

U.S. Department of Justice

Office on Violence Against Women



# **A National Protocol for Intimate Partner Violence Medical Forensic Examinations**

**U.S. Department of Justice Office on Violence Against Women**

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## **Acknowledgements**

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## **Foreword**

Intimate partner violence (IPV) is an issue that presents remarkable health, social, and legal problems within the United States. IPV affects the lives of individuals of all ages, races, genders, sexualities, abilities, and social standings. OVW supports communities nationwide in their efforts to effectively respond to victims who experience intimate partner violence. Providing victims with access to a medical forensic examination is an essential component of the response that addresses their<sup>1</sup> medical needs while fostering safety and healing. Clinicians performing the examination have the ability to collect forensic evidence during the process. This may include information provided by the victim during the medical history, documentation of findings from the examination, and collection of any available forensic samples. Should the victim decide to engage with the legal system, these items may help facilitate the processes of investigation and prosecution. The protocol guides clinicians within healthcare settings on the care and treatment of these patients, as well as the necessary collaborations with other disciplines during and beyond the medical forensic examination.

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<sup>1</sup> The terms “they” and “their” are used as singular-reference, gender-neutral pronouns throughout this protocol.

## Goal of the Protocol

The goal of this protocol<sup>2</sup> is to guide clinicians across a variety of healthcare settings in effectively providing medical forensic examinations to patients experiencing intimate partner violence (IPV), which may include strangulation. A medical forensic examination is defined as a comprehensive assessment that prioritizes the patient's health and well-being, while also planning for or preserving information for potential use by the legal system. The medical forensic examination includes:

- Medical forensic history gathering
- Comprehensive physical assessment
- Treatment of injuries
- Provision of care for other healthcare concerns identified during the examination
- Sample/evidence collection
- Photographic documentation of findings
- Written documentation of the patient encounter
- Safety and discharge planning, including targeted referrals based on the patient's specific needs

It is incumbent upon clinicians to recognize the pervasiveness of IPV across all aspects of society, and its impact on the health and well-being of the patient who seeks care in a hospital, community clinic, primary care office, or from another clinical service provider. Regardless of whether the patient is prepared to leave the abuser or report the abuse to law enforcement, clinicians have an opportunity to provide the patient experiencing IPV with an array of options that enable them to make the best possible choices for themselves and their loved ones to move forward. This protocol identifies the range of ways in which clinicians can work effectively with patients experiencing IPV to provide comprehensive care and preserve options for involving the legal system, should the patient choose that path. It also aims to mitigate the potential harms, as

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<sup>2</sup> For other medical forensic exam protocols, please see the [National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents](#) and the [National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric](#).

outlined in the Medical Power and Control Wheel ([Appendix A](#)), that the healthcare system may inadvertently cause if IPV is not taken seriously, not recognized as a potentially lethal healthcare concern, or simply not well understood by clinicians.

This protocol is intended to provide clinical guidance; it is suggested practice, not a mandate on how practice must occur.

Some additional considerations about this protocol:

- Some states, Tribes, local jurisdictions, and federal departments or agencies (e.g., [Indian Health Services](#), Department of Defense) have developed protocols for the screening and assessment of patients suspected or known to be experiencing IPV. This protocol is meant to supplement, rather than supplant, existing guidance in those cases.
- Clinicians strive to build and maintain an evidence-based practice. Evidence-based practice is defined as “applying the best available research results (evidence) when making decisions about healthcare. Healthcare professionals who apply evidence-based practice use research evidence along with clinical expertise and patient preferences” ([Agency for Healthcare Research and Quality, 2013](#)). Patient preferences are a critical component of evidence-based practice; alterations may be made in the exam process to accommodate these preferences. No single approach exists to conducting the medical forensic examination, and the patient’s agency is best considered in all aspects of the clinical encounter.
- Although this protocol focuses on providing the IPV medical forensic examination, this work should never be performed in a vacuum. Best practice for the IPV medical forensic examination includes not only referrals to appropriate victim-service providers and other community agencies, but also a warm handoff (the clinician connecting the patient to the resource personally while maintaining a safe and trauma-informed process, rather than providing them with a telephone number or a website) so the patient is not left making cold calls to unknown resources in the midst of a crisis. Therefore, the protocol assumes that clinicians will actively participate in multidisciplinary relationship-building to support patients during the examination process and provide them with a wide array of options as they prepare for discharge. Engaging in multidisciplinary relationships

underscores what the research has demonstrated: a collaborative approach can improve health; as well as access to, and knowledge of, services ([Clark, Wetzel, Renner, & Logeais, 2019](#); [Miller, McCaw, Humphreys, & Mitchell, 2015](#)). A protocol cannot replace ongoing clinical education. To maintain professional currency and competent practice, clinicians should have access and support for ongoing clinical education on a variety of topics related to IPV medical forensic examinations.

# Definition of Intimate Partner Violence

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## Definition of Intimate Partner Violence

According to the Centers for Disease Control and Prevention, the term intimate partner violence (IPV) encompasses physical violence, sexual violence, stalking, or psychological harm by a current or former partner or spouse ([Centers for Disease Control, 2021](#)). IPV occurs across genders and sexualities and does not require a sexual relationship. It includes coercive control: strategic patterns of behavior an abuser may use to gain power and control by eroding their partner's autonomy and sense of self. This may occur through a variety of actions such as threats, intimidation, disparaging remarks, isolation from loved ones, reproductive coercion, financial control, use of technology to monitor or spy, nonconsensual distribution of intimate images, and other activities which may or may not be illegal, but can affect the health and well-being of patients served every day in clinical practices. For this reason, this protocol's definition of intimate partner violence is broad—using a public health and not a criminal justice framework—to shape an understanding of the challenges the patient—either adolescent or adult—faces and the ways in which clinicians can and should respond. This protocol encourages the clinician to center their responses around the patient's unique needs, issues, and wishes, and to prioritize the patient's health over a legal response. In this way, every patient might benefit from this protocol, and not just the subset of patients who engage with the criminal justice system.

IPV frequently is used interchangeably with domestic violence (DV). However, this protocol defines domestic violence as a broader type of interpersonal violence encompassing an array of relationships, including, but not limited to current and former intimate partners: family members, such as siblings, parents and extended members across generations; caregivers; and other household members. This allows for recognition that while abuse by an intimate partner and abuse by a family or other household member can share many similarities, impacting a patient's health and potentially having legal consequences for the abuser, domestic violence may possess additional dynamics and challenges that are not necessarily addressed by an IPV protocol.

The health impacts of IPV are well documented in the research (see the list below). These include not only acute injury related to IPV, but also physical and mental health sequelae.



The National Intimate Partner and Sexual Violence Survey found that women and men who had experienced IPV reported a significantly higher incidence of frequent headaches, chronic pain, difficulty sleeping, and limitations in their activities than those not reporting IPV; a significantly higher proportion had been diagnosed with asthma and/or irritable bowel syndrome (IBS); and a significantly higher proportion of women specifically reported their physical and mental health as poor compared to women who had not reported IPV ([Smith et al., 2017](#)). In a meta-analysis of studies examining IPV among men who have sex with men, those experiencing IPV were more likely to have depression, be HIV positive, and engage in substance use and unprotected anal sex ([Buller, Devries, Howard, & Bachus, 2014](#)). Unfortunately, little research has focused on the health outcomes of IPV on the transgender and nonbinary or gender expansive community; data in this area is lacking.

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### **Health Consequences of Intimate Partner Violence, Including Strangulation<sup>3</sup>**

#### Cardiovascular

- Hypertension
- Hyperlipidemia
- Chest pain
- Cardiovascular disease

#### Endocrine

- Diabetes

#### Gynecological and Reproductive Health

- Dyspareunia
- Pelvic pain
- Recurrent vaginal infections
- Cervical cancer
- Unintended/unwanted pregnancy
- Increased risk of adverse outcomes for birthing parent and child
- Preterm birth
- Low birth weight

#### Mental Health

- Post-traumatic stress disorder (PTSD)

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<sup>3</sup> A number of health consequences are associated with intimate partner violence. The list provided presents some of those most commonly cited in the current literature and is not meant to be considered as an exhaustive list.

- Depression
- Anxiety/Panic attacks
- Difficulty sleeping
- Suicidal ideation

#### Neurological

- Headaches
- Dizziness
- Traumatic/acquired brain injury
- Artery dissection
- Stroke

#### Chronic Diseases

- Gastrointestinal disorders
- Respiratory diseases
- Musculoskeletal conditions
- Urinary and renal problems
- Liver disease
- Fibromyalgia
- Chronic pain

#### Infectious Diseases

- HIV
- Higher viral loads in HIV+ women
- Sexually transmitted infections

#### Substance Use

- Increase rates of smoking
- Increased rates of alcohol use
- Increased rates of intravenous drug use
- Increased generalized substance abuse

[\(Bichard, Byrne, Saville, & Coetzer, 2021; Machtinger et al., 2019; McManus et al., 2022; Samankasikorn, Alhusen, Yan et.al., 2019; Smith et al., 2017; Stubbs & Szoek, 2021;\)](#)

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## Prevalence

IPV occurs across all genders and sexualities. Currently, much of the data available focuses on women, who are the majority of victims of IPV around the world. “[G]lobally, 31% of women aged 15–49 have been subjected to physical and/or sexual violence from a current or former

husband or intimate partner, or sexual violence from a non-partner, or both in their lifetime (defined as since the age of 15). That is almost one in every three women, or up to 852 million women worldwide. Intimate partner violence accounts for the largest proportion of this violence: an estimated 27% of ever-married/ partnered women aged 15–49 experience physical and/or sexual intimate partner violence in their lifetime” ([World Health Organization, on behalf of the United Nations Inter-Agency Working Group on Violence Against Women Estimation and Data, 2021](#), p. 59).

To put this in context<sup>4</sup>:

- Between 641 million and 753 million ever-married/partnered women have experienced IPV at least once in their lifetime.
- Of women 20–44 years of age, 10–16% of women had been subjected to IPV in the past 12 months;
- Sixteen percent of women between the ages of 15 and 24 experienced IPV within the past 12 months.

The prevalence of IPV for women appears to be lower in older age groups (approximately 8% in the past 12 months for women 45–49 and 4% for women 65 and older) but data was limited for women 50 and older ([World Health Organization, on behalf of the United Nations Inter-Agency Working Group on Violence Against Women Estimation and Data, 2021](#)).

In the U.S., almost 1 in 2 women and more than 2 in 5 men reported some type of sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime. Additionally, almost half of women and men reported psychological aggression by an intimate partner in their lifetime (49.4% and 45.1%, respectively) ([Leemis et al., 2022](#)).

The burden of IPV is not shared equally among all populations within the U.S.; many marginalized and oppressed communities experience IPV at disproportionate rates. In the most

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<sup>4</sup> There is also a notable gap in the evidence about the prevalence, magnitude, and forms of violence against particular groups of women, including those with complex and multiple forms of overlapping discrimination—for example, older women, those with disabilities, migrants, Indigenous and ethnic minorities, and transgender women, who may be at higher risk of violence ([World Health Organization, on behalf of the United Nations Inter-Agency Working Group on Violence Against Women Estimation and Data, 2021](#), p. 40).

recent National Intimate Partner and Sexual Violence Survey, prevalence of lifetime contact sexual violence, physical violence, or stalking by an intimate partner was greater among American Indian and Alaska Native women, Black women and Hispanic women than Asian-Pacific Islander women or Non-Hispanic White women. Prevalence was greater among American Indian and Alaska Native men and Black men than Hispanic men, Asian-Pacific Islander men or Non-Hispanic White men. Multi-racial women and men had the highest prevalence rates of all, with more than half of multi-racial women and more than one-third of multi-racial men reporting they had experienced contact sexual violence, physical violence, or stalking by an intimate partner at some point in their life ([Smith et al., 2017](#)).

Lifetime rates of IPV among sexual minorities were comparable to or higher than their heterosexual counterparts, bisexual women had the highest rates of intimate partner sexual assault, physical abuse, and stalking ([Breiding et al., 2015](#)). However, the 2019 Youth Risk Behavior Survey (YRBS) data found that teens who identified as gay, lesbian, or bisexual collectively experienced physical and sexual dating violence at significantly higher rates than their heterosexual counterparts, as did those teens who reported they were unsure of their sexuality ([Basile et al., 2020](#)). In a separate survey of transgender individuals, more than half reported experiencing some form of IPV in their lives ([James et al., 2016](#)). A recent study examining the health of non-binary and binary transgender individuals found no significant difference in rates of IPV between the two groups ([Reisner & Hughto, 2019](#)).

Reflecting the global data, IPV in the U.S. begins early in life. Results of the 2019 YRBS found just over 12% of students reported experiencing some type of dating violence, with female students reporting rates approximately twice that of their male counterparts (16.4% vs. 8.2% for any type of dating violence; 3.2% vs. 2.1% for both physical and sexual dating violence) ([Basile et al., 2020](#)).

Having a disability increases the risk for various types of IPV, for men and women. Analysis of national data found that women with a disability were significantly more likely to report experiencing rape and other types of sexual violence, physical violence, stalking, psychological

aggression and control of reproductive or sexual health by an intimate partner<sup>5</sup> ([Breiding & Armour, 2015](#)). A study examining men working with a disability-specific non-residential IPV program found that two-thirds had experienced physical abuse by an intimate partner, and 41% had sought medical care related to the abuse<sup>6</sup> ([Ballan, Freyer, & Powledge, 2017](#)).

In the U.S., costs associated with violence across the lifespan are staggering: In 2010, the cost of treatment for injuries secondary to all types of violence was \$8.7 billion ([Grossman & Choucair, 2019](#)). The economic burden of patients experiencing IPV (or the lifetime IPV cost in the U.S. population) is \$2.1 trillion in medical costs. For example, one recent study found that nearly 80% of participants experienced some form of strangulation ([Messing, Patch, Wilson et al., 2018](#)). Traumatic brain injury is well documented in men and women since so much of IPV is focused on the face, head and neck, often in the form of blunt force trauma ([United States Government Accountability Office, 2020](#)). Many women have experienced repeated traumatic brain injury because of IPV ([Valera, Cao, Pasternak et al., 2019](#)). A recent study of older male and female patients experiencing IPV found that the head and neck were the most common sites of injury across the five injury diagnoses they examined: contusion/abrasion, fracture, laceration, internal organ injury, and strain/sprain ([Khurana & Loder, 2021](#)). Medical costs not only reflect assessment and treatment of injuries but also the subsequent range of healthcare issues these patients experience. This includes reports of chronic pain, to gastrointestinal (GI) issues, to a host of debilitating health conditions, which were found to be higher than in patients not reporting IPV. An additional \$1.3 trillion is attributed to lost productivity (either missed work or challenges being productive at work due to IPV) among victims and perpetrators ([Peterson et al., 2018](#)). Even after IPV has stopped for a patient, their healthcare costs continue to be higher in most categories than in those who have never experienced IPV ([Rivara et al., 2007](#)).

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<sup>5</sup> The Breiding & Armour (2015) study included those who reported 1) being limited in any way in any activities because of physical, mental, or emotional problems and/or 2) having a health problem that requires them to use special equipment (e.g., cane, wheelchair, a special bed, or a special telephone).

<sup>6</sup> The Ballan et al. (2017) study used the definition “a physical or mental impairment that substantially limits a major life activity,” further categorizing physical, psychiatric, developmental, or sensory disabilities.

# Multidisciplinary Collaboration

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Care for patients experiencing IPV should not occur in a vacuum. Patients benefit from clinicians collaborating with other disciplines, both within, and outside of healthcare. The interaction a clinician has with the patient during the medical forensic examination is brief, and in most circumstances, the patient will have concerns that continue long after discharge. Confidence in a clinician's ability to provide specific and relevant resources, including referrals, can increase the patient's trust in the care they receive ([Williams et al., 2017](#)).

A variety of models exist for structured, multidisciplinary collaboration. In many communities, multidisciplinary meetings already may be occurring (e.g., sexual assault response teams [SARTs], domestic violence coordinating councils), providing an opportunity to bring the clinician into existing meetings, expand the role of the clinician in the meetings, create additional meetings that focus specifically on IPV, or hybridize existing meetings to also address victims experiencing IPV. Examples of models of multidisciplinary collaboration include:<sup>7</sup>

## **Coordinating Council/Coordinated Community Response Team (CCRs)**

Can be established at the local or state level; may focus on systems issues, but may also focus on other issues, such as education, public awareness, prevention, and public policy ([Sample Protocols: North Carolina Coalition Against Domestic Violence](#)).

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<sup>7</sup> While not a direct response to living victims of IPV, it's important to note that one other example of multidisciplinary collaboration is the Domestic Violence Fatality Review Team. The review is a, "deliberative process for identification of deaths, both homicide and suicide, caused by domestic violence, for examination of the systemic interventions into known incidents of domestic violence occurring in the family of the deceased prior to the death, for consideration of altered systemic response to avert future domestic violence deaths, or for development of recommendations for coordinated community prevention and intervention initiatives to eradicate domestic violence" (<https://ndvfri.org/about/faqs/>). According to the [National Domestic Violence Fatality Review Initiative](#), fatality review teams can be found in almost every state in the U.S.

## Family Justice Center (FJC)

A collaborative, multidisciplinary [model](#) that co-locates services for victims of family violence in one location to ease access to services, increase support, and maximize efficiency of resources.<sup>8</sup>

## Combined Sexual Assault Response Team (SART)/CCRs

Particularly in rural and remote jurisdictions, a combined meeting may be reasonable when many of the same parties are responding in both sexual assault and IPV cases.

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For communities in need of a way to structure and formalize their multidisciplinary response, National Network to End Domestic Violence’s Technology Safety project offers model confidentiality templates, including the [Memorandum of Understanding \(MOU\): Partnership Agreement for Community Collaborations \(in English and Spanish\)](#). The template addresses the policies of the collaboration; the roles and responsibilities of all parties; and outlines information sharing and confidentiality.

Collaborative relationships should be built with an eye toward the broadest spectrum of patients the organization will serve, versus being limited to the disciplines that commonly comprise sexual assault response teams and similar community collaborative response teams: law enforcement, victim advocates from community-based domestic violence and/or sexual assault programs, and prosecutors. Organizations should acquaint themselves with the array of service providers in their community and surrounding jurisdictions whom the organization might engage on a case-by-case basis for specific patient populations and circumstances:

- Organizations that specifically work with patients with disabilities.

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<sup>8</sup> Some FJCs have further enhanced their response to victims through the addition of a multidisciplinary strangulation protocol. Although the [President’s Family Justice Center Initiative Best Practices](#) identified the inclusion of medical providers as a core service to increase safety and support for victims and their children, when and how healthcare professionals are used in FJCs varies widely—some provide medical forensic care and others provide preventative care, such as immunization clinics.

