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This project would not have been possible without the cooperation and participation of the staff at all three sites involved in this project. We thank them for their time and willingness to share their experiences to help us to learn about the practical workings of each department and the potential of each to respond more effectively to intimate partner violence. Providers' willingness to discuss their practices and opinions candidly enabled us to create training that more accurately addresses their concerns and needs. Additionally, we appreciate the participation of the legal, risk management and medical records departments of various local hospitals that allowed us to accurately respond to the concerns and obstacles raised by medical providers in our training.

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EXECUTIVE SUMMARY

Goal. Medical documentation regarding intimate partner violence, and testimony based on that documentation, are valuable tools for victims seeking legal relief from abuse. Inadequate documentation practices and under-utilization of medical records by attorneys currently hinder victims' efforts to secure legal relief. In this project we developed, implemented and evaluated an intervention designed to improve the abuse documentation practices of health care providers, by encouraging them to apply diagnostic and documentation skills traditionally understood to fall within the medical realm of professional competence and responsibility.

Health care professionals commonly encounter intimate partner violence (IPV) when caring for patients. Recent health care provider training has focused on screening, identification of IPV, and social service interventions for battered women. While providers are encouraged to identify and assist victims of IPV for services, focus groups and a review of training manuals and IPV protocols from around the United States reveal that providers rarely receive any direction regarding how and why to document IPV. While providers may be trained in screening and assessment, few who have received any training related to documentation of the assessment and treatment provided (Davidson, 2001). Providers have identified several issues that discourage them from documenting IPV in patient charts. These include: (a) not recognizing how helpful corroborative or direct documentary evidence of abuse may be to patients seeking protection, (b) misplaced fear that documentation can only increase provider's risk of medical malpractice liability, (c) belief that documentation of IPV can only hurt the patient if anyone outside of the health care setting views the record, (d) belief that documentation will increase the likelihood of being called to testify in court, and (e) lack of specific training regarding time efficient documentation of injuries, patient statements and observations.

Many patients who seek health care for injuries related to IPV eventually access legal means to achieve violence-free lives. Legal remedies include prosecuting abusers, obtaining abuse prevention orders, seeking custody of and visitation with children, applying for benefits and housing privileges, and securing immigration rights. Medical records that document abuse can make the difference between success and failure in obtaining any of these forms of relief. Currently, however, many attorneys do not utilize medical records in these contexts. Reasons for not using the records include (a) difficulty and expense in obtaining records, (b) illegibility, incompleteness or inaccuracy, of documentation and (c) the possibility that the information in records, due to these flaws, may be more harmful than helpful.

The current project builds upon the previous work of a unique medical-legal, researcher-practitioner collaboration. The prior project, hereinafter referred to as Legal Evidence Project 2002, explored the utility of abuse related medical records in legal proceedings, revealed the concerns and problems associated with documenting IPV in health care settings and made recommendations as to how providers should document IPV. Originally, the current project was designed to improve providers' documentation skills in order to improve the quality and continuity of care and provide patients with useful corroborative evidence of the health impacts of abuse. As a means of achieving this goal, we intended to develop a training program focused primarily on documentation of IPV. However, once we began investigating the current practice in each of our study settings, we concluded that focusing on documentation without first addressing assessment and response to IPV would be impossible given the frequency and quality of response to IPV in the three settings. In order to accomplish our primary goal of developing an intervention to improve documentation we needed to perform two additional tasks. We needed to develop a response to IPV that addressed the needs of the providers in each setting. At the same time, we needed to explore what structural changes and administrative resources were needed to support implementation of such a response. Once these additional tasks were accomplished, the research team developed a training that presented a recommended response to IPV that emphasized documentation, employed a patient empowerment model and relied on an interdisciplinary team approach.

Curriculum Development. In order to inform the development of the three training curricula for each of the study groups, we conducted focus groups with emergency medical technicians (EMTs), paramedics, nurses and residents from each study site. We also conducted separate focus groups with IPV survivors, IPV advocates, social workers, and hospital administrators. Hospital administrators included management staff from legal, risk management and medical records departments of area hospitals. Records from each site were reviewed for a three-month period prior to training delivery to supplement the record review conducted in our previous NIJ-funded project. IPV health care protocols and related literature were reviewed to determine current strategies relating to assessment and documentation. A thorough legal literature review augmented the findings from our previous projects on liability and patient privacy issues. Using this data, our curriculum development team formulated a 50-minute training for each provider group using a team-based approach that describes the benefits of a health care response to IPV, presents concrete strategies for assessment and documentation of IPV, and details a limited intervention that all providers can deliver within a five-minute interaction regardless of patient disclosures or readiness to take action.

Initial Focus Group Results. We conducted 10 focus groups with providers, 7 focus groups with survivors, six focus groups with hospital administrators and 20 interviews with providers, administrators, advocates and social workers from health care institutions that were not involved as study sites. Results from the focus groups provided valuable insights relating to what types of medical interventions are helpful and harmful to patients experiencing IPV and issues relevant to IPV that need to be addressed in order to prepare providers to respond to IPV.

Helpful medical interventions include:

- Providers who treat clients with care and respect.
- Providers sharing resource information for services that can be accessed subsequent to treatment.
- Medical record management that maintains patient privacy and confidentiality
- Recording abuse related information can be extremely useful to patients and may be the only outside account of the abuse.
- Patients want providers to recognize signs of abuse and inquire about abuse in a sensitive and private manner.
- Providers telling patients that help is available and change is possible without pressuring patients to take action.
- Providers who do not condition careful assessment of health condition or comprehensive treatment on the patient's willingness to disclose abuse.
- Health care institutions creating a safe environment for gay, lesbian, bisexual and transgender patients in abusive relationships.
- Provider recognition of how dangerous it is for most victims to seek any kind of help, including medical care, related to IPV.

Potentially harmful medical interventions include:

- Providers pressuring a patient to follow their advice to "leave the relationship," "call the police," or "get a restraining order."
- Providers underestimating the patient's own understanding of the danger posed to her and her children.
- Providers becoming angry, distant or blaming of patients who do not take recommended action steps
- Providers pressuring patients to disclose abuse or to retell incidents of abuse to multiple providers during the same visit.
- Health care institutions and providers failing to provide full protection of medical records and information related to treatment.
- Providers inadvertently placing patients in more danger through taking action that exposes patients' help-seeking to abusive partners.

Areas of inquiry for further exploration by institutional interdisciplinary teams include:

- What resources are necessary to implement an effective response to IPV in each department of the institution?

- What kind of training do providers in each department require and how can that training be tailored to meet the needs and resources of each department?
- What types of services must be referred outside of the institution?
- How can the institution and individual providers better protect patient privacy, confidentiality and privilege and thereby decrease vulnerability to legal liability?

Training Implementation. A training curriculum for each of the provider groups at the three sites was developed using data collected in the focus groups, results from the literature review, and the pre-training record review. Several trainings were offered over a period of two-three months in an attempt to capture 70% of the providers at each site. We were successful in training 237 EMTs and paramedics (78%) at the Pre-hospital site; 48 nurses (80%) and 23 residents (59%) at Emergency Department Site #1; and 41 nurses (51%) and 16 residents (57%) at Emergency Department Site #2.

Medical Record Review. At the pre-hospital site, 48 records of IPV from the pre-training period and 70 from the post-training period were examined. At Emergency Department Site #1, 59 records of IPV cases from the pre-training period and 48 IPV records from the post-training period were examined. Intake, nursing and resident notes from each record were reviewed. At Emergency Department Site #2, 16 records of IPV cases from the pre-training period and 20 IPV records from the post-training period were reviewed. Due to the small number of records identified at Site #2, the pre- and post-training records, including intake, nursing and resident notes, are described qualitatively while the pre- and post-training records from the pre-hospital site and Emergency Department Site #1 were compared using Chi-square methods.

Overall, our findings related to the effectiveness of the training remain inconclusive due to the small number of IPV records written by providers who had attended the training. While some changes in charting practices did occur and it appears that attending the training may increase provider identification of IPV, further study of the intervention is needed to fully ascertain its potential. However, we did collect informative data relating to current practices of providers, needs for resources and support to respond to IPV, and means to overcome obstacles and challenges to respond to IPV. Data collected from survivors, advocates and social workers also illuminated the benefits of interdisciplinary teams and implementing a team approach to IPV in medical settings. Information collected from legal, risk management and medical records staff working in hospital settings also reveal the importance of involving these departments when developing IPV protocols and policies. The evaluation speaks to the feasibility of IPV training in an emergency medical setting and the challenges related to evaluating provider practices.

Lessons. Several valuable lessons emerged over the course of this project. We have selected several lessons to share and made recommendations for future work and replication efforts.

Lesson One:

Most providers easily recognize physical symptoms related to IPV. Providers struggle with how to talk to patients who disclose abuse and how to deal with patients who present with symptoms but do not disclose abuse. Providers may become so focused on avoiding IPV or investigating it that they run out of time to do what they are most qualified to do: assessing, treating or documenting the patient's medical needs.

Recommendations:

- Providers need direction in how to talk to patients about abuse, the impacts of abuse on the patients' health and how to limit the scope of inquiry so that they can attend to medical needs.
- Providers need to remember to conduct thorough assessments of past, potential and current injuries, treat all injuries and better document observations rather than focusing all their attention on collecting details of an incident, safety planning or referring patients to IPV services.
- Providers must understand that it is not their responsibility to 'make a patient safe' or solve her problems. Providers can play an important role by educating patients that help and resources are available, breaking patients' isolation, build patients' trust in helping systems and creating a positive help-seeking experience.
- Providers need more training in how to recognize psychological and emotional abuse and how this type of abuse impacts a patient's physical and mental health and her ability to manage health care issues.

Lesson Two:

The feasibility of implementing an IPV protocol, delivering training related to the protocol and evaluating provider adherence to the protocol is dependent upon adequate resources and department-wide support.

Recommendations:

- Department resources must be carefully evaluated in order to assess the best means of implementing an IPV response.
- To maximize limited training resources, training sessions should be offered to as many providers as possible at the same time. However, obtaining full department participation may require offering several trainings at varying times to accommodate provider work schedules. Significantly more resources are necessary to implement a protocol in a 24-hour setting than one that operates during regular business hours.
- Administrative support for participation in trainings and implementing protocol practices in the form of monetary compensation and professional recognition would greatly enhance training participation and protocol implementation.

Lesson Three:

Implementing a team approach to respond to IPV in health care settings enables providers to use their medical skills to support victims and do so within their time and resource constraints.

Recommendations:

- Providers should provide a limited intervention that includes:
 - ❑ Inquiring in a kind and private way about symptoms or presentations that raise a concern of IPV;
 - ❑ Performing a careful assessment of all symptoms and conditions not just the most serious injury;
 - ❑ Inquiry into the healing of past injuries
 - ❑ Treating all medical conditions;
 - ❑ Documenting any patients descriptions of incidents of abuse resulting in need for medical care including facts relating to who, what, where, when, how, type of force and any weapons used. Quotes and "patient reports" is the recommended means of documenting the patient's description of events.
 - ❑ Documenting injuries and health conditions in a detailed and specific manner. Providers may have to draw their own body maps. Photographs are recommended if they will be sufficiently protected and stored with the medical record or given to the patient or patient advocate.
- Counseling, safety planning and advocacy work should **only** be performed by providers or others who have received extensive formal training in IPV.
- Providers need to plan for patient and provider safety during patient's stay in the institution. Providers should involve security personnel in safety planning rather than waiting until a problem arises.
- Providers can indicate to patients that help is available, that change is possible and offer resource numbers and referrals to IPV services in a five-minute intervention.

Lesson Four:

Many providers feel that they do not have the time or resources within the treatment setting to solve the problem of IPV. Most providers only consider a response effective if it achieves patient safety upon discharge. Such high expectations are unrealistic given the complicated nature of IPV.

Recommendations:

- Modifying expectations to create more realistic goals to achieve an effective response to IPV is necessary.
- A team approach to IPV in health care settings will optimize limited resources.
- Providers who conceptualize themselves as a part of a team of service providers are more likely to see the potential for successfully responding to IPV.

Lesson Five:

General Protocols developed by organizations or outside health care institutions serve as useful templates for devising a protocol but it must be tailored to meet the circumstances, needs and resources of each particular setting.

Recommendations:

- A thorough exploration of current workings and procedures, including forms and electronic record keeping systems, must inform any protocol related to IPV.
- Providers with extensive experience working in the setting are vital to the development of a working protocol.
- Patients should also be consulted for recommended responses.
- Relevant administrative offices including legal counsel, social work and medical records departments should be involved in developing the protocol.
- Protocols should incorporate local resources.

Lesson Six:

Medical documentation is not necessarily standardized among providers, even within the same department. Many medical record forms are not user friendly in cases of IPV and do not provide for photograph storage.

Recommendations:

- Standardizing documentation methods would improve patient records by clarifying what occurred at each visit.
- More consistent documentation strategies could only increase the quality and continuity of care.
- Providers within departments or institutions should adopt a list of abbreviations that everyone could use. A legend depicting commonly used abbreviations would greatly increase the likelihood that records could be introduced into court without requiring that a provider interpret the records.
- Medical record forms should be constructed to make response to IPV easier to document. A storage place for photographs and releases should be provided.
- Providers should be informed of rules governing their release of information related to patient treatment. Providers should also be familiar with rules and procedures relating to how their health care institution manages and protects patient records.

Lesson Seven:

Many of the providers involved in the study believe that if an IPV intervention cannot be executed fully from beginning to end with a patient, the provider should avoid the issue of IPV altogether. Many of the IPV training manuals and protocols may inadvertently reinforce this message.

Recommendations:

- It is better for providers to perform one step of an intervention than do none at all. Simply acknowledging abuse is important.
- Most patients are not expecting and may not want extensive services from a health care setting. Perhaps only certain aspects of an intervention will suit a patient's needs. Responding to each patient's unique circumstances is likely to encourage her or him to seek help again in the future.
- The quickest and easiest intervention for providers is to leave a card with resource numbers in a place where patients can review them in private and take them home without notifying hospital staff. Many patients prefer to receive resource numbers in this private manner.
- Most areas have a 24-hour hotline that IPV victims can call anonymously to talk to a trained IPV counselor. Providers without the time or skills to address IPV should provide patients access to a phone in a private room so they have an opportunity to make this call.

Lesson Eight:

A 50-minute training to a portion of the staff is not enough training to create significant change in how a medical site addresses IPV. Additional training time would better able trainers to address training priorities more fully.

Recommendations:

- Providers would be more likely to adopt practices if all providers were required to attend training, incentives to acquiring knowledge and skills were made available, and structural changes to procedures and medical records could be made to accommodate provider concerns.
- Training needs to be on-going and conditions that reinforce implementing knowledge and skills into practice needs to be established. Further study and thought should be given to training methods other than in-service group sessions. Alternatives could include:
 - ❑ Small group record reviews
 - ❑ One-on-One clinical consultations during work shifts
 - ❑ Partnering with a domestic violence advocate to deliver services on a case-by-case basis
- Training should be delivered to all staff, and it may be more effective to train across provider groups, preferably training providers who regularly work together as a team.
- Future studies should incorporate mechanisms to ensure maximum feedback from study participants as to usefulness of the training after some period of implementing intervention strategies.
- Further study of how to sustain effects of training and to continue to improve documentation processes is needed.

The Need for Institutional Support in Addressing IPV. Many helpful protocols, guidelines and training manuals are available to assist health care providers to develop more effective strategies for addressing IPV. Resources have been tailored to address different types of practice settings and the varying roles played by different types of providers. However, despite the tremendous effort devoted to improve health care response to IPV, current practice in most medical settings need to undergo significant changes in order to confront the health impacts of IPV through consistent identification, careful assessment, and comprehensive treatment of injuries and health related symptoms that result from IPV.

A review of this report and any protocol, guidelines or training manual addressing health care response to IPV reveals that providers are being asked to make substantial changes in the way they currently address patients presenting with IPV. Many providers, like professionals in so many other disciplines, did not choose to specialize in IPV work but instead have been thrust into it as a result of their chosen area of interest whether it is medicine, law, social work, or psychiatry. While they may prefer to avoid issues such as IPV, child abuse and neglect, elder abuse and other violent crimes it will inevitably be a part of their work. Accordingly, if providers are expected to adopt new approaches and implement them into their every day practice, they must be given adequate resources, support and training. In order to effect changes in provider behavior, institutions must recognize the needs of providers, develop approaches and practices that make sense within each treatment setting, and make structural and institutional changes to support recommended practices.

First, health care administrators who control budget decisions must also recognize how regularly providers may see patients experiencing IPV and acknowledge the resources necessary to properly respond to this problem. Resources include ongoing clinical training, access to private treatment rooms in a secured area, working partnerships with other relevant services within the health care setting (security, social work, IPV advocates, interpreters) and referral mechanisms to services outside the health care setting (IPV support groups, safe housing, police and legal advocacy programs.)

Next, institutions must coordinate designated persons from relevant departments within the institution to design a response to IPV for various departments that best suits the needs, circumstances and resources of each department. Creating an interdisciplinary working team made up of health care providers delivering direct services, legal counsel, risk managers, and medical records staff will increase the likelihood of devising a response that will work and protect providers and the institution from any liability or unnecessary costs. (Brouhard & Mahoney, 2002) When developing a response, institutions must also consider creating partnerships with services outside of the hospital in order to supplement their own resources.

Finally, the institution must implement the plan through infusing money and personnel resources where appropriate, making structural and systems modifications where necessary, working with providers to acquire the skills necessary to incorporate the IPV response into their practice and maintaining positive relationships with service partners outside the hospital.

When developing an IPV response institutions can help by creating attainable goals that emphasize skills commonly associated with health care delivery. Seen as a part of managing health care, providers can begin to view IPV as a problem that is solved over time rather than overnight and see themselves as one helper among many rather than a lone problem solver. A change in expectations can help providers to see the potential for success in their interactions with IPV patients. Providers often complain that it is difficult to help IPV victims because they view patients as, "unwilling to help themselves by taking action to leave the abusive partner." Expecting to effectuate drastic life changes in patients' lives in one treatment visit is unrealistic and typically results in providers and patients feeling disappointed and frustrated.

A Shift in Perspective. One of the most common misconceptions about IPV by many providers is that the problem should and can be solved immediately. This is especially true in certain health care settings such as the emergency setting. The truth is that with the exception of a few cases, most victims need time to end the IPV in their lives. IPV relationships rarely are ended quickly and simply. For this reason, providers need to shift their goal away from fixing a patient's problem or making the patient safe. Instead providers need to support a patient's effort to seek help and at the same time address her health needs and record observations. These behaviors are well-within the provider's expertise and help the patient in ways that can extend long past the visit. Documentation of a thorough assessment of injuries caused by IPV is a good example of important work that providers can do to assist patients.

Providers understanding how they can play a role in the larger scheme of IPV service delivery enables them to contribute their expertise to patients' problem solving, even if resolution of the problems occur sometime in the future. Providers may not see the beneficial outcomes of their work, but will know that by maintaining good treatment records, they afford patients what may be the only third party record of symptoms and injuries resulting from abuse. As such, these records can be vital in assisting patients to gain independence from their abusive partners.

Providers' experiences with IPV will be more rewarding and less frustrating if realistic expectations are set, adequate resources to accomplish goals are available, and providers learn to coordinate their work with other services providers in and outside the hospital.

Interdisciplinary and Institutional Collaboration. This evaluation project exists due to the working relationship built among research team members over several years. These relationships were built in the context of providing direct services to IPV victims in legal, shelter and health care settings. To improve services to clients, we forged new working relationships across institutions and disciplines. Such experiences taught us that sharing different areas of expertise, skills, access to resources and perspectives could only benefit each of our individual clients. Working cooperatively enabled us to spend more time with each client and turn fewer clients away. Each of us was released from the untenable task of being everything to every client and instead only responsible to deliver services within our skill and knowledge base. We provided services that were best suited to our professional role and referred clients to other services we knew well and to providers whom we trusted. Working across agencies and disciplines resulted in breaking the isolation that is so often associated with IPV service delivery in any professional setting. Surely, there are success stories of similar interdisciplinary working teams in other health care settings. However, this model has yet to be implemented completely enough to accurately assess its effectiveness.

Interdisciplinary working may not guarantee success in every case but it improves the likelihood of accomplishing small successes that may pave the way to patients' future safety. Supporting providers in each setting to implement a team-based approach and to build interdisciplinary working relationships increases the chances that change will occur on a level that will eventually change the culture of resistance that currently exists in many health care settings. Over time, implementing a consistent response to IPV will result in improved health care, increased satisfaction by providers who work with IPV victims and substantial economic savings to health care institutions.

Future Research. Further study is needed to explore what strategies will increase institutional and administration's investment and support of a consistent and effective IPV response in health care settings. Our project revealed that many providers have not been exposed to the wealth of knowledge and IPV resources developed over the past two decades. Even those providers who have been exposed to some information related to IPV have not had adequate incentive or support to incorporate this knowledge into their practice on a consistent basis. Lack of time was a serious concern for all participants in the study. Effective training and skills development to deliver health care that effectively responds to IPV takes time.

Additional research exploring different methods of disseminating information, incentive for acquiring increased knowledge, and identifying time efficient means of developing providers' skills is much needed. A useful area of study would be a more in-depth examination of what changes would need to be made so that IPV education and clinical training were required course work in medical, nursing and EMT schools. A critical look at how implementation of an IPV protocol on an institution wide basis may effect or transform the culture of the setting as opposed to training specific providers or individual departments would also add to current knowledge.

