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YOUR PATIENT. MY CLIENT. HER SAFETY: A PHYSICIAN'S GUIDE TO AVOIDING THE COURTROOM WHILE HELPING VICTIMS OF DOMESTIC VIOLENCE

Gael Strack & Eugene Hyman***

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 twenty 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.

One 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 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.

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[1] Ann Taket et al., *Routinely Asking Women About Domestic Violence in Health Settings*, 327 BRIT. MED. J. 673, 673 (2003).

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. Alternatively, 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 organizations to help them stay safe. They need access to legal assistance from attorneys to protect their rights. They also need abusers to be held accountable by the judicial system. Domestic violence is everyone's responsibility. One system cannot do it alone.

This article enlists the help of the medical community to improve collaboration among medical, legal, and domestic violence professionals, and ultimately increase and improve referral and documentation once abuse is suspected and/or identified.

I. RICH IN HISTORY. RICH IN RESOURCES. POOR IN IMPLEMENTATION.

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 professions of medicine, nursing and the health related social services must come forward and recognize violence as their issue. [3]

Robert McAfee, as president of the American Medical Association, prioritized concern for family violence, and initiated a campaign against family violence in 1992.[4] In 1992, the Family Violence

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[2] C. Everett Koop, *Foreward* to VIOLENCE IN AMERICA: A PUBLIC HEALTH APPROACH (Mark L. Rosenberg and Mary Ann Fenley eds., Oxford Univ. Press (1991)).

[3] *See* Anne Filtcraft, *Physicians and Domestic Violence: Challenges for Prevention*, 12 HEALTH AFF. 154, 155 (quoting foreward by Koop, *supra* note 2).

[4] JACQUELYN C. CAMPBELL & DAVID BOYD, VIOLENCE AGAINST WOMEN: SYNTHESIS OF RESEARCH FOR HEALTH CARE, at 9 (2003) (report submitted to the U.S.

Prevention Fund became the National Health Resource Center under the control of the U.S. Department of Health and Human Services, providing training and materials on domestic violence.[5] In 1995, Ronald Chez and Robert Jones started an American College of Obstetrics and Gynecology initiative with the goal of educating physicians to screen for and appropriately refer abused women.[6] In 1988 and 1989, the American Nurses Association passed major resolutions on domestic violence, which called for screening of women for domestic violence in all health care settings.[7] In 1987, the first nursing-social work hospital-based family violence intervention program was started at Rush-Presbyterian St. Luke's Medical Center in Chicago.[8]

Similarly, the criminal justice system has been on a parallel track improving the response to domestic violence. In 1984, at the direction of then U.S. 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 American and making suitable recommendations.[9]" 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. The report 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 continued—violence was seen as power and control behavior exercised through male privilege. 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 to address the issue. 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

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Department of Justice), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/199761.pdf [hereinafter CAMPBELL & BOYD].

[5] *Id. at* 9-10.

[6] *Id. at* 9.

[7] *Id.* at 10.

[8] *Id.*

[9] U.S. ATT'Y GEN. TASK FORCE ON FAMILY VIOLENCE: FINAL REP. at vi-vii (1984).

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 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.[10]

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 twenty 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, and have even encouraged lawsuits when all else failed. Advocates also promoted arrest as an effective intervention response to violence.[11]

In 1985, a federal jury awarded Tracy Thurman $2.3 million and found that the city of Torrington, Connecticut and twenty-four of its police officers violated Mrs. Thurman's Fourteenth Amendment right to equal protection.[12] For eight months, Mrs. Thurman had notified the police repeatedly of her husband's threats on her life. She attempted unsuccessfully to file complaints again 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 impermissibly grounded on a stereotype that husbands may beat their wives. The Court stated:

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[10] CASEY GWINN & GAEL STRACK, HOPE FOR HURTING FAMILIES: CREATING FAMILY JUSTICE CENTERS ACROSS AMERICA at 28 (2006).

[11] Barbra J. Hart, *Arrest: What's the Big Deal?*, 3 WM. & MARY J. WOMEN & L. 207, 207 (1997).

[12] *See* Christine O'Connor, *Domestic Violence No-Contact Orders and the Autonomy Rights of* Victims, 40 B.C.L. REV. 937, 941 (1999) (discussing damages in *Thurman v. City of Torrington*, 595 F. Supp 1521 (1984)).

> [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.[13]

In *Bruno v. Codd*, twelve battered women 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."[14] A consent judgment was negotiated, resulting in a major revision in the department's policy. The police agreed thereafter to arrest the abuser whenever there was reasonable cause to believe a felony had been committed against a victim, or the protective order had been violated, remain at the scene to prevent other offenses, and provide other assistance for the victim.[15]

The 1994 Violence Against Women Act (VAWA) was a success of historic proportions on various political and social fronts. VAWA 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.[16]

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. The CCRs took the form of coordinating councils, criminal justice center system reform and/or community intervention projects. One of the most well-

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[13] Thurman v. City of Torrington, 595 F. Supp. 1521, 1528 (1984) (quoting Bruno v. Codd 396 N.Y.S.2d 974, 976 (1976)).