- Organizations that work with people who are Deaf or hard of hearing.<sup>9</sup>
- Culturally-specific organizations; faith-based institutions who are addressing IPV.
- Although not traditionally considered a part of the multidisciplinary response, defense attorneys may be appropriate to engage in specific circumstances where IPV patients have also been arrested. These attorneys may assist with educating clinicians, particularly with issues involving testimony, the constitutional rights of criminal defendants, and differences in strategy from the defense perspective.
- Civil attorneys, such as those specializing in issues related to housing, family law, and immigration.
- Organizations that work with elders and Adult Protective Services.
- Because children are often present when violence occurs, organizations that work with children who witness violence should be considered.
- Organizations that address co-occurring violence, such as human trafficking, child abuse, and even gang violence.

### **Intradisciplinary Collaboration**

While much of the collaboration conversation is focused on how clinicians can work with other disciplines, not discussing intradisciplinary collaboration within this protocol would be a missed opportunity. For some patients, IPV may have limited their ability to access routine or episodic healthcare for themselves or their children, and the medical forensic examination presents an opportunity to connect patients with needed referrals for follow-up healthcare ([Ragavan et al., 2021](#)). Other patients may require healthcare follow-up related to acute issues associated with the specific violence they have experienced.

Creating and sustaining relationships within the healthcare community allows for targeted

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<sup>9</sup> Some people with disabilities and older adults who are experiencing IPV may be subject to mandatory reporting laws. As part of the multidisciplinary collaborative process, it is critical to be clear on mandatory reporting laws, including what must be disclosed during the report and to whom. Create confidentiality protocols that outline processes for maintaining patient privacy to the fullest extent possible under the law.



referrals, warm handoffs to colleagues, and identification of resources from which patients may benefit over the long-term, such as language-accessible obstetrical services for pregnant patients or clinics that can care for entire families. This is particularly important since patients who experience IPV are more likely to use healthcare resources at the time of the violence and in the years following the violence than their counterparts who have not experienced violence ([Hamberger et al., 2015](#)). These relationships may exist organically or may be built through participation in events such as Grand Rounds and other clinical lecture series, formalized publicity events, or even distribution of information to local providers.

# Trauma-Informed Care

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## Trauma-Informed Framework

Trauma-informed care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and seeks to employ practices that contribute to positive outcomes for survivors, staff, and systems ([Substance Abuse and Mental Health Services Administration, 2014](#), p. 9). Trauma-informed care also emphasizes physical, psychological, and emotional safety; trustworthiness and transparency; collaboration and mutuality; empowerment; and cultural sensitivity and responsiveness ([Substance Abuse and Mental Health Services Administration, 2014](#), p. 10). A trauma-informed approach benefits all patients, not solely those presenting following IPV assaults; integrating these practices elevates the quality of care across disciplines and can prevent [secondary stress](#) and [burnout](#) among staff, since this approach considers the impact of trauma not only on patients but on clinicians and other members of the healthcare team. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) defined the 4 Rs for a trauma-informed approach as:

1. **Realize:** How trauma affects individuals, families, groups, communities, and organizations, crossing disciplines within, and outside healthcare systems. This includes the realization that how people heal from trauma is varied, and will not necessarily take a linear, predictable path.
2. **Recognize:** Signs of trauma in patients, families, and staff involved with a program or practice (e.g., irritability, hypervigilance, and anger).
3. **Respond:** Applying principles of trauma-informed care across all aspects of the program or practice, from triage to discharge; staff training to policies and procedures (e.g., provide staff training on recognizing potential symptoms of trauma; provide valid and reliable tools to assess symptoms of trauma).
4. **Resist retraumatization:** To both patients and staff members, considering that many

program and practice staff may have their own trauma histories ([Substance Abuse and Mental Health Services Administration, 2014](#), p. 9–10).

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More recently, the trauma-informed care framework has been expanded to be trauma- and violence-informed care.<sup>10</sup> Building on the concepts of trauma-informed care, this framework encompasses the additional “intersecting impacts of systemic and interpersonal violence and structural inequities on a person’s life, emphasizing both historical and ongoing violence and their traumatic impacts” ([EQUIP Health Care, 2021](#)).

IPV patients may experience multiple forms of violence in their lives: “current and ongoing interpersonal violence (such as IPV, interpersonal racial violence) and ongoing structural violence, including systemic and organizational racism, absolute poverty, and other forms such as colonialism” ([Levine et al., 2020](#), p. 47).

This expanded framework provides an opportunity for clinicians to recognize intersectionality, a lens through which healthcare professionals can understand “the way in which both intersecting social identities and the interaction of these identities with sociopolitical structures affects clinical outcomes” ([Wilson et al., 2019](#), p. 11). More than just experiences of violence and trauma, as [Brooks and colleagues \(2021\)](#) note, intersectionality provides a framework to understand the absence of services for certain identities, as well as the absence of representation of certain identities in the research that informs clinical practice. “Intersectionality shows that paying particular attention to the ways that axes of identity and structural inequality converge can yield unexpected results” ([Wilson et al., 2019](#), p. 9).

Patients are complex and cannot be reduced to a single experience or identity. It is incumbent upon the clinician to see how the totality of a patient’s experiences and identities shapes their understanding of the world and how they navigate it.

“Survivors from marginalized groups not only face violence from their abusers (who may be an

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<sup>10</sup> For more information about trauma- and violence-informed care, see <https://equiphealthcare.ca/resources/trauma-and-violence-informed-care/>.

individual or an entire family) but also institutional violence in the lack of access to shelters, housing, finances, employment, healthcare, and welfare to name a few. In order to develop appropriate responses to survivors, it is critical not to downplay the significance of these elements and the intricacies of discrimination” ([Warrier, 2020](#), p. 7).

# Patient-Centered Care

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*Patient-centered.* Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.

([Institute of Medicine \(US\) Committee on Quality of Health Care in America, 2001](#), p. 6)

Sinaiko and colleagues ([2019](#)) identified that the following domains need to be addressed for care to be considered patient-centered. Research suggests that clinicians are less successful at applying the principles of patient-centered care when issues such as language barriers and poor clinician cultural competency are a factor ([Filler et al., 2020](#)).

## Goals

The patient's goals need to be considered as part of the healthcare plan, rather than an assumption or prescription of what the goals should be (this is consistent with trauma-informed care).

## Life Circumstances

The context in which healthcare delivery occurs in a patient's life matters—housing, social support, and financial circumstances all impact health, and can be responsible for structural inequities that make it challenging for a patient to access care and other services that affect health. Life circumstances also include issues such as racism, sexism, homophobia, transphobia, and other inequities that are not circumstantial, but exist as a reality for the patient despite what other issues may develop in their life.

## Values and Culture

Sociologists discuss culture as languages, customs, beliefs, rules, arts, knowledge and collective identities and memories developed by members of all social groups that makes their social environments meaningful (American Sociological Association, 2020). This concept of culture and the personal values that the patient holds, shaped by their upbringing, religion, community, and culture, influences their decisions about health and healthcare, and should be considered in care provision and treatment decisions to be truly patient-centered.

## **Care Preferences**

Engaging the patient in what they want is a natural part of patient-centered care, but the engagement must reflect informed decision-making, by providing patients with access to complete information and the ability to change their preferences.

## **Health Status and Symptoms**

A patient's current and past health status, and relevant information affecting health, including trauma, need to be considered in care planning and delivery.

## **Access**

A patient needs to be able to obtain quality care when and in the ways they need it, not just in a single model of care.

Organizations can define the ways in which these domains are specifically addressed within their policies and protocols to ensure consistency for both staff and patients (see [Program and Operational Issues](#) for additional resources).

# Use of Interpretation and Translation Services to Ensure Equitable Communication

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An *interpreter* is a person specially trained to convert oral messages from one language to another.

A *translator* is a person specially trained to convert written text from one language to another.

([Refugee Health Technical Assistance Center, n.d.](#))

The ability to provide care for all patients experiencing IPV requires thoughtful planning for interpretation services so that patients who are Deaf, hard of hearing, have limited English proficiency, or do not speak English as their dominant language, are autistic, have other language developmental challenges, or are visually impaired all have equal access to medical forensic services.<sup>11</sup> The following steps can help ensure equitable communication.

## 1. Develop written policies

Develop written policies for providing care to patients with communication needs (e.g., Deaf, hard of hearing, limited English proficiency), specifying how and when to deploy interpretation services.

## 2. Establish relationships

Establish relationships with local organizations that have experience working with diverse communities, including culturally-specific communities, and collaborate with trained interpreters.

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<sup>11</sup> The [Joint Commission](#), which accredits thousands of healthcare organizations in the U.S., requires provision of qualified interpreter services.

### **3. Provide training**

Provide specific training for staff<sup>12</sup> on interpretation services and working with patients to provide equitable communication across different types of interpretation platforms that may be used in the practice. Provide IPV-specific training to medical interpreters. This should include addressing potential cultural biases that could create inaccuracies in the translation services or discomfort for the patient seeking care.

### **4. Budget for services**

Consider a budgetary line item for interpretation services, including staff training, so that equitable communication is built into clinical service provision and staff sees its value reflected in the program's funding priorities.

### **5. Use trained interpreters**

Formal, trained interpreters (preferably medical interpreters with additional training on IPV/sexual assault, if possible<sup>13</sup>) are the ideal; friends or family members should never be used as interpreters.

- Using bilingual staff is not best practice. This should be considered only in the absence of other options or in the case of a clearly articulated patient preference.<sup>14</sup> If a staff member is used, it is necessary to have a conversation in advance about the breadth of their language skills and their comfort with more complex terminology, such as medical and legal terms that may arise as part of the patient encounter. All efforts should be made to avoid using staff as interpreters whenever possible.

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<sup>12</sup> Staff training should include education on cultural competency and cultural humility to assist the clinician with effectively communicating when there are barriers or cultural differences from their own (e.g., direct eye contact being seen as disrespectful).

<sup>13</sup> This may be an opportunity to collaborate and provide additional education to ensure that interpreters have necessary and relevant information to be prepared to interpret during medical forensic examinations.

<sup>14</sup> Some patients may not trust clinicians or interpreters based on previous experiences of their own, of their family, or others within their community. It may feel safer for these patients to have a family member communicate through the bilingual staff. Consistent use of appropriately trained interpreters should assist in breaking down this barrier to trust with patients.



- The provision of interpreters is in keeping with civil rights laws, including the [Americans with Disabilities Act \(ADA\)](#) and [Section 504 of the Rehabilitation Act](#).

## **6. Do not make assumptions**

For a patient who is Deaf or hard of hearing, do not make assumptions about signing or lip-reading. If they do sign, ensure that they understand and/or use American Sign Language (ASL) before securing interpretation services in ASL.<sup>15</sup> Do not make assumptions about literacy (or a patient's comfort in disclosing difficulties with reading or writing), or that communicating via paper and pen will be sufficient. None of these interventions are an appropriate substitute for interpretation services.

## **7. Brief the interpreter**

Brief the interpreter prior to the patient encounter to ensure they are informed of the nature of the content. Even if they are familiar with medical interpretation, the subject matter and terminology covered in the IPV medical forensic examination may still be a departure from typical content.

## **8. Plan for the interpreter's professional introduction**

The interpreter will provide introductory information for both the patient and clinician about the process. Regardless of how interpretation is being conducted, the clinician should ensure that their communication continues to be with the patient, even if the interpreted responses are coming through a third party. That means directing questions to the patient, making eye contact with the patient as answers are being provided, and continuing to actively listen, watching for nonverbal cues, and other important responses that are a critical component of the patient assessment.

## **9. Use teach-back strategies**

Use a [teach-back strategy](#) to confirm the patient's understanding of critical points, rather than only asking if they have questions or relying upon non-verbal responses, such as

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<sup>15</sup> According to the World Federation of the Deaf, more than 300 sign languages are used throughout the world. If the patient uses a sign language other than ASL, the specific type should be documented.

head nods. This strategy helps to clarify and reinforces important information (Allen et al., 2020; Lee et al., 2019; Nonaka, 2016).

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### **Resources for Working with Patients Who are Deaf and Hard of Hearing**

- [Deaf Etiquette](#)
- [National Deaf Domestic Violence Hotline](#)
- [Registry of Interpreters for the Deaf](#)
- [Tips for Working with Sign Language Interpreters](#)
- [Supporting Deaf and DeafBlind Survivors](#)
- [Language Access Tip Sheets and Palm Cards](#)
- [Working with Remote Sign Language Interpreters](#)

### **Resources for Working with Patients with Limited English Proficiency**

- [Asian Pacific Institute on Gender-Based Violence: Language Access, Interpretation, and Translation](#)
  - [National Standards of Practice for Interpreters in Healthcare](#)
  - [Best Practices for Communicating Through an Interpreter](#)
  - [Language Access Tip Sheets and Palm Cards](#)
- 

When evaluating the needs of the patient who is Deaf, hard of hearing, has limited English proficiency, or does not speak English as their dominant language, taking steps to plan for the patient encounter is important. It assists in ensuring the patient remains at the center of the medical forensic examination and allows for post-exam reflection to improve future encounters with patients who require interpretation services.

Based on the demographics of the jurisdiction, the clinician should consider collaborating with local translation services and/or culturally specific organizations to translate basic discharge materials into common languages spoken within the service area. This way written materials are available for patients to take home, if it is safe to take them, upon completion of the medical forensic examination. Consider recording discharge and safety information in audio form as well,

for patients who may be challenged by written materials, because of visual impairment, literacy, or safety concerns. Any materials provided or reviewed—as well as information about who provided interpretation and what portions of the examination were interpreted—should be included in the medical forensic documentation.

Finally, to ensure that *all* patients can understand and use the information provided, it is critical that materials are written in plain language. The Centers for Disease Control and Prevention offers recommendations for communicating using plain language in this [checklist](#).

# Gender-Affirming Care

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## Creating a Gender-Affirming Experience for All Patients

IPV occurs against and by anyone of any gender. In a national survey of transgender people, more than half (54%) reported experiencing some form of IPV in their lives. Thirty-five percent reported experiencing physical violence by an intimate partner (compared to 30% of the U.S. adult population) and 24% percent reported experiencing severe physical violence, such as being strangled, attacked with a weapon, or beaten with a fist (compared with 18% of the U.S. adult population) ([James et al., 2016](#), p. 209). Clinicians should be cognizant of best practices in providing services to LGBTQI+ people including using the correct gender identification, avoiding unnecessary invasive questions unrelated to the IPV medical forensic examination, and ensuring equal access to care.

In the same national survey of transgender people, one-third of the respondents who had sought healthcare in the past year reported a range of negative experiences with a clinician. Reports included: having to teach clinicians about transgender people in order to receive appropriate care; being misgendered by the clinician or staff members; being asked unnecessarily invasive questions unrelated to the purpose of the visit; being denied care; or in some instances, experiencing physically rough treatment by the clinician. This included 6% of respondents reporting verbal harassment, 2% reporting abusive treatment, and 1% being physically attacked by a healthcare provider. Almost 1 in 4 respondents reported that, at some point in the past year, they had decided not to seek needed healthcare due to concerns about how they would be treated as a transgender person ([James et al., 2016](#)).

Creating a gender-affirming experience begins with communication. Use these best practices as a guide to ensuring respectful, appropriate interactions with patients:

Best Practices	Examples
When addressing patients, <b>avoid using gender-specific terms</b> like “sir” or “ma’am”	“How may I help you today?”
When talking about patients, <b>avoid pronouns or other gender-specific terms</b> . If you have a record of the name used by the patient, use it in place of pronouns.	“Your patient is here in the waiting room.” “Max is here for a 3 o'clock appointment.”
<b>Politely ask</b> if you are unsure about a patient's name or pronouns used.	“What name do you go by, and what are your pronouns?” “I would like to be respectful. How would you like to be addressed?”
<b>Ask respectfully about names</b> if they do not match in your records.	“Could your chart be under another name?” “What is the name on your insurance?”
Did you use the wrong pronoun? <b>Politely apologize.</b>	“I apologize for using the wrong pronoun. I didn't mean to disrespect you.”
Only ask information that is <b>necessary for providing care</b> .	Ask yourself: What do I know? What do I need to know? How can I ask in a sensitive way?

(Adapted from [National LGBTQIA+ Health Education Center, 2020a](#))

Clinicians should clarify what name the patient uses versus what name may be listed on official documents (e.g., What may be used on insurance card, driver’s license, or other legal documents). The name may not be the same, and the patient should be consulted as to whether they are comfortable having their medical forensic record reflect the name they use or the name on their official documents.

- If the patient opts to have the name on the medical forensic documentation reflect the name on their official documents, the clinician should still refer to the patient by the name and pronoun used during the medical encounter. For safety or other reasons, a patient may not want to request a change.
- Some patients may use different names and pronouns depending on their presentation on a given day; in this case, changing the name and pronouns in the documentation is unnecessary.

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## Gender Affirming Care Glossary

### Common terms:

**Assigned female at birth/Assigned male at birth** – Refers to the sex that is assigned to an infant, most often based on the infant’s anatomical and other biological characteristics. Commonly abbreviated as AFAB (assigned female at birth) or AMAB (assigned male at birth) (National LGBTQIA+ Health Education Center, 2020b)

**Cisgender** – Individuals whose current gender identity is the same as the sex they were assigned at birth (Centers for Disease Control and Prevention, 2019).

**Gender binary** – Individuals who do not identify their gender as man or woman. Other terms to describe this identity include genderqueer, agender, bigender, gender creative, etc. (Centers for Disease Control and Prevention, 2019).

**Gender expression** – The ways in which a person expresses their gender through clothing, grooming, speech, likes and dislikes, body language, social interactions, and other behaviors. Gender expression (also known as gender cues) may intentionally or unintentionally communicate gender to others, and may or may not conform to socially defined behaviors and characteristics typically associated with being either masculine or feminine (Munson, 2014).

**Gender identity** – Gender identity is a person’s internal sense of self as being male, female, both, neither, or another gender. One’s gender identity is not necessarily visible to others. A person’s gender identity can be the same or different from one’s sex assigned at birth (Munson, 2014).

**Intersex** – Describes a group of congenital conditions in which the reproductive organs, genitals, and/or other sexual anatomy do not develop according to traditional expectations for females or males. Intersex can also be used as an identity term for someone with one of these conditions. The medical community sometimes uses the term *differences of sex development (DSD)* to

describe intersex conditions; however, the term *intersex* is recommended by several intersex community members and groups (National LGBTQIA+ Health Education Center, 2020b).

**Misgender** – The accidental or deliberate use of a name or gender pronouns that do not reflect the gender with which an individual identifies (Munson, 2016).

**Non-binary** – An umbrella term for gender identities other than male/man or female/woman. Some nonbinary people identify as a blend of both male and female; some identify as a gender distinctly different from or other than male or female; some do not identify with any gender; and some have constructed a gender that is new and unique. Non-binary people may or may not identify as transgender. Some common identity words include: Non-binary, Agender, Genderqueer, Gender nonconforming, Gender-expansive (Dreke, Crumrine, & Munson, 2020).

**Sex assigned at birth** – The sex (male, female, or intersex) assigned to an infant, most often based on the infant’s anatomical and other biological characteristics. Sometimes referred to as birth sex, natal sex, biological sex, or sex; however, sex assigned at birth is the recommended term (National LGBTQIA+ Health Education Center, 2020b).