Introduction

Medical documentation regarding intimate partner violence, and testimony based on that documentation, are valuable tools for victims seeking legal relief from abuse. Inadequate documentation practices and under-utilization of medical records by attorneys currently hinder victims' efforts to secure legal relief. In this project we developed, implemented and evaluated an intervention designed to improve the abuse documentation practices of health care providers, by encouraging them to apply diagnostic and documentation skills traditionally understood to fall within the medical realm of professional competence and responsibility.

Health care professionals commonly encounter intimate partner violence (IPV) when caring for patients. Recent health care provider training has focused on screening, identification of IPV, and social service interventions for battered women. While providers are encouraged to identify and assist victims of IPV for services, focus groups and a review of training manuals and IPV protocols from around the United States reveal that providers rarely receive any direction regarding how and why to document IPV. While providers may be trained in screening and assessment, few who have received any training related to documentation of the assessment and treatment provided (Davidson, 2001). Providers have identified several issues that discourage them from documenting IPV in patient charts. These include: (a) not recognizing how helpful corroborative or direct documentary evidence of abuse may be to patients seeking protection, (b) misplaced fear that documentation can only increase provider's risk of medical malpractice liability, (c) belief that documentation of IPV can only hurt the patient if anyone outside of the health care setting views the record, (d) belief that documentation will increase the likelihood of being called to testify in court, and (e) lack of specific training regarding time efficient documentation of injuries, patient statements and observations.

Many patients who seek health care for injuries related to IPV eventually access legal means to achieve violence-free lives. Legal remedies include prosecuting abusers, obtaining abuse prevention orders, seeking custody of and visitation with children, applying for benefits and housing privileges, and securing immigration rights. Medical records that document abuse can make the difference between success and failure in obtaining any of these forms of relief. Currently, however, many attorneys do not utilize medical records in these contexts. Reasons for not using the records include (a) difficulty and expense in obtaining records, (b) illegibility, incompleteness or inaccuracy, of documentation and (c) the possibility that the information in records, due to these flaws, may be more harmful than helpful.

The current project builds upon the previous work of a unique medical-legal, researcher-practitioner collaboration. The prior project, hereinafter referred to as Legal Evidence Project 2002, explored the utility of abuse related medical records in legal proceedings, revealed the concerns and problems associated with documenting IPV in health care settings and made recommendations as to how providers should document IPV. Originally, the current project was designed to improve providers' documentation skills in order to improve the quality and continuity of care and provide patients with useful corroborative evidence of the health impacts of abuse. As a means of achieving this goal, we intended to develop a training program focused primarily on documentation of IPV. We hoped that increased positive experiences with IPV patients would encourage providers to increase identification, continue to develop their assessment skills and provide patients with more information about the health impacts of IPV. However, once we began investigating the current practice in each of our study settings, we concluded that focusing on documentation without first addressing assessment and response to IPV would be impossible given the frequency and quality of response to IPV in the three settings. In order to accomplish our primary goal of developing an intervention to improve documentation we needed to perform two additional tasks. We needed to develop a response to IPV that addressed the needs of the providers in each setting. At the same time, we needed to explore what structural changes and administrative resources were needed to support implementation of such a response. Once these additional tasks were accomplished, the research team developed a training that presented a recommended response to IPV that emphasized documentation, employed a patient empowerment model and relied on an interdisciplinary team approach. The training was administered to pre-hospital providers (Emergency medical technicians and paramedics) and residents and nurses working in the emergency departments of two large urban hospitals. After training was complete, we reviewed the records of providers who had received the training and conducted focus groups with a small subgroup of providers trained at each site.

Expanding our project objectives resulted in our learning a great deal about what is necessary to develop and implement an effective intervention and gain insight as to what change must occur in order to improve providers' documentation of IPV. However, further study is needed to determine the extent to which this type of in-service intervention will improve providers' ability and willingness to document. Lessons learned the current project reveal a number of areas in need of further inquiry.

This report begins with a brief overview of related research and literature. What follows is a short description of the Legal Evidence Project 2002. Next, is the "Methodology Section" which describes curriculum development, training implementation, medical record review, and post-training focus group

data. In the following section, the results of our efforts are described. The conclusion contains important lessons learned about developing and evaluating an IPV intervention in a health care setting as well as recommendations for health care administrators and policy makers, health care providers, staff and ancillary services.

Literature Review

Statement of the Problem

In the past decade, the legal system has dramatically changed laws, procedures, and practices in an effort to provide protection to battered women and their children. The type of impartial, extrinsic evidence on which judges and juries normally rely is often lacking in cases of abuse between intimate partners. Medical records and health provider testimony, based on such records, constitute potentially invaluable sources of evidence.

Increasingly, victims of violence are disclosing partner abuse to medical providers. Because medical records are "kept in the ordinary course of business," relate to diagnosis and treatment, contain factual information such as the physical or emotional condition of the victim, or the behavior or demeanor of the perpetrator, they may be admitted into evidence in court proceedings (Ferris, 1997). Moreover, fact finders often view disclosures made to 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.

Unfortunately, recent studies -- including the Legal Evidence Project 2002 -- reveal that even in cases where victims have been treated for intentional assault or injury, medical records may be inadequate to corroborate the existence of abuse, and may provide far less documentary evidence than they could (Smock, 1997; Covington, 1995; Abbott, 1992; Sugg & Inui, 1992). At the same time, there is ample evidence that health care providers want to assist victims of domestic abuse. Protocols for universal screening for IPV abound, and many include elaborate guidelines for intervention (Enos & McGuigen, 1998; COBTH, 1997; MMS, 1997; Schornstein, 1997; Smock, 1997; PFVAP, 1996; WSNHC, 1996; Warsaw, A.L., Ganley, et al., 1995, CDPH, 1994 AMA², 1992, AWAKE, 1992, CSN, 1992). Unfortunately, these protocols often require the health care provider to perform assessments and take action outside their core area of expertise.

Most problematic, however, is that precise documentation of abuse in a patient's medical record -- a task that is squarely within the provider's core area of expertise -- has been given inadequate attention both

in the majority of protocols and in the training programs that accompany their use. Only a fraction of protocols provide specific attention to documentation providing examples and sample forms (Smock, 1997; Warsaw, A.L., Ganley, et al., 1995, Chez, 1994). Tools such as body maps, prompts, checklists and consent to photograph forms could be useful aids in many settings but there has been no investigation of what kind of effort or resources are needed to incorporate these forms in the medical record keeping system of a particular institution or the logistics related to ensuring consistent and accurate completion of these forms by providers.

Few resources incorporate a legal perspective of how records documenting abuse could be used to benefit or harm victims of IPV in legal, administrative and social service settings (Enos & McGuigen, 1998; Schornstein, 1997). Training materials rarely discuss the potential legal liability associated with treating patients experiencing IPV or medical record management.

In a series of focus groups with health care providers in Boston, Massachusetts, providers identified a need for specific instruction and direction in documentation. Moreover, providers had many concerns regarding confidentiality and liability, were fearful of being asked to testify, and expressed confusion over what type of medical documentation might inadvertently hurt a victim of IPV. A small percentage of providers likened documentation of patient reports of abusive incidents to evidence collection that is already performed by police. These same providers worried that making accusations of partner abuse against a non-patient puts the provider at risk of retaliation by that person. In a recent study exploring providers' attitudes, providers reported concern about patient safety, patient privacy and patients' fear of criminal justice involvement to be significant barriers to identifying and responding to IPV (Rodriguez, 1999).

The original design of the current project sought to develop and test an intervention specifically designed to improve providers' documentation of IPV. The rationale for the design was based on the years of health care attention to IPV indicated in research literature, clinically based resources and the multitude of protocols and training manuals available nationwide. We also assumed that each institution's compliance with the Joint Commission on Accreditation on Healthcare Organizations mandates (JCAHO, 1992) would ensure that providers were familiar with and trained to some degree in an IPV protocol. We confirmed that recommended responses to IPV had been introduced in each institution and that training in IPV had been conducted annually or bi-annually in previous years. Review of research literature and training materials indicated three areas that were well addressed: (1) screening and identification (2)

assessment (medical/social history, patient's description of events, degree of injuries, and patient safety); and (3) referring patients to IPV services. We intended to build on providers' current knowledge to improve health care delivered to victims and increase the likelihood of records accurately depicting the health care interaction in a way that best protected the patient, provider and institution

However, record review and focus groups conducted prior to our developing the training curriculum helped us to understand that our original expectations as to the standard of practice was misplaced and inaccurate. Analysis of provider records performed in each study setting revealed that providers' were not identifying IPV with any consistency. Focus groups with providers confirmed that screening practices and response to IPV were inconsistent. Providers who did respond focused on referring patients to IPV services rather than assessing and treating the health impacts of IPV. Focus groups also revealed that with the exception of a few providers, those who had attended previous IPV trainings did not incorporate the content into their regular practice. Only some providers were aware of IPV protocols. While all were familiar with the philosophy and procedures related to screening tools most still exhibited concern as to the viability of successfully responding to IPV in medical settings given time limitations, the multitude of other responsibilities and provider skills. Further, few providers articulated any incentives within their institutions to acquiring these skills or developing a consistent practice of identifying and responding to IPV. We were also surprised to find that specific methods of documentation were not used systematically within each site. General guidelines exist but each provider documents in his or her own personalized way.

From these findings we concluded that we would be unable to address documentation without first defining a successful interaction with patients in the context of an emergency setting. Identifying these previously unanticipated issues early on in the project convinced us to expand the project goals to include: exploring what, if any, institutional resources or administrative changes were necessary to change the way providers addressed IPV; developing time efficient strategies that emphasized healthcare specific tasks to be performed before referring patients to IPV services; and identifying incentives for providers to address IPV more regularly in their practice. Improving documentation remained the primary goal for our project but we determined there was no way to address it in isolation from these other topics. Given the expanded goals before us, we also knew that we would have narrow the focus of the training. Therefore, we ultimately decided to develop a training that focused on patients who presented with physical, emotional or psychological symptoms relating to IPV.

Background and Significance of the Research

Prevalence of IPV

Despite improvements in legal relief and resources over the past two decades, the number of women and children who are battered every year remains staggeringly high. According to a recent study performed jointly by NIJ and the CDC, approximately 1.9 million women are physically assaulted annually in the U.S. (Tjaden & Thoennes, 1998). This study estimates that between 20 and 30% of women and 7.5% of men in the U.S. have been physically and/or sexually abused by an intimate partner sometime in their adult lives. Heterosexual women are much more likely than heterosexual men to be victims of IPV (DOJ, 1998). While there has been minimal study of IPV in the lesbian, gay, bisexual, and transgender relationships, data available indicates rates similar to those in heterosexual adult and adolescent populations. Millions of children are exposed to IPV each year (Edelson, 1999). A healthcare based study conducted on a large sample of Kaiser Health Plan members in California confirmed that over 10% of members in the sample indicated exposure to IPV as a child and a personal history of child abuse (Felitti, et al., 1998). For over a decade research has indicated that children exposed to IPV are also at risk, physically, and emotionally (Wolak & Finkelhor, 1998; Campbell & Lewandowski, 1997; Stark & Flitcraft, 1988; Jaffe, 1988; Bowker, 1988). Estimates of non-sexual and sexual dating violence among adolescents (age 13-18) range from 25-60% (Cohall, et al 1999; Foshee, et. al, 1996). Studies also show abuse against women and teens during pregnancy and postpartum (Martin, et al 2001; Silverman, et al 2001; Parker & McFarlane, 1993). While there has been less research done in this area, studies indicate that IPV is also prevalent among elderly Americans (NEAIS, 1999; Toshiho, 1999).

Assistance and Protective Relief Related to IPV

The risks to abused parents (usually mothers) and children may be at their greatest when the abused parent takes concrete steps to end abuse (Mahoney, 1991. Dobash & Dobash, 1979). Inability to obtain financial support from the abusive partner, maintain employment, and access safe and affordable housing is a major cause of homelessness for battered women and their children (Zorza, 1991). Recognizing victims' need for assistance, state and federal legislators have responded through the enactment of abuse prevention order legislation and grants to victims of specialized status in the administration of welfare benefits, housing, and immigration & naturalization. (Chung & Orloff, 1998; Meier, 1997).

Meeting survival needs during and immediately following separation is only one of many steps a survivor will take during the long journey toward safety and independence. For example, continued, unrestricted access to the children through shared custody or visitation may present the abusive partner

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

While civil abuse orders and criminal prosecution can increase victim safety, there are many barriers preventing women from accessing and participating in these systems. A victim's willingness and ability to commit to these relief systems is almost always conditioned upon her access to the resources necessary to establish independence and restructure a life without reliance on the perpetrator. A woman who seeks immediate relief through an abuse prevention order or participation in a criminal proceeding must also consider how this will impact her ongoing ability to house, clothe, feed and emotionally care for herself and her children. Thus, a victim's ability to access safe housing, transitional assistance, health care, trauma counseling and immigration representation will often dictate whether she participates in a prosecution or seeks a restraining order.

Unfortunately, even those victims who are successful in obtaining restraining orders or prosecuting their abusers are not assured safety. One retrospective study of adult women in Seattle, Washington found that permanent, but not temporary, protection orders are associated with a significant decrease in risk of police-reported violence of women by their male intimate partners (Holt, et al 2002). However, another study of homicides in Massachusetts indicates that these forms of relief do not always provide the life-saving protection intended (Langford, 1999). Out of 194 individuals murdered in incidents related to intimate partner violence, 52% of perpetrators had a prior criminal history in Massachusetts, 24% had active restraining orders against them at the time of the homicide and at least 40% percent had previous restraining orders against them at some time. At least 81 children witnessed these homicides or the immediate aftermath. These figures underscore the importance of combining abuse prevention and criminal remedies with relief such as safe housing, employment or welfare, supplemented with child support and equitable property division, as well as custody and visitation arrangements that protect every family member and hold abusers accountable.

Documentation of Medical Treatment Can Assist Victims to Obtain Relief

Regardless of the type of relief sought, many IPV survivors will have contact with the legal system at some point. As abusive partners have become more familiar with legal systems, they learn ways to manipulate the systems originally designed to protect victims to initiate false actions in retaliation to their

partners' efforts to seek independence. Currently, medical documentation is an underutilized tool in legal settings (Belknap, 1999). However, medical records could provide a valuable source of information for attorneys representing victims in a variety of contexts (Aycock, et al 2000, Dalton, 1997, Cramer & Forte, 1988).

Accurate and comprehensive medical documentation of intimate partner abuse is a valuable evidentiary tool to corroborate or establish the occurrence of an incident of or pattern of abuse (Cramer, 1998). Medical documentation and testimony relating to medical treatment and diagnosis is admissible in a variety of legal settings. Medical documentation provides unbiased, factual information written at the time of, or shortly after abusive events, often long before any legal proceedings occur. Additionally, information regarding the impact of the abuse, physically and emotionally, is included in the assessments made. In the best of records, photographs capture the moment in ways that no description can depict months later (Belknap, 1999; Cramer, 1998). Medical records can be admitted in legal proceedings to establish the requirements necessary to obtain a range of protective relief and defend against false allegations or retaliatory legal actions by an abusive partner. Clinically accurate and comprehensive records provide a useful tool to attorneys working within settings where the rules of evidence are applied. Records may also be useful to victims without legal representation in less formal contexts to achieve specialized status or exemptions in the areas of public housing, welfare, immigration status, landlord/tenant disputes, health and life insurance, victim's compensation and employment.

Health Care Response to IPV

In Legal Evidence Project 2002, we learned that health care settings may be the first place where victims seek help when experiencing IPV. Our findings indicated that many women who receive treatment for abuse in emergency department settings have not accessed other IPV services for a variety of reasons including fear, distrust of systems, lack of access due to language or citizenship status, and isolation caused by abuse (Isaac & Enos, 2002). Medical systems, ranging from emergency medical services to extended outpatient and inpatient care, regularly provide services to a large number of women and children affected by domestic violence. Over one million women seek medical treatment for abuse-related injury each year (Stets & Straus, 1990). Data from several studies suggests that 22-35% of women presenting to emergency departments, for any health problem, are currently experiencing IPV and presenting with related symptoms. As many as 37% of patients seen in obstetrics departments are physically abused during pregnancy (Council on Scientific Affairs, 1992.) Up to 21% of women presenting to primary care practices have experienced IPV sometime in their lifetime (McCauley, 1995; Abbott, 1992). Of 218

women presenting to a metropolitan emergency department for injuries sustained during abuse by a partner, 13% required major medical treatment and 28% required hospital admission. Physical and emotional abuse are also linked to a number of adverse physical effects including arthritis, chronic neck or back pain, migraine and other frequent headaches, stammering, vision difficulties, sexually transmitted diseases, chronic pelvic pain, stomach ulcers, spastic colon, frequent indigestion, diarrhea or constipation and exhaustion (Coker, et al 2000; Kernic & Wolf, 2000; McCauley, et al 1998; Campbell & Lewandowski, 1997, Drossman, 1995). Patients, identified as victims of abuse, may be assisted by health care providers who may refer them to the internal social service department, or to outside programs such as a battered women's hotline, local law enforcement offices, or a local court.

Fortunately, IPV has been recognized as a significant public health issue for women. Health care professional organizations including the American Medical Association, American College of Obstetricians and Gynecologists, American College of Emergency Physicians, American Academy of Family Physicians, American Psychological Association, American Nurses Association, American Academy of Pediatrics, and the Institute of Medicine of have developed opinion papers, recommendations, policy statements and monographs about health care providers' response to IPV in recognition of this as an important health issue (FVPPF, 2002). Foundations, such as the Family Violence Fund in San Francisco, have played an important role in promoting routine screening and effective intervention through publications, national conferences and other educational programming. Regional medical associations have developed and disseminated protocols along with training materials. Some hospitals and health centers have developed and implemented their own protocols and training requirements. During the last decade significant research, policy making, intervention and outreach has been performed by hundreds of providers, public health policymakers and IPV advocates and counselors across the United States. However, despite these significant efforts made, research has yet to show that providers have incorporated identification and response to IPV into their everyday practice.

Efforts to train medical providers to address IPV have produced modest results in screening/identification and little or no change at all in assessment, treatment and documentation (Rodriguez, 1999; Derk & Reese, 1998; Parsons, 1995; Freidman, 1992). Providers seem to be uncomfortable with the issue of IPV and have little confidence in their abilities to respond to IPV effectively (Isaac & Enos, 2001; Sugg & Inui, 1992). One study of 400 physicians in California found that a majority of the providers reported that they routinely screen injured patients, relay concerns for safety, make referrals to shelter, counseling or police, and record battering in patients chart (Rodriguez, et al

1999). While these are encouraging findings, there was no description of how providers documented IPV, whether or not interventions were documented, and no description of how providers responded to the health care needs of injured patients. In this study, less than half of the providers reported lack of training, time or information as major barriers to physicians responding to IPV. In another study of health care providers' knowledge, attitudes, beliefs and behaviors, there was improvement in knowledge of legal requirements after IPV training (Gadomski, 2001), but the practitioners involved in the training were not followed to see if there was a demonstrable change in objective outcomes such as documentation as a result of the intervention.

While there has been some inquiry into the barriers providers encounter which deter them from identifying and intervening in IPV (Brown, 1993; Sugg & Inui, 1992), a closer examination of the specific concerns of providers, the reality of these concerns and strategies to alleviate concerns is warranted. Several studies show that many survivors are in favor of direct inquiry about IPV by health care providers so long as questions are asked in a compassionate and discreet manner, and referral services are made available to victims. One recent study revealed that 85% of IPV survivors who responded positively to IPV screens accepted the opportunity to speak with an advocate who could link them with community social service agencies (Krasnoff & Moscatti, 2002).

Clinically accurate and comprehensive record keeping maximize the quality of patient care. To date, there are no studies evaluating the extent to which proper medical record management improves patient care, however, it is reasonable to expect that the patient would benefit in a variety of ways. Thorough documentation increases the likelihood that providers will find the root cause of health problems sooner rather than later, thereby eliminating unnecessary diagnostic procedures and expensive testing. Identifying and addressing abuse is also likely to reduce the number of patient visits and prevent severe injuries or serious health conditions from occurring in the future. This will lead to more efficient use of limited resources and allow providers to have more time for each patient. However, an increase in documentation of IPV will occur only if issues related to patient privacy, safety, and providers' comfort in responding to IPV are addressed.

Precise medical documentation in the area of IPV could also lead to improved record management practices overall. These principles could easily be incorporated in every day practice, thereby lessening the risk of liability to providers and institutions. Additionally, thorough documentation of patients' problems

will increase the likelihood of continuity of care and safeguard against potential failure to diagnose or misdiagnosis.

Prior Work

Building a Practitioner-Researcher Partnership to Research Documentation of Domestic Violence in Health Care Settings

Northeastern University has had a medical/legal research collaborative exploring issues related to domestic abuse prevention since 1992. Recognizing the importance of IPV related medical documentation and testimony in legal settings, we established a researcher-practitioner partnership to explore the potential utility of medical records in legal proceedings involving battered women.