[14] Bruno v. Codd, 419 N.E.2d 976, 980 (1979).

[15] IACP NATIONAL LAW ENFORCEMENT POLICY CENTER, DOMESTIC VIOLENCE, (1996), *available at* http://www.theiacp.org/documents.pdfs.RCD/IACPDomesticViolenceConcepts&Issues.pdf.

[16] Jenny Rivera, *The Violence Against Women Act and the Construction of Multiple Consciousness in the Civil Rights and Feminist Movements*, 4 J. L. & POL'Y 463, 464 (1996) (citing 42 U.S.C. § 13981 (1994)).

known CCRs is the Duluth Domestic Violence Intervention Project (DAIP), which has served as a model for many CCRs.[17]

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. The center was launched as a public safety initiative to help victims of domestic violence and their children, promote victim safety and offender accountability, provide access to more services, avoid the run-around from having to go from place to place, and reduce the trauma of having to tell stories repeatedly. The San Diego Family Justice Center is a strong partnership among twenty-five government and non-government agencies, providing medical, legal, and social services from one centralized location. One of the key on-site community partners is the Forensic Medical Unit (FMU), which is 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 and answers over 3,000 phone calls per month.

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 effort connecting newly developing Family Justice Centers across America. By the end of 2007, it is estimated that there will be forty operating Centers in the United States, including the fifteen that were created in the President's Initiative. The movement toward this model evolved over many years. 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 thirty years. 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 have also been instrumental in teaching us the lessons of organizing through leadership.

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[17] MEG TOWNSEND ET AL., EVALUABILITY ASSESSMENT OF PRESIDENT'S FAMILY JUSTICE CENTER INITIATIVE at 5 (2005) (report submitted to the U.S. Department of Justice), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/212278.pdf.

II. 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 one in four women report having been harmed by an intimate partner during their lifetime.[18] Fewer than half of abused women ever report domestic violence to law enforcement.[19] Although domestic violence affects women about 85% of the time, men comprise about 15% of assault victims.[20] In 2000, 1,247 women were killed by an intimate partner, while in the same year, 440 men were killed by an intimate partner.[21] These statistics also do not even touch upon the health care costs, cost to businesses, the pain and suffering associated with repeated victimization, or 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 twenty years—by both the legal and medical communities—leaving us with good news and bad news.

A. 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 in prestigious journals and the internet, as well as guidebooks, manuals, brochures and checklists written for and by physicians on how to identify abuse. Training is now available through resource centers, on the internet, at conferences, medical schools, law schools, grand rounds, police regional academies, police stations, hospitals, and other places. Awareness tools such as posters, buttons, and fact sheets are now available in convenient kits for a nominal price.

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[18] PATRICIA TJADEN & NANCY THOENNES, FULL REPORT OF THE PREVALENCE, INCIDENCE AND CONSEQUENCES OF INTIMATE PARTNER VIOLENCE, at iii (2000) (report submitted to the U.S. Department of Justice).

[19] *Id.* at v.

[20] CALLIE MARIE RENNISON, INTIMATE PARTNER VIOLENCE, 1993-2001, at 1 (2003), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/ipv01.pdf

[21] *Id.*

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.

B. 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[22] and experts agree that it is good medicine to ask patients about domestic violence (and some even find it easy to ask),[23] the value of screening is subject to controversy.[24] "[A]lthough health professionals often treat abused patients, in the vast majority of treatment situations they fail to suspect abuse."[25] 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."[26] Lack of reporting can be attributed to many reasons, such as time constraints, discomfort with the issue, fear of offending the patient, lack of skills, failure of a patient to volunteer information, lack of training, prejudice,[27] ambiguity about the clinical evidence, uncertainties about the actions of protective services, and fear of court proceedings.[28]

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

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[22] *See* Jo Nurse et al., *Screening for Partner Violence makes a Difference and Saves Lives*, 325 BRIT. MED. J. 1417 (2000) (compilation of letters to editor regarding domestic violence).

[23] *See* Jennifer Robertson, *Domestic Violence and Health Care: An Ongoing Dilemma*, 58 ALB. L. REV. 1193, 1999 (1995).

[24] Therese Zink et al., *Medical Management of Intimate Partner Violence Considering the Stages of Change: Precontemplation and Contemplation*, 2 ANNALS OF FAM. MED. 231, 231 (2004).

[25] Virginia P. Tilden et al., *Factors That Influence Clinicians' Assessment and Management of Family Violence*, 84 AM. J. PUB. HEALTH 628, 628 (1994).

[26] Leslie L. Davidson, *Editorial: Preventing Injuries From Violence Toward Women*, 86 AM. J. PUB. HEALTH 12, 13 (1996).

[27] Patricia R. Salber, *Improving Emergency Department Response to Victims of Domestic Violence*, 159 WEST J. MED. 599, 599 (1993) [hereinafter Salber, *Improving Emergency Department Response*].

