Forensic documentation of Intimate Partner Violence in Primary Health Care

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INTRODUCTION

An increasing number of women who present to the health care settings with trauma and injuries are victims of intimate partner violence (IPV). There is evidence that women who experience IPV present to these settings with other short-term and long-term health consequences of ongoing abuse other than the obvious physical trauma. Often they do not disclose that they are victims of IPV.[1,2,3] Evidence also indicates an increase of IPV among pregnant women who are seen in antenatal clinics and other health settings presenting with maternal and foetal and or neonatal complications.[4] But this is not always documented in the antenatal records of these women. Health care providers have always documented the care rendered to all patients, but the documentation of intimate partner violence demands special attention because it has forensic ramifications and a potential to be brought up in the court of law for criminal and / or civil lawsuits.

The purpose of this article is to highlight the importance of forensic documentation, record keeping of injuries and experiences IPV victims share with health care providers. Forensic use of health records for abused women is also described. For the purpose of this article, intimate partner violence is defined as "physical and sexual assault that occurs in intimate partner relationships". An intimate partner is defined as "current or former spouses, opposite-sex cohabiting partners, same-sex cohabiting partners, boyfriends, girlfriends or dates." [5] There is also an increase in reports of intimate partner violence among lesbian, gay, bisexual and transgender (LGBT) relationships. [6] Thus the use of the term intimate partner violence is more appropriate than domestic violence or wife abuse.

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Forensic documentation

Clinical forensics (working with the living) is gaining popularity rapidly among health professionals globally, but most people still confuse it with forensic pathology, another growing branch of forensic science which deals with the dead. The term "forensic" means, "pertaining to the law". [7] Thus health records that contain forensic documentation such as cases of injuries sustained during intimate partner violence are likely to be subpoenaed to the criminal and / or civil court of law as evidence. Doctors and nurses in settings such as emergency units or primary health clinics are in the right place to note and document what they see, smell, hear and touch when caring for women who are IPV victims. Forensic evidence may be tangible, such as a written word, photograph or drawing of the sustained wound. It may also be intangible such as narratives, quotes from the patient or her significant others (sometimes called "excited utterances") or odours that are observed on a patient during treatment e.g. a smell of alcohol which are documented in writing on a health record. [8]

Education and training of health care professionals

The basic professional education and training of doctors, nurses, and other health care providers provides them with generic skills on documentation and record keeping. It does not include skills and competencies on specific forensic documentation of medico-legal cases such as victims of physical or sexual assault, other crime or trauma related evidence. Often there is also little or inadequate training regarding the dynamics of violence against women, including victim safety planning, health effects of violence and appropriate screening and documentation. [9] Literature suggests that some health care providers (especially forensic nurses, sexual assault nurse examiners and some doctors) have received some training in evidence collection and forensic documentation pertaining to sexual assault and sexual abuse. However there is no indication of training on documentation of intimate partner violence including the "physically abused" or "sexually and physically abused" which is very common among most cases of battered women.[2] This indicates a need for training of all health providers who are in the forefront of primary health care on evidence collection and documen-

tation of all forms of violence against women. Several authors support the need for training of health care providers in forensic documentation. They give different incidents whereby appropriate and inappropriate forensic documentation of evidence was used in IPV cases and the outcomes thereof.[8-12] A sad, but very common example of an incident of inappropriate forensic documentation was reported by Hoyt.[8] In this report, the perpetrator was acquitted because the health records incorrectly described the "incised wound or cut" as a "laceration".

Purposes of forensic documentation

Traditionally the primary purpose of health records is to document patient care. In cases of maltreatment, a health record can also be an essential evidentiary tool which serves to provide the chronology of care that was rendered (or not rendered) at a given time.[13] However, the multiple purposes of forensic documentation in IPV was described by Griffin and Koss as follows: [14]

a. To alert other health care providers of ongoing IPV in a patient's life.
b. To serve as an objective documentation that injuries that are consistent or not consistent with the accidental origin were observed.
c. To determine that screening for domestic violence and safety has occurred.
d. To contribute data to hospital or clinic policy decision makers regarding allocation of scarce resources and the problems that patients are typically presenting to the health setting.

Legal use of health records

In a study to determine the use of health records in legal cases of violence against women in relationships, Cory *et al* reported that in 16 out of 20 cases, health records were used in court against the victims and their claims.[9] In the two cases where the records supported the victims' claims, the health records documented that the victims received treatment for the injuries. The fact that they attempted to mask their cause was considered by the court to be consisted with this type of victimisation. In another two cases in which the health records were used to support the victims' cases, the fact that the abuse was not recorded in the health records was found admissible as evidence of the victims' fabrication of the allegations. In the same study, it was reported that health records were used to:

a. Discredit the woman.
b. Show her unfitness to care for the child or children.
c. Show that she has a psychiatric illness and therefore not a credible witness.
d. Show that alcohol and drug abuse affected her memory.
e. Show inconsistencies between her evidence regarding injuries and what is recorded.
f. To defend the abuser's character and reputation.

The study summarised the different uses of health records and importance of meticulous forensic documentation of history and description of injuries in IPV cases. Unfortunately, the health care providers who have not received forensic training are not usually aware of these additional uses of health records.