As an interdisciplinary researcher/practitioner project, there is both a medical and a legal background component of the research. From a medical perspective, the vast majority of health centers and hospitals in many states have developed and/or implemented comprehensive IPV protocols and trained their respective staffs accordingly. The goal of these protocols is ambitious--to identify all patients experiencing IPV and assist them in accessing abuse prevention services that help achieve safety.

While universal screening and intervention is theoretically ideal, protocols and training interventions often fail in practical application because hospitals and providers lack the resources to assist victims, and service organizations are often overwhelmed (McLeer & Anwar, 1989). Health care providers are often frustrated, and many abandon the protocol altogether. When the protocol is abandoned, battered women and their children are denied the unique skills of the health care provider-- diagnosis, medical treatment of the abuse and thorough documentation. Recent studies show that training that improves providers' attitudes, screening practices and referral rates, have little impact on documentation practices (Houry, 1999; Harwell, 1998; Kripke, 1998).

Executive Summary of the Prior Research

The Legal Evidence Project 2002 sought to describe, from a legal perspective, how domestic violence is being documented in abused women's medical charts. In total, 96 medical charts of 86 abused women covering 772 visits were reviewed. For 184 of these visits (24%), detailed information was

abstracted from the medical record documentation because there was an indication of domestic violence, an injury of some type, or both.

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

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

- The legal and medical communities hold many misperceptions of one another's roles in responding to domestic violence. Many barriers to collaboration are based on these misperceptions and false assumptions.
- The work of the interdisciplinary partnership demonstrates that a common meaningful goal, mutual respect for one another's professional expertise, and willingness to view a problem from a new perspective, can provide the context for productive medical/legal collaborations on the issue of domestic violence.
- Some legal advocates do not utilize medical records regularly in civil contexts or to their full potential in criminal contexts. Reasons for not using medical records include: difficulty and expense in obtaining records; illegibility, incompleteness or inaccuracy; the possibility that the information in them, due to these flaws, may be more harmful than helpful.
- Many if not most health care providers are confused about whether, how and why to record information about domestic violence in medical charts.
- In an effort to be "neutral" regarding abuse situations, some health care providers are using language that is likely to harm an abused woman's legal case and aid her abuser (in a legal context).
- Though physicians' poor handwriting is often the subject of jokes, it can in fact prevent use of the medical chart in court. In this study, among medical visits that contained some indication of abuse or an injury, one-third of the notes from doctors or nurses contained vital information that was illegible.
- With minor modifications to documentation practices, many more abused women's medical charts would contain the elements necessary to allow their statements about abuse to be introduced in court as "excited utterances." Such evidence can allow a prosecution to proceed even when the woman is unwilling to testify against her abuser in court due to fear or for other reasons. The element needed for excited utterance exceptions that was most frequently missing from medical records was a description of the patient's demeanor.
- Many providers record significant details regarding injuries and health conditions in abused women's charts. If these practices were consistent, and symbols and abbreviations were standardized, this type of documentation could act as effective corroborative evidence in court.

- Emergency medical services (EMS) personnel may be an underutilized source of legal documentation of domestic violence. It appears that EMS providers may already be recording patient statements; with additional training, the legal utility of this data could be greatly increased. This is especially true given the proximity of these providers (in time and space) to the actual violent events.
- Though many, if not most, protocols on healthcare response to domestic violence call for documenting injuries on body maps, this study found such maps or any types of drawing of injuries present in only a handful of medical visits.
- Photographs, the "sine qua non" of evidence regarding abuse-related injuries, were almost never present in the charts reviewed in this study. Only one of the 93 visits involving an injury contained a photograph. The medical records also omitted mention of photographs stored in other locations, e.g., with local police.
- Although the partnership discussions and prior focus group research had identified inappropriate, derogatory statements about abused patients as one current problem with medical documentation, such comments were found in physician or nurses' notes in only five instances, and in social work or psychiatry notes in four cases.

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

- Clinicians should, when at all feasible, take photographs of injuries that are known or suspected to have resulted from interpersonal violence. Optimally, there should be at least one photo each of the full body, the injury itself, and the patient's face.
- Clinicians should take care to write legible notes. Clinician training should emphasize that illegible notes may negatively impact health care and are likely to hinder a woman's ability to obtain legal remedies to address her abuse. The increased use of computerized systems is helpful in addressing this common problem.
- Clinicians should use quotation marks or the phrases "patient states..." or "patient reports..." to indicate that the information being recorded is coming directly from the patient.
- Clinicians should stay away from words that imply doubt about the patient's reliability ("patient claims...", "patient alleges..."). Alleges is a legal term. It implies the statement following it is unproven and may not to have occurred. Providers should instead use quotes around statements made by the patient. If the clinician's direct observations are in conflict with the patient's description of events, the clinician's reasons for doubt should be stated explicitly.

- Clinicians should not use legal terms such as "alleged perpetrator," "assailant," "assault", etc. All legal terms are defined with great detail by federal or state statute and case law. Typically, such terms are used by lay persons to mean something more ambiguous or larger in scope. By using legal terms, providers may convey an unintended meaning. For example, assault is defined as an attempt to cause an unwanted touching, whether or not the touching actually occurred. Naming the person who has injured the patient as her "assailant" or "perpetrator" after the patient has identified the person who has hurt her as a husband, boyfriend, father of her child or by name, is likely to be interpreted in a legal setting as the provider's doubting the patient's credibility. These terms are used regularly by attorneys seeking to raise doubt as to who committed an act.
- Optimally, providers should describe and name the person who hurt the patient in quotes exactly as the patient has identified him. This prevents the abuser from obscuring his responsibility by accusing the victim of having multiple partners.
- Practitioners should avoid summarizing a patient's report of abuse in conclusory terms such as "patient is a battered woman", "assault and battery," or "rape" because conclusions without sufficient accompanying factual information are inadmissible in court. Instead, providers should document the factual information reported by the patient that leads them to conclude abuse occurred.
- Placing the term "domestic violence" or abbreviations such as "DV" in the diagnosis fields of medical records is of no benefit to the patient in legal contexts. This practice should be reconsidered unless there are other clear benefits with respect to medical treatment.
- Clinicians should include words that describe a patient's demeanor, such as: crying, shaking, upset, calm, angry, agitated, happy. Clinicians should describe what they observe, even if they find the demeanor to be confusing given statements of abuse.
- Clinicians should record the time of day in their record, and (ideally) some indication of how much time has passed since the incident (e.g., "patient states that *early this morning* her boyfriend, Robert Jones, hit her...")

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

- The importance of photographing traumatic injuries needs to be re-emphasized in training programs on medical response to domestic violence. Research should determine the most common barriers to taking photographs. Interventions that aim at increasing the frequency of taking photographs should be developed and evaluated.
- Medical units that handle abuse cases routinely (e.g., emergency medicine, social work) should have cameras stored in a secure but easy to access location. Resources should be allocated to buy cameras and film, and to train providers in their use. Each institution's policy on response to domestic violence should include details on where the camera can be found, how to photograph injuries, where to store photographs, and how to document the existence and location of these photographs in the medical record.

- Non-clinical health professionals (medical records managers, administrators, risk managers) should work with domestic violence legal and clinical experts to examine changes that might facilitate the accessibility of medical records for legal use without compromising patient confidentiality.
- Training regarding current health care response to domestic violence should be provided to judges who hear domestic violence cases regularly.
- Domestic violence training programs and materials for health care providers should clarify that a failure to *document* domestic violence completely when treating an abused patient does not constitute taking a "neutral" stance about the incident. It will almost always convey a legal advantage to the abuser. In medical terms, it constitutes poor preventive medicine.

The summary final report from the Legal Evidence Project 2002 is contained in Appendix F. Nancy Isaac, Pualani Enos and Judy Linden have presented the study to professionals from medical, legal and social science disciplines. At each presentation, conference attendees from various disciplines showed great interest and concern related to documentation of IPV and the privacy, confidentiality and professional responsibility issues that documentation raises. Papers related to various aspects of the project are currently under development, including a paper that describes the creation and progress of the partnership and the vital role practitioners played in the study with suggestions for use of this model in future research. The full final report from this project and the NIJ published research in brief is available on the NIJ website.

This prior work provided us with the foundation on which to build the current project. The findings from the Legal Evidence Project 2002 will be further described and compared to data collected in the current project.

Building on the Findings of the Previous Research

In the current project, we sought to develop, implement and evaluate a training intervention designed to help health care providers utilize the skills of careful diagnosis and documentation. Our aim is to encourage all providers to improve those services to battered women that fall clearly within a health care provider's area of professional competence and responsibility.

Medical Information as Legal Evidence

Medical documentation of domestic violence has the potential to be an advocate's most helpful tool in representing a victim. At the most basic level, it corroborates that an incident resulting in some type of health condition or injury occurred as indicated by the victim or other incident reports.

Additionally, the clinician creating the documentation has a scientific background and is trained to make unbiased observations and conduct interviews solely for the purpose of responding to health care related issues. A provider's reliance on a patient's information to determine treatment demonstrates that the provider found the information to be credible. Likewise, when a health care provider takes actions such as helping a patient to seek shelter, police assistance or emergency court response, this demonstrates an objective third party's concern.

When a victim presents to a health care provider with injuries, accurate and specific details of injuries can be used to prove that a batterer acted abusively. Even more importantly, these details can be used without the testimony of the victim or other witnesses to the event. There are two ways medical records, including photos, may become part of a court case. If a victim is too intimidated or frightened to participate in a criminal prosecution, prosecutors can obtain the relevant medical records through court order.

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

The extent to which medical documentation can serve as a tool for victims in legal settings remains unknown because it has been used so rarely in legal settings (Belknap, 1999). When it is used, it is usually by prosecutors in felony cases or by attorneys in tort litigation -- in cases involving permanent physical injury or death (Dalton, 1997). These are typically the cases in which an attorney has the time and the resources to obtain, review, prepare and submit the victim's medical records for use at trial. Improving the content and format of medical records would assist these attorneys in presenting this crucial factual evidence to the court.

However, records could provide a valuable source of information for attorneys representing victims in a variety of other contexts, including: contested custody and visitation cases, child protective services proceedings where the abused parent is charged with neglect, and criminal cases where a former victim,

now defendant, seeks to rely on the defense of "self-defense" or establish that the instant allegations are merely the abuser's retaliatory accusations.

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

Photographs are incredibly persuasive because they help to make the results of a partner's abusive behavior real to the judge/jury (Belknap, 1999; Cramer & Forte, 1998). Legal proceedings that determine the type of relief necessary for protection often take place months or even years after the abusive incident. During this time, the victim may have sought support and safety, and may currently appear to be both physically and emotionally healthy. Judges/Jurors may observe the results of a victim's effective coping skills and conclude that the abuser did little harm. Photographs of damage done on a particular day are a real reminder of what an abuser is capable of, the most important consideration for a fact finder. Photography has been emphasized in most health care protocols on domestic violence (Enos & McGuigen, 1998; COBTH, 1997; MMS, 1997; Schornstein, 1997; Smock, 1997; PDFVP, 1996; WSNHC, 1996; Warsaw, 1995; CDPH, 1994; AMA, 1992).

In most states there are few admissibility requirements for photographs. If a witness can verify that the photograph accurately reflects the way the images contained therein looked at a relevant time, then it is admissible. While it is helpful to have an indication of the date, time, and place the photograph was taken, it is not essential. Additionally, there are no chain-of-custody requirements (i.e., there is no need for written documentation of who has had the pictures).

Even before undertaking the research component of this project, the legal practitioners strongly believed that photographs are not used as often as they could be. Practitioners who work regularly in health care settings shared common experiences of lack of access to cameras, inadequate film refills and little training among providers. While the Polaroid Corporation provides training for institutions that buy a number of their cameras, many budgets do not include resources for the purchase of cameras or film.

In a number of states, medical documentation may act as a substitute for live testimony by the provider, thereby relieving providers from the time and stress of testifying in court. Even when providers are required to testify, the provider can refer to records to refresh his or her memory. Unlike oral

testimony based only on memory of the event, legible and accurate documentation written at the time of the event is safe-guarded against manipulation and distortion on cross-examination. Likewise, photographs and body maps provide the information in black and white or in color. Even where documentation may be limited in its scope, it can provide the missing piece of corroborative evidence that brings the other evidence together in a way that makes sense. The use of evidence other than the victim's testimony also prevents the victim from bearing the sole burden of making a case against her abuser.

Clear documentation of abuse in medical records not only assists the victim and her legal advocate, but may also ease the burden on medical providers. Thorough and compelling medical documentation of abuse often encourages an abuser to settle a civil case or plead guilty to a criminal action without the need for extensive pre-trial and trial appearances by physicians and other providers. Even when the health care provider must appear, good records provide accurate and complete information regarding specifics that no individual provider could reasonably remember. Careful documentation of IPV also prevents malpractice actions against health care providers and institutions for failure to diagnose or properly treat partner abuse.

Evidentiary Considerations

After identifying the documentation needed to corroborate abusive incidents, the legal practitioners considered in-court *presentation* of the information contained therein. Before facts may be considered by a judge or jury, they must be offered and accepted into evidence by the presiding judge. Oral or written statements must comport with the applicable "rules of evidence" before a judge will allow the statements to be "admitted" into evidence.

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

At the first working group meeting, legal practitioners noted the complexity and difficulty of identifying all the evidentiary pitfalls surrounding the use of information from medical records in legal contexts. Additionally, they felt strongly that the analysis of evidentiary issues should be limited to Massachusetts law for the following reasons: they practice in Massachusetts; the records would most likely be used in Massachusetts courts; and analysis of an additional state's law would increase the information sought exponentially. Legal practitioners summarized a number of the evidentiary rules for the non-legal

practitioners so that a joint decision about the scope of analysis could be made. After lengthy discussions regarding the number of factors to be considered, and recognition that there would be variability in each judge's interpretation, the group unanimously decided to focus its attention on only a portion of Massachusetts' evidentiary rules. The practitioners prioritized a handful of rules, weighing the predicted persuasiveness of information, the relative difficulty of meeting the rules' requirements and the frequency with which providers identify and record such information.

Using these criteria, we limited our analysis to three evidentiary topics:

Hearsay Exceptions Related to Admissibility of Information in Medical Records

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

Photographs and Body Maps

- ◆ Photographs
- ◆ Body Maps
- ◆ Drawings

Issues Relating to Privilege and Confidentiality

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

The Hearsay Rule and Related Exceptions

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

Information Related to Diagnosis and Treatment & The Medical Record Exception

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

Another exception is the "Medical Record Exception". A handful of states, including Massachusetts, Maryland, Michigan, Maine and Utah, allow written records to "speak" in the place of providers in order to save providers the time, inconvenience and stress of testifying in court. The "medical records" exception provides that any portions of a certified medical record that are "related to diagnosis and treatment" may be included in the evidentiary record without requiring that a physician testify to the contents. Thus, a provider who writes comprehensive, specific, legible notes may be spared the burden of testifying in court.

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

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

Sims is the first case to acknowledge domestic violence intervention and similar information as relevant to "diagnosis and treatment". Massachusetts' courts have yet to interpret the scope of the medical record exception as broadly; however they consistently look to medical practice to guide their understanding of what is related to "diagnosis and treatment." Even if statements are determined to fall outside the medical record exception, they may satisfy the requirements of other exceptions, such as the excited utterance exception, the prior inconsistent statement exception or the prior consistent statement

exception. Also, even if not admissible as evidence, the statement may be used simply to refresh a witness's memory.

Excited Utterances

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

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

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

Photographs and Body Maps

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

Body maps are described in most domestic violence intervention protocols. Generally, body maps are outlines of the front and back view of a human body, providing clinicians an opportunity to diagram a patient's injuries rather than describing them in a narrative. Body maps vary in size and some include a legend of symbols to use when drawing. Body maps are intended to save providers time by allowing them to draw what they see. Even if a body diagram is not contained within the paper work provided to physicians, providers may draw their own picture of the injury with notations regarding color, size, texture etc. Detailed drawings, whether in the form of a body map or hand written, effectively portray specific characteristics about a patient's injury that can later be used to corroborate abuse.

Privilege and Confidentiality

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

Health care institutions are legally responsible for protecting patients' privileged relationship with providers. As part of this responsibility, institutions may only release information in the medical record when a patient consents through written release or upon court order. Frequently, only parts of the record are authorized for release. Under these circumstances, the institution is responsible for redacting those

portions of the records that have not been authorized for release. The resources required to perform such redaction are dependent on the quantity and location of such information.

Attorneys may request medical records without providing the patient's consent for release or court order, either by telephone communications with the treating provider or by sending a letter or subpoena to the medical records department within the institution. Occasionally, information confirming that a patient has been treated within a particular institution or related information is released by that institution before privilege requirements are met. Similarly, information with special protection, such as counseling records, may be released when consent or court order has only authorized that information related to health care treatment be released. Institutions that fail to protect patient privilege may be liable to the patient for any harm resulting in unauthorized release.

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

Developing, Implementing and Evaluating a Documentation Training

Overview

Our approach to developing the documentation training involved three areas of inquiry: 1) What has been done in other settings and how well have those efforts worked?; 2) What are the opinions, concerns and experiences of providers and survivors?; and 3) What is the state of current documentation practices? We approached these inquiries through three different methods.

To investigate our first inquiry we performed a comprehensive review of the medical and social science literature. This included extensive research into the confidentiality, privilege and professional mandates for various providers and potential liability of noncompliance with such requirements. Next, we solicited unpublished protocols, training manuals, guidelines and recommendations from health care institutions, agencies and organizations around the United States. To complete our second area of inquiry, we conducted focus groups with providers, social workers, psychiatrists, and advocates from study sites. During the same time period, focus groups with victims of IPV who had received health care from area hospitals were conducted. We also conducted focus groups with personnel from the risk management, medical records, and legal departments at these sites. Additionally, we conducted a number of interviews with legal counsel and risk management workers from other institutions to better understand hospital administration's view of its institution's response to IPV and whether provider's concerns are acknowledged, relieved or heightened by messages they receive from the administration. Conducting the last area of inquiry involved reviewing the records of providers at each of the three settings to ascertain their documentation of IPV within the last year.

Based on the results from the literature review, focus groups, and record reviews, we set out to develop a curriculum that acknowledged providers' strengths, addressed their concerns, and improved their confidence and ability to document identification of and their response to IPV. We created a limited intervention that would enable providers to respond to IPV effectively within the time frame and using skills with which they are most comfortable. This limited intervention is unique in that it is dependent upon a team approach, employs a patient empowering approach and is not dependent upon the patient disclosing abuse. Once a core curriculum was developed, it was tailored to address the particular training needs of the three different health care providers: pre-hospital personnel (primarily EMTs and paramedics), emergency nurses and emergency medicine residents. The trainings addressed not only the type of setting

and role of the providers but also how that provider interacted with other providers. The trainings also incorporated particular logistical differences between the three sites.

Our goal was to reach 70% of the staff at each of the three sites. Over a period of 16 months, project faculty presented the training to 78% of workers at the Pre-hospital site, 60% of all nursing staff at Site #1, 42% of all nursing staff at Site #2, 59% of all residents at Site #1 and 57% of the residents at Site #2.

To evaluate the effectiveness of training at each site, we performed a post-training record review following the procedures used to conduct the pre-training record review and compared the two sets of data. Additionally, post-intervention focus groups were conducted with a small number of the providers trained at each site.

Curriculum Development

Focus Groups with Survivors, Medical Providers and Hospital Administration

From the beginning of the grant 2001 until July 2003, we conducted a number of focus groups with providers, patients, IPV advocates, social workers, and hospital administration. We conducted seven focus groups with survivors of abuse who had accessed medical care sometime during their abusive relationship. Groups were conducted at battered women's shelters, women's centers, or health care sites. Survivors remained anonymous through the study and all identifying information has been modified to protect their identities. We also conducted two focus groups with each of the provider groups at the three sites to learn more about providers' experiences, skills, and concerns about responding to patients experiencing IPV. We also conducted four focus groups with legal, risk management and medical record departments at each of the sites. To supplement this data, we conducted 20 individual interviews with providers, advocates, social workers, and hospital administration from area hospitals and health centers. Data collected in these groups are summarized below.

What is striking about this focus group and interview data (presented in the three charts below) is the significant lack of a shared perspective, or, sometimes, even awareness of another perspective, with one exception. The survivors appear to have a keen awareness of the constraints and limitations on providers, and basically want thoughtful, respectful, confidential medical treatment, acknowledgment of their situation, and referral information. They don't expect or want the medical professionals to be their counselor or to "do it all." To be fair, many providers would like to help IPV survivors, are empathic to their plight, and do the best they can, but they feel hampered by time constraints and lack of expertise and

knowledge about resources. In addition, providers have been trained to be problem solvers, and the complexity of IPV is not amenable to action-oriented problem solving in one, or even many visits. This clearly makes many providers feel overwhelmed—as if they weren’t doing, or can’t do their job. If they understood the abused woman’s perspective presented above, and had an awareness of the complexity of the process of change, they might feel more comfortable simply doing their job—asking about IPV, documenting it in the chart, validating the abused woman’s reality, and having available referral sources.