[28] Tilden, *supra* note 25, at 628.

low priority. Officers were reluctant to intervene, failing to make arrests even when serious injuries were inflicted and treating serious domestic violence cases as misdemeanors as opposed to felonies.[29] Judges, too, have historically viewed domestic violence as a personal family issue and did not want to intervene or be seen as interfering.

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."[30]

A steady volume of this kind of case also can cause burnout. Family matters, particularly disputes involving children and domestic violence cases, are often contested, murky, ambiguous and difficult to resolve.[31] Also, 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 doing so will require greater involvement with batterers and victims. Judicial College, in California, now requires that all judges take a section on domestic violence, 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 sixty-nine witnesses at six public hearings throughout the state. They focused on four areas: protective orders, prosecutors,

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[29] IACP NATIONAL LAW ENFORCEMENT POLICY CENTER, DOMESTIC VIOLENCE, (1996), *available at* http://www.theiacp.org/documents/pdfs/RCD/IACPDomesticViolenceConcepts&Issues.pdf.

[30] Deborah Epstein, *Effective Intervention in Domestic Violence Cases: Rethinking the Roles of Prosecutors, Judges and the Court System*, 11 YALE J. L. & FEMINISM 3, 39 (1999).

[31] Ann E. Freedman, *Fact-Finding in Civil Domestic Violence Cases: Secondary Traumatic Stress and the Need for Compassionate Witnesses*, 11 AM. U. J. GENDER SOC. POL'Y & L. 567, 580 (2003).

batterer intervention programs (in particular how program providers and courts held batterers accountable), and, finally, reporting of domestic violence by health care practitioners. Repeatedly, the task force found disturbing examples of agencies that failed to respond to domestic violence victims, to enforce the law, to comply with the law, or to work in collaboration with other agencies.

III. VICTIMS ARE COUNTING ON US TO GET IT RIGHT

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.[32] 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 woman refuses to 'take it' anymore and is acting on her own behalf."[33] 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." [34]

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."[35] Physicians were also encouraged by participants in that study to affirm the abuse, know local resources, make appropriate referrals, educate victims, and document the abuse.

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[32] Karla Fischer & Mary Rose, *When "Enough is Enough": Battered Women's Decision Making Around Court Orders of Protection*, 41 CRIME & DELINQ. 414, 422 (1995).

[33] Judith McFarlane et al., *Protection Orders and Intimate Partner Violence: An 18 Month Study of 150 Black, Hispanic and White Women*, 94 AM. J. PUB. HEALTH, 613, 617 (2004).

[34] Tonya McCormick, *Convicting Domestic Violence Abuser When the Victim Remains Silent*, 13 BYU J. PUB. L. 427, 437 (1998-1999) (citing Maryland Network against Domestic Violence, Pro-Prosecution Initiative 8-2 (1995)).

[35] Therese Zink et al., *Medical Management of Intimate Partner Violence Considering the Stages of Change: Precontemplation and Contemplation*, 2 ANNALS FAM. MED.,231, 231 (2004).

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."[36] 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 overcome our own biases and attitudes towards domestic violence.

Ignoring the problem only allows for domestic violence to go undetected.[37] "Failing to report domestic violence injuries is tantamount to aiding and abetting a batterer and deprives the victim of the opportunity for the criminal justice system to work."[38] "[L]ack 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."[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.

IV. ABUSE IDENTIFIED—NOW WHAT?

After the abuse has been identified, the next step is to validate the victim's report of 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.[40] "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

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[36] *See* JANET NUDELMAN & HELEN RODRIGUEZ TRIAS, BUILDING BRIDGES BETWEEN DOMESTIC VIOLENCE ADVOCATES & HEALTH CARE PROVIDERS at 4 (1999) (quoting Council on Ethical and Judicial Affairs, AMA, 1992), *available at* http://new.vawnet.org/Assoc_Files_VAWnet/BCS6_HC.pdf.

[37] Tilden, *supra* note 25, at 628.

[38] Heidi M. Bauer et al., *California's Mandatory Reporting of Domestic Violence Injuries: Does the Law Go Too Far or Not Far Enough?*, 171 WEST. J. MED., 118, 120 (1999).

[39] Catherine Shaffer, *Therapeutic Domestic Violence Courts: An Efficient Approach to Adjudication?*, 27 SEATTLE U. L. REV. 981, 987 (2004).

[40] Salber, *Improving Emergency Department Response*, *supra* note 27 at 600.

for change."[41] 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."[42]

A. 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. The professionals working in these programs are experts in their field and many have received specialized training from state coalitions and/or local domestic violence programs. Local domestic violence programs also work closely with survivors to develop their programs to be sensitive to the needs of domestic violence victims and their children.