**Transgender** – Transgender or trans is an umbrella term for people whose gender identity or expression is different from cultural expectations associated with their sex assigned at birth. Some common transgender identity words include: Trans/transgender, Trans woman / Trans man, Woman or man of transgender history, AFAB (assigned female at birth) and AMAB (assigned male at birth) (Dreke, Crumrine, & Munson, 2020).

**Trans man/transgender man** – A transgender person whose gender identity is man/male may use these terms to describe themselves. Some will use the term *man* (National LGBTQIA+ Health Education Center, 2020b).

**Trans woman/transgender woman** – A transgender person whose gender identity is female may use these terms to describe themselves. Some will use the term *woman* (National LGBTQIA+ Health Education Center, 2020b).

**Transfeminine** – A person, generally someone assigned male at birth, who identifies with femininity to a greater extent than masculinity or gender neutrality. Transfeminine is a broad term that includes trans women but also feminine people who do not necessarily identify as female, such as feminine non-binary individuals (Munson, 2014).

**Transmasculine** – A person, generally someone assigned female at birth, who identifies with masculinity to a greater extent than femininity or gender neutrality. Transmasculine is a broad term that includes trans men but also masculine people who do not necessarily identify as male, such as masculine non-binary individuals (Munson, 2014).

**Two-Spirit** – A male bodied or female bodied person with a masculine or feminine essence. Two Spirits can cross social gender roles, gender expression, and sexual orientation (Matthews-Hartwell, 2014)

# Setting the Stage for Open Communication

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Many patients are unaware of the connection between IPV and health and do not recognize or understand the clinician's role in responding to patients experiencing IPV. The patient needs to know that the clinician is receptive to hearing about IPV; is prepared to assist with potential safety planning and resources, if appropriate; and is willing simply to listen if the patient wants to talk about the challenges they face in living with violence or the threat of violence in their lives. Clinicians may also be uncomfortable broaching the subject or unsure of the best way to introduce questions about IPV to patients. Therefore, setting the stage for open communication about IPV is a multifaceted process:

## 1. Preparing the department, practice, or program

To ensure the patient receives optimal care, staff and program leadership need to recognize and be invested in the value a medical forensic response can bring to the patient who is experiencing intimate partner violence. This means ensuring IPV-specific education for all staff who may come in contact with patients, not just clinical staff. Additionally, policies and procedures should be developed and implemented to support the clinician in their care of this patient population.<sup>16</sup>

Visual cues, such as pamphlets, posters, and other print and digital information can provide a level of comfort that can make it easier for the patients to disclose IPV to the healthcare professionals or allow patients to recognize clinicians as a potential resource for assistance. In Williams et al. (2017), participants identified “a need for more pamphlets, signs, posters, and so forth related to gender-based violence in health settings. Several also suggested that these resources provide more information about how health providers are a resource for gender-based violence and the specific health risks related to abuse” (p. 5563).

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<sup>16</sup> See [IPV Health Partners](#) for suggested resources and tools.



## 2. Prioritize staff wellness and health

Providing trauma-informed care requires that hospitals and organizations prioritize staff wellness, not only to ensure that team members who have experienced violence are supported in addressing their own experiences as the needs arise, but that the organization creates safeguards to monitor for secondary or vicarious trauma or burnout, which can undermine quality care, create turnover, and impact the health of staff ([Schulman & Menschner, 2018](#)). The organization should ensure these safeguards extend to all patient-facing staff, including in-house interpreters, who routinely may be left out of programs and services addressing these types of issues.

## 3. Identifying Patients

[Screening](#) for IPV is an essential part of setting the stage. The U.S. Preventive Services Task Force recommends that clinicians screen all women for violence ([Health Resources & Services Administration, 2022](#)); the Joint Commission requires that hospitals use written criteria to identify victims of abuse, regardless of gender or age ([The Joint Commission, 2022](#)). A number of tools have been published to promote and improve clinical screening of patients of all genders, including a compendium of screening and assessment tools from the Centers for Disease Control and Prevention ([Basile et al., 2007](#)). See the Screening Tools tab in the *Screening for Intimate Partner Violence* section of this protocol. Despite federal recommendations, assessment tools, and guidance from myriad healthcare organizations, clinician screening remains inconsistent. A recent review of research on clinician screening practices across disciplines and settings found rates of screening for IPV ranged from 2–50%.<sup>17</sup> Clinicians were more likely to screen when they had on-site support for patients experiencing IPV; the presence of medical forensic services for these patients may improve clinicians' willingness to screen.<sup>18</sup>

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<sup>17</sup> Clinicians reporting they always or almost always screened.

<sup>18</sup> Lack of knowledge about IPV resources, lack of comfort with local services, and lack of organizational support for screening were some of the greatest barriers to screening identified across the studies ([Alvarez et al., 2017](#)).

#### 4. A trauma-informed approach

Clinicians and other members of the healthcare team can effectively obtain information about a patient's current experiences with IPV or recent and historical trauma that may include IPV, using the following techniques, grounded in a [trauma-informed approach](#):

- **Current IPV:** To identify a patient who is currently experiencing IPV, the clinician should *privately* conduct a standardized screening tool. Positive disclosures should prompt direct inquiry about the trauma, safety assessments, and acknowledgment that no one deserves to be a victim of violence. A warm hand-off should occur for referred services, including medical forensic services, social work, or other medical consultation. It is crucial that the patient is to be included in decisions about their course of care and not merely provided options the clinician believes may be best for the patient.
- **Past IPV as a component of a trauma history:** A clinician may choose to assume that every patient presents with a trauma history that potentially includes IPV and offer appropriate resources as a standard referral. The clinician may choose to screen all patients for the most common health consequences of past trauma, such as depression, PTSD, or chronic pain. Another approach is to query every patient, using either a screening tool that is specific to past trauma or open-ended questions in a conversation with the patient about trauma and its impact on health ([Machtiger et al., 2019](#)). The [Brief Trauma Questionnaire](#) is one such tool.

#### 5. The right place to disclose

Not every patient recognizes the healthcare system as a resource for assistance with IPV. Many patients have had unpleasant, judgmental experiences with healthcare professionals in the past, or simply do not trust that the clinician will not divulge information to law enforcement, child service agencies, or the abuser. Factors that can increase a patient's comfort in disclosing IPV include:

- Having the opportunity to talk with the clinician alone, away from the abuser

- Understanding the clinician's obligation to maintain confidentiality, and under what circumstances confidentiality may be breached (e.g., [mandatory reporting obligations](#))
- Empathy, concern, and validation from the clinician
- Specific care and referrals that are tailored to reflect the patient's individual concerns and needs
- Not feeling rushed by the clinician
- Understanding what the clinician is able to do for the patient and why the clinician sought specific information
- Helping the patient understand how their history of trauma has impacted their health ([Heron & Eisma, 2021](#); [Iverson et al., 2014](#); [Williams et al., 2017](#))
- Understanding who has access to the [documentation](#) of the patient encounter and what safeguards are in place

## 6. Educating patients about abuse

Some patients may not recognize their experiences as abusive or may not believe that IPV can happen in their community. For instance, in their recommendations for addressing IPV in the LGBTQI+ community, [Ard & Makadon \(2011\)](#) suggested that one important reason to screen patients is to bring awareness that IPV is an issue that cuts across all genders and sexualities. Similarly, by inquiring about forced sex (or following a positive screen for IPV with in-depth questions about specific experiences of abuse, such as reproductive coercion, birth control sabotage, and non-consensual distribution of intimate images), the patient may be able to identify other aspects of IPV and how it has impacted their health. In the process of educating the patient about abuse, however, the clinician must clearly inform the patient which acts or information trigger mandatory reporting and to whom the report will be made, so the patient does not feel ambushed. This should occur at the beginning of the discussion, so the patient may make fully informed decisions about what they wish to disclose.

## 7. Considering all available options

Part of the IPV discussion must be working with patients to consider available options for safety and self care going forward. Clinicians must be cautious about asserting a single option, such as leaving the abuser, as the only or best available option for patients. It is not the role of the clinician to convince patients to leave their abuser, and ultimately clinicians can be most helpful to patients by discussing an array of choices with patients, listening to their needs and desires, recognizing their autonomy and self-determination, and providing the resources to allow patients to make the best choices for themselves and their families or loved ones. In some circumstances [the safest option](#) for the patient may require remaining with the abuser until the patient's plans can be fully realized. Clinician beliefs that leaving the abuser is the patient's best or safest option, or the only option worthy of the clinician's time and efforts is ultimately misinformed, and may lead to increased frustration on the part of clinicians ([Beynon et al., 2012](#); [Tarzia et al., 2021](#)). Programs may want to focus ongoing education on this topic to reduce burnout and ensure patients receive consistent care regardless of their choices upon discharge.

# Screening for Intimate Partner Violence

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## How to Screen

Face-to-face screening for IPV is effective, particularly when the clinician administers a valid and reliable screening tool in a private, one-on-one setting ([Arkins et al., 2016](#); [Chang et al., 2012](#); [Paterno & Draughon, 2016](#)). In the emergency department setting, the nurse should be particularly cautious about screening in triage, where often little privacy exists, and screening questions may be easily overheard. Patients may find computerized, self-administered screening more comfortable, and may be apt to disclose more freely with this type of screening, although they may have concerns about completing a self-administered tool if they are unclear whether the responses will generate further counseling or follow-up ([Hussain et al., 2013](#); [Iverson et al., 2014](#)). Additionally, self-administered screenings may be completed in the presence of the abuser, so it is important that all self-completed screenings be reviewed by the clinician with the patient once they are alone in the examination room or office.

## What to Say

Introducing the topic as a routine component of the patient encounter allows the clinician to discuss IPV within the context of healthcare and emphasize the frequency with which it occurs across patient populations. Some examples of statements that introduce or frame IPV screening are:

- Violence can be a problem in many people's lives, so I now ask every patient I see about trauma or abuse they may have experienced in a relationship.
- Many patients I see are coping with an abusive relationship, so I've started asking about intimate partner violence routinely.
- I've started talking to all of my patients about safe and healthy relationships because it can have such a large impact on your health ([American College of Obstetrics and Gynecology 2019](#); [Alpert, 2015](#), p. 36).

## What to Use

Many healthcare organizations, including the [American Medical Association](#), the [American College of Obstetrics and Gynecology](#), the [American College of Emergency Physicians](#), the [American Nurses Association](#), the [American College of Nurse Midwives](#), the [Emergency Nurses Association](#), the [International Association of Forensic Nurses](#), the [American Academy of Family Physicians](#), the [American Academy of Pediatrics](#), and the [Association of Women's Health, Obstetric and Neonatal Nursing](#) have affirmed the need to routinely screen for IPV, but generally stop short of endorsing a specific screening tool. Although many of the available screening tools have been validated, their sensitivity and specificity<sup>19</sup> can range widely. Furthermore, not all screening tools screen for the same type of abuse; for example, many screening tools do not screen for sexual violence. Finally, **not all tools have been evaluated with a variety of patient populations, including immigrant populations, patients with disabilities, or transgender and gender-expansive patients, or in a variety of clinical settings, such as in mental health clinics or HIV/STD clinics.**

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## Screening Tools

TOOL	TYPE OF ABUSE SCREENED	ACCURACY
<a href="#">Abuse Assessment Screen</a> (AAS) (includes a Spanish language version)	Physical, sexual, and emotional abuse (not strictly IPV)	Sensitivity: 92%; Specificity: 55%
<a href="#">Humiliation, Afraid, Rape, Kick</a> (HARK)	Emotional, sexual, and physical abuse	Sensitivity: 80%; Specificity: 95%

<sup>19</sup> Sensitivity refers to a test or tool's ability to accurately identify the condition for which individuals are being screened. It is also referred to as the true positive rate. The specificity refers to a test or tool's ability to identify individuals who do not have the condition for which they are being screened. It is also referred to as the true negative rate.

TOOL	TYPE OF ABUSE SCREENED	ACCURACY
<a href="#">Hurt, Insulted, Threaten, Scream</a> (HITS) & <a href="#">Extended</a> (E-HITS)	Frequency of IPV (Extended adds a question about sexual violence)	Sensitivity: 75–78%; Specificity: 80–83%  E-HITS: Sensitivity: 75%; Specificity: 82%
<a href="#">Ongoing Abuse Screen</a> (OAS)	Ongoing physical, sexual, emotional IPV, and fear	Sensitivity: 60%; Specificity: 90%
<a href="#">Ongoing Violence Assessment Tool</a> (OVAT)	Ongoing physical and emotional IPV	Sensitivity: 87%; Specificity: 83%
<a href="#">Partner Violence Screen</a> (PVS)	Physical IPV in the last year and current safety	Sensitivity: 65–71%; Specificity: 80–84%
<a href="#">Slapped, Things Threatened</a> (STaT)	Physical IPV and threats	Sensitivity: 94%; Specificity: 38%
<a href="#">Women Abuse Screening Tool</a> (WAST) (includes a Spanish language version)	Physical, sexual, and emotional IPV	Sensitivity: 87%; Specificity: 89%

([Feltner et al., 2018](#))

For patients with disabilities, screening may need to be expanded to include abuse by a personal care attendant, in addition to intimate partners. Unfortunately, patients with disabilities often may not be screened for abuse in any form. One study found that although 90% of women reporting a diverse array of disabilities had experienced abuse in their lifetime (and 68% in the past year), only 15% had ever been asked about abuse or safety by a healthcare provider ([Curry et al., 2011](#)). Always screen patients with disabilities in private before allowing a personal care attendant or intimate partner to accompany them to assist with communication or mobility.

# Consent

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Consent can be defined as a discussion between patient and clinician that results in the patient authorizing or declining an intervention ([The Joint Commission, 2016](#), p. 1). Obtaining informed consent is a foundational component in any patient-centered encounter and includes the following steps:

- Disclosing information that a reasonable clinician would share and/or that a reasonable patient would want to know in a similar situation, including the issue prompting the intervention or treatment; benefits and potential for success; risks and complications; alternatives and their risks and benefits; and potential consequences if no action is taken
- Ensuring equitable language access to the information through medical interpretation if the patient and clinician do not share a language
- Providing information through the patient's preferred system of delivery where possible: verbal communication, written materials, video, interactive online information
- Ensuring the patient is able to make a decision that is free from bias or coercion by the clinician, other first responders, or the patient's family or other support persons
- Documenting all processes of consent in the medical forensic record, including information shared and the patient's questions and concerns

(Adapted from [Tillman, 2020](#))

When caring for the patient experiencing IPV, the clinician needs to obtain informed consent for physical assessment and treatment of the patient, and for additional components that might not be covered by standard hospital or clinic consent forms.

Depending on the patient's needs and desires, this may include:

- Collection of samples for evidence
- Photography
- Permission to contact the patient for medical purposes



- Release of exam documentation and/or the samples collected for evidence

If not already available within the hospital or organization, additional forms should be developed to provide explicit consent for these components. See [Appendix B](#) for a sample consent form.

Obtaining informed consent for the medical forensic examination is a flexible process; the patient may decline any portion of the examination. Additionally, the patient should clearly understand their ability to withdraw consent at any point during the process.

Certain conditions or circumstances may raise questions about a patient's ability to consent to the medical forensic examination, including the presence of an intellectual or cognitive disability, mental health diagnoses, and intoxication. However, these do not automatically negate a patient's ability to consent. With intellectual or cognitive disabilities, providing appropriate accommodations can enhance understanding. A patient's ability to consent must be evaluated on an individual basis, considering the following:

**1. Can the patient communicate the choice to have the medical forensic examination (based on their report of a specific history of IPV)?**

- Ensure interpretation, if needed
- Provide the patient with clear choices and respect the choices made, providing the opportunity for the patient to control the process throughout the medical forensic examination

**2. Is the patient able to understand what they are agreeing to in consenting to the medical forensic examination, including all available options?**

- Provide clear information about the health impacts of IPV
- Encourage the patient's questions and offer opportunities for the patient to ask questions throughout the encounter
- Use methods like a [teach-back strategy](#) to assess the patient's understanding

**3. Is the patient able to appreciate the consequences of participating in the medical forensic examination, including verbalizing decisions around evidence collection and involvement of law enforcement?**

- Ask the patient about their greatest health concerns at this time, as well as any concerns about involving law enforcement, the criminal justice process, immigration-related matters, or safety in general

**4. Is the patient able to participate in decisions about their care and the available choices, including all risks and benefits?**

- Provide treatment options as choices, reviewing the various risks and benefits of opting or declining as they arise
- Ask the patient about their preferences and respect their choices without judgment or pressure

(Adapted from [Miles et al., 2022](#))

If the patient is too intoxicated to consent to the medical forensic examination, based on the clinician's application of the above criteria, the clinician may monitor the patient until they are able to participate in the medical forensic examination. It is important to note that no specific blood alcohol level is recommended at which an individual is considered able to consent. Therefore, a blood alcohol concentration is not necessarily helpful in determining capacity, particularly for patients who may have chronic alcohol use disorder.

If a patient is unconscious or otherwise unable to consent, the clinician should follow their organization's protocol for obtaining consent and consult with the organization's risk management or legal counsel, where available. This may include obtaining third-party consent. Laws vary from state to state, but obtaining a third-party to provide consent may require assigning a family member, such as a sibling, to be the patient's guardian, since often the person who typically serves in this role (the intimate partner) is the person who inflicted the harm. However, the clinician needs to consider privacy concerns; patients may not want to involve other family members. Additionally, in certain circumstances, family members, such as adult children, may not be appropriate to make decisions due to a conflict of interest from their relationship with both the victim and the assailant. In such cases, a third-party guardian ad litem may be an option.

In the case of an [adolescent patient](#), the clinician should follow jurisdictional statutes governing consent and access to care. For instance, a state statute may allow minors to receive reproductive

healthcare, but not other aspects of an examination without parental or guardian consent. In some jurisdictions, a minor may consent to the examination but may not keep the results private from a parent or legal guardian. Exceptions to parental consent requirements also exist when the parent or guardian is the suspected offender or where the parent or guardian cannot be contacted and time constraints exist on the evidentiary needs of the patient. In such cases, the law generally specifies who may give consent in lieu of the parent or guardian, such as a police officer, representative from the jurisdiction's children's services department, or judge ([Office on Violence Against Women, 2013](#)).

# Confidentiality

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The medical forensic examination is bound by certain confidentiality laws, depending on the patient's age and circumstances, and the location of the examination. The most well-known of these is the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. HIPAA applies to health plans, health clearinghouses, and providers (defined as a person, business, or agency that furnishes, bills, or receives payment for healthcare in the normal course of business, and transmits those covered transactions electronically) ([Centers for Medicare and Medicaid Services, 2019](#)). Unless a patient provides a written consent to release information, HIPAA limits access to protected health information with certain exceptions, including compliance with mandatory reporting laws ([Markowitz et al., 2021](#))<sup>20</sup>. Other federal laws have since built upon HIPAA's protections. The Health Information Technology for Economic and Clinical Health Act (HITECH) expanded HIPAA to address electronic transmission of health information and specifically defined business associates who could receive electronic protected health information and the necessary requirements for maintaining confidentiality ([U.S. Department of Health & Human Services, 2017](#)). The [21st Century Cures Act](#), was enacted to promote information sharing and ensure healthcare providers may use technology to both exchange health information with patients and allow patients to access their health information, based on what is already available to patients under HIPAA.