Comparing Perspectives (Pre-Training) on

Helpful Medical Interventions for Patients Experiencing IPV

Survivors	Providers
<p>Treating the patient with care and respect</p> <ul style="list-style-type: none"> • “The nurse treated me like she really felt badly about what happened to me. I don’t know that it was anything she said in particular but how she talked to me and how she listened.” • “I really appreciated how my doctor believed what happened to me and didn’t ask me what I did to make my husband disrespect me.” • “I was shocked when the doctor actually believed me about the abuse.” • “The only reason I ever got help and moved to a shelter is because of the nurse I saw after being raped and beaten. She made me believe that I didn’t deserve this, no one does. After I left that appointment I kept thinking about things she said about how things could be different.” • “Talking to the doctor made me realize what happened to me wasn’t right and there was no excuse for it. He made me realize I had rights.” • “The nurse told me what was going to happen, how bad the injuries were, what pain to expect and how long they would take to heal. Even though I was addicted to drugs at the time, she treated me like a normal person.” 	<p>Little mention of building trust with patients.</p> <ul style="list-style-type: none"> • focus on problem solving • concerned with significant action steps • persuading the patient to <ul style="list-style-type: none"> ○ leave the abusive partner, ○ going into shelter or ○ calling the police <p>Exceptions</p> <ul style="list-style-type: none"> • “When patients come in with injuries that seem to come from IPV, I want to ask them about abuse immediately, but first I address their medical needs and try to develop some kind of relationship with the patient as I treat her medically. Then, at the end of the interview I’ll ask how things are at home, is there stress at home and if she is ever hurt at home.” • “The best time to ask patients if they are afraid of their partner or someone at home is at night when the department is slow and you have more time to talk with them.”
<p>Sharing resource information</p> <ul style="list-style-type: none"> • “There are some times when you can’t tell anyone what is going on. You are too frightened or traumatized by what happened and you don’t know who to trust. I don’t see why they have to press you to tell them. They obviously know what happened. Why can’t they just give you numbers to call or treat your injuries and let it go. Instead it’s like they want to punish you for not telling them.” 	<p>Most providers know little about resources for IPV</p> <ul style="list-style-type: none"> • “I don’t know where to tell victims to go and even if I did I wouldn’t have the time to do so. I usually refer them to a psychiatric nurse who can help them call the police or whatever they need.” • “Sometimes we can get the police to come in and interview the patient, but usually she had to go to the station.” • “It probably wouldn’t take too much time to give patients numbers of resources if we had something to hand out.”

Comparing Perspectives (Pre-Training) on

Helpful Medical Interventions for Patients Experiencing IPV (cont'd)

Survivors	Providers
<p>Maintaining patient’s privacy and confidentiality</p> <ul style="list-style-type: none"> • “It is so unsafe for victims to go any where for help. It’s really important that health settings know how to protect your privacy and medical information.” • “Information relating to abuse should be given extra protection so victims know it’s safe to go to hospitals for help.” 	<p>Mentioned No Concerns About Maintaining Patient Privacy And Confidentiality.</p>
<p>Recognizing the risk to patients who seek help</p> <ul style="list-style-type: none"> • “The biggest danger to you is telling someone what’s going on.” • “You have to know you can trust someone before you can ask them for help.” • “Due to isolation, EVERY person you reach out to is a big deal.” 	<p>Some recognize the risk of victims’ help-seeking while others do not.</p> <ul style="list-style-type: none"> • “I don’t know that these victims realize how unsafe they are. It’s really sad.” • “At least when they are in the ED, I feel like we can keep them safe.”
<p>The medical record may be the only record of the pattern of abuse</p> <ul style="list-style-type: none"> • “When I finally had the resources to divorce my husband, he told the family court that I was a drug addict so that he could get full custody of our child and prevent me from having any visitation. Thankfully my doctor had documented my husband’s abuse against me for several years prior, so the records could show that my weight loss and other facts that my husband claimed were symptoms of drug addiction were actually responses to abuse. He also documented how my husband was never present for prenatal visits, the birth of our son or any follow-up pediatric visits for my son.” • “I would have lost my children to child protective services if my doctor had not documented injuries related to abuse by my husband.” • “I don’t know how I would use the records, because I never had to. But I guess it’s good to have some record of what happened, just in case something happens to you.” • “Comprehensive documentation is very helpful in that it saves you from having to tell the same story to different people over and over again.” • “Providers can be on the same page if they all update the file.” • “Records that are incomplete or negative toward the victim can be more harm than help because batterer’s attorneys can use the records to retaliate or discredit the victim.” • “I don’t care if my abuser’s name is in the record. I want everyone to know what he did to me. Maybe it will put him in jail.” • “Records should include physical injuries but also symptoms related to verbal and emotional abuse.” 	<p>The less documentation the better</p> <ul style="list-style-type: none"> • especially with social problems like IPV <ul style="list-style-type: none"> ○ “I’ve just been told to be very vague about what we ask and how the patient answers. Many times I won’t include anything about IPV for the patient’s protection.” ○ “I’m afraid if I document in too detailed a way, I will hurt the patient because someone can use that information against her later.” ○ “We share the most important information -- most personal information about IPV-- we share through oral communications rather than writing it down.” • patients should be able to choose whether IPV is written in their medical records. • only a few write down statements in quotes and include facts about physical and emotional abuse. <ul style="list-style-type: none"> ○ “Sometimes there is so much to document it is hard to get it all down. But when I have time I try to get down as much about what happened as possible.” • Most did not mention taking photographs as a part of documentation. <ul style="list-style-type: none"> ○ “We don’t take photos. I think the social workers or police do it.”

In addition to the points discussed above, the second of the charts comparing perspectives on harmful medical interventions highlights two important issues: pressuring patients to talk about or do something about the abuse, and concerns about privacy. With regard to privacy concerns, it was not even mentioned by the providers, while it is clearly a big concern to abused women.

As mentioned earlier, a successful outcome in medicine is often defined by getting the patient to do something that the provider thinks s/he should do. Battered women spend a great deal of time being told what to do by their abuser. It is not helpful for medical providers to continue treating them as if they do not know what is in their best interest. Davies, et al. (1998) in *Safety Planning with Battered Women*, have put forward a cogent argument on woman-defined advocacy and safety planning, that focuses on helping the abused woman do what she wants to do. This position is made explicit by one of the survivors, "Doctors and nurses shouldn't tell victims that they need to get safe, they already know that. What victims need is someone to help them to figure out HOW to get safe." Keeping the survivor from leaving, in a misguided attempt to keep her safe, is another example of seeing things only from the providers' perspective and not understanding the importance of the abused woman defining her own needs.

**Comparing Perspectives (Pre-Training) on
Harmful Medical Interventions for Patients Experiencing IPV**

Survivors	Providers
<p>Providers trying to do more than they have time for</p> <ul style="list-style-type: none"> • “Some doctors try to do everything, be your counselor, safety plan and all of that but I know they don’t have time for that. The best thing my doctor ever did was treat my medical problems and call in an advocate who could work with me not only at the hospital but help me to get into housing, move me and my kids and explain to me how to get what I needed from the courts.” • “The doctors were so concerned about how I felt and what I was going to do about calling the police, he never fully examined me, wrote down my injuries, or took pictures. He ended up misdiagnosing me with muscle ache instead of the real problem which was nerve damage.” 	<p>Most try to do as much as they can with the time they have.</p> <ul style="list-style-type: none"> • “I really don’t know what to do, but when I have time I try to do what I can.” • “If I can I ask about whether a patient feels safe at home and then talk to her about who she can talk to for help.” <p>A few think they have no time to deal with IPV and that it is not a part of their role/expertise.</p> <ul style="list-style-type: none"> • “So many of my previous experiences with patients who are abused were so frustrating. They were time consuming and seemingly ineffective. If you are limited time wise, I’d just as soon spend my time doing something I know will be useful.”
<p>Provider discomfort with IPV</p> <ul style="list-style-type: none"> • “It is obvious when a nurse or doctor is uncomfortable with abuse – they ask you but its clear they don’t want an honest answer because then they have to deal with it.” • “Medical people shouldn’t ask the screening questions if they don’t want an answer. The worst thing is when they ask you, you say ‘yes’ you are in danger from abuse by a partner, and then they do nothing. Why bother asking if they aren’t going to do something about it.” 	<p>Fear of being intrusive and feeling incompetent</p> <ul style="list-style-type: none"> • “Most patients are uncomfortable telling us about IPV, why should they tell us, they don’t even know us.” • “Feelings of incompetence relating to “making people safe”; counseling skills, knowledge of resources and protection systems”
<p>Pressuring patients to talk about abuse</p> <ul style="list-style-type: none"> • “There are some times when you can’t tell anyone what is going on. You are too frightened or traumatized by what happened and you don’t know who to trust. I don’t see why they have to press you to tell them. They obviously know what happened. Why can’t they just give you numbers to call or treat your injuries and let it go. Instead it’s like they want to punish you for not telling them.” • “It’s obvious by what is going on in the emergency department that the doctors and nurses don’t have time to listen to all your problems and help you like a counselor would. So what is the point in telling them the whole drawn out story.” • “Of course I wanted to tell someone what was happening. When he asked if my boyfriend hurt me, I wanted to scream, “YES! How else do you thing this happened.” But I was too afraid of what might happen if my boyfriend found out I told someone. I tried to give a glance or look but they never figured it out.” • “Instead of asking so many questions they should tell ... you of choices.” 	<p>Many described frustration dealing with IPV</p> <ul style="list-style-type: none"> • they feel patients lie about the abuse or • they do not want to do what is necessary to end abuse in their lives. <p>“There are times when you know abuse is happening but the patient just denies it. What can we do if the patient doesn’t tell us about the abuse.”</p>

Comparing Perspectives (Pre-Training) on Harmful Medical Interventions for Patients Experiencing IPV (cont’d)

Survivors	Providers
<p>Inadvertently creating unsafe situation for patients</p> <ul style="list-style-type: none"> • “Medical Staff has to understand that trying to get you to talk to them when your abusive boyfriend is waiting outside in the waiting room is not safe. It’s just not a safe time to talk. What would be best is if they arranged a time for you call or come back to talk.” • “When the staff won’t let you leave or threatens to call child protective services on you if you don’t leave your partner, they are not helping you to get safe. Many victims go to the ED in secret, without their partner knowing. When someone from the ED calls looking for the patient, the victim has to make up lies as to why they are calling. This can prevent her from ever going back to that institution.” 	<p>Most stated that they worried if they don’t separate the patient from her abusive partner and prevent her from going home, she will be at risk.</p> <ul style="list-style-type: none"> • “I tell patients that I’m most worried about, ‘I’m not going to let you go home if you are going back to him. You need to find a way to ensure me that you’ll be safe when you leave here.’ It’s my job to make sure the patient is safe when she or he leaves the department.”
<p>Pressuring patients to: call the police, go to shelter, get a restraining order, and/or leave the abusive partner</p> <ul style="list-style-type: none"> • “Doctors and nurses shouldn’t tell victims that they need to get safe, they already know that. What victims need is someone to help them to figure out HOW to get safe.” • “They don’t have as many resources for gay, lesbian, bisexual and transgender folks like they do for heterosexuals. You never know how the police or people at the court will treat you. It might be more dangerous to you than what is happening with your partner.” • “The medical staff was so helpful but then they wanted me to call the police. I told them I was too scared. They didn’t want to help me after that.” 	<p>“Success stories” are when patients leave their partner, call the police, or go to a shelter. Providers enjoyed spending their time on these cases but they were the exception to what usually happens.</p> <ul style="list-style-type: none"> • “IPV is so frustrating because it just keeps happening and gets worse over time, and the patients just keep going back. How are we supposed to help if they don’t want help?”
<p>Failing to protect patient privacy</p> <ul style="list-style-type: none"> • “Sitting out in the waiting room or hallway while you are waiting for treatment is so humiliating. They should have a special room for victims that is private.” • “The way they write your name, medical condition and ‘DV’ on board in the ED for everyone to see is a violation of privacy. There is no reason why everyone needs to have all that information.” • “The medical files are kept in places that anyone could grab them and read through them.” • “An abusive partner can easily get information from your medical record by saying he is the husband and concerned about the patient or by having a woman call and pretend she is the patient.” • “I don’t mind telling my doctor about the abuse but I don’t want to him to tell everyone he works with or write about me in some article.” 	<p>Providers did not raise this as a concern.</p>

This last chart compares the perspectives of the different stakeholders who have an interest in what goes on in the emergency department with regard to IPV, and goes beyond just the survivors and providers. Legal counsel, risk management, and medical records present their views with regard to hospital administration and liability issues. Again, there is a significant lack of awareness of each other's perspectives, except for the survivors who are very aware of the providers' need for more resources. It may simply be that they are in a position to observe the need for resources, as it so directly affects their own needs. There is one other example of awareness—this time on the part of legal counsel/risk management. They seem to be aware of providers' tendencies to want to solve the IPV problem, as one says, "Providers are not required to solve the problem of IPV but are required to recognize symptoms of IPV, and impacts on health, and address those impacts." However, legal counsel/risk management made no mention of resources for the providers to deal with IPV, no mention of the liability issues related to documentation, and while they had a number of cogent comments on how to document, it was clear from the provider statements that these had not been passed on to the people who needed them. Legal counsel/risk management had another astute observation about liability--"The best way to avoid litigation is to have a positive relationship with patients which includes honesty, trust and open communication." It is not clear if this advice was delivered to the providers.

The medical records comments appear to exist in a vacuum with little demonstrated awareness of the complexity for the institution as a whole of the problem that is being documented in the record. It is ironic that the survivor/patient who is having trouble getting her IPV needs met in the emergency department is the one stakeholder who doesn't mention liability issues.

Enos, et al, “An Intervention to Improve Documentation of Intimate Partner Violence in Medical Records”

**Comparing Perspectives (Pre-Training) on
Providers’ Concerns Relating to Hospital Administration and Liability**

Providers	Legal Counsel & Risk Management	Medical Records	Survivors
<p>Lack of resources is a big problem for us</p> <ul style="list-style-type: none"> • “Often, we have to rely on family members or staff to interpret because there are no interpreters available for that particular language. This can create real problems if the abuser is the interpreter.” • “The DV services here are very limited. The advocates are only available part of the day.” • “What the patients need from us requires more than the 5 minutes we have to give. It’s very difficult to spend lots of time with one patient when the other patients also need your attention.” • “We (residents) don’t have time to get involved in IPV. Nurses do it.” 	<p>No mention of resources to deal with IPV</p>	<p>Providers are required to document comprehensively in medical records.</p>	<p>Providers need more resources</p> <ul style="list-style-type: none"> • “There is no way doctors or nurses can help us with what we’re going through and deal with all the medical problems of all the patients. What they need is an advocate or social worker to refer to.” • “Many times it seems like they are understaffed and dealing with many patients at the same time.” • “When some doctors ask about abuse, they are so rushed you can tell they are praying you say no.” • “My experience was great, the doctors and nurses all knew what was going on, I just had to tell one person what happened, rather than telling one after another the same story.”
<p>IPV problems cannot be solved in the ED</p> <ul style="list-style-type: none"> • “Its very hard to ask about a problem when half the time you don’t have any solutions for the patient.” • “We are in the business of saving lives, not changing lives.” • “I find ways to do what I can, with the time I have. I might not change someone’s life but at least I’m doing something.” 	<p>Required to recognize, not solve IPV</p> <ul style="list-style-type: none"> • “Providers are not required to solve the problem of IPV but are required to recognize symptoms of IPV and impacts on health and address those impacts.” 		<p>Can’t change life in one visit</p> <ul style="list-style-type: none"> • “No patient’s life can be changed in one hospital visit.”

**Comparing Perspectives (Pre-Training) on
Providers’ Concerns Relating to Hospital Administration and Liability (cont’d)**

Providers	Legal Counsel & Risk Management	Medical Records	Survivors
<p>Vague understanding of patient privacy and confidentiality rights</p> <ul style="list-style-type: none"> • “I know we can’t release records but if a family member wants to know what is happening to a patient, of course we want to let them know.” 	<p>Confidentiality governed by HIPPA (April 2003)</p> <ul style="list-style-type: none"> • Staff access is on a need to know basis; Information is shared among people with the same type of privilege • Heightened privilege—DV advocates, rape counselors, some social workers, psychiatrists, psychologists • Medical information is only released through consent of patient, when statute mandates, or court order. Institution should assert the privilege upon subpoena 	<p>All Medical Record Departments abide by nationally promulgated procedures to handle records.</p> <ul style="list-style-type: none"> • “We have strict polices and adhere to practices of a national organization to manage our records and protect [them] from inappropriate release.” 	<p>Providers and Institutions need to better protect patient records.</p> <ul style="list-style-type: none"> • “Records should only be released upon request by patients.” • “Records should be coded.” • “Psychiatric records should not be part of the regular record.”
<p>Documentation training and supervision is sparse.</p> <ul style="list-style-type: none"> • “I’ve just been told to be very vague about what we ask and how the patient answers. Many times I won’t include anything about IPV for the patient’s protection.” • “I’m afraid if I document in too detailed a way, I will hurt the patient because someone can use that information against her later.” • “No one really tells you how to document. It is very intuitive. It depends on how much time you have.” • “There is no specific place on the form to write everything the patient tells you. A checklist of some sort might be helpful to cut down on writing time.” 	<p>Documentation should be comprehensive, but not extensive</p> <ul style="list-style-type: none"> • “It’s best to document facts and observations only. The less extra information or commentary by physicians the better.” • “Providers should note any inconsistencies between IPV symptoms and patient’s reports.” • “Providers should document that they identified IPV, offered resources and that the patient acknowledged resources. They don’t have to note how the patient used the resources.” • “Providers should not editorialize.” • “The fewer details in the record the better, given how often providers are inconsistent in their notes. Documentation in broad terms reduces likelihood of inconsistencies.” 	<p>IPV should be documented within the medical chart, if it is related to visit.</p> <ul style="list-style-type: none"> • “IPV should be documented like any other clinically diagnosed problem.” “Once something is written in a record it is permanent so providers should show care in what they write. While some information may be redacted for certain purposes, nothing may be altered.” • “The record has no place to store photographs or body maps.” 	<p>IPV should be documented in medical records, but survivors are concerned that information is released improperly.</p>

**Comparing Perspectives (Pre-Training) on
Providers’ Concerns Relating to Hospital Administration and Liability (cont’d)**

Providers	Legal Counsel & Risk Management	Medical Records	Survivors
<p>Lack of understanding about liability risks & documentation</p> <ul style="list-style-type: none"> • “I have only been told, ‘don’t create a liability.’ I assume that means less is more, so I write as little as possible.” • “I really don’t know about liability. No one has ever trained us about it.” • “We (residents) don’t know much about it but we’re covered by the hospital.” • “We (nurses) have to buy our own malpractice insurance and it is expensive. If something happens, the blame is going to be directed at us.” 	<p>Did not mention liability with regard to documentation</p> <ul style="list-style-type: none"> • “The best way to avoid litigation is to have a positive relationship with patients which includes honesty, trust and open communication.” • “We help to prevent adverse events and help providers to manage events should a mistake happen.” • “Even unsuccessful litigation can create months of stress and humiliation for providers.” • “The legal department consults to providers, advises them in how to respond to complaints or problems and helps them prepare for court appearances. If a provider is sued, an outside firm represents them.” 	<p>Don’t release records without consent & Difficulty getting charts back from providers</p> <ul style="list-style-type: none"> • “If a patient doesn’t consent to all information, including sensitive information with heightened privilege, we won’t release the records.” • “We have a lot of difficulty getting files back from providers.” 	<p>Did not mention liability with regard to medical providers or institutions.</p>

In addition to the comments presented in the charts, survivors had some specific recommendations for providers who want to help them.

Patient Recommendations for Providers:

- Hospital feels like "home" to you but it is scary for us.
 - Be kind and caring.
 - Don't use humor to release stress in front of patients
 - Don't joke about patient concerns in front of them
- It's important to take battered women's health seriously. Providers need to take physical injuries seriously, not just focus on emotional symptoms of a victim.
- How to talk to us
 - Even if people don't say "yes" to questions about whether they are being abused, you should still give them access to information and resources about how to get help.
 - Don't give advice – talk about options, provide information that gives a different perspective than what your partner is telling you.
 - When hearing about emotional problems, don't put us on tranquilizers. Just ask what's going on and what might help us to get through it
- Documentation
 - Documentation is beside the point. A trusting relationship is most important.
 - Write a referral was given but don't say to where or what kind
- Confidentiality
 - Doctors [providers] should be trained on confidentiality.
 - Real sanctions should be in place to enforce confidentiality.
- Dealing with batterers
 - Batterers are very manipulative even though they seem caring and concerned. Don't let them fool you.
 - Don't ask me if I want my husband to leave when is standing right beside me, there's no way I can say 'yes' in front of him. Tell him you need to meet with me alone with so it looks like its normal procedure, not that I want my husband to leave.

Current Literature Review

-- Existing Protocols Attention to Documentation --

In order to assess how often documentation was addressed in training materials and protocols designed to assist providers in responding to IPV, we reviewed over 60 protocols from Massachusetts and other states nationwide. Many of the protocols paid only brief attention to documentation directing providers to document "carefully" or "well." None of the protocols addressed the provider concerns relating to documentation that were raised in focus groups conducted for this current or previous project. We did find some helpful examples and examples in a few of the training manuals. These protocols are listed in the references list of this report.