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.[43] These specialists would take complete histories of the abuse, thoroughly document additional disclosures of the abuse, maintain the medical record, 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 by state law, and inform the physician about all interventions.[44]

B. Risk Assessment and Safety Planning

Risk assessment is the evaluation of the presence of violence or abuse in a patient's life and assessing how safe she is before she leaves

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[41] PATRICIA SALBER & ELLEN TALIAFERRO, THE PHYSICIAN'S GUIDE TO INTIMATE PARTNER VIOLENCE AND ABUSE at 41 (Volcano Press 2006) (citations omitted) [hereinafter SALBER & TALIFERRO, PHYSICIAN'S GUIDE TO INTIMATE PARTER VIOLENCE].

[42] Brigid McCaw, *Detecting, Documenting and Reporting Domestic Violence, "Nuts and Bolts" Guidance, in* DOMESTIC VIOLENCE RESOURCE GUIDE at 4, *available at* http://www.accma.org/Content/NavigationMenu/PublicHealth/Domestic-Violence-Resource-Guide.pdf.

[43] Barbara Gerbet et al., *Simplifying Physicians' Response to Domestic Violence*, 172 WEST. J. MED, 329, 330 (2000).

[44] *Id.*

the medical office.[45] As Jackie Campbell has noted, "injured women seeking medical care may represent the highest risk for lethality."[46] Safety and risk assessment tools assist professionals in many settings to help determine a victim's danger and also raise a victim's awareness of the danger. Campbell's Danger Assessment tool was specifically designed for health care system administration to increase battered women's awareness of the potential for homicide.[47] At the San Diego Family Justice Center, for example, every new client seeking services receives a service plan, a risk assessment (specifically using 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.[48]

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. A battered woman is the only one who "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."[49] 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 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."[50]

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[45] SALBER & TALIFERRO, PHYSICIAN'S GUIDE TO INTIMATE PARTER VIOLENCE, *supra* note 41 at 44.

[46] Jacquelyn C. Campbell et al., *Lethality Assessment and Safety Planning in Domestic Violence Cases*, 5 CLINICS FAM. PRAC. 101, 104 (2003).

[47] *Id.* at 101 (discussing the dangers of homicide caused by domestic violence).

[48] CAMPBELL & BOYD, *supra* note 4 at 17. It is also available on line at *www.dangerassessment.org*.

[49] Mia McFarlane, *Mandatory Reporting of Domestic Violence: An Inappropriate Response for New York Health Care Professionals*, 17 BUFF. PUB. INT. L.J. 1, 22 (1998-1999).

[50] SALBER & TALIFERRO, PHYSICIAN'S GUIDE TO INTIMATE PARTER VIOLENCE, *supra* note 41 at 45. A sample copy of a safety plan is available at http://www.endabuse.org or http://www.sandiegofamilyjusticecenter.org/get-help/learn-more/victim-what-to-do-now.

C. You have been Subpoenaed–Now what?

It is 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 because 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 involvement. 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 determines 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 are concerned 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. When that happens, the victim will likely be conflicted with many different emotions and financial considerations: she may still love her abuser while fearing him at the same time; she may have returned to provide a better home for her children or the belief that her children need a father; the abuser may have directly coerced her into returning home and/or changing her story; she may have return for religious reasons or because of pressure from the church, friends and/or family.

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. The prosecutor may want to introduce these statements in trial to corroborate the victim's initial story given to the police and to discredit any new statements she makes in trial.

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 the

likely questions are that he will ask you, and what the likely questions are that 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 caused the injuries.

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 the victim told you. 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, it is more likely 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. This diagram can either be used for your own preparation and/or as a helpful illustration for the jury at trial. 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.

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 the medical treatment provided and not all aspects of background information. Recording everything the victim told you may not aid you in providing treatment, and it may also take 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, lest 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 credence

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.

You thank John for his advice. There is a lot of work that needs to be finished before you are adequately prepared for trial.

D. Document It or Tell It to the Judge

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 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 witnesses, 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, and 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 the physician is unable to give reliable answers. 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 such evidence will persuade a judge or jury.[51]

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[51] V. PUALANI ENOS ET AL., AN INTERVENTION TO IMPROVE DOCUMENTATION OF INTIMATE PARTNER VIOLENCE IN MEDICAL RECORDS, at 31 (2004) (report submitted

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.[52] Fact finders, such as judges and juries, often view victim 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 litigation.[53] Physicians question the victim in order to make a determination as to the cause of the injuries. A proper diagnosis is of great importance in determining a proper treatment plan. A patient's answers 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. Thus, a complete medical record of victim's statements may eliminate the need for the victim to testify for the prosecution's case. To help you avoid having to go to court to "tell it to the judge," please read on.

1. Legal and Medical Benefits for Documentation

Documentation is the key to a successful intervention. Accurate and objective 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 matters, 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, landlord/tenant disputes, and/or lawsuits against her abuser for the abuse, or against employers for wrongful termination of the victim as a result of the abuse. Documentation of domestic violence in the medical record can be used not only by a victim's attorney but also by the victim herself in order to corroborate the abuse and obtain a range of protective, legal and financial relief.[54]

Victims of domestic violence are known to recant.

