Some studies have shown that victims who have had access to advocates have an improved quality of life, are more effective at accessing needed community resources, have greater social support, and experience less violence than women who did not work with advocates.109

Find out More About Domestic Violence Courts Near You

There are now more than 200 domestic violence courts. These courts are another example of recent and dramatic changes in the way in which the criminal justice system and courts approach domestic violence. Judges are realizing that criminal behavior is frequently linked to other issues, such as substance abuse, mental health problems and domestic violence. In an effort to deal with these issues, many judges have moved toward assuming a role beyond adjudication. Domestic violence courts take an integrated approach and judges, prosecutors, court personnel and other professionals are brought into one court to provide a more effective and efficient response to domestic violence cases.

In 1999 the Superior Court of the County of Santa Clara (California) began the juvenile delinquency domestic violence and family violence court. The court was designed with the purpose of intervening in teen dating violence and in family violence against parents or siblings. It was hoped that by early intervention that the number of teen batterers could be reduced, especially when they became adults. The court has been found to be effective with juveniles who are appearing in the delinquency system for the first time.

Find out More about Victim Rights

Victims of crimes have many rights, including the right not to speak with the defense attorney or their investigator prior to trial. Victims can wait until they are required to appear in court or choose to have another person present when questioned by the defense. Victims may even choose to notify the prosecutor and have the prosecutor present during questioning by the defense. Victims should always ask for identification and an explanation of the purpose of an interview before answering any questions. Victims also have the right to have a support person in court when they are testifying.

Help your patients understand their local resources and legal rights

Keep up-to-date resource lists of national and local domestic violence agencies. They will likely need to know about emergency housing and shelter, legal services, counseling centers, social services, and need financial aid. Most importantly, you can memorize just one important number – the National Domestic Violence Hotline which is 1-800-799-SAFE. Many victims will take family members and friends with them to seek medical attention and/or legal action. Placing materials and information about domestic violence

in your medical office will not only help a victim but also serve to educate her family and friends and ultimately provide a support system for the victim to make it through the medical and legal system. Dr. Brigid McCaw has been quoted as saying: “Do not underestimate the impact of what patients see in an exam room or in a restroom in the medical office. Having informational materials (such as posters and tear-off resource information sheets) readily available conveys the message that domestic violence is common, it’s an important health issue and that it is appropriate to discuss with a clinician.” Dr. Brigid McCaw has been quoted as saying: “Do not underestimate the impact of what patients see in an exam room or in a restroom in the medical office. Having informational materials (such as posters and tear-off resource information sheets) readily available conveys the message that domestic violence is common, it’s an important health issue and that it is appropriate to discuss with a clinician.”

- **Buy a camera and use it.**

Dr. Walker from the VIP Center in Dallas, Texas says "Capturing high-quality photos can provide a victim of abuse or violence with his or her biggest advocate." Photos of the injuries can show the victim, prosecutor, judge and defense attorney weeks later -- when there is no visible evidence of injury -- just how extensive the abuse was. The problem is photographs are rarely found in the medical record. In a study conducted by Nancy Isaac and Pualani Enos, they found only one of 93 medical records contained a photograph. They also found that: “In the best of records, photographs capture the moment in ways that description can capture months later.” A court will almost always order police, prosecutors, and medical institutions to release injury photographs because they are highly relevant and probative.

- **Go to training.**

Many practicing clinicians have not received specialized training in the area of domestic violence. Professionals who receive training in family violence are more likely to identify suspected child, adult and elder abuse, both physical and sexual, among their patients. Training increases knowledge, comfort, skills for effective inquiry and intervention and even screening practices. Training of health professionals to respond appropriately to women disclosing abuse and increasing their knowledge of local advocacy and support services has been shown to alleviate their concerns about “opening a can of worms” and to encourage professionals to ask about abuse. Training has also been shown to overcome some of the other barriers to routine inquiry. These include ambivalent

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115 http://www.polaroid.com/instantevidence/instantevidence_03_03_hc.htm


attitudes of staff, difficulties in framing questions or seeing the patient alone, recording
information, legal implications, confidentiality, child protection concerns, lack of
awareness of support services, frustration at survivors’ responses, raising expectations of
the clients, safety, time management and issues relating to ethnicity and class.120

- **Provide Training to legal and domestic violence professionals.**

You can be a valuable and precious resource to your local police, prosecutors, civil
attorneys and advocates by offering to share your medical training and expertise with
them. Most domestic violence professionals have not received basic training on the
identification and documentation of domestic violence injuries. They need a better
understanding on how to identify domestic violence injuries, from head to toe, including
the subtle signs of attempted strangulation, concussions, post traumatic stress disorder as
well as being able to differentiate between offensive and defensive injuries.

**Conclusion:**

People are still dying. People are still crying. Domestic violence is everyone’s
responsibility. One system cannot do it alone. Your patient, my client, will benefit from
a strong partnership between the medical community and criminal justice system.
Ultimately it is her safety we are both concerned about. We encourage the medical
community to reach out to the legal and domestic violence professionals in your
community and offer your assistance in the fight against domestic violence. You will be
warmly received and quite likely surprised by the positive results your efforts will make.