-- Legal liability related to IPV intervention --

We performed extensive local and national legal research to ascertain what, if any, liability is associated with medical providers responding to IPV. In our previous project, some of the providers articulated concern that they could be held liable for documenting abuse in a patient's medical record, if the partner accused of committing the abuse, could later prove that such abusive behavior did not occur. In the current project, none of the providers identified liability relating to defamation or libel as a concern. However, many were concerned that but an ineffective response to IPV or allowing the patient to leave the medical site without ensuring her safety could make them vulnerable to liability. We reviewed legal, medical, social science and public health publications and found no indication that such liability exists. While the lack of existing case law or statutory law directly addressing this issue does not preclude the possibility of such liability, it does demonstrate that it should not be a pressing concern for providers at this time.

While it was not identified as a concern by any of the providers, our research indicated that liability is more likely to arise from improper release of confidential medical information. A patient's right to privacy in health care settings is explicitly set forth in the Health Insurance Portability and Accountability Act of 1996 (hereinafter HIPPA). One of the primary intents of this law is to reduce the cost of health care by creating a more efficient transmission of payment through electronic transmission. The Department of Health and Human Services (hereinafter DHHS) has been promulgated regulations to ensure the patient's privacy rights would be protected under this law. Since April 2003, hospitals, health care providers, health plans, and health insurers and health care clearinghouses are all required to comply with measures set forth in the finalized DHHS regulations, 45 C.F.R. section 160.101-164.534. These regulations establish federal privacy rights for patients and simultaneously create new civil and criminal liability for health care

providers. These regulations firm up any common law privacy rights held by patients prior to the April 2003 and create incentive for medical care institutions to take great care in releasing medical records and for training providers of the risks related to sharing patient information through in-person, phone or fax communications. Specific provisions for IPV also create expanded protection for medical records of IPV survivors. The penalties for non-compliance with these regulations are fines up to \$25,000 per person per year, punitive fines and the possibility of incarceration.

We also investigated is whether adopting a protocol within a healthcare setting would somehow increase the risk of medical malpractice to providers who did not adhere to protocol guidelines. We were unable to identify any jurisdictions where any IPV protocol has become so part of practice as to be considered, "a standard of care that would be exhibited by the care and skill of an average qualified practitioner." While some states evaluate a medical providers behavior against others within their locality, Massachusetts compares providers to others within their specified area of medical specialty (Jane Doe, Inc., 2003). While there are no cases in Massachusetts that address IPV specifically, there is one case that indicates that juries could reasonably find a provider liable for not have the necessary protocol in place (Derry v. Podkin, MD, 1999). Given the requirements of JCOAH and several other professional organizations, and the availability of protocols and training materials from national, state and local organizations, it is foreseeable that a jury would find a provider or institution liable for failing to implement appropriate protocols.

While medical providers in seven states (California, Colorado, Kentucky, Mississippi, Ohio, Rhode Island, and Texas) are mandated to reporting of IPV to law enforcement (Linden, 2002), Massachusetts medical providers are not so required. However, providers in Massachusetts are required to report gun shot wounds, rape and knife wounds, so if these injuries occur in the context of IPV, they are required to report them although these reports are not necessarily made to law enforcement. Since mandatory reporting of IPV was not a concern for providers at our three sites, we did no more than assure them that they were not required to report cases of IPV to the police.

Pre-Training Medical Record Review at the Three Sites

Our original research design indicated that we would rely on the record review conducted in Legal Evidence Project 2002 to evaluate the efficacy of the documentation training. However, due to funding delays and other circumstances, the project was not initiated until two years after the first project's completion. Accordingly, we felt it necessary to do a current review of provider records at each site. We

decided to use this opportunity to confirm findings from the first project and ascertain specific problems in providers' current note taking to inform training curriculum development.

We used a modified version of the abstraction tool used in our previous project, Legal Evidence Project 2002, to review the records. We used a modified Delphi method to create tool in the first project. The interdisciplinary team of lawyers, doctors, nurses and social workers were presented with variables of interest selected from well-known health care intervention protocols, a summary of relevant legal background and evidentiary rules, and data from focus groups conducted with providers. The group met three times to discuss the interpretation of background materials and prioritize variables of interest. Variables included in the tool were agreed upon by consensus of the group. For the current project, we used the tool as a starting point. A small group consisting of a doctor, a nurse, a lawyer and a social worker met to discuss the variables and prioritize which variables addressed the needs of the current project. Decisions were made by consensus. For the most part, variables were chosen because they had been chosen as topics of interest for the training by the curriculum team. The curriculum team used a similar modified Delphi method to identify training topics and methods for the training.

Assigning an overall value to a medical record is impossible given that it may be used in a variety of legal settings and for different purposes. We decided instead to identify particular characteristics of medical records that would make the records useful to the survivor, or potentially damaging to the survivor (which would also tend to make it useful to the perpetrator.) We also recognized that each type of health care provider has a different role with the patient and therefore is exposed to different types of information and varying documentation responsibilities. To accommodate these differences we developed separate tools (abstraction forms) for EMS, Nurses and Residents. A separate tool, the Intake Tool, was created to capture information written by either Nurses or Residents since note taking from both providers are written in one ED record. All abstraction tools are included in Appendix C of this report.

We relied on Massachusetts Law and evidentiary rules to inform the tool given the location of study sites. First, we identified characteristics that would increase the likelihood medical records admissibility based on the medical records exception. Next, but equally as important to our review, we identified types of information that would be most useful to patients attempting to obtain legal relief. We prioritized factual information that is only available in medical settings. Last, we identified information or characteristics most likely to facilitate quality health management.

A table listing the most significant abstraction form items and the rationale for inclusion of each follows:

Abstraction Tool Item	Importance of Information as Legal Evidence
Criteria for inclusion	We were interested in tracking how victims were described in medical records.
Time, Date and Method of Arrival	Establishes the time that patient came into contact with hospital which provides a foundation for the excited utterance exception.
What other providers were involved with the Patient?	Is there a team approach to IPV?
Patient’s Gender	How does gender play a role in provider’s identification of IPV and any response?
Photographs	Photographs are easily entered into evidence. In the last project, we found only a few charts that referenced photographs having been taken.
Confidential or Privileged Information	In the previous study we concluded that specially privileged information should not be contained in the main body of the record but should be contained in consulting notes or in a special section that could be easily identified and protected by medical records staff upon release.
IPV Screen	Results from the previous study and focus group data indicated that most providers do not screen. Only one of the sites actually included a screen in the chart.
Chief Complaint	Documenting “DV” as the chief complaint rather than an actual medical problem is a common occurrence. We hypothesized that it may be more likely that patients will be identified if they present with a trauma injury than any other reason (e.g. medical condition, psychiatric, substance abuse, somatic symptoms with no apparent etiology.)

Abstraction Tool Item	Importance of Information as Legal Evidence
Intoxication	The focus groups and experience of the practitioners/researcher indicated that providers are less likely to address IPV if the patient is intoxicated.
Relationship to the Abuser	Results from the last review revealed that providers were likely to omit “who” (described by name or relationship) committed the act to cause injury and health problems. We also wanted to know whether the partner was present during treatment since this may significantly decrease providers’ ability to thoroughly assess and treat a victim of IPV.
Description of IPV incident	We wanted to examine whether providers wrote patient’s descriptions of what, where, how, and when the IPV event occurred. We also reviewed whether the provider paraphrased the incident, used terms such as ‘patient reports’, ‘complains of’ or ‘indicates’, or used quotation marks.
Inclusion of Legal Terms	One common practice among providers is to document IPV as an assault, or an act by an assailant (without mentioning the relationship to the patient) or that the ‘patient alleges’ her partner committed abuse. The training would emphasize using only well-accepted medical terms in notes.
Verbal abuse/Controlling Behavior by Partner and Present of Partner during medical treatment	One of the primary flaw identified in the previous project was providers failing to see how a partners controlling behavior can have negative impacts on a patient’s health and deter a patient from taking steps to improve her health or quality of life.
Patient’s Demeanor	Results from the last project and focus groups revealed that providers are likely to omit patients’ demeanor under the rationale that a patient’s being anything but calm would lessen her credibility regarding statements of abuse.
Physical Exam	For residents only (Nurses are not responsible for conducting the physical exam and pre-hospital providers perform only a limited exam)

Abstraction Tool Item	Importance of Information as Legal Evidence
Description of Injury	One of the major deficits identified in the last project was providers’ failing to describe injuries observed. Most of the records lacked a description of the size, location, color, stage of healing, and pain or swelling associated with the injuries. Given this is a task that is well within providers’ medical expertise, we looked to emphasize the importance of this type of documentation in the training.
IPV services offered	We tracked how often referrals were made to services available within the medical institution, to services outside the institution and when no referrals were made.
Referrals made and patient’s response to referrals	Referrals can be made in person, by phone or through giving the patient numbers to call. We wanted to track whether patients’ responses to referrals or intervention were noted and if so if the notation was written in a positive, negative, or neutral way.
Discharge Instructions	We reviewed how often providers wrote domestic violence as a diagnosis, and whether information related to IPV or related referrals were written in the discharge sheet.
Legibility, Inconsistencies and Incompleteness	Information related to IPV or signatures were reviewed for these problems.
Observations on the scene	Applicable to pre-hospital workers only.

In the pre-intervention period (Pre-hospital August-November 2001; ED Site #1 January-March 2002; ED Site #2 March-June 2002), domestic violence was identified in 59 EMS records out of 400 reviewed, 49 ED Site #1 records out of 14,000 reviewed, and 16 ED Site #2 records out of 8,000 reviewed. Only the records reviewed at ED Site #1 captured the entire time period of records.

Summary of Record Review Findings at Pre-hospital Site

Almost all of the EMS records reviewed were injuries caused by IPV. Four cases were also sexual assaults. EMS forms do not include any type of IPV screening prompt but during the pre-training record review, EMS employed its own IPV advocate and EMS forms contained a check box for IPV advocate referrals. While this check box was not created to serve as a screening tool, it functioned as such. For this

reason, the check box served as criteria for inclusion. The referral box was checked in a majority of records. The regularity of these referrals encouraged us to make referrals to the IPV advocate an integral part of the EMS intervention to be presented in the training.

EMS personnel identified IPV as an issue in the body of 73% of the charts. In most charts (45%), patient reports of abuse were paraphrased but in small portions did preface descriptions of events with 'patient reports' or 'patient complains of (c/o),' and sometimes used quotation marks. IPV labels such as 'Domestic Violence (DV)' or 'Battered Woman (BW)' or euphemisms such as 'relationship problems' or 'trouble at home' were used rarely. Only one EMS provider used the term assailant, but many records contained the term 'assault.' Providers consistently wrote who caused the patient's injuries (e.g., boyfriend, husband, father of kids), the mechanism and the location of the injuries and the abusive incident. A significant portion of providers asked about weapons. No providers asked about any kind of controlling, isolating or restraining behaviors but a few did make notations about verbal abuse.

Providers rarely described patient demeanor. In the few occasions where they did, they used terms such as 'angry,' 'anxious,' 'crying,' 'hysterical,' 'shaky voice,' and 'scared'. 'Upset' was the most commonly used descriptor. Only a few providers used 'No apparent distress (NAD).' Providers sometimes described their observations of the scene, including whether children were present.

EMS providers described injuries usually in terms of the kind of injury, location, and swelling in almost 75% of the charts. Providers were less likely to note pain, size or color. One hand-drawn body map was included in one record.

Most of the patients seen were transported to the hospital but a small number did refuse transport. Reasons for the patient's refusal of transport refusal were usually included in the record. Very few providers gave patients IPV resources. However, in a small number of cases the EMS IPV advocate made in-person contact with the patient during treatment.

Providers indicated the date consistently but sometimes omitted the time. Police were involved in about 20% of the cases which is a much smaller percentage of involvement in EMS calls than indicated by providers in previous focus groups. A small number of records contained illegible notes within the body of the record.

Summary of Record Review Findings at ED site #1 and ED site #2

A majority of the records identified for review were included in the study because patients had reported an injury caused by an abusive partner to the triage nurse. Relatively few were included due to positive outcomes from universal IPV screening, a finding that supports other research and reports from providers in focus groups. At each of the sites only one or two records were included in the study because of IPV screening that was not triggered by a patient report or obvious pattern of injury.

While only two of the resident physicians completed a positive screen, almost 50% of the records showed IPV screens performed by the nurses. The screening tool on the form for one site was ambiguous so it was difficult to determine whether a marking on the positive screen meant that the screen was completed or that the patient responded positively to the screen. The screening tool was changed during the time the trainings occurred which made it impossible for us to make any conclusive statements about screening practices.

In contrast to our previous study, we identified no omissions or inconsistencies with regard to the date or time the patient was treated. Accuracy of this type of information can help a patient to establish a time period from which to track an abusive event. Additionally, if the time of the abusive event is close enough in time to treatment, patient statements properly identified as the patient's statements through use of quotation marks or a notation such as "patient reports" can provide a basis for allowing those statements from the record to be considered in a legal setting when under other circumstances they may not.

A majority of patients from each site arrived at the ED by their own transportation rather than by ambulance. This finding is consistent with the EMT and paramedic reports in focus groups that many patients treated by pre-hospital services refuse transport to the hospital or decide on the way to the hospital that they will not report the abuse to providers at the hospital. All of the records studied showed patients being discharged from the ED, except for those few patients admitted for further psychiatric assessment or treatment.

At ED site #1 approximately 50% of the patients were seen by a consulting psychiatric nurse or doctor, and only 17% were seen by a social worker. At ED site #2, patients were likely to see either a psychiatric doctor or a social worker but not both, and each occurred with equal frequency (4 out of 16 patients). In 15-20% of the cases police were involved, due to transporting the patient to the department or responding to a request from the medical staff. Security was involved in 25% of the cases at ED site #1 but was only involved in one case from ED site #2.

At ED site #2, about 1/5 of the records contained inconsistencies. While a few of the records included contradictory descriptions of how the patient was injured or the mechanism used (e.g. "boyfriend threw a lamp at her face," versus "boyfriend hit her in nose with snow globe,") most of the inconsistencies occurred in the way that various providers depicted the abusive person's relationship to the patient. An abusive partner could be labeled boyfriend, significant other, husband and father of children simultaneously within the same record. While the record indicated there was only one perpetrator of abuse, a husband who was actually the perpetrator could later argue that it was a boyfriend who actually committed the abuse.

In at least 1/3 of the records at each ED site, photographs would have been helpful to memorialize patient injuries, however, only three patients at ED site #1 had photographs taken by domestic violence advocates providing consulting services to the medical providers and no photographs were taken at ED site #2. Only one record contained a hand-drawn body map.

At ED site #2, 3 out of the 16 records were incomplete, missing either a resident note or discharge information. This may have been the case because the patient was an employee who has been assaulted while working or because the patient had absconded prior to conclusion of assessment and/or treatment. However, an explanation for an incomplete record were not noted anywhere in the record, thereby exposing the institution to liability. Only a few patients indicated the need for an interpreter, but according to their records none of them received hospital-based interpretive services.

Eighty percent of the patients from ED site #1 were women, most of who identified as heterosexual. The remaining 20% were men, none of whom were identified by staff to be gay. A majority of the patients from ED site #2 were identified as heterosexual women while a few patients identified as gay men. None of the patients identified as bisexual or transgender. Less than 10% of the women patients at each site were pregnant. Many of these women were unaware of their pregnancy prior to their visit.

The most common chief complaints noted in records reviewed at both ED sites were 'injury domestic violence' or 'status post assault' (s/p assault). Only one of the providers who wrote "s/p assault" also described the specific injury resulting from the assault. Residents were slightly more likely to write 'domestic violence' as the chief complaint than the nurses. It appeared to be common practice for providers to note substance abuse or mental health diagnosis (oftentimes 'suicidal ideation') as the chief complaint even when IPV was reported as the patient's primary complaint. A stark example of this was a case involving a woman who presented with multiple injuries in various stages of healing and reported being raped by her boyfriend. However, after reporting that she had been prescribed an anti-depressant

within the last two years and refusing to participate in the Sexual Assault Nurses Exam (SANE), she was diagnosed as delusional and paranoid and referred for a psychiatric assessment. While these patients may have needed psychiatric attention, there was no indication in the records that the IPV was also being addressed.

The nurses at both ED sites were more likely than residents to describe the patient's relationship to the abusive person. Less than 10% of the records indicated that the abusive partner was present at the ED site during treatment.

Nurses and residents at both sites were equally as likely to paraphrase incidents of abuse rather than use quotation marks or write 'patient reports or c/o'. Fragmented notes such as "beaten", "kicked during argument," or "fell down stairs during fight," are examples of paraphrasing. Less than 30% of the descriptions included who committed the abusive act, when it happened and how it occurred (e.g., kicked with a boot, punched repeatedly). About 20% of providers asked about whether weapons were involved. Surprisingly, residents were much more likely than nurses to note who committed the abuse, when the events occurred and provide details about how the abuse occurred. Only two nurses and two providers from ED site #2 asked patients about the type of force used.

Nurses and residents frequently used legal terms such as assailant, assault, and alleged. Resident notes was illegible in more than 30% of the records at both sites. Nursing notes from ED site #1 were illegible only 10% of the time and there were no illegible notes in any of the nursing notes at ED site #2. Even though nurses appear to do much more documentation than the residents, their writing was consistently much more legible than the residents. Resident signatures were illegible in almost 50% of the records while nurses signatures were illegible in 20% of the nurses at ED site #1.

At both sites 30% of the patients identified as victims of IPV had recently used ETOH or presented intoxicated. Aptly, one provider included a qualifying note, "clinically sober despite + ETOH." A note like this accurately addresses any alcohol intake by the patient but serves to preserve the patient's credibility regarding any statements or presentation made to ED staff.

None of the providers at ED site #2 identified any controlling behaviors while residents and nurses at the ED site #1 noted controlling behaviors in three records.

Residents were much more likely than nurses to describe patients' demeanor. Residents were most likely to write "NAD"(no apparent distress) while nurses almost never used this term. Nurses and residents who described demeanor used terms such as "anxious," "crying" or "upset." Only one resident used the term "flat affect." Terms with negative connotations such "uncooperative," "hostile," "agitated,"

"combative," and "angry," were only used once or twice in all the records. When descriptions were included, they were often quite detailed. Patients' fear was identified only once out of all the ED records reviewed. Providers seemed more likely to ignore the issue of IPV when the patient was upset, angry or hostile. Rather than documenting identification of IPV, assessing injuries or treating the injuries, providers seemed to focus their documentation on detailing the patients' offensive behavior and steps taken to restrain the patient.

Providers were even less likely to write detailed notes about patient injuries. Most providers described the kind of injury incurred (e.g., cut, abrasion, bruising) when it was visually apparent and in those cases almost half of the records contained the location of the injury. However, only a small number of nurses and resident physician noted the color, size, swelling or pain associated with an injury.

Nurses were much more likely to make a referral to a consult inside the hospital (53% of records) where resident physician were more likely to make a referral outside the hospital (10% of the records). More of the referrals were made person to person rather than giving the patient a phone number. No referrals were made by phone. Patient's responses to services were not noted by any of the residents and only noted by 10-15% of the nurses at both sites.

In more than 50% of the records from ED site #1, residents documented conducting a full physical exam, whereas only 30% of ED site # 2 residents did so.

At ED site #1, domestic violence was written as the diagnosis in 17% of the records, and details regard interventions related to IPV or follow-up were included in 30%. S/P assault was written as the diagnosis for 20% of the resident discharge notes at ED site #2.

Many of the records that showed indicators of IPV could not be included in the study because the perpetrator of the abuse was unclear. The most common examples of an unnecessary ambiguity include, "patient fell over table and broke her arm", "punched in face," "kicked in head," and, "towel wrapped and tightened around neck leaving red marks." In all of these examples, the very important detail of *who* committed the acts causing injury was omitted. While the name of the person is optimal to reduce any ambiguity upon subsequent review of the record, naming the relationship between the abusive person and the patient (husband, live-in boyfriend, boyfriend, father of children) is also a very helpful.

Many records also had to be excluded from the study because the abuse was generally described as "problems at home," "family problems," "hurt at home," or "trouble with man he is living with." Despite indicators of IPV, it was impossible to determine whether abuse had been caused by an intimate partner, family member, or roommate.

We did not include data contained in the consulting notes of psychiatry, social work or other providers since these providers would not to participate in the training. However, the notes of these providers were useful to determine the kind and extent of information omitted from nursing and resident physician notes.

Conclusions from Data Collection for Curriculum Development

- Providers seem to know how to recognize physical symptoms of IPV. However, they assess and treat the patient is not clear from documentation. Crucial information related to health care needs such as extent, location and type of injuries is often missing. A brief generalization about abuse (b/f hit in face) is repeated throughout the record.
- Anyone can ask the questions relating to IPV – the difficult task comes in determining what to do when a patient confirms he or she is experiencing abuse. Providers need to know more about how to respond and how to document their response.
- Addressing IPV without proper tools and resources is overwhelming for any professional. Current protocols and recommendations can only be adhered to if providers are trained, have adequate resources in the setting and are familiar with resources to make referrals with confidence.
- Providers who are not trained to do IPV counseling or safety planning are not making the best use of their time by trying to accomplish these tasks. Health care providers are equipped to do so many other things that are helpful to the patient. Specially trained advocates and social workers are better situated to provide counseling, safety planning and assist patients to consider options. Sending messages to the patient that she or he is believed, abuse occurs to many people, and special services to address this problem are available is an important intervention that takes little time or training to execute. An outsider presenting these ideas may give a patient a new perspective and inspire her to consider seeking help from IPV services.
- Careful assessment and documentation is an intervention -- a valuable one that can help patients weeks, months or years after treatment when patients are better prepared to take steps to eliminate the violence in their life.