For some patients, instead of HIPAA, the Family Educational Rights and Privacy Act (FERPA) may apply. FERPA is a federal law that specifically protects the privacy of student educational records. Generally, this statute will be a concern limited to clinicians providing services on college or university campuses that receive any funds from the U.S. Department of Education. FERPA recognizes inherent privacy for medical records (known as treatment records within the act). What is considered a treatment record, however, is defined narrowly:

“Records on a student who is eighteen years of age or older, or is attending an institution of postsecondary education, which are made or maintained by a physician, psychiatrist,

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<sup>20</sup> Many states have laws that exceed the protections of HIPAA; clinicians should refer to their state laws for guidance.

psychologist, or other recognized professional or paraprofessional acting in his professional or paraprofessional capacity, or assisting in that capacity, and which are made, maintained, or used only in connection with the provision of treatment to the student, and are not available to anyone other than persons providing such treatment, except that such records can be personally reviewed by a physician or other appropriate professional of the student's choice" ([U.S. Department of Health and Human Services & U.S. Department of Education, 2021](#), p. 4–5).

Once that information is provided to law enforcement, prosecutors, or the patient by obtaining a copy, those protections may be removed, making them accessible within the “educational record” and, thus, available to certain parties, including school officials with legitimate educational interest and the patient's parents ([U.S. Department of Education, 2021](#)). The rules related to FERPA and HIPAA, including an overview of each and where they may intersect, can be reviewed in the [Joint Guidance on the Application of the Family Educational Rights and Privacy Act \(FERPA\) and the Health Insurance Portability and Accountability Act of 1996 \(HIPAA\) To Student Health Records](#). Clinicians providing medical forensic examination services on college and university campuses should consider consulting with their Office of the General Counsel to develop program policies to protect patients' confidentiality within the existing federal privacy laws that apply.

Finally, clinicians should be mindful to hold conversations about privacy and confidentiality with the patient early in the clinical encounter. The patient may have concerns about who has access to their healthcare information, which can have significant safety implications. IPV Health Partners' [Privacy Principles for Protecting Survivors of Intimate Partner Violence, Exploitation, and Human Trafficking in Healthcare Settings](#) recommends the following:

- The patient should receive an explanation of how their health information is used, shared, and disclosed, including specific notification of the limits of confidentiality;
- The patient should be made aware of their rights to access, correct, amend, and supplement their own health information;
- Personal and sensitive health information should be de-identified whenever possible;

- The provider must offer and respect the patient's choice of communication preferences;
- Privacy safeguards and consents should follow the data and the clinician should clearly identify limitations on consents if/when health data is shared with another provider who may not have the same privacy settings;
- The providers should have broad discretion to withhold information when disclosure could harm the patient as per provider determination and on an ad hoc basis;
- Systems should be set up to allow for sensitive information to be partitioned between providers when appropriate;
- Strong and enforceable penalties should exist for violations of privacy and consents both in a clinical setting, and across information exchanges ([Health Partners on IPV + Exploitation, n.d.](#), p. 2).

# Safety

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The patient's safety should always be the clinician's priority. The clinician should provide the patient with as much information and as many resources as possible to make the best decisions they can to maintain their safety and that of their loved ones. If a clinician assumes they know what will keep the patient safe, the clinician's seemingly benevolent or well-intended interventions, such as calling law enforcement or directing the patient to leave the abuser, may inflict unintended harm ([National Domestic Violence Hotline, 2015](#)). See the [Mandatory Reporting](#) section for further guidance on safe reporting. Calls to law enforcement may result in later reprisals for the patient. Leaving an abuser may place the patient in greater danger than staying in the home. Leaving an abuser and finding alternate housing, including in shelters, is not plausible for all patients.<sup>21</sup> For these reasons, safety planning is an individualized, collaborative process that is not achieved by providing a preprinted patient handout. As with other aspects of the medical forensic examination, the safety plan should be [documented](#) in the medical record.

Language access must be a priority for all aspects of the medical forensic examination, including safety planning. If [language](#) is a barrier, it is impossible for the clinician to help the patient assess safety issues and identify plans meant to create safety.

## IPV Risk Assessments

It is important for the clinician to discuss risk with the patient. One structured, tested, evidenced-based, and validated assessment is [Campbell's Danger Assessment](#). This tool has been adopted in many healthcare settings, particularly in forensic healthcare programs. It has been shown to be predictive for both assault and homicide, but in its original form, its use is specific to cisgender women who have been assaulted by men.<sup>22</sup> Subsequent iterations have been created for use with [immigrant \(cisgender\) women](#) ([Messing et al., 2013](#)), and for [females in same-sex relationships](#)

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<sup>21</sup> According to the 15th Annual Domestic Violence Counts Report, in just one 24-hour period in the United States, more than 3,700 emergency requests for shelter went unmet due to funding shortfalls ([National Network to End Domestic Violence, 2020](#)).

<sup>22</sup> Training for using the Danger Assessment, which is needed to administer the tool properly, is available online at: <http://www.dangerassessment.org/>.

([Glass et al., 2008](#)). To date, however, this tool has not been adapted for use with abused men, or with transgender or gender expansive individuals.

**Clinicians should remember that tools are not infallible, but one aspect of a comprehensive assessment. A patient who believes they are in significant danger, regardless of their scoring on any tool, should always be considered the most reliable source of information about potential lethality.**

IPV risk assessments are only one component of a larger safety planning process. As with the larger [discharge planning process](#) this process is not one in which the clinician tells the patient how to be safe, but must comprise a dialogue with the patient about safety and what that looks like within the context of their life. Safety will not always mean leaving the abuser; this action should not be the baseline for the planning process. Patients generally know the best ways to manage their safety and that of their loved ones. That may include managing safety within the confines of a violent relationship, which they may recognize as a safer option than leaving the relationship.

## **Examples of Safety Planning Tools and Resources**

### **Tools for Patients**

- [U.S. Dept of Veterans Affairs Intimate Partner Violence Safety Planning Guide](#)
- [National Domestic Violence Hotline](#)
- [National Coalition Against Domestic Violence](#)
- [myPlan app](#)
- [StrongHearts Native Helpline](#)

### **Tools for Clinicians**

- [Encuentro Latino](#) (Spanish)
- [Safety Planning: A Guide for Transgender and Gender Non-Conforming Individuals who Are Experiencing Intimate Partner Violence](#) (FORGE)
- [Safety Planning for Persons with Disabilities](#) (Safety First Initiative)



In some instances, the clinician may not be the professional responsible for detailed safety planning. In such cases, the clinician should ensure a warm hand-off with the social worker, victim advocate, or forensic nurse who will be completing this portion of the patient encounter. The clinician should clearly document the hand-off in the medical forensic record and include any safety planning information the clinician provided.

# Mandatory Reporting

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Mandatory reporting laws determine the manner and circumstances under which a clinician must report the abuse or neglect of a patient. Requirements for reporting IPV vary widely. Some states require the reporting of all IPV-related injury, and others require the reporting of specific injuries, such as gunshot wounds, stab wounds, or burns, regardless whether they occurred within the context of IPV.<sup>23</sup> While the intent behind such laws is to protect victims and hold offenders accountable, these laws can create unintentional barriers to the patient's disclosure of abuse. Studies examining attitudes about mandatory reporting to law enforcement found such policies can increase reluctance to disclose abuse to clinicians specifically ([Gielen et al., 2000](#); [Sachs et al., 2002](#); [Smith & Parsons Winokur, 2004](#)). Fears about having children removed because of IPV also feed into concerns about mandatory reporting policies. A recent survey of individuals seeking assistance through the National Domestic Violence Hotline's chat services found that 28% of respondents chose not to seek medical care due to concerns about mandated child protective service reporting. While survivors of IPV have mixed experiences with and perceptions of mandatory reporting laws, recent studies demonstrate that some populations, including people who are transgender and gender nonconforming, and people of color experienced more unintended harms. When provided a warning about mandatory reporting, nearly two-thirds of individuals in the same study reported altering the substance of what they disclosed ([Lippy et al., 2019](#)). For immigrant survivors of IPV, the simple belief that healthcare providers are mandatory reporters may be enough to keep many from even seeking healthcare, let alone disclosing abuse ([Kimberg, Vasquez, Sun et al., 2021](#)). However, the clinician can take steps to ensure that the mandatory reporting process is transparent and trauma-informed, decreasing the chances that the patient will feel ambushed or deceived:

- **Begin the discussion early.** The initial discussion about mandatory reporting should not occur immediately before the report happens. At the beginning of the patient encounter,

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<sup>23</sup> For the most recent overview of state mandatory reporting laws, see the Futures Without Violence [Compendium of State and U.S. Territory Statutes and Policies on Domestic Violence and Health Care](#). To ensure compliance with the most current laws, however, clinicians should consult local legal resources.

as the clinician is initially discussing IPV with the patient, the clinician must clarify what acts or information trigger mandatory reporting and to whom. This will allow the patient to make fully informed decisions about what they wish to disclose. In addition, the clinician should describe their process for reporting so the patient understands how that process will unfold, as it may differ from what they have envisioned or experienced in past encounters with healthcare professionals.

- **Ensure that there is an actual requirement to report.** Without a requirement to report, and in the absence of the patient's explicit permission, contacting law enforcement or another agency is a breach of the patient's confidentiality. A clinician can work with their facility's legal or risk management department or consult other local legal resources to clarify the mandatory requirements in their jurisdiction.
- **Ensure the report is being made to the correct agency.** Some reports may need to be made to multiple agencies, such as adult protective service agencies and law enforcement agencies. However, some reports may not require notifying law enforcement. Policies and procedures for mandatory reporting should include detailed information about the receiving agency to eliminate confusion for both the clinician and the patient. The clinician should clearly inform the patient about what agency has received the mandatory report and be provided with contact information for the agency, assuming no safety concerns are present.
- **Report only what is required.** The information needed to satisfy a mandatory report varies widely by jurisdiction. The clinician should include only what is specified unless the patient has given explicit permission to provide additional information. The clinician should inform the patient what is being reported and document the content and the details of the receiving agency in the medical forensic record.
- **Recognize the process does not cease to be patient-centered because mandatory reporting is necessary.** Measures exist to continue making the encounter patient-centered, even though the mandatory reporting requirement has been triggered. A clinician can help protect a patient's right to self-determination by: giving them the opportunity to safety plan with the mandatory reporting information factored into the process; allowing them to be present to hear what is being reported, particularly if they

are concerned about a mandatory report to child protective services<sup>24</sup>; even delaying the mandatory reporting process until after they have been discharged, depending on the patient's needs and concerns. Patients view mandatory reporting policies more favorably when clinicians consider their autonomy in the process ([Rodríguez et al., 2002](#)).

- **Review with the patient where confidentiality still exists.** Mandatory reporting does not require a patient to forfeit all confidentiality. The clinician should emphasize that even when they are mandated to report to law enforcement or other agencies, the patient's other confidentiality protections remain in place.
- **Remember state mandatory reporting laws must be followed for child abuse/neglect, as well.** In some circumstances patients will disclose involvement of children, either as witnesses to the abuse, or as additional victims, which may necessitate reporting to local child protective service agencies. Clinicians should be clear about what necessitates a mandatory report,<sup>25</sup> being mindful not to use the report to ambush or threaten the patient. If a report must be made, unless the patient is suspected of abusing the child themselves, provide the patient with a detailed account of the report so they can be prepared for follow-up with the agency.

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<sup>24</sup> Although not a common occurrence, the patient's actions may trigger a mandatory report. In such a case, having the patient present for the reporting would not be advised.

<sup>25</sup> Clinicians can work with their legal department to ensure that they understand the exact parameters of their state's child abuse mandatory reporting laws.

# Program and Operational Issues

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As with programs that provide sexual assault medical forensic examinations, no one model exists for providing IPV medical forensic examinations. This section of the protocol reviews basic program and operational issues to be considered for establishing the foundation for a reliable and sustainable IPV programs.

## Care Models

IPV medical forensic examinations may be provided across a number of care models. Each has its own strengths and challenges in care provision.

MODEL	STRENGTHS	CHALLENGES
Emergency department (ED)	<ul style="list-style-type: none"> <li>• Array of medical resources available</li> <li>• Forensic nurses, who are specialists in working with victims of violence, may be available in some EDs</li> <li>• Around the clock access to care</li> </ul>	<ul style="list-style-type: none"> <li>• Potential patient wait times</li> <li>• Lack of privacy compared to other care settings</li> <li>• Potential time pressures for responding clinicians who may also have a variety of patients competing for the clinician’s time</li> </ul>
Hospital-based (outside of the ED)	<ul style="list-style-type: none"> <li>• Access to array of medical resources</li> <li>• Proximity to ED for consults/transfers</li> <li>• Likely to be managed by forensic nurses, who are specialists in working with victims of violence</li> </ul>	<ul style="list-style-type: none"> <li>• Patient may need to go through the ED to access the program</li> <li>• Around the clock access not guaranteed</li> </ul>

MODEL	STRENGTHS	CHALLENGES
Community-based healthcare clinic and provider	<ul style="list-style-type: none"> <li>• Greater privacy for patients</li> <li>• Patient may have an established relationship with the provider</li> <li>• May understand language, culture, and community of patient</li> </ul>	<ul style="list-style-type: none"> <li>• Emergency issues require transfer</li> <li>• Healthcare resources may be limited (e.g., laboratory facilities and other diagnostic adjuncts)</li> <li>• Hours of care are likely to be limited</li> <li>• Safety concerns may be heightened for both patients and staff depending on available security</li> </ul>
Advocacy- or law-enforcement- based program (e.g., Family Justice Center)	<ul style="list-style-type: none"> <li>• Greater privacy for patients</li> <li>• Patient likely to have far more time with care providers than in other settings</li> <li>• Access to other victim service professionals on site</li> </ul>	<ul style="list-style-type: none"> <li>• Emergency issues require transfer</li> <li>• Healthcare resources may be limited (e.g., laboratory facilities and other diagnostic adjuncts)</li> <li>• Hours of care may be limited</li> <li>• Patient may fear law enforcement and other “systems”, only wanting to engage with healthcare</li> </ul>

## Budgeting

- Identifying costs for caring for patients experiencing IPV should include, at a minimum: personnel, equipment and supplies (below), patient materials (e.g., printing discharge materials), interpreters, translations services and other patient accommodations, and staff education (both initial and continuing education).

- Forensic nursing programs that are expanding to add this patient population should assess whether their existing staffing would be sufficient to serve an anticipated increase in patient numbers or if more staff would need to be hired. The budget would have to support the increase.
- Although geared toward sexual assault, the [SANE Program Development and Operation Guide](#) (OVC) provides recommendations for budgeting that may apply for expanded forensic healthcare programs, including those serving patients experiencing IPV.

### Equipment and Supplies

From a practical perspective, an IPV medical forensic examination program does not require expensive or technical equipment: a stethoscope, [a 12-megapixel minimum camera that can competently be used by all clinicians on the team](#), good lighting to adequately assess the patient and photograph remarkable findings, and space in which to evaluate patients comfortably is all that is required. Programs may opt to invest in more high-tech equipment or purchase additional accessories to supplement the foundational equipment, but it is not necessary to be able to successfully care for patients experiencing IPV.

If a patient requires evidence collection as a component of the medical forensic examination and acute sexual assault<sup>26</sup> is not a part of the incident of abuse, then some basic supplies would be needed for [evidence collection](#). Most of the necessary supplies generally can be found throughout hospitals and clinics. A brief list of supplies that are typically used for evidence collection are:

- Paper bags
- Saline solution or distilled water

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<sup>26</sup> Most jurisdictions approve collection of evidence between 96–120 hours after the assault has occurred; however, some jurisdictions extend the time period to 168 hours or more after the assault. Regardless of the time after assault, if the patient reports continuing pain, injury, discomfort, or other symptoms, the clinician should still consider an exam to assess and document any existing injuries.

- Sterile swabs
- Self-sealing envelopes
- Nail clippers
- Scissors
- Collection paper
- Evidence tape or other method for sealing paper bags such as patient labels
- [American Board of Forensic Odontology \(ABFO\) ruler](#) or other measuring device

If a patient discloses sexual assault as a component of the abuse, a sexual assault evidence collection kit should be used.

## **Billing**

The goal should be to avoid having the patient take on the burden of covering the cost of the medical forensic examination.<sup>27</sup>

## **Reimbursement**

Unlike with sexual assault, in most jurisdictions, no state-level reimbursement mechanism exists for IPV examinations. This means that healthcare services likely will be billed to the patient's health insurance provider. Supporting the patient to offset the cost of related services could be done through a variety of avenues, such as: federal and private grants, donations, fundraising, or potentially establishing a Memorandum of Understanding (MOU) with a supporting agency.

## **Safety Issues**

Numerous safety issues are endemic to billing for the medical forensic examination, particularly if the patient is not the insurance policy holder. Examples include:

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<sup>27</sup> If the patient has also experienced sexual assault as a part of IPV, and receives evaluation and treatment in relation to the sexual assault during the medical forensic examination, then the laws related to payment for the medical forensic examination apply. Please reference the [National Protocol for Sexual Assault Medical Forensic Examinations Adult/Adolescent 2nd ed.](#)



- The dissemination of patient surveys, such as Press-Ganey. Facilities should consider working with hospital administration to ensure that patients experiencing IPV are either not sent surveys following their care or have the opportunity to opt out of receiving the survey as it may create a safety or privacy issue for the patient.
- The Explanation of Benefits (EOB) is an automatically generated letter sent to the insurance policy holder following medical care. The letter describes what covered benefits were paid to the healthcare provider. Sensitive information may be included in the EOB, including details of care provided and the location of that care—information a patient may not want their abuser to know ([Futures Without Violence, n.d.](#)). These letters are also available through most insurance company’s online portals, so simply intercepting the letter is not an effective strategy. The patient should be informed about the EOB and the various routes that it may be received. If a concern exists, the patient can contact their insurance provider by either calling or having a medical professional assist them in calling the toll-free number on the back of their insurance card. The patient can request that the EOB not be sent by mail and that the electronic version reflects only the Current Procedural Terminology (CPT) codes or that the EOB be de-identified as much as possible. It is important to note that not all insurance companies allow such requests.<sup>28</sup>

## **Transfers**

In circumstances in which the patient is required to be transferred to another facility, the patient needs to be informed of the costs for which they may be responsible. For instance, if a patient receives an examination at one facility, but needs a higher level of care, the facility arranges for the patient to be transported via ambulance to a second facility. The patient should be informed that a billable cost may be associated with the transfer of care to the other facility.