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to the U.S. Department of Justice), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/207146.pdf.

[52] CAL. EVID. CODE § 1370 (West 2007).

[53] ENOS, *supra* note 51, at 18.

[54] NANCY E. ISAAC & PUALANI ENOS, MEDICAL RECORDS AS LEGAL EVIDENCE OF DOMESTIC VIOLENCE, at 2, (2000) (report submitted to U.S. Department of Justice), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/184528.pdf.

> 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 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.[55]

criminal or civil case,[56] especially if that documentation is absent of bias. As stated by Isaac and Enos:

Unfortunately, attorneys and victims are often prevented from using medical records as evidence to assist them. Records may not be used, because of: "(a) difficulty and expense in obtaining records, (b) illegibility, incompleteness, or inaccuracy of documentation, and (c) the possibility that the information in the records, due to these flaws, may be more harmful than helpful."[57]

It is important to remember that 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.[58] 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, and may have had further contact with the batterer, who is now remorseful and begging her 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.

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[55] ISAAC, *supra* note 54, at 10.

[56] ARIELLA HYMAN, *Mandatory Reporting of Domestic Violence by Health Care Providers: A Policy Paper*, at 4 (1997), *available at* http://www.endabuse.org/health/mandatoryreporting/policypaper.pdf.

[57] ENOS, *supra* note 51, at 4.

[58] People v. Bledsoe, 36 Cal. 3d 236, 249-51 (1984). The relevance of battered women's syndrome evidence and the common experiences of battered women was initially defined by the criteria in this case.

2. Knowing 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[59]. The purpose of pro-prosecution policies in intimate partner violence cases is to hold the batterer accountable for his actions while trying to protect the victim. Taking the responsibility for the prosecution away from the victim and placing it on the prosecution 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 blame the victim for prosecution. Pro-prosecution policies also recognize that a victim faces 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.[60] "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 the abuse.[61] "No drop" prosecution has substantially improved the circumstances for domestic violence victims, including increased conviction rates, more effective sentences

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[59] *See generally* WILLIAM L. HART, ATTORNEY GENERAL'S TASK FORCE ON FAMILY VIOLENCE: FINAL REPORT (1984).

[60] Esta Soler, *Domestic Violence is a Crime: A Case Study – San Francisco Family Violence Project in* DOMESTIC VIOLENCE ON TRIAL at 29 (Sonkin ed. 1987).

[61] S. Kuehl, *Forum: Mandatory Prosecution in Domestic Violence Cases*, 7 UCLA WOMEN'S L. J. 169, 170 (1996-1997); Naomi R. Cahn, *Innovative Approaches to the Prosecution of Domestic Violence Crimes: An Overview, in* DOMESTIC VIOLENCE: THE CHANGING CRIMINAL JUSTICE RESPONSE 161, 162-75 (Eve Buzawa & Carl Buzawa eds.) (1992).

for abusers, as well as enhanced access to social services for victims.[62] 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, *Crawford vs. Washington*,[63] 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 *Crawford* is provided below.

3. Medical Records and the Testimony of Health Care Providers after *Crawford*

Traditionally, under Federal Rules of Evidence, statements made 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.[64] The presumption was that "[a] patient [was] expected to be honest with a health care provider in order to receive an accurate diagnosis and appropriate treatment."[65] Under Federal Rules of Evidence, Rule 803(4), statements made for purpose of medical diagnosis or treatment were allowed into evidence under a hearsay exception, regardless of whether the patient testifies.[66] In

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[62] Deborah Epstein, Margret E. Bell et al. *Transforming Aggressive Prosecution Polices: Prioritizing Victims' Long-Term Safety in the Prosecution of Domestic Violence Cases*, 11 AM. U. J. GENDER, SOC. POL'Y & L. 465, 466 (2003) [hereinafter Epstein & Bell, et al.].

[63] Crawford v. Washington, 541 U.S. 36 (2004).

[64] FED. R. EVID. 803(4) adv. comm. note on exception (4).

[65] Allie Phillips, *"I have an 'owie' " Health Care Providers' Roles after Crawford, Davis & Hammon, National Center for Prosecution of Child Abuse*, 19 AM. PROSECUTORS RESEARCH INST. 2 (2006), *available at* http://www.ndaa-apri.org/publications/newsletters/update_vol_19_number_4_5_2006.pdf.