- Providers' attention to and time spent on IPV should not be conditioned upon a patient's willingness to disclose abuse. Providers should not interpret patients' silence as resistance to or rejection of providers' concern. Any help-seeking steps, including seeking medical treatment, creates a risk to the patient of retaliation by the abusive partner. Fear of what the abusive partner would do if he found out about abuse may prevent a patient from disclosing, regardless of provider attributes.
- Pre-hospital providers, nurses and resident physicians perform very different functions and have different intervention and documentation opportunities with patients. Trainings must be tailored to address these differences.

Creating the Curriculum

The training team was made up of two doctors, a social worker and an attorney. All members had extensive experience in developing IPV curriculum and delivering training to medical providers and others working in medical settings. Three of the members worked extensively on the previous study, Legal Evidence Project 2002. The team was presented with a summary of the most commonly used training tools, pre-intervention focus group data, and record review results. After several meetings, the team identified nine training priorities, determined the most effective methods for presenting various topics and outlined the training.

The training priorities identified included the following:

Priority One:

Present IPV as a health care issue. Increase providers' knowledge of various efforts to respond to IPV in various medical settings. Increase providers' understanding of the impact of IPV on patient's health and the cost of ignoring IPV medical settings.

Priority Two:

Help providers to understand the importance of learning from patients. Share patients' perspectives regarding how certain behaviors or responses could benefit patient health care and patients' ability to increase safety and well-being.

Priority Three:

Create realistic expectations of what can be accomplished for patients who are seeking help in emergency care settings. Most survivors will not and should not make significant life decisions or drastic

change in their life when in crisis subsequent to abuse that requires medical care. Providing patients with an opportunity to share what is happening to them, treating them with respect, attending to their medical needs, documenting their treatment and sharing resources is a comprehensive intervention. No service providers can make a patient safe or change a patient's life during the time allotted for treatment in these settings. Share the model of brief advice and referral used by domestic violence advocates.

Priority Four:

Introduce a team approach that enables providers to do as much as time allows with each patient, even if that means not performing every intervention step possible. Teach providers to prioritize activities and make referrals to others when time is limited. Emphasize that performing one aspect of an intervention well is more likely to have a positive effect than touching on every aspect superficially or doing nothing at all.

Priority Five:

Addressing providers general and specific concerns related to addressing IPV, including patient privacy and safety issues, interviewing skills, referral and resources information, and liability.

Priority Six:

Identify and discuss concrete assessment, treatment and documentation strategies. Use real examples shared by the providers to identify intervention and documentation strategies they can be implemented in their everyday practice to reduce their concerns.

Priority Seven:

Emphasize the benefits and efficacy of employing a client empowerment approach rather than a medical model approach to IPV.

Priority Eight:

Address safety in the department and attempt to find support for providers from ancillary staff on site.

Priority Nine:

Comprehensive medical documentation of IPV may enable patients to get the help they need to end the violence in their lives. Good medical record keeping can also prevent a provider from testifying in court or can make testimony much easier.

All decisions regarding the curriculum content and presentation were made by consensus. Whenever consensus was not reached, we presented each approach and described the benefits and risks associated

with each. An example of this was the use of DV as a chief complaint or diagnosis. While the designation of DV does apprise anyone reading the record that abuse is an issue, it is not useful unless other information relating to the abuse is also included in the record. Many providers mistakenly see this designation as complete documentation of IPV and fail to document relevant information that would be useful to other providing on-going care. Additionally, notation of DV in the record, without accompanying notes, would not be helpful to a patient in legal settings without requiring that the provider interpret the note through in-person testimony. Because there was some disagreement about whether noting DV somewhere is better than no documentation at all, we included a discussion of the "pros" and "cons" of this practice in the training. For the most part though we were able to shape each topic in a way that satisfied each member's concerns. Once the core training was completed, the team met four more times to tailor the core training to each provider group (EMS, Nurses and Residents), refine presentation methodology and choose resource materials for dissemination.

Over the course of creating the training, we determined that that it would be difficult to address the nine training priorities identified in a single 50-minute training. For this reason, we carefully documented our rationale for training and planned to present findings to interested parties at each study site in hope that someone from each site would continue training efforts after the conclusion of our project.

Delivering Training to Providers at Three Sites

All trainings were presented in power point incorporating interactive activities, documentation examples, photographs, body maps and/or video clips. We implemented various adult learning strategies. Our goal was to build on information and skills providers already possessed and to provide new information of interest to them (e.g., tips on how to interact with lawyers, prepare to testify in court, avoid testifying in court through complete record keeping and reduce risk of liability.) We sought to convince providers that responding to IPV is an essential part of quality medical care. This curriculum assumed that providers had experience in recognizing signs of abuse. The training focused on how to respond to IPV once it was identified rather than universal screening.

In order to accommodate providers' schedules and coordinate trainings with record abstraction timelines, trainings for providers at each of the sites were conducted from November 2001 through April 2003. Pre-hospitals providers were the first to be trained in November and December of 2001. Trainings were included as part of an eight-hour annual training program intended to reach all EMS providers.

Trainings were held at 7:30 am, 8:30 pm, or Midnight. Pre-hospital providers who participated were paid as though they were working out in the field and fulfilling an otherwise required training segment. As a result, we trained 237 EMTs and Paramedics (78%).

Training for the residents at each site were conducted as part of weekly rounds. All residents who were not working, visiting at another hospital or on approved leave were required to attend these meetings. We trained 23 residents (59%) at ED Site #1 in April 2002 and 16 residents (57%) at ED Site #2 in April 2003. We were permitted to present the training at one weekly rounds. We offered several alternative training times to residents who were unable to attend the weekly rounds but no one expressed a willingness to attend the extra sessions.

Training the nursing staff at each site was far more challenging than the research team originally anticipated. We worked extensively with nursing management at each site to determine feasible training times. In order to train 48 nurses (80%) working in the ED of Site #1, we held 24 trainings over a 4-week period from May-June 2002. Trainings were delivered at 5 am, 7:30 am, 11 am, 2pm, 3:30 pm, 7 pm, or 11pm so that providers could attend during a break, right before or right after their shift. Seven of the trainings offered had 0 attendees. The other trainings averaged 3-5 attendees. At site #2, 41 nurses (51%) were trained as a result of 16 trainings offered over a 4-month period from January-April 2003. Trainings were delivered at 7:30 am, 11:00 am, Noon, 1 pm, 2 pm, and 3:30 pm. Eight of the trainings offered had 0 attendees. The other trainings averaged 3-5 providers.

Providers at each site were considered in attendance if they participated in at least 75% of the training. Because training was offered during shifts in order to achieve attendance, some staff were called out of the training to treat patients. EMTs and Paramedics included all permanent staff working at the pre-hospital services site. Residents included only those residents who were permanent and formal members of the residency program. Nurses included full-time, part-time, per diem, SOL, and visiting nurses. Nurses from the Pediatric division at Site #1 also attended the training but were not included in any other aspects of the study. Nurses at each site received 1 hour of continuing education credit for attendance at the training.

At the conclusion of each training, each provider was given a palm card, and each department received five "Help" Books (a comprehensive directory containing local IPV resources), a Polaroid camera and a supply of film.

Post-Intervention Record Review

The goal of this project was to improve quality of documentation of IPV among providers. Our evaluation was conducted to determine the effect of the documentation training on the quality of subsequent record keeping of those who attended the training. While we anticipated this training would have a ripple effect on the entire departments studied, we did not evaluate this effect. To obtain baseline data, we reviewed records of all providers from each department. To obtain post-training data we reviewed only those records of providers who attended the training. Pre-training records from the pre-hospital site were abstracted from August - November 2001 and post-training records were abstracted from January – May 2002. Pre-training records from ED Site #1 were abstracted from January – March 2002 and post-training records were identified from April-June 2002. Pre-training records from ED Site #2 were identified from March – June 2002 and post-training records were identified from February 2003 - June 2003.

Identification Process

All adult patient records that fit study criteria and involved at least one provider who attended the training were reviewed and compared to records collected prior to the training. The records were abstracted as a whole rather than focusing only on the documentation of the provider(s) trained. The pre-hospital records and records from hospital ED site #1 were abstracted by the same research assistant who abstracted the pre-training records using the same decision rules and access database.

At the pre-hospital site, we identified 45 post-training pre-hospital records to compare to 59 pre-training records. At ED site #1, we identified 48 post-training records to compare to the 59 pre-training records. At ED site #2, we identified only 16 pre-training records and 20 post-training records. Given the limited statistical analysis permitted using such a small number of records, records from ED site #2 were not abstracted or compared statistically to ED site #1 records. Instead records from this site will be described qualitatively later in this section.

We used three different mechanisms to identify post-training records at each of the three sites in order to accommodate each setting's record storage system. At the pre-hospital site a person responsible for flagging all potential IPV cases flagged these records and a research assistant reviewed records to determine which records satisfied study criteria. In the other two sites, research assistants reviewed individual records for a three-month period. 130 pre-hospital records were reviewed to yield 70 records meeting the criteria. At ED site #1 12,000 records were reviewed to yield 59 records, capturing the entire

time period. At ED site #2, 8,000 records were reviewed to yield 16 records, capturing records from various times of each day during the period of review. Due to limited resources and strict time restrictions, we were unable to devote any more resources or time to identifying additional records.

Abstraction Process

Variables of interest were selected by a modified Delphi method as described in the pre-training record review section above. Decision rules were formulated into a manual, and an abstraction form was created in Microsoft Access® for direct data entry using a laptop computer. After training and piloting, two abstractors entered data independently. Results were imported into SPSS for descriptive analysis. Chi-square methods were used to evaluate differences between pre and post training performance.

Four distinct chart elements were abstracted and analyzed: EMS records from the Pre-hospital site and the intake, the nursing, the physician notes from IPV cases identified at ED site #1. While the EMS dataset may have included some patients who were subsequently treated at ED site #1, many EMS patients were transported to other ED sites that were not involved in the study. For this reason, we did not link EMS records to ED records.

Results

Findings from each site are described below. Implications of the results are described later in the record review conclusions.

Pre-Hospital Records

We abstracted 118 EMS records, 48 from the pre-training period and 70 from the post-training period. We tracked items related to intake (date, time, names of persons at the scene, description of the scene, and chief complaint), statements about causality (identification of domestic violence and sexual assault, and patient statements), event descriptors, physical exam descriptors with particular reference to injury, statements about the patient's demeanor, and treatment/disposition items. Significant improvements were noted in 12 items from the pre-training to the post-training period. EMS providers were more likely to identify domestic violence (97% vs 73% of the time, $p=.000$). They were more likely to write the patient's name legibly (100% vs 88%, $p=.004$). They also were more likely to describe abusive incidents, and using reporting language (63% vs 45%, $p=.05$), and 'the patient discloses...' (54% vs 8%, $p=.000$). Providers paraphrasing patients' reports of abusive events (46% vs 45%, $p=.017$) also increased, despite training recommendations to write patient reports specifically. However, while the format of the describing the abusive event is not optimal, the fact that the incident was not omitted altogether is a positive outcome. They were more likely to chart who (97% vs 75%, $p=.000$), what (99%

vs 77%, $p=.000$), and why (97% vs 69%, $p=.000$). Descriptions of the injury were also more common in the post-training period (93% vs 67%, $p=.000$), especially location (96% vs 73%, $p=.001$) and pain (57% vs 25%, $p=.000$).

ED Site #1 Records

Intake

Intake records were examined for 59 domestic violence cases from the pre-training period and 48 from the post-training period. Over a third of these cases (35%) were accompanied by documented injury, and 40% arrived by ambulance. Charting elements that were evaluated include accuracy of record for name, date, time, gender, address and language barrier. Confidentiality warnings to protect address were also noted, as was residence in a shelter. Documentation was ascertained for involvement of a domestic violence advocate, psychiatrist or psychiatric nurse, social worker, interpreter, hospital security guard or police officer. Documentation of photography was noted. Handling of sensitive information (past or current substance abuse, STDs, HIV/AIDS and pregnancy) was evaluated. Consults with other services were noted. Abstractors also counted the number of contradictions within a patient's record. Finally, discharge status was noted.

On four of these items, there was a distinct improvement after training. Charting of psychiatrist's involvement improved from 0% to 6% ($p=.09$) and for psychiatric nurses from 21% to 50% ($p=.005$). Consistent charting of the patient's name improved from 93% to 100% ($p=.085$). Documentation of appropriateness of photographs increased from 11% to 42% ($p=.000$).

Nursing Notes

Nursing records were examined for 59 domestic violence cases from the pre-training period and 48 from the post-training period. Items tracked in nursing notes included the triage encounter (chief and secondary complaint and notes about intoxication), the event description, the description of the patient's demeanor, the description of the injury, provision of domestic violence services, and the nursing discharge note.

There was improvement in 13 variables from the pre-training to the post-training period. In the post-training period, the perpetrator was identified by relationship to the patient much more frequently (71% vs 20%, $p=.000$), and documentation of the partner's presence increased from 14% to 65% ($p=.000$). Notation of crying increased from 7% to 21% ($p=.032$), and documentation of demeanor increased from 20% to 48% ($p=.002$). Domestic violence was more likely to be listed as the chief complaint (48% vs 20%,

$p=.003$) or secondary complaint (39% vs 32%, $p=.000$). Nurses were more likely to use reporting language i.e. patient reports or states, patient told me (40% vs 24%, $p=.06$). They were also more likely to describe the force that resulted in injury (46% vs 3%, $p=.000$), and they were more likely to provide the patient with the diagnosis of domestic violence at discharge (38% vs 20%, $p=.04$). In the post-training period, none of the charts contained illegible information, compared to 12% illegible in the pre-training period ($p=.013$). Domestic violence terms were used 63% of the time post-training, compared to only 40% in the initial period ($p=.003$). Finally, there was improvement in the charting of the perpetrator's use of alcohol in association with a domestic violence event (15% vs 2% pre-training, $p=.014$).

Resident Records

We abstracted 59 physician records from the pre-training period and 48 from the post-training period. Items tracked were similar to those reported for nurses, but included more extensive detail of the physical examination. Physician reporting quality was decreased overall, reflecting an increase in patient numbers and acuity and accompanying stressors on physician time, but there were improvements in 6 measures. Physicians were less likely to chart 'no apparent distress' or NAD (down from 39% to 14%, $p=.004$) or fail to chart patient attributes (down from 46% to 16%, $p=.001$). They were more likely to list DV as a chief complaint (55% vs 25% in the initial period, $p=.006$). They were more likely to note the use of alcohol by the perpetrator (12% vs 2%, $p=.031$), and less likely to write a blanket statement of intoxication for the patient (2% vs 12%, $p=.057$). They were also more likely to describe the extent of force that resulted in an injury (21% vs 3%, $p=.005$).

Qualitative Description of Hospital ED Records from Site #2

We identified only 20 IPV records written by either a nurse or resident who attended the training. Of the 20 records, 5 included notes of trained residents notes and 16 included notes of trained nurses.

Record review indicated improvements in 9 measures. Nurses decreased their designation of 's/p domestic violence' or 'domestic violence' as a chief complaint, a common mistake in pre-training records that we emphasized in the training. Nurses decreased their use of legal terms such as assault or assailant. Nurses and residents also increased taking photographs and drawing body maps, although the increase was only slight (one photograph and one body map of past injuries). Providers were more likely to include descriptions of abusive events, using quotes and 'patient reports.' Providers also increased documentation of an abusive partner's presence in the ED. Legibility of the note taking also increased. Similarly to ED

site #1, more providers used descriptive terms to describe demeanor and decreased their use of "NAD." Unfortunately, many of the terms were negative rather than positive or neutral in nature. Providers increased describing injuries, including location, swelling and pain. This is a drastic change from pre-intervention records which tended to focus on the abusive behavior (e.g., "punched by partner) rather than the injuries or health impacts of the abusive behavior. Providers made more referrals to in-hospital IPV services but failed to make notations of these referrals specifically in the record. Additionally, more records included neutral notes regarding patient response to services offered.

The only negative difference in post-training records is that several records did not contain the date of treatment. We did not emphasize this element in the trainings because it was not a problem identified in the pre-training record review at any of the sites. However, this finding is consistent with the results from Legal Evidence Project 2002.

None of the records contained inconsistent notes regarding the patient's relationship to the abusive person. However, we did see inconsistent descriptions of the abusive incident that preceded treatment in two patient records.

Record Review Conclusions

In this outcome assessment, we attempted to measure the effect of training on a segment of the EMS and ED study sites. Results are interesting if somewhat attenuated. Several important improvements appeared in records from each site.

Improvements

IPV identification increased despite the fact that routine screening and the use of screening tools was not a topic of the training. Despite the low numbers of IPV records identified for review, the number of records pre- versus post- suggests that the training may have increased identification overall, especially in ED site #2 where no more than half of the providers were trained. We were able to identify more or the same records at all sites even though the pool of records eligible was reduced by at least 20% given only a portion of each provider group received the training. Another important change in practice was that providers increased their descriptions of abusive incidents and used reporting language and specific details more often. Providers also reduced their use of non-descriptive terms of demeanor such as "NAD" and increased their use of specific demeanor descriptions such as 'upset' and 'tearful.' Legibility also increased and the providers also seemed to recognize the importance of detailing injuries more thoroughly, including using drawings and photographs.

On-Going Problems

Problems in documentation included providers' not specifying *who* caused an injury to the patient, failing to document past injuries, and omitting detailed descriptions of injuries. Providers also failed to address IPV when psychiatric symptoms or substance abuse problems were also present. Provider notes also indicated little time spent addressing the health impacts of abuse. While some notes described providers' notifying patients of resources or offering to call the police, none of the notes indicated that providers described the health impacts or potential risks to health caused by abuse.

While all providers recognized that documentation is essential for good clinical care and seemed to understand how documentation could help IPV victims access protective relief, most providers raised several obstacles to thorough and consistent charting during the training. What was clear, even from poor records, is that providers recognize when patients are experiencing abuse and treat them differently. Data from this project suggests that physicians want to give quality care but are resistant to developing skills and new habits to address IPV.

Inability to Isolate Documentation Skills from Quality of Response

Unfortunately, since the focus of this study was on documentation, we are unable to ascertain the quality of care apart from documentation strategies. It may be that providers' behavior has changed but their documentation skills did not change significantly enough to indicate the change in behavior. One study in progress indicates that providers who spend their time making a change in the way they deliver service may have less time or feel less capable of documenting their accomplishments (McCloskey, 2003). We suspect that changes in practice must occur before we can expect a significant change in how those practices are documented. Additionally, any educational process to expand the skills of providers must be accompanied by changes in forms to make documentation more efficient including triggers, designated areas for documenting important information, and a standardized abbreviations list consistently used by providers. For example, when items have to be initiated by the practitioner, the record may continue to be less than complete, even following successful training experiences that result in a change in practice.

Challenges Faced

We faced several challenges in implementing the training and evaluation. We were unable to mandate that providers attend the training and did not have the resources to pay them for their attendance. Had we been able to train more providers, our results would be more conclusive. Additionally, patients in the study were seen by a team of 3-6 providers depending on the time of day the patient presented for

treatment. Since documentation in each department is performed as a team, our results may have been diluted by not training all providers. Saturation would have increased the impact on the department overall and may have reinforced recommended behaviors.

We also anticipated that a higher rate of patient cases would fit our criteria for IPV. Another factor out of our control was the number of women presenting to each site with IPV and whether patients were treated by trained providers. The time restrictions imposed by the schedule of the residents combined with the length of time it took to identify records to review proved to be more obstructive to the methodology than originally anticipated. Residents work together for one year from June-July. In order to capture as many residents as possible, we needed to accomplish all of our work within that year and also accommodate the residency program schedule. Other institutional changes that proved problematic were a dramatic change in medical record forms at one site and significant budget cuts and lay offs of nurses at another site.

Training and Resources Needed to Implement an IPV Protocol in an Emergency Care Setting

Originally, we anticipated that providing IPV training to the target groups of providers would be easily attainable. One of the unintended but important outcomes of our project is the exploration of the feasibility of implementing and evaluating an IPV intervention in an emergency care facility. While we have yet to truly ascertain the effectiveness of the intervention to improve documentation through a larger scale study with a higher percentage of providers trained and more records studied, we have learned many valuable lessons related to the feasibility of conducting a full-scale intervention in an emergency setting that is open for business 7 days a week, 24-hours a day. We have also learned much about what types of information providers are looking for, incentives for changing behavior and provider behavior that is preferred by patients. Lessons and recommendations are described in a later section of this report.

To learn more about provider's opinions and attitudes about the training, focus groups were conducted at each of the sites.

Post-Intervention Focus Groups

Background

Purpose. Focus groups were used to assess the impact of the documentation training intervention on provider attitudes and knowledge. The focus groups also provided a forum for providers to “vent” about difficulties they are having with documentation. This feedback provides critical information for refining the training and planning “refresher” sessions.