## **Billing and Coding**

The clinician is encouraged to work with their billing and coding department to identify the responsible party for billing for the clinician’s department. In doing so, the clinician can ensure

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<sup>28</sup> For information about protecting confidentiality for individuals insured as dependents, visit the Guttmacher Institute: <https://www.guttmacher.org/state-policy/explore/protecting-confidentiality-individuals-insured-dependents>.

that the responsible billing staff are aware of the safety and privacy issues that exist for this patient population. In the event they receive a call from a patient, they will be prepared to assist the patient appropriately. The facility's billing and coding staff can be educated on the state's Crime Victims' Compensation (CVC) program and how the patient would be able to access CVC applications and other information. The clinicians may also consider educating other departments as well if they exist within the facility: facility administration, compliance, and other medical staff (e.g., registration staff, nurses, physician assistants, physicians, social workers, etc.).

## Resources

Visit the [Medical Forensic Exam Payment Technical Assistance Project](#) (OVW) for examination payment resources by state, and other billing and coding tools and resources.

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## Protocols, policies, and procedures

Policies and procedures describe how tasks will be completed; protocols are descriptive guidelines that address how to achieve the tasks. Although the terms are often used interchangeably, policies and procedures are more granular than protocols. More importantly, policies and procedures serve to keep licensed clinicians and patients safe. Although protocols are helpful, policies and procedures are essential.

For organizations creating protocols, the following resources may be useful in either creating or updating them:

- [Minimal Elements of a Domestic Violence Healthcare Protocol](#) (Futures Without Violence)
- [Sample Health Center Protocol on IPV/HT/Exploitation](#) (Futures Without Violence)
- [Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care](#) (Ohio Domestic Violence Network)
- [Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines](#)

Policies and procedures will vary depending on specifics like the location of care provision and the types of clinicians providing care. Suggested policies and procedures include:

## General Policies

- [Mandatory Reporting](#)
- Medical Record including Storage, Retention, and Release Payment/Billing Procedures
- Photography
  - Consent
  - Procedure
  - Storage
  - Back-Up
- Sample/Evidence Collection and Release Procedures
- General Medications/Prophylactic Medications/Standing Orders
- Follow-up examinations

## Forensic Nurse Examiner Programs

- Forensic Nurse Examiner Roles/Responsibilities
  - Response times
  - General care
  - Examination
  - Arrival/Flow
- Program Mission and Goals
- Credentialing
- Education and Certification Expectations
- Physician Consultation/Guidelines for Physician Intervention
- Employment Requirements
- On-Call Procedure (if applicable)
- Telehealth (if applicable)
- Job Descriptions (Forensic nurse examiners/Program managers/Medical directors)

(Adapted from the SANE Sustainability Policy Checklist: [National Sexual Violence Resource Center, 2014](#))

## Non-emergency department based IPV Programs

### Emergency department transfer/referral

- Particularly for programs that are operating outside the hospital setting, having specific policies in place for how and when patients will be transferred or referred to an emergency department is a critical component. Programs should consider transfer agreements with area emergency departments and outline specific circumstances in which patients will be transferred or referred. Circumstances should include issues related to injury (e.g., strangulation, penetrating trauma) and concomitant impacts on health status (e.g., suicidality, exacerbations or identification of serious health issues). Policies should reflect any limitations of access to diagnostic adjuncts, such as labs and imaging, based on an understanding of the potential for a broad range of injury amongst patients who experience IPV.

### Body-Worn Cameras

An additional area for program policy consideration is police body-worn cameras. Many law enforcement officers keep their body-worn cameras operational while in hospitals and clinical spaces as the default. Although national recommendations state that law enforcement turn off body-worn cameras in any location where individuals would have a reasonable expectation of privacy (unless the recording is being made as part of an arrest or in the active pursuit of a subject of an investigation), this may not necessarily extend to healthcare facilities ([International Association of Chiefs of Police, 2019](#)). Some states have addressed the use of body-worn cameras in healthcare spaces, either legislatively or through protocols; however, the majority of states have not. Individual jurisdictions need to decide how to address the issue.<sup>29</sup> The authors of a recent article published by the American Health Information Management Association (AHIMA) proposed recommendations for healthcare facilities, including:

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<sup>29</sup> New Hampshire, for example, addresses this issue statutorily and underscores it in its statewide SANE protocol: “If wearing a body worn camera (BWC), advise victim, obtain express consent (verbally and/or in writing) to continue recording per RSA 105-D” ([State of New Hampshire Governor’s Commission on Domestic and Sexual Violence, 2018](#)).

1. Developing a policy about the use of body-worn cameras within the medical facility;
2. Identifying all potential law enforcement agencies that may respond to the facility and their policies about body-worn cameras;
3. Notifying law enforcement agencies and officers of the new healthcare policy and posting signage at any entry point where the use of body-worn cameras may be restricted or prohibited; and
4. Educating staff members on the adopted policy and steps to take when policy breeches occur ([DeMasters & Peterson, 2016](#)).

Creating policy that requires law enforcement to turn off body-worn cameras when entering the healthcare facility (excluding instances where law enforcement is responding to the facility in an emergency) protects the privacy and confidentiality of all individuals seeking care within the healthcare setting.

### **Compliance with Privacy Regulations**

Programs must ensure compliance with all privacy regulations in the course of caring for patients experiencing IPV. Privacy must be balanced with patient autonomy and safety, and carefully navigating this balance should be done in consultation with the healthcare facility's risk management or legal professionals, where possible:

- [Health Insurance Portability and Accountability Act of 1996 \(HIPAA\)](#): The original privacy law that protects individual patient medical records and other personal health information. Enacted in 1996, it has undergone significant additions since, including with the 2009 HITECH Act.<sup>30</sup>
- [Health Information Technology for Economic and Clinical Health Act \(HITECH Act\)](#): Promoted and expanded the use of electronic health records by clinicians, strengthened privacy and security under HIPAA, and ensured that healthcare organizations and their business associates complied with obligations to provide patients with copies of medical records upon request.

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<sup>30</sup> Clinicians should be aware that a HIPAA covered entity may disclose PHI to law enforcement without the individual's signed HIPAA authorization in certain incidents. See <http://www.hhs.gov/ocr/privacy> for details.

- [Family Educational Rights and Privacy Act \(FERPA\)](#): Federal law enacted to protect student education records. This law specifically impacts clinicians who care for students in campus-based programs, such as student health services, where the issue of when a healthcare record becomes an education record (and therefore potentially enjoys fewer privacy protections) is relevant.
- [21st Century Cures Act](#): Intended to promote information sharing and to ensure that clinicians are able to use technology to both exchange health information with patients and allow patients access to their health information.

Explore these topics further in [Consent](#), [Confidentiality](#) or [Medical Forensic Documentation](#)

## Quality Assurance and Improvement

All programs should have a process in place to evaluate the systems established to provide care and the quality and consistency of the care provided. The approach may focus on addressing specific problems or deficiencies, particularly with individuals, that have occurred—akin to a quality assurance (QA) process. Or they may be more proactive, with a goal of preventing future issues, rather than addressing past problems, reflecting the philosophy of quality improvement.

Some aspects of a quality process can serve a dual role: chart review, for example, allows for both quality assurance (e.g., making sure that documentation is complete for every patient seen in the program) and quality improvement (e.g., noting that multiple clinicians appear to have issues obtaining clear photos at close range). Peer review also can serve both functions, bringing to light issues with individual documentation or interpretation of findings, but also serving as an educational opportunity that informs the clinical knowledge of all participants ([Markowitz, n.d.](#)).

In many circumstances, quality assurance documents are protected under [state QA and peer review privilege statutes](#), as well as under the federal [Patient Safety and Quality](#)

[Improvement Act](#). However, not every state has laws to protect all QA or peer review, and circumstances exist when this privilege may no longer apply; consulting legal counsel and risk management is recommended to ensure whether your process is protected ([Office for Victims of Crime, n.d.-a](#)).

[IPV Health Partners](#) provides a quality tool for community health centers, for example: [IPV Health Partners QA/QI Tool](#). For clinicians providing medical forensic examinations within emergency departments, forensic nursing programs, or regardless of the setting, the tool in [Appendix C](#) may be a better fit.

# Transferring Patients

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In the course of providing care to a patient experiencing IPV, it may become necessary to transfer them to another facility, either because that facility is able to provide a higher level of necessary care or because the facility has specialized clinicians or programming appropriate to conducting the medical forensic examination. In either instance, specific issues must be considered:

## **Transferring from outpatient and community health settings to the emergency department**

Outpatient or community-based healthcare facilities are encouraged to establish formalized transfer agreements with their local hospital(s) to ensure that, in the event a patient needs to be evaluated emergently, care of the patient may be continued as seamlessly as possible by the receiving facility. The clinicians in these settings should have clear guidelines for when a patient should be transferred, as well as where and how the transfer will occur. The patient may not recognize the seriousness of their injuries or the potential for delayed sequelae, such as in strangulation assaults. In such cases, transferring the patient is not only possible, but likely, and the clinician should be prepared to provide a warm handoff to the receiving department to ensure continuity of care and coordination of services. Some patients may be more comfortable or trusting with a known resource, such as a primary care clinic and other clinician, even when an emergency department is the most appropriate point of care. These feelings may be related to previous experiences involving gender, race, or disability, and may pose a challenge for the clinician in communicating to the patient why transferring care to the emergency department is the clinically appropriate choice. In these circumstances, by providing a thorough explanation to the patient about the clinician's concerns and plan for the transfer, as well as specific communication to the receiving facility, the clinician can help to ease the patient's concern. Working with community partners, such as victim advocacy agencies and culturally specific organizations, may further support the patient's decision-making process. Details of the transfer process should be documented in the medical forensic record.



## **Transferring patients from emergency departments to other emergency departments or specialty programs outside the emergency department**

In some circumstances, emergency medicine clinicians may determine the most appropriate clinicians to provide the medical forensic examination reside in another emergency department or outside the emergency department, such as in a free-standing forensic nursing program or Family Justice Center. In these instances, the Emergency Medical Treatment and Labor Act (EMTALA) applies. Although often thought of as legal protection for ensuring patients are not turned away from receiving care at emergency departments due to insurance status or ability to pay, EMTALA mandates that emergency departments must provide medical screening and stabilization of any patient prior to transfer to another facility, including other emergency departments:

Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented ([Centers for Medicare and Medicaid Services, n.d.](#)).

Therefore, even when emergency department clinicians determine that a patient is best served by an alternate facility, that patient cannot properly be sent to that facility without the clinicians first ensuring that the patient is medically stable. Policies and procedures should be in place to guide these processes in a consistent and coordinated manner.

# Medical Forensic Documentation

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When a patient presents for a medical forensic examination, the entire encounter is both medical and forensic. No separation exists. Even if a patient has no samples/evidence collected, they still undergo a medical forensic examination; forensic simply references the examination's potential to be used in the legal arena. Forensic is, in this context, the intersection of healthcare and the law.

## Considerations for medical forensic documentation:

1. Documentation should reflect the healthcare focus of the IPV medical forensic examination.
2. Documentation should be free of judgment or bias, forgoing terms such as “noncompliant,” “frequent flier,” and “alleged.”<sup>31</sup> For the clinician who is concerned that documenting IPV without use of the qualifying term alleged is akin to drawing a legal conclusion, consider alternative phrasing, such as “intimate partner violence per patient history,” or “patient reports assault at the hands of their spouse,” as more appropriate alternatives.<sup>32</sup>
3. The clinician should consider the clinical rationale behind how and what they document, particularly the information about the history of the assault. The clinician needs to ensure that their documentation reflects what is needed to best care for the patient. Summarizing aspects of the history, as clinicians do with all other types of patients, is appropriate for patients experiencing IPV.
  - Use of audio or video recording devices, or having patients write out their own account of the abuse may be appropriate for law enforcement interviews, but

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<sup>31</sup> As Dr. Anna Valdez, a professor of nursing writes in a recent editorial, use of labels like “noncompliant” and “frequent flier” may cause harm to patients regardless of chief complaint. Their use can create biases among treating clinicians who may delay care or misdiagnose patients based on these labels ([Valdez, 2021](#)). The need for healthcare documentation free of judgement is not specific to the forensic patient. No clinical encounter can be truly patient-centered if it is laden with bias related to a patient's motive, state of mind, or general existence.

<sup>32</sup> Some electronic medical records (EMRs) prepopulate the word “alleged” into the history. All efforts should be made to delete this word, which can be accomplished by working with the EMR company directly. Terminology within the ICD coding includes the word “alleged” throughout. Billing language differs from clinical documentation. There is no need for prepopulated language within the EMR to align with the ICD coding language because they serve different purposes.

incompatible with the basic tenets of healthcare documentation.

- Although verbatim documentation is unnecessary, the clinician should take care not to sanitize important statements made by the patient. When a summary does not capture the patient's description of the incident, quotes should be written verbatim.
4. Unlike sexual assault, which is more likely to have common documentation forms across states or within evidence collection kits, IPV medical forensic examination documentation forms are far less likely to be standardized.<sup>33</sup> Programs that want to develop specific medical forensic documentation forms should include at a minimum:
- Patient consent specific to the medical forensic examination
  - Medical history, including review of systems
  - History of abuse/assault, including identification of the assailant(s)
  - Physical assessment
  - Body diagrams
    - [Photography](#) is not required to be able to provide care for patients experiencing IPV. Even when available, the patient may opt to decline it.
    - The clinician should diagram injuries on body maps as a component of the medical forensic documentation, regardless of whether photos have been taken.
  - Photography log (if applicable)
  - Samples/evidence collected and submitted to law enforcement (if applicable)
    - This should include sources/sites of collection, time of collection, and name of person who collected the samples/evidence.
    - A section to document chain of custody should also be included. Even if law enforcement uses its own form, it is critical that a copy of chain of custody is maintained with the medical forensic documentation.
  - Discharge plan

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<sup>33</sup> California is one of the few states that has a [standardized IPV medical forensic exam documentation form \(CAL OES 2-502\)](#).

- This should include medications, referral appointments, safety planning, and other instructions provided to the patient, such as returning for follow-up photography.
5. [Informed consent](#) should be formally documented in the medical forensic record. At a minimum, the consent language should address the following areas:
    - Consent for treatment
    - Photography
    - Collection of samples
    - Written authorization to release information to law enforcement and/or other victim services agencies that the patient may be working with, as well as the release of other items, such as swabs from suspected bite wounds or damaged clothing to law enforcement
  6. Depending on jurisdictional requirements and/or specific details of the patient's assault history, the clinician may have [mandatory reporting](#) obligations. The ways in which these have been satisfied, or any deviations from the required reporting, should be documented in the medical forensic record.
  7. A need exists to balance patient privacy regarding sensitive information in portions of the medical forensic record and provider accessibility to relevant portions of the documentation for the patient's future treatment. Organizations that see patients experiencing IPV as part of a hospital or clinic system should work with their medical records department and other pertinent professionals to identify ways to limit access to particularly sensitive portions of the record, including anogenital photographs, in ways similar to those processes often employed for sexual assault medical forensic records. With the implementation of the [Cures Act](#), the clinicians should also discuss these concerns with the patient, if possible, so they are informed and agree about which other clinicians will be able to access the IPV medical forensic examination documentation.
  8. Regardless of location, clear protocols are necessary for how to store and maintain medical forensic records (including photographs, if taken as a part of the examination process). There is no single standardized federal record retention schedule to which clinicians and organizations must adhere. A list of federal record retention requirements

can be found at <https://library.ahima.org/PB/RetentionDestruction#.YO8odRNKi3I>.<sup>34</sup> Additionally, the American Health Information Management Association provides the following guidance:

At a minimum, record retention schedules must:

- Ensure patient health information is available to meet the needs of continued patient care, legal requirements, research, education, and other legitimate uses of the organization
  - Include guidelines that specify what information is kept, the time period for which it is kept, and the storage medium on which it will be maintained (e.g., paper, microfilm, optical disk, magnetic tape)
  - Include clear destruction policies and procedures that include appropriate methods of destruction for each medium on which information is maintained ([American Health Information Management Association, 2013](#))

9. Organizations should work with professionals within departments such as compliance, legal, risk management, and health information management to identify how and what information will be released to both patients and their proxies. This recommendation applies whether the program uses an electronic medical record or maintains paper records. See [Judicial Proceedings and Medical Testimony](#) for more information on the subpoena of medical records.

## Sample Body Diagrams

See [Appendix D](#) for examples of diagrams that may be used in the documentation of a medical forensic examination.

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<sup>34</sup> Many of the federal retention requirements are determined by state statutes. An overview of those can be found at <https://www.healthit.gov/sites/default/files/appa7-1.pdf>.

## 21st Century Cures Act<sup>35</sup>

- The Cures Act is intended to promote information sharing and to ensure that healthcare providers are able to use technology to both exchange health information with patients and allow patients access to their health information.
- The law applies to clinicians, electronic health technology vendors, and health information exchanges.
- It specifically addresses electronic health information; it would not apply to programs that do not use electronic medical records.
- It applies only to identifiable electronic health information that would be available to the patient under the Health Insurance Portability and Accountability Act (HIPAA).
- Information blocking occurs when clinicians, healthcare networks, or other applicable entities interfere or obstruct a patient's access to their electronic health information, and is not allowable under the Cures Act. However, under certain circumstances, some information may not be disclosed; these include a preventing harm exception ("reasonably necessary practices to prevent harm to a patient or another person") and a privacy exception ("refusing to fulfill a request to protect a person's privacy") ([The Office of the National Coordinator for Health Information Technology, n.d.-a](#)).<sup>36</sup>
- If the medical forensic record is fully accessible under the existing system as a default, organizations can work with their electronic health record vendors to establish processes for keeping specific portions private, in accordance with Cures Act guidelines.
  - If protected portions of the medical record are not automatically

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<sup>35</sup> The rule in its entirety can be found at <https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-one-health-it-certification>.

<sup>36</sup> Read about the eight information blocking exceptions, including their objectives and key conditions, at <https://www.healthit.gov/cures/sites/default/files/cures/2020-03/InformationBlockingExceptions.pdf>.

shared with patients, patients can still gain access to or obtain copies of their record, but a delay may occur or a different process may exist for obtaining the record.

- If all portions of the records are shared, the access may be near to real-time. This process of access may be confusing, upsetting, or even dangerous for patients: because the abuser may be with the patient as they review the record; because the patient reviews the record before the clinician has an opportunity to explain results, plan of care, or meaning of terminology; or because the record includes a discussion or notification of mandatory reporting purposes and the clinician has not yet discussed this with the patient.

# Medical Forensic History

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## Accompaniment During the History and Examination

Before obtaining extensive information from the patient about their history, the clinicians should ensure that they are able to speak to the patient alone, or with a victim advocate or the patient's chosen support person.<sup>37</sup> A personal care attendant may accompany the patient with a disability yet the patient still should decide who is present during the patient's examination. To ensure the patient has a choice, the clinician initially should screen the patient alone, if possible, to offer the option rather than making assumptions about the patient's safety. As with family members and friends who may accompany patients, care attendants may also be abusive, may be the main source of violence, or may communicate information back to the abuser, so initial caution is warranted.