[66] FED. R. EVID. 803(4); Philips, *supra* note 68, at 2.

another words, if a domestic violence victim was unavailable to testify, prosecutors were still permitted to introduce statements made by the victim to the attending health care provider, given that those statements were obtained during the health care provider's primary duties.[67]

In *Crawford*, the U.S. Supreme Court held that testimonial statements are no longer admissible in court, unless the witness testifies and there is an opportunity to cross-examine the defendant.[68] Because the *Crawford* court did not define "testimonial," prosecutors throughout the country became confused and concerned.[69] At first, prosecutors feared that medical records might not survive *Crawford*. Since *Crawford*, over 2,000 cases have addressed the issue of testimonial statements by asking two questions in determining whether a statement is testimonial: (1) whether a governmental agent was 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?[70]

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 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?" "Who did this to you?"[71] Because doctors and nurses are asking these questions for a different purpose, courts are ruling that they do not possess the "government agent" label and this agency status will not transfer to the health care provider.[72] Therefore, statements of the victim relevant to the diagnosis and treatment, under these circumstances, will be admissible through the health care provider's testimony.[73]

Similarly, statements made to emergency medical technicians (EMTs),[74] sexual assault nurse,[75] a neighbor who was a surgical

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[67] Philips, *supra* note 65, at 2.
[68] Philips, *supra* note 65, at 1.
[69] *Id.*
[70] *Id.*
[71] *Id.* at 2.
[72] *Id.*
[73] *Id.* at 2.
[74] State v. Saunders, 132 P.3d 743 (Wash. Ct. App. 2006).
[75] State v. Castilla, 87 P.3d 1211, 1214 (Wash. Ct. App. 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

medical assistant[76] have also been permitted into evidence through the medical hearsay exception.[77]

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[78] and will not be admissible if the sole purpose was to collect evidence.[79] In order words, if the 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, 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.[80]

When seeking to introduce a victim's statement to a health care provider through the medical hearsay exception, the American

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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 complainant, but denied that it occurred in a treatment session. "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." *Id.*

[76] People v. Cervantes, 12 Cal. Rptr. 3d 774, 781 (Cal. Ct. App. 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.

[77] FED. R. EVID. 803(4).

[78] *See generally* Phillips, *supra* note 65 (discussing cases addressing the issue of admissibility of statements made by victims to health care providers).

[79] Medina v. State, 143 P.3d 471, 476 (Nev. 2006).

[80] *See generally* Phillips, *supra* note 65 (discussing cases addressing the issue of admissibility of statements made by victims to health care providers).

Prosecutors Research Institute[81] 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? 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 health care provider should not advise or inform the patient-victim regarding the possibility of court testimony or court appearance.

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.[82]

4. Getting the Medical Records and Admitting the Records

Generally, prosecutors will seek copies of medical records through a subpoena *duces tecum*, which is 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 the 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,

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[81] *Id.* at 5-6.

[82] Phillips, *supra* note 65 at 6.

arguments of the attorneys, and the evidence itself.

For medical documentation to be properly admissible in court, under the business records exception,[83] health care professionals or the custodian of records need to be prepared to testify or provide an affidavit. The affidavit should state that the records were made during the regular course of examination or interview, that they were made in accord with routinely followed procedures, that they have been properly stored and access was limited to professional staff, and that they were made at or near the time of the act or event recorded.

5. 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 dentists. "Abused women 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."[84] 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.[85] They may also report being anxious, depressed and having suicidal thoughts, which may be associated with being abused.[86] 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.[87] The literature reports, 36 to 95% of battered women are suffering injuries to the face, neck or head.[88] Abused women are more likely than accident victims to sustain multiple injuries.[89] "The pattern of injuries in abuse cases typically involves injury to the head, face, neck,

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[83] FED. R. EVID. 803(6).

[84] Epstein & Bell et al., *supra* note 65 at 473.

[85] Lorraine E. Ferris et al., *Documenting Wife Abuse: A Guide For Physicians*, 7 CAN. MED ASS'N J. 1015-22 (1997), *available at* http://www.cmaj.ca/cgi/reprint/156/7/1015.pdf.

[86] Salber, *supra* note 27 at 599.

[87] Teri Randall, *Domestic violence intervention calls for more than treating injuries*, 264 JAMA 939, 939 (1990) (citations to original studies omitted).

[88] Howard A. Ochs et al., *Are head, neck and facial injuries markers of domestic violence?*, 127 J. AM. DENT. ASS'N. 757-61 (1996); Family Dentistry, http://www.cincytoothdoc.com/abuse.html (last visited May 30, 2007).

[89] Evan Stark et al., *Medicine and Patriarchal Violence: The Social Construction of a Private Event*, 9 INT. J. HEALTH SERV. 461, 472 (1979).

breast, and abdomen."[90] Sexual assault 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.[91]

While detection of domestic violence injuries is generally not difficult, it does require the healthcare professionals to be perceptive. Abused patients tend to minimize domestic violence and/or hide their injuries. Evidence also suggests that male attackers may tend to avoid striking the face so that injuries will not be apparent to onlookers; instead, blows to the back of the head may be more common.[92]

Abused victims may also be strangled and may not have visible injuries. 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 prescribing sedatives or antidepressants, which may increase the risk of suicide or place the woman at greater risk of injury from escalating violence.[93]

6. 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. 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 that can lead to death 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

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[90] Ferris, *supra* note 85 at 1016.

[91] Jacquelyn C. Campbell, *Health Consequences of Intimate Partner Violence*, 359 Lancet 1331, 1332, *available at* http://download.thelancet.com/pdfs/journals/0140-6736/PIIS0140673602083368.pdf.