Groups. Seven focus groups were conducted between January and December 2003. These groups took place from six months to a year after the training intervention. There were two groups of physicians (n=4 and n=2), four groups of nurses (n=4, n=3, n=4, and n=4), and one group of Emergency Medical Technicians (EMT) (n=10). We worked with the clinical coordinators at each site who recruited participants who had taken part in the intervention training. The groups varied in time from 30 to 80 minutes. Most were about an hour. Recruiting and scheduling the groups in an ER setting was difficult, resulting in small numbers. The groups were tape recorded and transcribed. No individual comments are identified and names were removed from the transcripts. It is important to emphasize here that conclusions based on these groups must be tentative because of the small numbers—particularly in the size of the groups in which an individual voice can have a disproportionate influence. It is noted in the discussion which comments were made across most groups and which were made by only one or two people.

Demographics of the Sample. Thirty-one providers participated in the groups. There were six physicians (three females, three males), fifteen nurses (12 females, three males), and 10 EMS providers (three females, seven males). In sum, 18 females and 13 males participated in the groups. The age range of the participants was 26 to 54, with a mean of 40. Years of experience as a health care professional ranged from three to 32. We asked the participants about prior interest in or experience with domestic violence. Eleven responded with “none.” Twelve left the question blank. Eight participants wrote in comments. Five of the comments indicated experience with domestic violence was a part of their job. One said “limited;” one said “yes;” and one indicated being a volunteer at a battered women’s shelter. There was some variability among the professional groups by age and years of professional experience. The physicians (mean age 31) were significantly younger than the nurses (41) and EMS (42). The physicians also had significantly less professional experience (5 years) than the nurses (16 years) and EMS (21 years). This is not surprising as the physicians in the groups were Residents.

Organization of the Data. The qualitative data from the focus groups are organized into four sections: 1) the providers' recall and opinions of the training; 2) experiences with domestic violence and documentation issues—major and sub-themes; 3) suggestions for better documentation and further training; and 4) implications for future interventions.

Recall & Opinions of Training

Recall of content. The recall of content varied both within and among provider groups. Some providers gave detailed accounts of what they learned, others remembered less. Some of these focused on the training bringing awareness to them about screening for domestic violence, but had little recall of the documentation issues. One provider noted, "I remember very little." A small number of providers remembered inaccurately—"put patient alleges...." "write nothing down except medical stuff." Overall, recall appeared better than average, particularly given the training had occurred six to twelve months earlier. Almost all providers wanted refresher courses or further training.

Physicians' recall of the content of the training was good. Overall they listed the main points of documentation content: physical exam—write everything you find, be specific and detailed, size and location of injuries; how to approach the topic; verbatim accounts from the victim—"woman states," not "alleges"; never put your thoughts or opinions in account—omit non-factual, subjective; be more inclusive—e.g., the name of the person. One physician noted, "Now I say, 'Twenty-two year old woman struck by so and so, her boyfriend, three times on face with closed fist.'"

Nurses' recall of the documentation content was also fairly good, but with an additional emphasis on awareness and screening issues. One nurse responded to the recall question with, "It opened up my vision of who could potentially be a victim, and that is what I took home with me the most." Another commented, "I can remember vignettes on tape...good for interview purposes...but I can't remember what they told us about documentation....I thought the emphasis was probably more on getting us to ask the questions." All four of the nurses' focus groups commented on awareness and screening during the recall question. As nurses are the first contact for most patients and usually expected to do the screenings, this is an expected focus. In addition they recalled the steps to go through when a domestic violence patient is suspected or identified. Some also noted being educated about the complexity of the process of change for abused women.

EMTs' recall of the content appears confused. More accurately, there was a great deal of debate and disagreement about what the documentation training actually wanted them to do and whether that was in conflict with their EMT training. Many believed it was. This will be discussed in detail below. However, some EMTs clearly understood the main thrust of the training. "Document injuries to substantiate allegations." "...put patient states X,Y,Z did this."

Opinion of training. Opinions of the training were wide and varied. A number of providers in all professional groups thought the training was too long and repetitive and that it should be condensed. One thought it was too short. Another said that repetition and reinforcement is how they learn. Another thought it was a good review. Most providers liked the vignettes/case studies and discussion that illustrated what should be documented and what should not be documented. In addition they appreciated real examples of what actually helped or hindered a victim legally. "When writing notes now I think of it...[and]...want it very descriptive. I think that's what people see, something that is shocking to them or something that stands out that this is wrong and someone clearly meant to hurt this person." They all want further training.

The EMTs felt the trainer did not understand the context in which they work. "The trainer has to know what we deal with day to day—what goes on, on the street—it's not a hospital, clean, secure, warm environment." "...nobody can sit there and tell us what we have to do or what we should do without the benefit of knowing what we do, and 99% of the people that come and give us these lectures don't have a clue." They explicitly described it as a barrier to communication. "They tell you what your job is and what to do, and they have no idea what you're going through." One of the nurses expressed a similar view, indicating the trainer did not understand the ER context and couldn't appreciate the medical side of the battered woman. Describing a case in which a woman died from a beating and they had to deliver the baby, one nurse said, "I mean, you have to make sure they live."

In one of the physician groups there were two different takes on the same training. The two male physicians felt cautioned by the trainer not to put down anything negative about a domestic violence patient—e.g., "unreliable" or "impaired" or "combative." As one said, he felt "pressured to paint a picture that would help the patient later.... even if I didn't feel it was 100% accurate." The two female physicians responded, "I think the guys kind of felt that way and we never felt that way." The female physicians felt they should put down information like "intoxicated" or "uncooperative"—what is actually going on—and that they should "be aware that there are things that you can say that will suggest what you were thinking,

and to avoid that, and to be aware that if you do use those things that you can then be harming the subject...."

In two of the nurses' groups they commented on the chaos of being trained in the ER with nurses coming and going to check on patients, or coming off a night shift to the training, and being too tired to take it in. One nurse noted that doing the focus group itself required having four extra nurses on so they would not have to leave the group to deal with patients. They appreciated having clear steps to go through in dealing with domestic violence cases, as well as concrete suggestions for ways to talk to abused women. For some, being educated about the complexity of change helped to reduce their own frustration and "keep the door open" for women who were not yet ready to publicly confront their abuse. One nurse indicated that the actual information delivered was good, but that it wasn't designed for the ER environment. "...Hers was the perfect world sort of thing, where you can take someone and separate them and talk to them and spend time. Triage can't do that...." "So when the woman said well, statistics show that most battering happens in the late evening and early morning, I'm getting annoyed 'cause I'm saying so why do we have a battered women's advocate working 8 to 4?"

The EMTs' opinions of the training were complicated by the perceived conflicts. However, the EMTs did indicate that the initial focus group done with them was good. They described it as "interactive" and an experience that dealt with them and the issues they face. They described the subsequent training as tedious and too long. In addition, they indicated being "inundated" with domestic violence trainings from various sources that were "not all on the same page." They found this confusing and frustrating.

How training helped. For both groups of physicians, heightened awareness of domestic violence was a key point from their training. Their comments included: "to even look for it;" "more prone to ask;" "ask all the time now;" "not feeling helpless—there's something you can do—services and a legal record." Another commented that he does a complete physical now in which the patient is entirely undressed in order to check for bruising. Physicians also reported awareness of the importance of documenting all their findings. "I try to document everything now." They noted that documentation in general is heavily stressed by the attending physicians for fourth year residents. One commented that his legal documentation had improved, but the way he cared for his patients medically, or find resources has not changed.

The nurses reported that they didn't know the steps to go through with a DV case before the training. Now they have a clear set of procedures. Others reported that heightened awareness has made them screen

more. "My compliance with [the screening question] has increased. I used to ask sometimes, now I ask everyone....I've gotten a lot of 'thank you for asking' out there and that ...made me more aware of how important it is to ask." "What you are telling the patient is we handle that sort of thing here, so if they have a friend...."

Experiences and Difficulties in Documenting Domestic Violence

Major Themes Across Provider Groups

Screening as a Documentation Issue

Screening for domestic violence was not a focus of the post-intervention focus groups. There were no questions about screening practices. In spite of this, screening and its related issues were mentioned frequently in these groups. The information is presented below. Clearly, screening and documentation are closely intertwined. Without screening there may not be appropriate documentation. One physician put it boldly: Discovery, not documentation, is the issue—"focus on how to teach emergency physicians how to screen better—We don't ask and they don't tell and they just get discharged."

One of the hospitals is emphasizing completion of the screening section on the triage forms. In addition, screening for DV is part of a "spot check tool," and the nurses feel that will help them meet the goal of universal screening for DV. Some nurses respond to this and ask everyone. Others don't necessarily do that. "I think we get a lot of those kind of patients (DV), but...we may miss a lot of them...if that's not the reason they're here." One nurse noted seeing charts with questionable injuries, and no one had asked about domestic violence.

Both physicians and nurses run the gamut of whether and how frequently they screen for domestic violence. A couple of nurses reported asking everyone. "I ask everybody. I always say to people, 'I don't mean to be rude but we ask these questions to everyone.'" "My compliance with [the screening question] has increased. I used to ask sometimes, now I ask everyone....I've gotten a lot of 'thank you for asking' out there and that ...made me more aware of how important it is to ask." Others find it very difficult to ask about DV. "It's hard to ask the question—it's a private issue" "We don't really screen too well." Some physicians "rely on the nurses to let me know during their admission screening process." Other physicians take the initiative more. "I find I ask a lot, lot more than I ever, ever did in the past and I think that if I didn't train here where DV was a big issue I probably would never really have asked that much."

The majority of providers, however, ask if they suspect DV (bruises, story not making sense, vague complaints). Others note how easy it may be to miss DV cases, and try to be more alert to signs. "And how many of those are there out there that we totally and completely miss? And so I try to ask...anything that's sort of just not right, ...like why does she have a ruptured TM?"

Logistical problems in screening were mentioned by many of the nurses. It is hard to get the potential DV patient alone when the hospital has a policy that the family accompanies the patient. Some mentioned problems with getting appropriate interpreters and dealing with the family about interpreting if they suspect DV. One nurse noted that she tries to ask the screening question in triage because sometimes that is the moment they have them alone. However, most nurses felt that triage is not the place to ask about DV. They felt that you need more rapport to broach the subject, and that the primary nurse and/or doctor that will be taking care of them in the back is a better person to ask the question. One nurse was emphatic about this. "I have a history of this and I would definitely not have said yes to a stranger...never.....Not in a triage group, no." Others commented: "...reality of expecting them to do it right off the bat doesn't fit.....They're gonna need to take some time, be treated, come into the system, I don't think they want to admit to being...battered and sit in the waiting room for a few hours before you go see a doctor." "It's better for them if you get down to that later."

While most providers felt everyone should be screened, a number of them admitted to discomfort with asking about DV. Some just don't feel comfortable talking about what is perceived as a private issue. One male noted, "I think I get a different look than a woman would get if she asked that question. That's my perception." In one physician group, only one of the four residents asks males about DV. In the other physician group, one physician only asked males if DV was suspected, whereas all females were asked as part of the history.

All of the nurses in one group felt their screening question, "Are you safe at home?" is too vague and ambiguous. They wanted more specific questions—e.g., Is there anyone at home that is hurting you, threatening you, verbally putting you down, etc.? They felt they could miss DV cases by a question that could be interpreted as having to do with household safety instead of domestic violence.

Three Inter-related Themes: Time, Medicine First, and "Not my expertise"

The providers in emergency medicine mentioned three major inter-related themes fairly consistently—time pressures, a focus on "medical" over "social" issues, and discomfort with going outside

one's area of expertise. Time constraints in the ER pressure providers to focus on medical issues, which is their area of expertise and first order of business. They are uncomfortable going outside their area of expertise because they don't know what to do. They are unfamiliar with information about, resources for, and practices of domestic violence experts. Lack of familiarity means that anything they do will take more time than the DV experts doing the same thing—time they do not feel they have. They are also concerned that their ignorance, or relative lack of knowledge, may not help DV victims, and/or may inadvertently harm them.

While all these themes are inhibitions to providers making changes in their documentation practices, in fact they are making changes, and they want to help in the ways they feel they are best suited for. They are willing to provide accurate documentation in the medical record, but would like more and regular training with examples of good and bad case records. A one to two hour, one time training session is not sufficient to change practices. They need "repetition and reinforcement." They also want more materials as handouts and reminders of what to do when they identify a DV case. They want resources for themselves and their patients—e.g., in a resource book and on the computer. They emphasize that they need assistance from DV experts to deal with the more "social" aspects of domestic violence and to fill in the gaps of what they don't know: taking complete histories, talking to the victims, providing support and access to resources, taking the time to follow-up the non-medical aspects of the DV case.

Many providers appear to feel overwhelmed by the complexity of domestic violence cases in an environment in which they experience time pressures, lack DV knowledge and expertise, and in which their medical expertise addresses only one of the problems facing a DV victim. They talk as if they feel they are expected to deal with it all. In the absence of DV experts to assist in the cases, they do feel as if they are opening "Pandora's box" (see quote below) when they encounter a domestic violence case. In addition, one nurse made reference to nurses' need to "fix it." "Once you ask the question and find out it's DV, you have to have a plan. You can't let it go, because then you'd be negligent—it's a huge weight. But you can't fix DV. It's very frustrating to work with victims."

While the primary emphasis in the training is on appropriate documentation in the medical record, the nurses and physicians talked a lot about screening issues. It is in the screening, the necessary antecedent to documentation, that most of the following issues first emerged.

Time Pressures in the ER. Time is a "huge factor" in the ER with domestic violence cases and was mentioned in all groups, except the EMTs. "Don't tell me about DV—it takes too much time and I have

six other patients." "When you're the only nurse on and it's busy...DV will take a back seat, there's too much else to do." "The training was great, but in reality I wouldn't...I don't have the time to do that. I would call the psych nurse." "I'm screwed now. What have I done? Pandora's box. I'll never get out of this room. There's a guy in 8 who needs to get discharged, the lady in 5 needs an IV, what is this woman gonna tell me?..." "Triage can't do that [take time]. There's six people screaming at you to get triaged before they can wait to see a doctor and so it's like...." "We just don't have the time."

The preceding comments were all from nurses. The physicians also mentioned time as a serious issue, but without concrete elaboration. Since nurses are the primary screeners for DV, either in triage, or "in the back" of the ER, they may experience the frenzy of time constraints in a much more concrete way. The EMTs did not mention the time factor in their discussion of difficulties with domestic violence cases. It may be that the structure of their work "on the street" is more elastic and responsive to the immediacy of what is going on—where they intervene, stabilize and transport to the ER—than would be the case in a hospital emergency room—where the cases pile up and have to be dealt with in varying levels of urgency. Or it may simply be that the other issues discussed by the EMTs were far more salient for them than time constraints.

Focus on medical, not social issues. All provider groups mentioned the medical emphasis in their work. Essentially, they focus on and do what they were trained to do which is provide medical assistance in emergency settings. "We're medical nurses, we're not psych nurses, and we're not denying the other side of it but we always see medicine as the first need and emotion as the second need." "No problem documenting the physical things, but no time for the other stuff—send it on to psych to do and document—they have all the resources and knowledge." "You can handle the broken bones and the pain and the anxiety, and so forth...but I can't handle all the social part of their problems." "As an ER nurse, it's not our real specialty. It's nice to consult and move on...You probably have 5 other patients that are all different degrees of illness and although DV is very important, and it needs action, it's just what you can do about it as an ER nurse is limited."

The EMTs' focus is also medical, "not legal and allegations." More than the physicians and nurses, they raised the issue of what you put in a medical document. As they put it, "who did it is for police to deal with." "You're more focused on when you go in what you see and think of the medical aspect of the record." "...our primary focus is medicine, the provision of emergency medical services. Not to investigate legal statements or accusations that are made from one individual to another involved in a

domestic dispute....when you're documenting, your primary concern is to document the injury or injuries, psychological state, if it's pertinent to what's going on with the individual." Many EMTs perceived the documentation training as expecting them to focus on legal issues that they felt were in conflict with their EMT training.

Discomfort with going outside one's area of expertise. Providers often feel inadequate to deal appropriately with the DV cases. They feel they do not have the knowledge, expertise or ready access to resources to help their patients beyond their medical needs. Physicians said they can "discover" DV cases and treat the medical aspects, but they need DV experts to do the rest. They do not have the time or the expertise.

Providers from the hospital without any DV team are emphatic about the need for DV experts to help them with their patients. Providers from the hospital that has a DV team are concerned about the lack of coverage during nights and weekends when they get a lot of the cases. Patients end up leaving or sitting in the ER all night. Sometimes they are put into a "safe bed."

Nurses without access to advocates said, "We definitely miss the advocates....they would help you and the patient and be in there for 45 minutes....they helped us do things we didn't know how to do, and they did follow-ups." "You don't give me the tools to deal with domestic violence. You make me ask, you leave me hanging out there and my only resource is now a psych nurse who is stretched beyond belief some days with an entire psych suite full of patients and she's also going to the term rooms dealing with families there." In contrast, nurses with access to advocates noted the importance of being able to call in the DV team to deal with issues and resources that the nurses don't know about. One nurse noted, "[We]...See the same people over and over again and after six or seven 'I fell down the stairs' or 'I hit my head'...we would call the social worker to see the patient. They are better able to get the information out."

The EMTs had concerns about putting in the documentation "Injuries consistent with...." They perceived the documentation trainers wanted them to say this, but they only want to describe the injury and let someone else say what the injury is consistent with. They feel that is the job of the experts. The doctors and other experts should draw those conclusions. "...we're not supposed to diagnose....this sounds like they're asking us to diagnose the situation."

The EMTs also had concerns that naming names of who did what to whom makes the documentation a "legal document." They felt police officers are required to name the names and are protected by law, but "there's no DV law," so they feel open to liability—"sort of puttin' our asses out there in a sling, I hate to

tell you, because when you start writin' people's names and accusing them of stuff, that becomes a legal document." They will record what people say, but they don't want them to say too much because it may end up in court. They don't want to name names. They want the police to put the names in. There was a heated discussion about this with some EMTs insisting that it was all right for them to write, "So and so states 'John Smith' hit her with a closed fist."

Sub-Themes

EMTs' Perceived conflict between medical training and documentation training.

Many of the EMTs perceived a conflict between the EMS training and the domestic violence documentation training. "Some of the things they wanted you to write and we block those out. We said we can't write those and they said, well you should write them and we said we can't write those. Some of the instruction they gave us on how to document things were in total conflict with everything we've been taught throughout the years." They described a "big debate" after the initial training, a "department-wide debate because everybody said you gotta listen to 'em. And it became an issue. And I forget exactly what it was but it was this debate over, you know, we can't be writin' that because what we usually write is what we observe and not really like an opinion or to point fingers at a person on a sheet." Not all the EMTs felt there was a conflict. What is clear is there is a great deal of confusion about what is expected with regard to documentation and whether the expectations are in conflict with their EMT training. There was discussion and disagreement about "pointing fingers" at someone.

"...you go to a call and it's he said, she said and finding out that it wasn't him, it was someone else. So it just sort of made the ability to someone to stop pointing fingers at another person, whether they were right or wrong. And that was the way our documentation was supposed to be, observations, examinations, and we don't write an opinion. We write, you know, what we observe, what we see, just the facts. And it became that, at the end of it, they wanted you to write an opinion and that became the issue." Others disagreed. "I didn't get it like that....thing they were saying is put patient alleges or patient states that X, Y, Z did this." This group felt that the primary focus of the training is to document injuries so the medical record can support an investigation.

Some EMTs don't want to name people. They will write "husband," "boyfriend," but won't name them. They feel it's not their job. Others disagreed and said you are just saying what she said—you're not saying it. You're reporting her words—"You're not liable for a statement that you record on behalf of an individual and I think that's the key." One EMT described giving a name and then the victim said, "no, not

that one." There was clear concern that naming names makes it a "legal document." They will record what people say, but don't want them to say too much because it will end up in court—don't name names—let the police put the names in.

Pointing fingers and naming names are clearly connected to concerns about retaliation. They are concerned for their safety in causing people legal problems. "You're a witness." "That's not gonna stop us from goin' to the call, it just happens to be that just now all of a sudden, you know...they remember you better than you rememberin' them." "Let the police be the ones that document..." Some clearly feel that extra info can come back to bite you, therefore you shouldn't get it in the first place. There was much disagreement and discussion on this. Some were focusing on "it's not my job," while others wanted to help the DA by documenting. They wanted to get the guy off street. The abuser shouldn't get away with the crime.

What about men?

The EMTs talked about encountering DV toward men and same gender DV, and noted the lack of training on those issues. "There's somethin' about when a woman kicks the crap out of a guy, and you say you know that asshole probably had it comin' to him.[laughter]" "How often do you hear the term he probably deserved it? All the time." "No, I hear she probably deserved it..." "NO!!!" "I've heard it both ways."

"There's a lot of same gender domestic violence that goes on because we have a very big gay community and there's a lot of same gender and yeah, they're right, there is nothing...I've never, ever sat in on any domestic violence thing where it said, you know anything about a guy kickin' another guy's butt or even a woman kickin' a buy's butt. It's like the men are left out of the picture. They're not...I mean like, what? So they don't get hurt too?"

Two of the six physicians noted they screened males for DV if they suspected something. Two of the nurses indicated they "asked everyone."