Even when a patient has disclosed an aspect of violence in their life, it may not be safe or comfortable for them to continue to discuss the extent of the violence, depending on who is present. The clinician should not assume that it is appropriate to speak in front of family members or friends who are present. Additionally, IPV may not be the only form of victimization in the patient's life; talking with the patient alone or along with their chosen support person improves the opportunity for other disclosures.

## Obtaining the medical forensic history

The medical forensic history is a critical component of the patient encounter. For the patient experiencing IPV, it is similar to other history gathering when patients seek healthcare services. Its primary purpose is to identify the patient's vital medical information (including medications,

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<sup>37</sup> Patients should be informed that different types of confidentiality and privilege exist among victim advocates. Community-based advocates serve only victims, and the information shared by victims is confidential. Furthermore, many jurisdictions provide statutory victim advocate privilege that shields any communications from disclosure. Conversely, systems-based advocates, such as those who work for police departments or prosecutors' offices, are bound by the prosecutors' discovery obligations, and therefore cannot serve as a confidential resource for victims ([SAKI, n.d.](#)).



allergies, and past medical history) and obtain information about the presenting medical issue for which the patient seeks care (in this case, IPV). The specific history of violence, including acute and non-acute acts, will help guide the patient's course of care and shape the details of the safety and discharge plan. The history should include dates and times of assaults (or general timelines of assaults where the patient is unable to specify dates). The information obtained during the medical forensic history guides the rest of the patient encounter, from the physical assessment and treatment plan, to the sample collection, to the safety and discharge plan; a clinical rationale supports every question posed. Given its healthcare purpose, the medical forensic history differs from the [forensic interview](#), which is a component of many child abuse medical forensic examinations. Law enforcement personnel and the forensic interviewer conduct the forensic interview, the purpose of which is to assist the investigation of allegations or suspicions of abuse and assault. Because medical forensic histories are conducted to assist clinicians in caring for their patients, any **information that is subsequently used in a legal setting** is a secondary benefit of the information, and not the primary purpose for gathering the information.

Even in instances when the patient chooses to engage with law enforcement, the medical forensic history should be a separate process from the law enforcement interview. As in sexual assault medical forensic examinations, joint interviews between clinicians and law enforcement are not recommended. Law enforcement's presence while obtaining a medical forensic history can transform the process from a healthcare-focused conversation with the patient to a fact-finding interview. This can have an adverse impact on both the patient encounter and the criminal case by inadvertently placing the clinician in the role of investigator rather than a clinician, and can potentially create challenges to clinician objectivity ([SAKI, n.d.](#)).

## General areas of the medical forensic history

### Past and current medical history:

The medical history is essential for several reasons:

1. It is a foundational component of healthcare. Although the clinician may collect samples for DNA or photograph injuries that may be useful in a legal proceeding, the clinician's

priority is always the health and well-being of the patient. Understanding the patient's medical history allows for safer and more effective healthcare provision.

2. Knowing the medical history helps the clinician prioritize care, particularly for the patient who presents with more significant physical trauma. Knowledge that the patient has an underlying illness that needs to be attended to immediately, such as diabetes, allows the clinician to effectively plan the order and timing for completion of the medical forensic examination components, with aspects of medical assessment and treatment preceding any sample collection, even in cases where that collection may appear to be time-sensitive.
3. The medical history may provide context for what the clinician observes during the medical forensic examination. For example, a patient who takes anticoagulant medication likely bruises more easily, providing a potential explanation for the appearance of more significant bruising on that patient's body. A clinician would need to consider such information in any interpretation of findings. The medical history will encompass a thorough review of systems, which can provide context for appropriate healthcare decisions and potential forensic implications, and include:
  - Any current pain, bleeding, discharge, injuries, illnesses, or other physical symptoms
  - Allergies
  - Medications (including over-the-counter and nonprescription)<sup>38</sup>
  - Recreational drug use, including alcohol
  - Medical/Surgical history (including dental issues)
  - Vaccination status
  - Anogenital-urinary history

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<sup>38</sup> A recent study found that nearly 10% of transgender patients were taking hormones not prescribed by a healthcare provider; uninsured patients were more likely to use nonprescription hormones than their insured counterparts. Respondents assigned male at birth also had higher rates of nonprescription use than respondents assigned female at birth ([Stroumsa et al., 2020](#)).

- Pregnancy history
- Contraception usage
- Last menstrual period
- Psychosocial history, including housing, employment, parenting/caregiving, military service, suicidal/homicidal ideation, self-harm<sup>39</sup>

## Anatomical Inventory

Because some transgender and gender expansive patients undergo gender-affirming surgeries, it may be useful to conduct an anatomical inventory (sometimes referred to as an organ inventory) as part of the medical history; this helps to ensure accurate diagnosis, treatment, and referrals. So that the discussion can be raised in a way that is organic to the history-taking process and sensitive to the fact that conversations about anatomy may feel triggering to some patients, a clinician may consider the following example as a way to talk about the anatomical inventory: “In order to provide you with the best clinical care, it is important for me to know if you have certain body parts. Is it okay if we talk through a list of body parts, and you can let me know whether you have these? If you use different words for different parts of your body, please let me know” ([Grasso et al., 2021](#), p. 2532).

See [Appendix E](#) for an example of a thorough inventory that can be used by organizations that do not have an existing form within their electronic health records (EHRs), or wish to expand the one they are currently using.

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<sup>39</sup> Rural Health Information Hub provides examples of specific screening tools for social determinants of health: <https://www.ruralhealthinfo.org/toolkits/sdoh/4/assessment-tools>.

## **IPV history/History of the chief complaint**

In some cases, IPV will be identified secondary to screening; it will not be the patient's chief complaint. In other circumstances, patients will present following an acute IPV assault or because of health issues directly related to the IPV they are experiencing. In either scenario, the IPV history is an important part of the medical forensic history for a number of reasons: to help the clinician understand: the extent and progression of the violence; the nature of the assaults, including mechanisms of injury; the impact of the IPV on the patient's health status; the involvement of others within the household in the abuse (as perpetrators or victims of violence); and any co-occurring victimization the patient might be experiencing. This information can help direct the patient's care and inform their discharge plan, including any medical follow-up, community referrals, and safety plans.

This section includes a detailed history of the IPV. Previous experiences of abuse at the hands of other partners should be documented separately within the past medical history, as should other types of violence the patient has experienced in their lifetime. A comprehensive history includes:

- Acute vs. non-acute acts
- Date and time of event(s) or timeline/timeframe as appropriate
- Location of event(s)
- Abuser information
- Threats (including non-verbal threats such as throwing a false punch; placing a gun within the patient's sight during a fight; destroying property)
- Use of restraints
- Use of recording devices (photographs or videos of the event)
- Sexual violence or assault (including determination of acute vs. non-acute)
- Reproductive coercion or birth control sabotage
- Involuntary ingestion of drugs/alcohol
- Mechanisms of injury such as strangulation, suffocation, or assault with a weapon
- Other victims of violence in the home, such as elders, children, or pets

The clinician should also inquire about other acts by the abuser that have affected or are currently affecting the patient's health beyond what is typically considered abuse—these may include access to needed healthcare or medication; access to adaptive equipment, such as mobility aids or assistive listening devices; and opportunities to heal after surgical procedures, such as cesarean sections.

# Physical Assessment

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The patient who experiences IPV requires a comprehensive evaluation as dictated by both the history of the acute assault and any other relevant concerns that may be impacting their current health status. For example, a patient's access to necessary medication may have been limited related to the abuse they experienced, so although the acute event may have been blunt force trauma to the body that the clinician assesses through physical examination and radiography, lab work might also be necessary to assess the impact of an untreated health condition.

Comprehensive assessment should include:

- Physical assessment as dictated by the patient's presenting complaint
- Patient's general appearance, demeanor, cognition, and mental status
- Evaluation of body surfaces and oral cavity for physical findings
- Additional testing, including laboratory specimens<sup>40</sup> and imaging
- Assessment of violence (acute and long-term)
- Specialty assessments depending on the history (e.g., strangulation assessment)
- Review of how the patient perceives the violence has impacted their health
- Damage to auxiliary aids such as wheelchairs
- Present safety concerns and needs
- Safety of children/abuse of children/child witnessing (when applicable) or other vulnerable household members
- Dangerousness, lethality, and/or risk assessment, depending on the type of tool used

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<sup>40</sup> Clinicians should be aware different cultures may permeate meaning in the provision of samples such as blood, hair, and nails. They should be cautious to obtain only what is absolutely necessary for the care of the patient.

## Potentially relevant information when assessing injury:

- Location
- Pain
- Tenderness to palpation or manipulation
- Limitation of movement
- Type of injury (e.g., abrasion, laceration, bruise)
- Size
- Shape
- Color<sup>41</sup>
- Orientation
- Causation
- Time of injury causation (if known)

(Adapted from [Payne-James et al., 2020](#))

## Injury Definitions

### ABRASION

A superficial injury that occurs as the result of pressure and movement, such as scratches from fingernails or dragging along a surface.

### AVULSION

A tearing away of a structure or part ([Sheridan, 2007](#), p. 215)

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<sup>41</sup> Color is of limited value in most instances, and clinicians cannot use color reliably to age most injury, particularly bruises. In combination with other indicators—heat and swelling, for example—redness can sometimes indicate a relatively recent finding. However, even in this instance other explanations may exist for such a clinical picture and the actual age of the injury may not be able to be pinpointed.

<b>BITEMARK</b>	A physical alteration or representative pattern recorded in a medium caused by the contact of the teeth of a human or animal ( <a href="#">American Board of Forensic Odontology, 2018</a> ).
<b>BRUISES/CONTUSIONS:</b>	Visible evidence of leakage of blood into soft tissues as a result of injury to blood vessels. Bruising is visible because a force has damaged the blood vessels, causing the blood to leak into the perivascular tissue, where it can be seen on the skin or organ surface.
<b>BURN</b>	Injury caused by exposure to thermal, chemical, electrical, or radiation energy.
<b>CHOP WOUND</b>	A combined blunt and sharp force injury that is produced by a relatively sharp object wielded with a tremendous amount of force, as from an ax, crowbar, or hatchet ( <a href="#">Prahlow, 2016</a> ).
<b>FRACTURE</b>	A break in bone or cartilage.
<b>HEMATOMA</b>	A collection of liquid blood forming a fluctuant mass under the skin.
<b>INCISED (SHARP FORCE) WOUND</b>	Wounds caused by a blade or any implement with a sharp edge, such as a piece of glass. Margins tend to be clean, straight, and unbruised (as compared to lacerations).
<b>LACERATION</b>	Splitting, tearing, or breaking of the tissue due to blunt force.
<b>PENETRATING WOUND</b>	Injuries caused by objects forced through the skin, such as knives or bullets.
<b>PETECHIAE</b>	Small intradermal hemorrhages less than 3mm in diameter that do not blanch with pressure.
<b>SCALD</b>	A burn caused by contact with hot liquid or steam.
<b>STAB WOUND</b>	An incised wound in which the depth is greater than the width.

(Adapted from [Payne-James et al., 2020](#), except where noted)



## Considerations for the assessment of different types of mechanical and physical trauma seen in patients experiencing IPV

### Gunshot Wounds

Nearly one million women have been shot or shot at by an intimate partner at some point in their lives. Female patients hospitalized for gunshot wounds are 3.6 times more likely to have been shot by a spouse or intimate partner than a stranger as compared to male patients hospitalized for gunshot wounds ([Sorenson & Schut, 2018](#)). In 2020, 61% of women (n=1,057) killed by an intimate partner were killed by a firearm. That same year, 298 men were killed with a firearm by their female partner ([Violence Policy Center, 2021](#)).

- Assessment of patients with injuries from firearms should proceed according to the Advanced Trauma Life Support (ATLS) protocol.
- Unless the clinician has had specific and significant forensic education to understand and evaluate ballistic trauma, they should focus on general wound assessment and documentation, rather than opining on specifics about entrance and exit wounds, caliber of weapon, or range of fire.
- Five factors determine wounds from firearms (entrance and exit wounds): the size, shape, configuration, and velocity of the bullet as it contacts tissue, and the characteristics of the impacted tissue ([Smock, 2007](#)).
- If bullets have penetrated clothing, clinicians should avoid cutting through any holes when removing clothes. All clothes should be packaged in individual paper bags for analysis by the crime lab.

### Burns

- Burns are classified according to the depth of tissue injury: epidermal (first-degree), partial-thickness (second-degree), or full-thickness (third-degree). Fourth-degree burns are beneath the subcutaneous tissues and involve fascia and/or muscle. Burns that require amputation because of devastation of deep tissue or loss of a body part are considered fifth-degree ([Kagan et al., 2013](#)).

- Clinical characteristics:
  - Epidermal: Red, painful, but do not blister. Pain subsides after 2–3 days, and by day 4 injured epithelium peels away to reveal healed epidermis, as with many sunburns. Partial-thickness: May be categorized as superficial or deep partial-thickness burns. Superficial partial-thickness burns will develop blisters within 24 hours; they generally heal within 1–3 weeks, and scarring is unusual. Deep partial-thickness burns extend into the deeper dermis, blister, and will take 3–9 weeks to heal if infection is prevented. Scarring almost always occurs.
  - Full-thickness: Involve all layers of the dermis, and often the underlying subcutaneous adipose tissue. The burn eschar, the dead tissue, is usually intact. The eschar eventually separates from the underlying tissue and reveals an unhealed bed of granulation tissue. Complete spontaneous healing is not possible; surgery is required ([Kagan et al., 2013](#)).
- The extent of a patient’s burns is estimated and expressed as a percentage of the total body surface area (PTSA). Consider using either the [Rule of Nines](#) or the [Lund-Brower chart](#) to assess the PTSA (Note: the PTSA does not include superficial burns.)

## **Bite Wounds**

- The American Board of Forensic Odontology (ABFO) has identified the following specific criteria outlining what allows for positive identification of a bitemark:
  1. The pattern demonstrates class characteristics of human teeth, including prosthetic replacements when present.
  2. The discernable features are sufficient such that other causes for the pattern were considered unlikely or excluded.
  3. A curvilinear pattern or patterned injury, which is generally circular or oval and often consists of two opposing arches that may or may not be separated at their bases by unmarked space. Sometimes only one arch is clearly visible.

4. Individual marks, impressions, abrasions, contusions, striations, or lacerations from specific teeth may be found within the pattern.
  5. A central area of contusion is sometimes present.
  6. In severe human bitemarks, material may be forcefully removed from the element bitten.
  7. The marks present reflect the size, shape, arrangement, and distribution of the contacting surfaces of teeth. (The contacting surfaces of human teeth include the incisal and occlusal surfaces of teeth and may also include the lingual surfaces of anterior teeth.)
  8. Some marks made by individual teeth can be recognized and identified based on the class characteristics and location relative to other features.
  9. The size and shape of each visible arch conforms to the varying ranges of size and shape of the human dentition ([American Board of Forensic Odontology, 2018](#)).
- The clinician is not required to make a definitive identification in the medical forensic record if the patient reports being bitten during an assault. “Bite wound per patient history” is sufficient to initiate appropriate evaluation and treatment protocols; ABFO criteria do not need to be satisfied for clinical care.<sup>42</sup>
  - The clinician’s goal is to prevent infection, in addition to documenting the injury and collecting any relevant samples, as indicated.
  - If samples are to be collected: Use two lightly moistened swabs (sterile or distilled water), for each affected area, and package per jurisdictional policy. If bitemark impression evidence is to be collected, an expert in forensic odontology, forensic dentistry, or a professional who is specially trained in such collection should gather this evidence (e.g., CSI personnel, clinical forensic specialists). If this is not feasible, the aforementioned experts should be consulted as to the collection of this evidence.

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<sup>42</sup> The ability to identify bitemarks and associate them with specific individuals has come under considerable scientific scrutiny. Forensic bitemark analysis is not supported by sufficient data at this time ([NIST, 2022](#)).

## Traumatic Brain Injury

The head, neck, and face are the most common sites for injury in IPV ([Khurana & Loder, 2021](#); [Wu et al., 2010](#)).

- Studies specifically looking at mechanisms of injury with correlating injuries to the face and head have found them overwhelmingly caused by blunt force trauma, including punches, kicks, blows with objects, and headbutts ([Brink, 2009](#); [Saddki et al., 2010](#)).
- The prevalence of brain injury from IPV is difficult to identify; studies report a broad range, from 11%–79%, with a great variance in sample sizes ([U.S. Government Accountability Office, 2020](#)).
- The Centers for Disease Control and Prevention defines traumatic brain injury (TBI) as an alteration in brain function caused by a bump, blow, jolt to the head, explosive blast, or penetrating head injury.<sup>43</sup> Alterations in brain function are considered any of the following:
  - Any period of loss of or decreased consciousness;
  - Any loss of memory for events immediately before (retrograde amnesia) or after the injury (post traumatic amnesia);
  - Neurologic deficits such as muscle weakness, loss of balance and coordination, disruption of vision, change in speech and language, or sensory loss;
  - Any alteration in mental state at the time of the injury, such as confusion, disorientation, slowed thinking, or difficulty with concentration ([Centers for Disease Control and Prevention, 2015](#), p. 15).

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<sup>43</sup> Strangulation can cause anoxic or hypoxic brain injury. Although TBI and anoxic/hypoxic brain injury are similar in clinical presentation, debate exists whether strangulation is more appropriately classified as an acquired brain injury, rather than a traumatic brain injury ([Bichard et al., 2021](#)). Regardless, similar clinical symptoms may be present in patients after strangulation, particularly those who have experienced strangulation with any neurological signs or symptoms. Emerging research indicates patients who experience strangulation-related alterations in consciousness performed more poorly on a measure of working memory, even when controlling for confounding variables such as previous IPV-related TBI ([Valera, Daugherty, Scott, & Berenbaum, 2022](#)).

## TBI Severity

TBI severity can be determined accordingly:

Criteria	Mild	Moderate	Severe
Structural imaging	Normal	Normal or abnormal	Normal or abnormal
Loss of consciousness	Less than 30 minutes	30 minutes to 24 hours	Greater than 24 hours
Post traumatic amnesia	0–1 day	More than 1 but less than 7 days	Greater than 7 days
Glasgow Coma Scale score (best available score in 24 hours)	13–15	9–12	3–8
Abbreviated Injury Scale score: Head	1–2	3	4–6

([Centers for Disease Control and Prevention, 2015](#), p. 17)

- Consider the use of a standardized tool, such as the HELPS Brain Injury Screening Tool.<sup>44</sup>
- For mild TBI (mTBI), the CDC and the American College of Emergency Physicians (ACEP) [created clinical guidelines](#) to assist with care decisions. Note: An IPV-specific assessment tool, the Brain Injury Severity Assessment tool (BISA) has been developed, but its validity and reliability has not been formally tested as of this writing ([Smirl et al., 2019](#)).
- Some who experience mTBI will also experience what is referred to as postconcussion (or postconcussive) syndrome (PCS). Although no consensus exists on the definition of PCS, the most common clinical features associated with PCS include headache, dizziness, fatigue, irritability, anxiety, sleep disorder, impaired attention and memory, and sensitivity to noise and light ([Dwyer & Katz, 2018](#)).