In a study that addressed intimate partner abuse in the health care setting by listening to survivors' voices, Hathaway *et al* reported that 4% of the women felt that documentation of the abuse in health records was crucial for legal action against the abuser.[15] A quote from one woman states *"A lot of providers listen but do not put it down… I'm involved in an enormous legal situation right now. It would be nice if things I noted had been documented, but there is nothing written down."* Another participant also highlighted the importance of the photograph of her injuries that was taken after a physical assault by her partner. These signify that even though an abused woman may not indicate initial interest in going to court, she may decide to do so later. In that case, she may need a well-documented health record of her visit(s) to the health setting as evidence in court. If routine screening for IPV and thorough forensic documentation is routinely done for all women who are in abusive relationships, when such documentation is needed in court, they will be there to lend credibility to the case [(14)].

Time constraints and pressure from other patients with emergency health needs are reported to be a major limitation in time spent on identification and documentation of evidence of intimate partner violence in health records.[9, 14, 16] Sheridan supports this and further states that it is logistically difficult and unrealistic to document an entire patient's history. He recommends verbatim documentation of "juicy quotes" followed by paraphrasing of the remainder of the history of the reported assault.[17]

Narrative forensic documentation

This includes a statement by the IPV victim about the abuse, clear descriptions of all injuries and history of the first, worst, and most recent incidents of abuse.[18] It also includes the type of assessment, planning and care that was rendered, all follow-up dates, referrals to other health team members as well as referrals to shelter and other social services. A study on emergency department documentation of intentional assault found that social service involvement and shelter referrals were recorded in less than 25% of domestic violence cases.[19] Wisser recommends that the health care provider should maintain a position of a neutral reporter in order to ensure that the scope of documentation is comprehensive and relevant.[20] The report should include not only physical concerns, but psychosocial and emotional observations such as her affective presentation. The following example demonstrates the report of psychosocial and emotional observations made by a health care provider during history taking: *"When asked what had caused her injuries, patient's eyes filled with tears and she answered that her husband (LS) stabbed her all over with the kitchen knife. She then sobbed uncontrollably."* This record gives a clear picture of what happened during the history taking.

In his address to forensic sexual assault nurse examiners of a community-based sexual assault centre in Memphis Tennessee, Judge C. Craft said that narrative forensic documents are "snapshots" of how the victim presented in the health setting.[21] He further stated that the forensic nurses are the "eyes and ears of the jury and the judge who never saw the injuries or heard the story of the victim". He encouraged them to provide as much of narrative documentation as they possible could because as he puts it,

"this enhances sentencing and punishment of offenders".

He demonstrated how forensic document by one nurse from the same

Table I: Knowledge and skills in forensic documentation of Intimate Partner Violence

- Identification of IPV victims in the primary care setting i.e. screening
- Accurate documentation of wounds and other forensic evidence
- Forensic photography (where possible)
- Objective and non-judgemental history taking, examination and documentation
- Clear documentation of relevant legal documents e.g. J88 form
- Good record keeping skills

centre was used in court in the absence of the victim. The offender of sexual assault was sentenced to sixty years without parole. The sentence was based on the documented forensic evidence, DNA (from semen collected vaginally by the forensic sexual assault nurse) and the narrative documentation of what the patient said about the identification of the suspect.

According to Craft, forensic documents should be treated as business records with the health care provider (hospital or clinic) as custodian of such records.[21] They should be kept in the regular course of business and not under individual nurse's or doctor's care. Late entries to the records should be avoided as much as possible because this practice may render the records inadmissible in the court of law. If and when necessary, any late entry should be indicated as such and added as an addendum (dated and signed).

The following information should be in the narrative forensic document of all IPV patients:

- Name (alias as well) of the attacker (it is not adequate to state boyfriend, husband or ex-husband).
- What happened before, during and after the attack (including any previous attacks and their severity).
- Number of times the patient was struck and how (i.e. whether she was punched, stabbed, slapped or hit), including an object or weapon used to inflict the injury.
- Parts of the body that was targeted as well as parts of the body that were hit (to identify defence wounds that indicate the posture of a victim protecting herself)
- Time of the attack and where it took place.
- Name of person (s) who witnessed the attack.
- Whether children witnessed the attack (this can have implication regarding children safety).
- Whether the abuser made threats during the attack or anytime before or after the attack (the abuser's threats should be recorded verbatim especially if it includes killing the victim or any of her significant others).
- Whether the perpetrator is in the health setting (e.g. waiting room) accompanying her.

Curnow suggests description of the interaction between the abuser, patient and health care provider (if he is present) e.g. his refusal to let the health provider interview the woman alone, answering questions directed to the partner and giving explanations that do not match the woman's injuries or her condition. The woman's behaviour in his presence should also be recorded. [22]

Conclusion

Intimate partner violence is a major public health concern with legal and social implications. Education and training is needed on the identification and forensic documentation of evidence of the victims of intimate partner violence. Documentation should not only include care rendered, but referrals to other health team members. Where necessary and feasible, forensic documentation should be supplemented by photographs. It is recognised that intimate partner violence cannot be prevented only by the health care providers, but it is hoped that knowledge and skills in forensic documentation will ensure that IPV will not receive secondary victimisation from health care providers who use inappropriate, incorrect and out-dated documentation in health records. **Table I** summarises the knowledge and skills needed in forensic documentation of IPV.

See CPD Questionnaire p.49

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