[92] *See* DEPARTMENT OF HEALTH & SOCIAL SERVICES OF ALASKA, EMS RESPONSE TO DOMESTIC VIOLENCE, A CURRICULUM AND RESOURCE MANUAL (1998) (discussing types of injuries present in domestic violence), *available at* http://www.chems.alaska.gov/EMS/Assets/Downloads/EMSDomesticViolence.pdf.

[93] AMA, Council on Ethical and Judicial Affairs. *Physicians and domestic violence – ethical considerations*, 267 JAMA 3190, 3190 (1992) (citations to original studies omitted).

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.[94]

7. 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 – "Is 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
- Results of all tests (with 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)

8. How to Document

Language is critical. Victims of abuse need to feel believed. The process of documenting abuse can serve to validate the patient. The manner in which any professional conducts an intake, questioning and/or documentation matters. Victims need professionals to care about them and hear nonjudgmental statements of concerns. Personal beliefs,

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[94] *See* Casey Gwinn et al., *Domestic Violence: No Place for a Smile*, 32 J. CAL. DENTAL ASS'N (2004) (enlisting professionals in the dental and medical community to help detect and document domestic violence injuries).

bias, 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.[95] 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.

9. 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. Today, there are many resources for medical professionals to improve their documentation. The Family Violence Prevention Fund has developed Health Kits, which may be easily obtained to address the issue of domestic violence in your office.[96]

Most trauma centers have specialized domestic violence report forms, which are templates to assist the medical provider in the documentation of the patient's medical presentation.[97] 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 documented and undocumented violence, use of weapons, presence of drugs and/or alcohol, existence of restraining orders, and threats of future violence.

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[95] *Id.*

[96] *See generally* http://www.endabuse.org.

[97] *See, e.g.* CAL. MED. ASS'N, http://www.cmanet.org/bookstore/cmaoncall.cfm?templateinc=oncall3&article_id=917 (link to purchase information regarding physician's awareness of domestic violence) (last visited May 30, 2007); *see also* California Medical Training Center, http://web.ucdmc.ucdavis.edu/medtrng (last visited on Feb. 22, 2007).

Some even contain risk assessment tools embodied in their report. It has been called "a revolutionary sheet of paper," as its use by police in collecting evidence has resulted in prosecutors winning 90% of cases and a 62% decline in domestic violence homicides.[98]

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.[99] 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.

E. 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."[100] 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 significant difference in someone's life.

1. 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.[101] Abuse is physical, sexual, emotional, economic, or

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[98] Tonya McCormick, *Convicting Domestic Violence Abusers When the Victim Remains Silent*, 13 BYU J. PUB. L. 427, 439 (1998-1999) (citing MARYLAND NETWORK AGAINST DOMESTIC VIOLENCE: PROSECUTION, INVESTIGATION INITIATIVE: CECIL, TALBOT AND FREDRICK COUNTIES (1996)).

[99] The form can be located at http://www.sharp.com/news/index.cfm?ID=203.

[100] Kit Gruelle, Domestic Violence Prevention, Intervention and Education Specialist. Foreward in Salber & Taliaferro, PHYSICIAN'S GUIDE TO INTIMATE PARTNER VIOLENCE, *supra* note 41 at ix.

[101] National Domestic Violence Hotline, http://www.ndvh.org.

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.[102] 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 dating. Domestic violence affects people of all socioeconomic backgrounds and education levels.[103]

Two leading experts, Dr. Patricia Salber and Dr. Ellen Taliaferro, have written *An Introduction to Intimate Partner Violence and Abuse* specifically for health care professionals.[104] The American Medical Association has produced comprehensive diagnostic and treatment guidelines for domestic violence, child abuse, child sexual abuse, and elder abuse.[105]

2. Understand What Laws Apply to You and Your Patients

Significant changes in the law and improvements to the legal system have occurred in the last ten to fifteen years to help 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.[106] 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, which came out of the 1976 case, *Tarasoff v. Regents of University of California*,[107] and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[108]

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[102] The National Domestic Violence Hotline, http://www.ndvh.org (last visited on Feb. 22, 2007).
[103] *Id.*
[104] Salber & Talifarro, PHYSICIAN'S GUIDE TO INTIMATE PARTER VIOLENCE, *supra* note 41 at 1-12.
[105] AMA, DIAGNOSTIC AND TREATMENT GUIDELINES ON DOMESTIC VIOLENCE, *available at* http://www.ama-assn.org/amal/pub/upload/mm/386/domesticviolence.pdf.
[106] ENOS, *supra* note 53 at 22.
[107] *See generally* Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976).
[108] *See generally* 42 U.S.C. § 1320(d) *et seq.* (2006)

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 abusers 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.[109]

3. Find Out how Your State Has Been Graded

The State-by-State Report Card on Health Care Laws and Domestic Violence is an at-a-glance evaluation of state activity in passing laws to improve health care response to domestic violence.[110] The Report Card grades each state based on whether it has enacted effective laws as of June 30, 2000. It covers five policy areas: training, screening, protocols, reporting, and insurance.