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<sup>44</sup> The Brain Injury Alliance of Nebraska developed a [modified HELPS tool](#) specifically tailored for patients who have experienced IPV. The tool includes questions about strangulation.

- Limited research is available on IPV and PCS specifically. Kwako and colleagues ([2011](#)) note, “Many common outcomes of IPV share features with documented outcomes of postconcussive syndrome” (p. 122).
- Because research demonstrates that a majority of women who have experienced IPV have suffered repeated head trauma, the clinician must consider “not only the effect of IPV related TBI and head trauma, but also the effects of repetitive hits to the head in this population as these confer greater neural, cognitive, and psychological impairment over the lifespan” ([Esopenko et al., 2021](#), p. 491).

## Strangulation

Strangulation is the obstruction of blood vessels and/or airflow in the neck by external compression resulting in asphyxia ([Training Institute on Strangulation Prevention](#)). Strangulation is one of the most common mechanisms of injury in IPV. Because of this, the clinician must know how to thoroughly assess the patient following a strangulation assault.

### Related terms:

- **Asphyxia:** Within the medical forensic context, a condition in which the body does not receive or use an adequate amount of oxygen ([Sauvageau & Boghossian, 2010](#)).
- **Hypoxia:** Decreased oxygen to the tissues
- **Hypoxemia:** Decreased oxygen to the blood
- **Anoxia:** Total absence of oxygen to the tissues and organs
- **Suffocation:** A broad, non-specific term encompassing several different types of asphyxia. Although it is often used interchangeably with smothering, its definition is source-dependent. Some define suffocation more expansively to include entrapment and environmental suffocation where there is a reduction of oxygen in the atmosphere, as well as choking, where food or a foreign body are obstructing the airway ([Sauvageau & Boghossian, 2010](#)). It should be noted that another type of asphyxia, *traumatic asphyxia*, where external weight is placed on an individual's chest or abdomen restricting breathing, is often brought under the umbrella of suffocation in IPV cases. Many patients report the experience of an abuser sitting or lying on them during an assault, compromising their ability to breathe. It is appropriate to assess these patients like other patients experiencing suffocation.

The clinician should consider using a standardized evaluation tool that includes the following information:<sup>45</sup>

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<sup>45</sup> Because of the potential for serious healthcare sequelae following strangulation assaults, including delayed fatalities, clinicians in outpatient and community health settings should have clear guidelines for when the patient should be referred or transferred to the emergency department for more in-depth assessment and evaluation. These criteria may be based on specific signs and symptoms or may be implemented for all strangulation patients, but should be memorialized in policy and adhered to consistently.

- Date and time of strangulation or suffocation event
- Number of times patient was strangled
- Specific history of the strangulation or suffocation assault(s)
- Method/manner of strangulation
  - One or two hands (or both)
  - Front or back approach (or both)
  - Use of ligature
  - Use of chokehold
  - Patient wearing jewelry around neck during strangulation
  - Abuser wearing jewelry on hands during strangulation
  - If suffocation occurred, the manner of suffocation
- Specific occurrences during strangulation:
  - Loss of consciousness
  - Incontinence of urine and/or stool
  - Bleeding
  - Patient’s feet lifted off the ground
  - Suffocation in addition to strangulation
- Strangulation pressure (using a scale from 0–10)
- Pain scale to assess current pain levels

**Signs and symptoms since the strangulation or suffocation assault(s)**

Coughing	Dyspnea	Droling
Neck pain	Nose pain	Nausea/Vomiting
Vision changes	Voice changes	Loss of memory
Headache	Lightheadedness	Neck swelling



Sore throat	Uncontrolled shaking	Ptosis/Facial droop
Weakness/Numbness/Loss of sensation	Dysphagia/Odynophagia	Crepitus
Bleeding	Irritability/Combativeness	Paralysis/Tingling in extremities

## Physical Assessment

- Is the patient pregnant?<sup>46</sup>
- Is there an abnormal carotid pulse?
- Are petechiae present? (Note: in some types of asphyxia, such as suffocation, petechiae may appear beyond the head and neck.)
  - Facial
  - Ears (including ear canals)
  - Nasal passages
  - Eyes
  - Conjunctiva
  - Oral
  - Scalp
  - Other (describe)
- What is the patient's neck measurement?
- Is tongue injury present?
- Is oral cavity injury present?
- Is subconjunctival hemorrhage present?

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<sup>46</sup> In the emergency department setting, the patient should be treated according to the institution's trauma pregnancy protocol; in a primary care, clinic or other community setting, programs should have clear guidelines for when the patient should be referred or transferred to the emergency department for more in-depth assessment and evaluation. For the patient who is pregnant or concerned about possible pregnancy and who was also sexually assaulted, please reference the [National Protocol for Sexual Assault Medical Forensic Examinations Adult/Adolescent 2nd ed.](#)

- Is an absence of normal crepitus felt during manipulation of cricoid cartilage?
- Is there visible injury?
- Are there [cranial nerve deficits](#)?

(Adapted from Memorial Hospital: University of Colorado Health Emergency Department, Colorado Springs, CO)

## Resources

A particularly helpful tool for prehospital clinicians and law enforcement, is the Training Institute on Strangulation Prevention's [Strangulation Assessment Card](#). This card provides guidance for transport and considerations at the scene.

Additional Resources: [Training Institute on Strangulation Prevention's CDAA Investigation and Prosecution of Strangulation Cases Manual](#) (see Chapter 5: Medical and Forensic Evaluation in Non-Fatal Strangulation Cases) and the [International Association of Forensic Nurses Non-Fatal Strangulation Documentation Toolkit](#).

### Imaging After Strangulation: What is Best Practice?

A regularly asked question is whether to obtain imaging, particularly computerized tomography (CT) scans of the neck for all adult patients following reported strangulation assaults. Imaging allows for identification of life-threatening conditions, such as laryngeal fractures and arterial dissections, with CT angiogram (CTA) of the neck considered the gold standard ([Stellpflug, Weber, Dietrich et al., 2022](#)). Recent research demonstrates that vascular injury following strangulation is an infrequent finding: just 1.5% of patients had positive vascular injury on CTA following non-fatal strangulation in a study out of Australia; 2.1% in a U.S. study ([Williamson, Collins, Dehn, & Doig, 2021](#); [Zuberi, Dixon, Richardson et al., 2019](#)). Low incidence of vascular injury combined with concerns about issues such as radiation exposure (not fully understood based on limited research, particularly in cases of multiple exposures and younger patient populations) and costs incurred by the patient make it difficult to justify routine CTA in non-fatal strangulation. However, just because an issue is infrequent doesn't mean it doesn't occur, and statutory (e.g.

EMTALA) and ethical obligations require clinicians to make determinations based on more than simple probabilities.

Ultimately, in the absence of well-validated protocols, clinicians need to make decisions on a case-by-case basis. “It is reasonable to pursue advanced imaging of the neck for patients with a Glasgow Coma Scale score <15, focal neurologic symptoms, clear signs of airway injury, or dysphagia” ([Stellpflug, Weber, Dietrich et al., 2022](#), p. 3). Clinicians may also choose to obtain images on patients with significant visible neck injury, even in the absence of other symptoms.

### Considerations for physically assessing patients who experience IPV

1. While some injuries may be correlated to particular mechanisms of injury, the clinician should still explore the possibility that findings may result from medical conditions or disease processes, and complete a thorough evaluation rather than make assumptions based on the acute history.
2. Sample/evidence collection may occur contemporaneously to the physical assessment. However, a patient has the right to decline this collection and doing so shall not impact the quality of the healthcare they receive. As discussed in [Consent](#), the collection of samples requires separate patient consent and release.
3. The need to deploy trauma interventions and/or additional medical consultation (such as other specialties such as neurology or obstetrics) takes priority over any evidence collection. However, hospitals can work to minimize evidence loss or degradation by implementing basic protocols (e.g., not cutting clothing through wound holes; placing clothing in paper bags rather than plastic bags) and working with specialists, such as forensic nurses, where available.
4. Use of telehealth in the care of patients experiencing IPV is still in its formative stages. Some guidance exists for clinicians, but limited evaluation has been conducted on how patients experience its use compared to face-to-face encounters ([Jack et al., 2020](#); [Simon, 2021](#)). Several communities throughout the U.S. have employed telehealth to provide medical forensic examinations in cases of sexual assault and child abuse, and many more communities have adopted telehealth technologies to conduct case review, photo review, and testimony preparations ([Office for Victims of Crime, n.d.-a](#)). The use of trained, experienced forensic

clinicians to assist the less experienced clinician remotely conduct a comprehensive evaluation and sample/evidence collection as a tool for performing IPV medical forensic examinations through telehealth, however, is relatively unexplored at this time. Privacy issues related to telehealth are significant, and the inability to fully assess a patient's safety requires the clinician to thoughtfully consider how and when telehealth is used, including understanding that abusers may use technology, such as password trackers and other spyware, to stalk and harass.

# Photography

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Photography is a useful tool for medical documentation of injury as well as memorializing damage to a patient's clothing or other belongings (e.g., assistive devices or mobility aids). However, should a patient decline photographs or an organization does not have camera equipment available, the clinician can still perform a comprehensive medical forensic examination, relying on narrative documentation and body diagrams. Medical forensic examinations are more than a photographic catalogue of injury.

## **All encounters with patients who have experienced IPV are healthcare encounters**

There may be instances when law enforcement or other first responders transport patients who have experienced IPV to a facility specifically to obtain photographs. Clinicians should be wary of being relegated solely to the role of injury documenter—patients who have experienced IPV should be provided the opportunity for comprehensive care, something clinicians have an ethical obligation to address. Even in circumstances where a patient has been treated acutely for IPV-related injuries, the clinician is still able to complete a focused medical forensic examination (with the patient's consent), approaching the exam similar to a specialist seeing a patient after treatment by another clinician.

## **Taking Photographs**

The best photographs are clear and well-lit with consistently identifiable subject matter.

- Camera equipment costs can range from several hundred to tens of thousands of dollars. A clinician considering an equipment purchase for their team should consider issues, such as:
  - **Location of the medical forensic examination**  
Is the program stationary or moving between multiple locations?
  - **Storage**  
Is there secure storage space? Is adequate space available for storing accessories or is space available only for storing one camera?
  - **Training**  
Will the organization invest in training clinicians in new technologies?
  - **Lighting**  
Does the exam space allow for manipulating lighting conditions? Does the exam space require additional lighting to adequately capture images?

- Point-and-shoot cameras all team members can competently operate may be a better investment than more intricate Digital Single-Lens Reflex (DSLR) cameras that may intimidate or confound some users. In choosing cameras, 12 megapixels is the minimum number needed for photos that provide clarity with magnification ([Gouse et al., 2018](#); [Staggs, 2014](#)).
- The main goal of photo-imaging is to preserve (as closely as possible) and document the appearance of an injury as assessed by the clinician at the time of the examination. For that to occur, the clinician must consider lighting and camera positioning to ensure accuracy, completeness, and minimal distortion. If the images do not accurately portray the injuries in question, they should be retaken. This is not only to provide adequate images for legal proceedings, but to ensure that subsequent treating clinicians are able to assess wound healing; and to provide accurate documentation for quality assurance/quality improvement/peer review purposes.<sup>47</sup> For more information, refer to *Quality Assurance and Improvement* in the [Program and Operational Issues](#) section.
- To ensure the identity of the patient in the photo series is clear, the clinician should begin and end the patient's photos with a reference photo (e.g., a photo of the patient's hospital identification sticker). An identification photo of the patient may also be used, although patients or clinics may prefer to have basic identifying information, such as the patient's name and birthdate and date and time of care captured in the first and last images.
- To capture injuries as accurately as possible, the camera should be held perpendicular to the injury, rather than pointed at the injury obliquely.
- Photographs should minimize clutter or distraction, such as detritus from procedures or background medical equipment.

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<sup>47</sup> Some debate exists about deleting photographs during the examination. Although clinicians should follow existing jurisdictional policy, during the course of taking photos, a clinician ordinarily may delete a photograph that is distorted, blurry, or otherwise unusable and replace it with a higher quality image of the same subject matter. It's true that law enforcement should not delete photographs, but medical photography serves a different purpose, even when the photographs are later used in legal proceedings. Once downloaded to a hard drive or burned to a disc, photographs should never be deleted or otherwise altered.

## **Types of photographs include:**

### **Identification**

May be head-to-toe or from mid-torso; intended to establish the patient's identity at the beginning of the image series and should always be completed while the patient is dressed or wearing a hospital gown. The patient should not be posed as if in a mug shot and a profile view is unnecessary unless it is taken to photo document injury.

### **Injury Orientation**

Although some refer to this image as the “midrange image”, this protocol uses the phrase “injury orientation.” “Injury orientation” more accurately encapsulates the purpose of the image—to capture a region or multiple regions of the body to orient the viewer to the location of the injury on the body.

### **Close-Up**

Each wound should be photographed close-up, with and without a reference scale, ensuring that the scale does not obscure any aspect of the wound if at all possible.<sup>48</sup>

See [Appendix F](#) for a sample photograph log.

For some patients, photography may be traumatic, so the consent process at the beginning of the medical forensic examination must include a thorough discussion of photography, including how it will be conducted; the equipment to be used; how the images will be stored, shared, and with whom; and who will have access to the images once taken. The clinician should reaffirm the patient's consent/ assent to have photos taken immediately prior to obtaining them and allow the patient the opportunity to decline to undergo photography at any point during the examination process.

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<sup>48</sup> Reference scales can be any standardized object, such as a quarter or a ruler without advertising. However, the most common reference scale used in forensic nursing and medicine is the [American Board of Forensic Odontology \(ABFO No. 2\) scale](#).

**Consent:** Consent can be defined as a discussion between patient and healthcare provider that results in the patient authorizing or declining an intervention (The Joint Commission, 2016, p. 1).

**Assent:** The expressed willingness to participate in an activity (e.g., examination procedures) (Office on Violence Against Women, 2016 , p. 181)

### **Additional Photography Considerations**

- The clinician should consider that, for some patients, images have been used as a form of abuse, such as nonconsensual pornography (the distribution of sexually graphic images of individuals without the patient’s consent). A recent study of more than 3,000 adults found that 1 in 12 had been victims of nonconsensual pornography at some point in their lives, with women and lesbian, gay, and bisexual individuals experiencing higher rates than heterosexual men ([Ruvalcaba & Eaton, 2020](#)).
- Photography may also trigger some forms of disability, such as dissociative identity disorder.
- Personal-use cameras (e.g., those on a clinician’s cell phone or tablet) should not be used for patient photographs, unless the organization uses a dedicated application with integration into a specific electronic medical record system. In these cases, an image may be captured properly with the cell phone and transmitted directly and securely into the electronic medical record, without storing the image on the clinician’s personal device ([Harting et al., 2015](#)).
- Similarly, a clinician should not take photographs for law enforcement on law enforcement’s imaging equipment if asked to do so during the medical forensic examination. The clinician has specific privacy obligations to the patient that law enforcement does not. Additionally, should a case proceed to trial, issues may arise about authenticating the images, which would be part of the law enforcement case file, but would have been taken by the clinician. These unnecessary complications are best avoided by maintaining clear professional boundaries.
- When photographing the patient, the clinician should articulate the clinical rationale for



obtaining the images they choose to capture and ensure they take the photographs in a patient-centered manner. If there is nothing to document on the body surface, images likely are not warranted. If the purpose of the photograph is to obtain an identification image, that photograph can be taken while the patient is clothed or in a hospital gown, and not posed as if the patient is being detained in custody. If a full body image is necessary because of the distribution of injury, the clinician should cover the patient strategically to preserve modesty to the fullest extent possible.

- Patient-centered approaches to photography include being thoughtful about issues such as privacy and comfort. For a patient with a disability, the clinician should work directly with the patient to determine their preference and ability to be positioned rather than the clinician making any assumptions. Clinicians should also work with the patient to identify and photograph damage to adaptive equipment if it is available during the medical forensic examination.
- If possible, have the patient return for follow-up, to include additional photodocumentation of developing and resolving injuries at specified intervals, per jurisdictional policy.<sup>49</sup>
- Photographs are part of the medical record; originals should not be turned over to law enforcement. With a signed release from the patient, copies of the patient's body surface photos can be released for either 1) emergency concerns for restraining/orders of protection or 2) an immediate need for use as part of the criminal investigative process. Copies of the anogenital photos generally should not be provided to anyone except the patient without a subpoena or a signed release of information from the patient. The clinician should clearly explain to the patient that, once copies of the photos are released, they are no longer protected by HIPAA.
- Organizations should establish policies and procedures related to digital imaging, including: procedures as part of medical forensic examination, image security and authorization for access, image enhancement details, duplication and release, storage, and a secure image back-up system. Digital images included in the medical record should be preserved in the original

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<sup>49</sup> Follow-up visits may be considered billable to the patient and clinicians should work with their billing department to ensure accurate billing. For general payment information, including specific billing codes, see IAFN's Medical Billing and Coding Fact Sheet and associated information about examination payment: <https://www.safeta.org/page/paymentfactsheet/>.