Priorities

One nurse brought up the issue of shifting priorities in the hospital, and questioned the hospital's commitment to battered women at this point in time. In an earlier time physicians did safety plans for any physically injured woman. "She crushed her finger in the window, I want a plan of safety for her. You know, she stubbed her toe, I want a plan of safety for her, you know, and they did it. And [the director of

residency] harassed them for a while until it became routine and second nature and no big deal. And they can do that tomorrow.....the Director of Residency can say do this starting now and it's done. Well, they don't do it. You know, that doesn't take a whole lot of implementation. That just shows attitudinal priority."

Frustration with victims reluctant to press charges

A few nurses reported frustration with victims reluctant to make overt changes. "What's frustrating is that if the patient doesn't care themselves, then you feel like....What am I going to do? I'm going against a brick wall here." Others pointed out the difficulty of "fixing" DV makes it frustrating to work with victims. You can't fix it. You can only deal with the medical issues.

An EMT reported frustration with a victim recanting and not pressing charges:

"I'm going to court a week from today on a domestic violence case. The woman that's involved, she gave me a lot of statements and I wrote everything she said. ...It's not necessarily medicine, but I think it's something the prosecution could use. She's not gonna prosecute this guy cause two days later she's gonna be back with the same guy just like she was the last time he beat her up. You know, it's kind of frustrating for me to see it but she's been beaten up by this guy a dozen times. ... my job, like I say, is medicine but she's probably not gonna take the initiative to getting this guy off the street and I will."

Suggestions

Training. A number of providers suggested expanding training to other groups: medical schools, pediatrics for teenage relationship violence, psychiatric nurses, and other hospital staff—e.g., front desk, security, and secretaries. The physicians noted that as 4th year ER physicians they may be "secondary" on the chart documentation. "Primary" will be a younger non-ER resident who will be primarily responsible for documentation on the chart, and these residents have not had the documentation training. As the secondary physician, the ER resident will oversee what the other resident has done, but will not necessarily redo the documentation. They may only add a line or two. The 4th year ER residents felt that expanding the training to the other specialties would be helpful.

All providers wanted further training and suggested annual refresher courses. They all found discussion groups focused around chart reviews, preferably with a lawyer, a very helpful format. They all also wanted concrete examples of what should and should not be written in a chart. What five or six things would further the case in court, and what things would keep documentation from helping a victim?

In general, some of the nurses indicated that education makes them more aware and more comfortable dealing with domestic violence cases. They specifically wanted training on the process the abused women go through in trying to end the abuse in their lives—"go over more of the steps... women have to go through before they finally leave...." In addition, they want training in how to talk to battered women—what to say that may help them "get out." "We just have to be able to communicate....Each nurse should be educators in domestic violence and not leave it to the psych nurse.....without the talking there is not showing of caring and I think that these people need to be shown that someone cares. And you're not going to show you care by stuffing a piece of paper in their hand. You do have to do that talking and that eye to eye....Training would help us try to get that across in a short amount of time."

One nurse suggested educating patients and professionals about the health issues of violence: "The hospital will hire people to teach diabetics how to take care of their toes. Well, they should. It's very necessary if you have diabetes, you need a lot of education. But they won't deal with the health issues for women being beaten. Well, if it's a health issue, if you're gonna teach about diabetes because it's health, why don't you teach about violence because it's health?"

Domestic Violence Experts. Physicians and nurses want 24 hour on-call DV experts to help them deal with the cases. It was one of the most consistently emphasized suggestions from these providers. If they lost the advocates, they want them back, and if they have them now during the day, they want them on nights and weekends. They clearly report that "discovering" DV cases without expert assistance to do those things the providers feel they don't have time or expertise to do, leaves them feeling overwhelmed.

Materials. There was a clear call for additional materials for both staff and patients. They want more visible, available information: posters, leaflets, and tear-offs, cards in the bathroom, a resource book, laminated cards—with information on the red flags of DV, what to document 1-10, phone numbers of resources, how to access DV experts. They also suggested putting this information on the website, so that everyone can access it—not just the ER—and so that information can be printed out for patients who may need it.

Forms. Most providers reported that the existing forms had very little room to write. The space is too small to document what they need to. They would like more room and/or a different sheet of paper with more questions—like a check off to cue the interviewer about what to ask.

Institutional priorities. In response to the question, "How can we better facilitate documentation?" One nurse suggested it had to be made an institutional priority. It is clear from many of the provider comments that they need institutional support in a variety of ways. Perhaps most emphatically, they want

on-call, or on-site access to DV advocates. They want to know it's a priority for the institution by the provision of resources, by compensated training time, and by a clear mandate from administration that the institution is committed to screening for and documenting IPV.

Break down barriers. Many of the EMTs felt the trainer really did not understand what their world was like and that created a barrier to good training. "They tell you what your job is and what to do and they have no idea what you're going through." Their solution to this lack of awareness was to "have them come ride with us." "...You go out, you ride like in one of these trucks where they're doing 15 calls a shift and they're goin' into some of the worst areas and going into some of the worst situations." The trainers should then create a course guided by the EMTs' needs on the street and then cover the legal aspects of it.

Implications of the Findings for Further Interventions

- Most of the providers want to help DV victims
- They are, in fact, adjusting their documentation practices
- They want help from DV experts in dealing with DV cases
- They want further and ongoing training
- They need clarification about what is and is not expected of them
- They want to feel the trainer understands their particular work situation
 - They want training tailored to their needs
- They want the commitment of the institution to the screening and documentation efforts

It is important to emphasize that many providers feel that just doing their job, with the addition of asking about IPV, accurate documenting for IPV, and proffering referrals, is not perceived as enough, or even good medicine. They feel overwhelmed by the problem. For some reason they are not receiving the message of the training. The reasons for this may be complex, but it is clear that the tendency to try and "fix it" or to be focused on active problem solving, when all the battered woman wants is recognition, validation, getting her medical needs taken care of, and a possible referral, is getting in the way of providers adding a few small things to what they already do. The lack of institutional support appears to be a part of the problem, but a lack of understanding by providers about the complexity of making changes in the life of someone dealing with IPV may also contribute to unrealistic expectations of what they should do. One nurse explained that being educated about the process of change for abused women reduced her own frustration.

They can't fix it, but they can have a powerful impact just by doing their job with a modicum of sensitivity. They may not see the immediate result of what they do, but the impact on the lives of abused women is very real, as they themselves have said.

Training for Advocates working in Health Care Settings

In our proposal, we proposed to create and deliver a training to attorneys on how to use medical records in legal cases involving IPV. However, during the course of the project it became clear that it was too soon to try to predict with any certainty the reliability of the information that would be in the records. Rather than trying to reach attorneys we determined our time would be better spent presenting our findings and suggestions to advocates, social workers, and attorneys who attend IPV conferences. These advocates are more likely to work closely with patients and have access to patients' attorneys including prosecutors and family law attorneys. They are also more likely to have contact with medical providers and know of the existence of documentation that could be used in court. Therefore, we increased chances of improving care to victims and informed use of records in health care through training advocates who regularly work with clients in health care settings. We sought to train advocates, social workers and attorneys in how to consider issues related to provider testimony, methods of record keeping that ensure patient privacy, and how medical records may be more useful to patients than social work or advocacy records. Advocates and social workers working in these settings are also more likely to have regular contact with providers and may have the most access to and influence on providers with regard to changing their attitudes about working with clients. One on one training through advocates may be the best way to create change and change the culture of medical settings rather than department wide training. Also, attorneys are more likely to track down the advocate or social worker if there is a need for evidence. Training advocates and social workers how to work with attorneys and how to assist the relationship between doctor and attorney is helpful in increasing the amount of medical testimony and evidence introduced into legal settings. Finally, if an attorney is not incorporating the medical treatment history or health impacts of abuse suffered by a woman, the advocate or social worker can empower the client to raise these issues or contact the attorney to tell them what kind of information exists and how it could be helpful, particularly for those attorneys who do not regularly represent victims of IPV.

Fortunately, The Family Violence Prevention Fund sponsored Jane Doe, Inc, to conduct a statewide project as part of a national campaign to address health care response to IPV. This project is called "The Massachusetts Statewide Healthcare Awareness, Response, Resources and Education on Domestic

Violence (SHARED) Project and is directed by Liza Sirota White. The PI actively participated in one aspect of this project that examined issues related to documentation, privilege and confidentiality. Comparing the roles and responsibilities of the various providers working in different health care settings and making recommendations related to documentation for each was one focus of this project. A presentation developed for two national conferences and three regional domestic violence advocacy conferences is contained in the Appendix.

Lessons Learned & Recommendations

Several valuable lessons emerged over the course of this project. We have selected several lessons to share and made recommendations for future work and replication efforts.

Lesson One:

Most providers easily recognize physical symptoms related to IPV. Providers struggle with how to talk to patients who disclose abuse and how to deal with patients who present with symptoms but do not disclose abuse. Providers may become so focused on avoiding IPV or investigating it that they run out of time to do what they are most qualified to do: assessing, treating or documenting the patient's medical needs.

Recommendations:

- Providers need direction in how to talk to patients about abuse, the impacts of abuse on the patients' health and how to limit the scope of inquiry so that they can attend to medical needs.
- Providers need to remember to conduct thorough assessments of past, potential and current injuries, treat all injuries and better document observations rather than focusing all their attention on collecting details of an incident, safety planning or referring patients to IPV services.
- Providers must understand that it is not their responsibility to 'make a patient safe' or solve her problems. Providers can play an important role by educating patients that help and resources are available, breaking patients' isolation, build patients' trust in helping systems and creating a positive help-seeking experience.
- Providers need more training in how to recognize psychological and emotional abuse and how this type of abuse impacts a patient's physical and mental health and her ability to manage health care issues.

Lesson Two:

The feasibility of implementing an IPV protocol, delivering training related to the protocol and evaluating provider adherence to the protocol is dependent upon adequate resources and department-wide support.

Recommendations:

- Department resources must be carefully evaluated in order to assess the best means of implementing an IPV response.
- To maximize limited training resources, training sessions should be offered to as many providers as possible at the same time. However, obtaining full department participation may require offering several trainings at varying times to accommodate provider work schedules. Significantly more resources are necessary to implement a protocol in a 24-hour setting than one that operates during regular business hours.
- Administrative support for participation in trainings and implementing protocol practices in the form of monetary compensation and professional recognition would greatly enhance training participation and protocol implementation.

Lesson Three:

Implementing a team approach to respond to IPV in health care settings enables providers to use their medical skills to support victims and do so within their time and resource constraints.

Recommendations:

- Providers should provide a limited intervention that includes:
 - ❑ Inquiring in a kind and private way about symptoms or presentations that raise a concern of IPV;
 - ❑ Performing a careful assessment of all symptoms and conditions not just the most serious injury;
 - ❑ Inquiry into the healing of past injuries
 - ❑ Treating all medical conditions;
 - ❑ Documenting any patients descriptions of incidents of abuse resulting in need for medical care including facts relating to who, what, where, when, how, type of force and any weapons used. Quotes and "patient reports" is the recommended means of documenting the patient's description of events.
 - ❑ Documenting injuries and health conditions in a detailed and specific manner. Providers may have to draw their own body maps. Photographs are recommended if they will be sufficiently protected and stored with the medical record or given to the patient or patient advocate.
- Counseling, safety planning and advocacy work should **only** be performed by providers or others who have received extensive formal training in IPV.
- Providers need to plan for patient and provider safety during patient's stay in the institution. Providers should involve security personnel in safety planning rather than waiting until a problem arises.
- Providers can indicate to patients that help is available, that change is possible and offer resource numbers and referrals to IPV services in a five-minute intervention.

Lesson Four:

Many providers feel that they do not have the time or resources within the treatment setting to solve the problem of IPV. Most providers only consider a response effective if it achieves patient safety upon discharge. Such high expectations are unrealistic given the complicated nature of IPV.

Recommendations:

- Modifying expectations to create more realistic goals to achieve an effective response to IPV is necessary.
- A team approach to IPV in health care settings will optimize limited resources.
- Providers who conceptualize themselves as a part of a team of service providers are more likely to see the potential for successfully responding to IPV.

Lesson Five:

General Protocols developed by organizations or outside health care institutions serve as useful templates for devising a protocol but it must be tailored to meet the circumstances, needs and resources of each particular setting.

Recommendations:

- A thorough exploration of current workings and procedures, including forms and electronic record keeping systems, must inform any protocol related to IPV.
- Providers with extensive experience working in the setting are vital to the development of a working protocol.
- Patients should also be consulted for recommended responses.
- Relevant administrative offices including legal counsel, social work and medical records departments should be involved in developing the protocol.
- Protocols should incorporate local resources.

Lesson Six:

Medical documentation is not necessarily standardized among providers, even within the same department. Many medical record forms are not user friendly in cases of IPV and do not provide for photograph storage.

Recommendations:

- Standardizing documentation methods would improve patient records by clarifying what occurred at each visit.
- More consistent documentation strategies could only increase the quality and continuity of care.
- Providers within departments or institutions should adopt a list of abbreviations that everyone could use. A legend depicting commonly used abbreviations would greatly increase the likelihood that records could be introduced into court without requiring that a provider interpret the records.
- Medical record forms should be constructed to make response to IPV easier to document. A storage place for photographs and releases should be provided.
- Providers should be informed of rules governing their release of information related to patient treatment. Providers should also be familiar with rules and procedures relating to how their health care institution manages and protects patient records.

Lesson Seven:

Many of the providers involved in the study believe that if an IPV intervention cannot be executed fully from beginning to end with a patient, the provider should avoid the issue of IPV altogether. Many of the IPV training manuals and protocols may inadvertently reinforce this message.

Recommendations:

- It is better for providers to perform one step of an intervention than do none at all. Simply acknowledging abuse is important.
- Most patients are not expecting and may not want extensive services from a health care setting. Perhaps only certain aspects of an intervention will suit a patient's needs. Responding to each patient's unique circumstances is likely to encourage her or him to seek help again in the future.
- The quickest and easiest intervention for providers is to leave a card with resource numbers in a place where patients can review them in private and take them home without notifying hospital staff. Many patients prefer to receive resource numbers in this private manner.
- Most areas have a 24-hour hotline that IPV victims can call anonymously to talk to a trained IPV counselor. Providers without the time or skills to address IPV should provide patients access to a phone in a private room so they have an opportunity to make this call.

Lesson Eight:

A 50-minute training to a portion of the staff is not enough training to create significant change in how a medical site addresses IPV. Additional training time would better able trainers to address training priorities more fully.

Recommendations:

- Providers would be more likely to adopt practices if all providers were required to attend training, incentives to acquiring knowledge and skills were made available, and structural changes to procedures and medical records could be made to accommodate provider concerns.
- Training needs to be on-going and conditions that reinforce implementing knowledge and skills into practice needs to be established. Further study and thought should be given to training methods other than in-service group sessions. Alternatives could include:
 - ❑ Small group record reviews
 - ❑ One-on-One clinical consultations during work shifts
 - ❑ Partnering with a domestic violence advocate to deliver services on a case-by-case basis
- Training should be delivered to all staff, and it may be more effective to train across provider groups, preferably training providers who regularly work together as a team.
- Future studies should incorporate mechanisms to ensure maximum feedback from study participants as to usefulness of the training after some period of implementing intervention strategies.
- Further study of how to sustain effects of training and to continue to improve documentation processes is needed.

Conclusion

The Need for Institutional Support in Addressing IPV. Many helpful protocols, guidelines and training manuals are available to assist health care providers to develop more effective strategies for addressing IPV. Resources have been tailored to address different types of practice settings and the varying roles played by different types of providers. However, despite the tremendous effort devoted to improve health care response to IPV, current practice in most medical settings need to undergo significant changes in order to confront the health impacts of IPV through consistent identification, careful assessment, and comprehensive treatment of injuries and health related symptoms that result from IPV.

A review of this report and any protocol, guidelines or training manual addressing health care response to IPV reveals that providers are being asked to make substantial changes in the way they currently address patients presenting with IPV. Many providers, like professionals in so many other disciplines, did not choose to specialize in IPV work but instead have been thrust into it as a result of their chosen area of interest whether it is medicine, law, social work, or psychiatry. While they may prefer to avoid issues such as IPV, child abuse and neglect, elder abuse and other violent crimes it will inevitably be a part of their work. Accordingly, if providers are expected to adopt new approaches and implement them into their every day practice, they must be given adequate resources, support and training. In order to effect changes in provider behavior, institutions must recognize the needs of providers, develop approaches and practices that make sense within each treatment setting, and make structural and institutional changes to support recommended practices.

First, health care administrators who control budget decisions must also recognize how regularly providers may see patients experiencing IPV and acknowledge the resources necessary to properly respond to this problem. Resources include ongoing clinical training, access to private treatment rooms in a secured area, working partnerships with other relevant services within the health care setting (security, social work, IPV advocates, interpreters) and referral mechanisms to services outside the health care setting (IPV support groups, safe housing, police and legal advocacy programs.)

Next, institutions must coordinate designated persons from relevant departments within the institution to design a response to IPV for various departments that best suits the needs, circumstances and resources of each department. Creating an interdisciplinary working team made up of health care providers delivering direct services, legal counsel, risk managers, and medical records staff will increase the likelihood of devising a response that will work and protect providers and the institution from any liability or unnecessary

costs. (Brouhard & Mahoney, 2002) When developing a response, institutions must also consider creating partnerships with services outside of the hospital in order to supplement their own resources.

Finally, the institution must implement the plan through infusing money and personnel resources where appropriate, making structural and systems modifications where necessary, working with providers to acquire the skills necessary to incorporate the IPV response into their practice and maintaining positive relationships with service partners outside the hospital.

When developing an IPV response institutions can help by creating attainable goals that emphasize skills commonly associated with health care delivery. Seen as a part of managing health care, providers can begin to view IPV as a problem that is solved over time rather than overnight and see themselves as one helper among many rather than a lone problem solver. A change in expectations can help providers to see the potential for success in their interactions with IPV patients. Providers often complain that it is difficult to help IPV victims because they view patients as, "unwilling to help themselves by taking action to leave the abusive partner." Expecting to effectuate drastic life changes in patients' lives in one treatment visit is unrealistic and typically results in providers and patients feeling disappointed and frustrated.

A Shift in Perspective. One of the most common misconceptions about IPV by many providers is that the problem should and can be solved immediately. This is especially true in certain health care settings such as the emergency setting. The truth is that with the exception of a few cases, most victims need time to end the IPV in their lives. IPV relationships rarely are ended quickly and simply. For this reason, providers need to shift their goal away from fixing a patient's problem or making the patient safe. Instead providers need to support a patient's effort to seek help and at the same time address her health needs and record observations. These behaviors are well-within the provider's expertise and help the patient in ways that can extend long past the visit. Documentation of a thorough assessment of injuries caused by IPV is a good example of important work that providers can do to assist patients.

Providers understanding how they can play a role in the larger scheme of IPV service delivery enables them to contribute their expertise to patients' problem solving, even if resolution of the problems occur sometime in the future. Providers may not see the beneficial outcomes of their work, but will know that by maintaining good treatment records, they afford patients what may be the only third party record of symptoms and injuries resulting from abuse. As such, these records can be vital in assisting patients to gain independence from their abusive partners.

Providers' experiences with IPV will be more rewarding and less frustrating if realistic expectations are set, adequate resources to accomplish goals are available, and providers learn to coordinate their work with other services providers in and outside the hospital.

Interdisciplinary and Institutional Collaboration. This evaluation project exists due to the working relationship built among research team members over several years. These relationships were built in the context of providing direct services to IPV victims in legal, shelter and health care settings. To improve services to clients, we forged new working relationships across institutions and disciplines. Such experiences taught us that sharing different areas of expertise, skills, access to resources and perspectives could only benefit each of our individual clients. Working cooperatively enabled us to spend more time with each client and turn fewer clients away. Each of us was released from the untenable task of being everything to every client and instead only responsible to deliver services within our skill and knowledge base. We provided services that were best suited to our professional role and referred clients to other services we knew well and to providers whom we trusted. Working across agencies and disciplines resulted in breaking the isolation that is so often associated with IPV service delivery in any professional setting. Surely, there are success stories of similar interdisciplinary working teams in other health care settings. However, this model has yet to be implemented completely enough to accurately assess its effectiveness.

Interdisciplinary working may not guarantee success in every case but it improves the likelihood of accomplishing small successes that may pave the way to patients' future safety. Supporting providers in each setting to implement a team-based approach and to build interdisciplinary working relationships increases the chances that change will occur on a level that will eventually change the culture of resistance that currently exists in many health care settings. Over time, implementing a consistent response to IPV will result in improved health care, increased satisfaction by providers who work with IPV victims and substantial economic savings to health care institutions.

Future Research. Further study is needed to explore what strategies will increase institutional and administration's investment and support of a consistent and effective IPV response in health care settings. Our project revealed that many providers have not been exposed to the wealth of knowledge and IPV resources developed over the past two decades. Even those providers who have been exposed to some information related to IPV have not had adequate incentive or support to incorporate this knowledge into their practice on a consistent basis. Lack of time was a serious concern for all participants in the study. Effective training and skills development to deliver health care that effectively responds to IPV takes time.

Additional research exploring different methods of disseminating information, incentive for acquiring increased knowledge, and identifying time efficient means of developing providers' skills is much needed. A useful area of study would be a more in-depth examination of what changes would need to be made so that IPV education and clinical training were required course work in medical, nursing and EMT schools. A critical look at how implementation of an IPV protocol on an institution wide basis may effect or transform the culture of the setting as opposed to training specific providers or individual departments would also add to current knowledge.

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