4. 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."[111] 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

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[109] *See e.g.* Tarasoff, *supra* note 107.

[110] http://www.endabuse.org/statereport/list.php3.

[111] Nicole E. Allen et al., *Battered Women's Multitude of Needs: Evidence Supporting the Need for Comprehensive Advocacy*, 10 Violence Against Women, 1015, 1016 (2004) (quoting JILL M. DAVIES, ET AL, SAFETY PLANNING WITH BATTERED WOMEN: COMPLEX LIVES/DIFFICULT CHOICES at 2 (1998)) *available at* http://vaw.msu.edu/core_faculty/cris_sullivan/Articles/Allen,%20Bybee%20&%20Sullivan%20(2004).pdf

battered spouse experience or syndrome.[112] A study has 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.[113]

5. Find Out More about Domestic Violence Courts Near You

There are now more than 200 domestic violence courts in the United States.[114] 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."[115] Domestic violence courts take an integrated approach—judges, prosecutors, court personnel and other professionals are brought into one court to provide a more effective and efficient response to domestic violence cases.[116]

In 1999, the Superior Court of California, County of Santa Clara 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. The hope is that, with early intervention, the Court could help reduce the number of teen batterers, and have an impact on reducing teen violence grow to adult violence. The court has been found to be effective with juveniles who are appearing in the delinquency system for the first time.[117]

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[112] *See supra* note 66 and accompanying text.

[113] Cris M. Sullivan & Deborah I. Bybee, *Reducing Violence Using Community-Based Advocacy for Women with Abusive Partners*, 67 J. OF CONSULTING AND CLINICAL PSYCHOL. 43-53 (1999).

[114] Bruce J. Winick, *Therapeutic Jurisprudence and Problem Solving Courts*, 30 FORDHAM URB. L.J. 1055, 1058 (2003).

[115] Hon. Catherine Shaffer, *Therapeutic Domestic Violence Courts: An Efficient Approach to Adjudication?* 27 SEATTLE U. L. REV. 981, 988 (2004).

[116] *Id.* at 993.

[117] BRENDA UEKERT ET AL., JUVENILE DOMESTIC AND FAMILY VIOLENCE: THE EFFECTS OF COURT-BASED INTERVENTION PROGRAMS ON RECIDIVISM at 14 (2006) (report submitted to U.S. Dep't of Just., Nat'l Inst. Just.) *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/216614.pdf.

6. Find Out More about Victims' Rights

Victims of crimes have many rights, including the right not to speak with the defense attorney or their investigator prior to trial. Also, victims can wait until they are required to appear in court or choose to have another person present when questioned by the defense. A prosecutor may also be present during questioning by the defense. Before answering any questions, victims should always ask for identification and an explanation of the purpose of an interview. Finally, support persons are allowed to accompany victims in court when the victim is testifying.

7. Help Patients Understand Their Local Resources and Legal Rights

Keep up-to-date resource lists of national and local domestic violence agencies. Victims or abused patients will likely need to know about emergency housing and shelter, legal services, counseling centers, social services, and financial aid. 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 said:

> 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.[118]

[118] Brigid McCaw, *Detecting, Documenting and Reporting Domestic Violence: "Nuts and Bolts" Guidance*, *in* DOMESTIC VIOLENCE RESOURCE GUIDE at 4-5, *available at* http://www.accma.org/Content/NavigationMenu/PublicHealth/Domestic-Violence-Resource-Guide.pdf.

8. 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." [119] 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. Unfortunately photographs are rarely found in the medical record. In a study conducted by Nancy Isaac and Pualani Enos, only one out of ninety-three medical records contained a photograph. Isaac and Enos also found that: "In the best of records, photographs capture the moment in ways that no description can capture months later."[120] A court will almost always order police, prosecutors, and medical institutions to release injury photographs because they are highly relevant and probative.

9. 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.[121] Training increases knowledge, comfort, skills for effective inquiry and intervention, and even screening practices.[122] Training health professionals to respond appropriately to women disclosing abuse and increase knowledge of local advocacy and support services has been shown to alleviate doctors concerns about opening a can of worms. Training also encourages professionals to ask about abuse.[123]

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[119] Patrick D'Amico, *Treating Victims of Domestic Violence Like V.I.P.s*, *in* INSTANT EVID., http://www.polaroid.com/instantevidence/instantevidence_03_03_hc.htm (last visited Feb. 14, 2007).

[120] ISAAC, *supra* note 54 at 1.

[121] Tilden, *supra* note 25 at 630.

[122] Heidi M. Bauer et al., *California's Mandatory Reporting of Domestic Violence Injuries: Does the Law Go Too Far or Not Far Enough?*, 171 WOMEN'S J. MED. 118, 119-120 (1999).

[123] Taket et al., *supra* note 1 at 673-76 (2003).

10. 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.

V. CONCLUSION

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