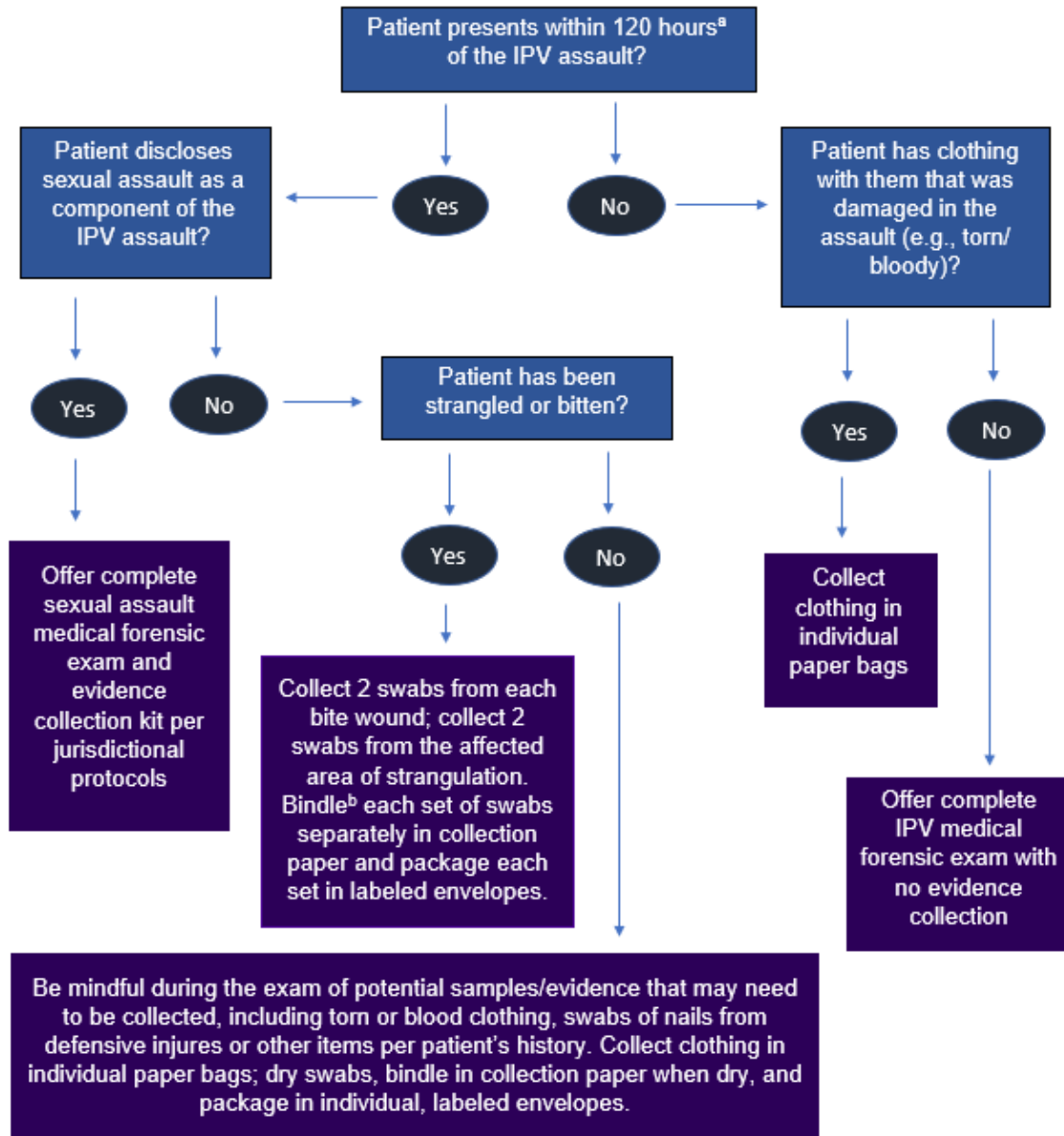
file format. If an image is to be enhanced, a new file should be created (the original remains unchanged) and details of the enhancement should be documented. The facility should make available, to those with legitimate access, image copies in an encrypted format ([Office on Violence Against Women, 2016](#), p. 133).

- To ensure quality and accuracy of digital images, programs are strongly encouraged to employ a clearly defined peer review process.

# Sample/Evidence Collection

## Flowchart for Sample/Evidence Collection

This sample flowchart guides sample/evidence collection when conducting a medical forensic examination. See [Appendix G](#) for the text description of this graphic.



a. The *National Best Practice for Sexual Assault Kits: A Multidisciplinary Approach* informs that samples/evidence should be collected up to 120 hours or longer after the assault and is considered best practices recommendations. Where jurisdictional protocols differ, please adhere to jurisdictional protocols ([National Institute of Justice, 2017](#)).

b. **Bindle:** (also referred to as bindle paper) Clean paper folded to use to contain trace evidence ([National Institute of Justice, 2009](#))

### Considerations for handling of samples/evidence:

- The clinician should maintain control of any sample/evidence collected during the examination, while it is being dried, and until it is packaged, sealed, and turned over to law enforcement.
- Documentation should demonstrate the transfer from the clinician to law enforcement, known as chain of custody. This establishes the integrity of the handling and transfer of the sample/evidence should it be needed for legal purposes.
- For healthcare programs unused to routine collection of samples/evidence or who may not have forms to establish chain of custody, the responding law enforcement agency should be able to provide the appropriate form. If using an external form, a copy should be made after all samples/evidence have been signed over to responding law enforcement to maintain with the patient's medical record.
- If a patient's adaptive or assistive equipment is broken during the assault, this should be documented. If possible, the damaged equipment should be photographed. If the equipment has already been repaired or replaced, the clinician should narratively document the damage in the medical forensic record.
- In cases where a patient was strangled and lost control of their bladder/bowels, underwear and/or the next layer of clothing the patient was wearing should be collected with the patient's permission. The items should be dried, if possible, and packaged in individual paper bags. If they cannot be completely dried, they should be packaged, and law enforcement should be notified upon transfer of the items that the items need additional drying time.
- Sample/evidence collection may occur contemporaneously to the physical assessment. However, patients have the ability to decline this collection, and it should be clear that this is within their rights to do so. The patient's decision shall not impact the quality of the healthcare services they receive.

As discussed in the [Consent](#) section, collection of samples requires separate patient consent and release. See [Appendix H](#) for a sample evidence collection supply checklist.

## Chain of Custody

To maintain the integrity of any evidence collected, the clinician must properly document chain of custody as a component of the medical forensic record. “Chain-of-custody documentation identifies all persons who have had custody of evidence and the places where that evidence has been kept in chronological order from collection to destruction. When done properly, the chain should be an unbroken trail of the collection, custody, control, transfer, and disposition of the evidence” ([National Institute of Standards and Technology Technical Working Group on Biological Evidence Preservation, 2013](#), p. 25). When reviewing the chain of custody, the identity of the clinician who collected samples/evidence from the patient and the date and time they were collected should be clearly noted; if a different clinician was charged with releasing the evidence to law enforcement, this should also be clearly documented. See [Appendix I](#) for a sample chain of custody documentation form.

## Collection Instructions for Samples in IPV Patients:<sup>50</sup>

*Please note: the following are considered national best practices but may not conform with jurisdictional policies for sample/evidence collection. Where recommendations differ from jurisdictional policy, please adhere to jurisdictional policy or consult your local crime lab with questions.*

Sample Type	Instructions for Collection & Packaging
Clothing	Each item should be packaged in its own paper bag
Hands	Use one lightly moistened swab to concentrate any potential DNA recovery. Swab the entire palmar surface of each hand separately, and then package and label each envelope separately as left palm or right palm.
Nails	Swab the underside of the fingernails with a lightly moistened swab, unless the patient’s history (scratching) indicates that nail clippings would yield additional DNA. One swab should be used for each hand to concentrate the potential for DNA yield. Package and label swabs separately as right and left hand and/or right and left feet (per patient history). Use of tools to scrape underneath the fingernails should be avoided, as it is a potential source for injury and/or infection to the patient.

<sup>50</sup> For a comprehensive overview of sample/evidence collection instructions, including genital samples and other samples/evidence collected in cases where sexual violence has also been reported, please reference the National Institute of Justice’s National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach, p. 18-23 <https://www.ojp.gov/pdffiles1/nij/250384.pdf>.

Sample Type	Instructions for Collection & Packaging
Nails (clippings)	As indicated by a history of scratching the assailant: package and label separately as right and left hand and/or right and left feet (per patient history). In the alternative, swabbing the nails is acceptable.
Skin (from bite wounds or oral contact)	Use two lightly moistened swabs, from each affected area, packaged per jurisdictional policy. If bite mark impression evidence is to be collected, it should be done by an expert in forensic odontology, forensic dentistry, or a professional specially trained in the collection of such evidence (e.g., CSI personnel, clinical forensic specialists). If this is not feasible, the aforementioned experts should be consulted as to the collection of this evidence.
Skin (for touch DNA)	Use two lightly moistened swabs across the affected area (as in cases of strangulation), packaged per jurisdictional policy.

Adapted from National Institute of Justice, [\*National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach\*](#).

## Discharge and Follow-Up

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As with any patient who presents for treatment, discharge and follow-up are a standard part of the care process. For patients experiencing IPV, the discharge and follow-up plan must attend to a spectrum of potential needs with an overarching concern for the patient's safety. The clinician must work with the patient to create a plan that is achievable, meets the patient's specific goals, and does not inadvertently create more safety issues for the patient. To this end, the clinician should explicitly ask the patient whether it is safe to send them home with printed materials or other items that could potentially place them in danger.

When discussing options for discharge, the clinician should not expect that a patient will follow a given course of action (e.g., going to shelter rather than returning home to the abuser). Nor should services be predicated upon the patient's choice of action upon discharge. As Alpert identifies, "A patient who remains in a dangerous or potentially dangerous relationship should not be labeled as a 'treatment failure' or 'noncompliant.' Choosing not to leave usually reflects the survivor's constrained resources, or their reasonable assessment of available options and safety needs" ([Alpert, 2015](#), p. 51). Patients don't leave for a number of reasons, including fear of losing their children, fear of increased violence, financial concerns, lack of access to safety or support. Patients with disabilities may be physically unable to leave. A recent meta-analysis found specifically for Black, Asian, minority ethnic and immigrant women, leaving abusive relationships was also hampered by punitive immigration laws, systemic and structural racism, language barriers, and police brutality ([Hulley, Bailey, Kirkman et al., 2022](#)). Members of the LGBTQI+ community may face these barriers with additional layers of homophobia and/or transphobia.

Likewise, it is impossible to anticipate a patient's priorities, so the clinician should avoid assuming what resources a patient will want or need based solely on the patient's clinical presentation or their medical or assault history. It should be understood that the clinician's priority for the patient may not be the patient's actual priority, so the discharge process must be a dialogue. Identifying all the issues that need to be addressed upon discharge with the patient, in tandem with the patient, and not just the ones the clinician has identified, ensures effective discharge planning, and allows the clinician to identify as many necessary resources as possible. For example, the clinician may be most concerned about having the patient fill a prescription for antibiotics to prevent infection from a bite wound

inflicted by their intimate partner, but the patient may be much more concerned about finding a resource to help replace the apartment door that was broken in the midst of the assault.

Discharge and follow-up planning can be separated into three different categories:

**1. Medical and Mental Health**

Medical examples include injury-specific discharge information (e.g., such as with [strangulation](#), concussion) and anticipatory guidance for emergent issues that may require immediate assessment. Mental health examples include referrals for counseling, safety planning specific to issues of self-harm, and review of available emergency services, if needed.

**2. Victim Services**

Victim services, to provide the spectrum of needs the patient may have regardless whether law enforcement is involved in the response. Services may include victim advocacy, children who witness violence programs, legal assistance, and shelter.

**3. Community Connections**

Community connections, including housing programs, employment programs, childcare assistance, local independent living organizations, and other organizations that are able to assist with aspects of daily life that may provide greater safety, independence, or support.<sup>51</sup>

Consider connecting the patient directly with these resources, whenever possible, rather than simply sending the patient home with a pamphlet or contact information. This means helping the patient set up follow-up appointments or contact victim service agencies prior to discharge. As with all aspects of the medical forensic examination, the clinician should clearly [document](#) discharge and follow-up recommendations in the medical record.

In some instances, the clinician may not be the professional responsible for detailed discharge planning (or [safety planning](#)). In such cases, the clinician should ensure a warm hand-off with the social worker, victim advocate, or forensic nurse who will be completing this portion of the patient encounter. The clinician should clearly document the hand-off in the medical forensic record and include any initial discharge and follow-up information the clinician provided.

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<sup>51</sup> To better acquaint team members with local resources, see [Appendix J](#), which may be completed and routinely updated with names and contact information for organizations in the clinician's community.



# Judicial Proceedings and Medical Testimony

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Information documented in the medical forensic record may be used in both criminal<sup>52</sup> and civil proceedings. The civil law system handles complaints as diverse as divorce and custody, housing-related issues,<sup>53</sup> and orders of protection. The criminal law system addresses violations of criminal statutes, such as assault, rape, stalking, and murder. The clinician who provides care for a patient who has experienced IPV is more likely to be called to testify in a criminal rather than a civil case, yet a subpoena (an order to appear in court) to testify may be issued for either type of case. If this occurs, the clinician is expected to take the witness stand and provide testimony in a clear, objective manner, consistent with the ethics of their profession.<sup>54</sup>

Since clinicians will most frequently provide testimony in criminal proceedings, understanding how a case moves through the criminal justice system is beneficial. Movement through the criminal justice system involves a series of steps, which may vary from jurisdiction to jurisdiction. Universally, entry into the criminal justice system begins with a crime that is reported and investigated. In most state and local jurisdictions, if the investigation leads to an arrest, the person is either released without prosecution or booked. If the person is booked, they proceed to the phase of prosecution and pretrial activities, which may eventually lead to the scheduling of a criminal trial ([American Bar Association, 2019](#)). In federal jurisdictions, if the prosecutor commences or recommends federal prosecution, after a full investigation, charges may be filed via indictment or complaint. Thereafter, the subject is arrested and arraigned before a judge ([U.S. Justice Manual 9-27.220](#)).

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<sup>52</sup> This includes State, Federal, Military, and Tribal courts.

<sup>53</sup> The Violence Against Women Act (VAWA) protects federally subsidized tenants from being denied housing or from being evicted because they are the victim of domestic violence, dating violence, sexual assault, or stalking. A federally subsidized tenant includes someone who lives in a public housing project, has a Section 8 voucher, or lives in a rental unit that receives federal housing assistance ([National Network to End Domestic Violence, 2021](#)).

<sup>54</sup> Although most professional organizations do not provide specific guidance for their members about trial testimony, some, like the [American Medical Association](#) and the [American Academy of Pediatrics](#), are clear about expectations. Some codes of ethics limit guidance to the role of the expert witness as it pertains to medical malpractice and peer review, but remain silent on the clinician's testifying in any other capacity (e.g., [American College of Emergency Physicians](#) and the [American Association of Legal Nurse Consultants](#)). The clinician is encouraged to investigate their professional organizations' guidance regarding trial testimony to familiarize themselves with recommendations and expectations, should any exist.

## Commonly Used Legal Terms

<b>ARRAIGNMENT</b>	The first step in criminal proceeding where the defendant is brought in front of the court to hear the charges and enter a plea.
<b>BENCH TRIAL</b>	A type of trial in which there is no jury. The judge determines both questions of law and questions of fact.
<b>BOOKING</b>	The process where information about a criminal suspect is entered into the system of a police station or jail after that person's arrest. Exact procedures may vary amongst jurisdictions, but most share similar features.
<b>CROSS-EXAMINATION</b>	During a cross-examination, the opposing party questions the witness. Generally, a witness is initially questioned by the party that called them to the stand on direct examination. Afterwards, the opposing party has the opportunity to question the witness on cross-examination, often using targeted or leading questions.
<b>DEPOSITION</b>	A witness's sworn out-of-court testimony. It is used to gather information as part of the discovery process and, in limited circumstances, may be used at trial.
<b>DIRECT EXAMINATION</b>	The initial questioning of a witness by the party that called them to the stand.
<b>DISCOVERY</b>	The formal process of exchanging information between the parties about the witnesses and evidence they'll present at trial ( <a href="#">American Bar Association, n.d.</a> ).
<b>INDICTMENT</b>	An indictment formally charges a person with a criminal offense. The indictment enables a government prosecution of a suspected criminal actor for the offenses charged in the indictment.
<b>JURY TRIAL</b>	A type of trial in which a judge determines questions of law and entrusts designated questions of fact and determination of guilt to a panel of jurors.

<b>OBJECTIONS</b>	A formal protest raised during a trial, deposition or other procedure indicating that the objecting attorney wishes the judge to disallow either the testimony of a given witness or other evidence that would violate the rules of evidence or other procedural law. At trial, these are typically raised after the opposing party poses a question of the witness, but before the witness can answer, or when the opposing party seeks to enter an exhibit into evidence.
<b>PLAINTIFF</b>	In a civil matter, the party who initiates a lawsuit.
<b>PLEA AGREEMENT</b>	Agreements between defendants and prosecutors in which defendants agree to plead guilty to some or all of the charges against them in exchange for concessions from the prosecutors, e.g., reduction of length of sentence.
<b>SENTENCING</b>	A criminal sentence refers to the formal legal consequences associated with a conviction. Types of sentences include probation, fines, short- or long-term incarceration, suspended sentences, which only take effect if the convict fails to meet certain conditions, payment of restitution to the victim, community service, or drug and alcohol rehabilitation for minor crimes.
<b>SUBPOENA</b>	A subpoena is a written order to compel an individual to give testimony on a particular subject.
<b>SUBPOENA <i>DUCES TECUM</i></b>	A type of subpoena that requires the witness to produce a document or documents pertinent to a proceeding.

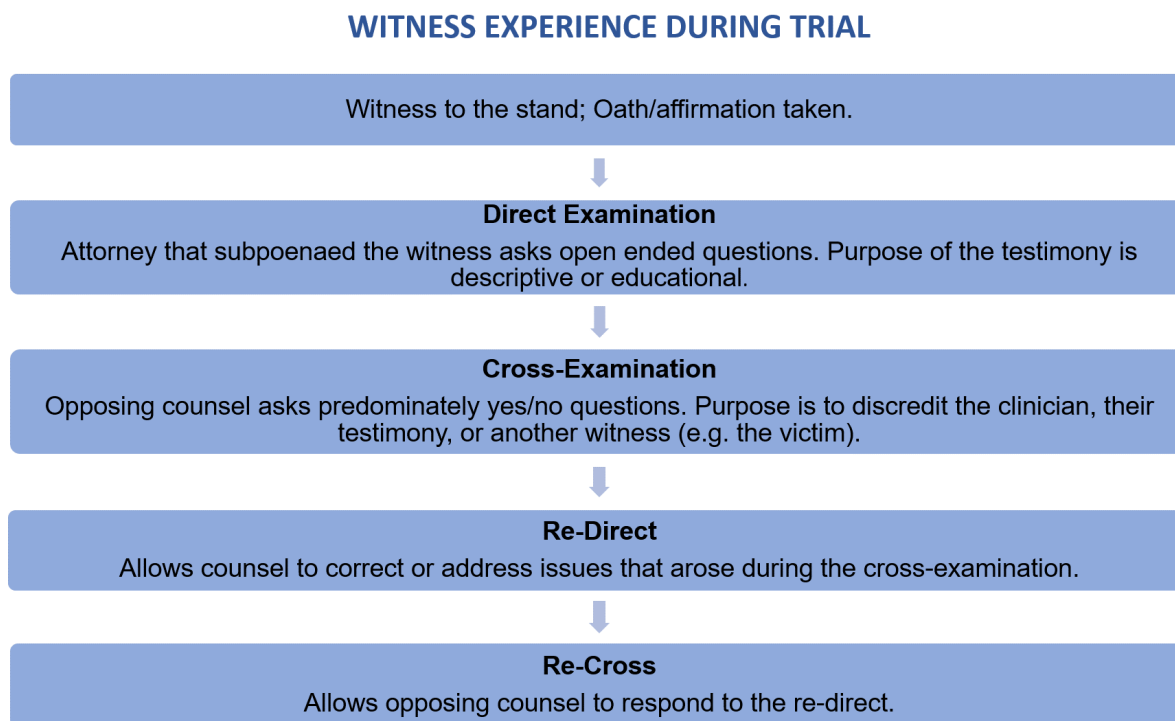
(Except where noted, all definitions are from [Cornell Law School, n.d.](#))

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As a fact witness, the primary role of the clinician in the courtroom is to testify as to events or facts about which they have personal knowledge. In some cases, this includes testifying about the patient encounter, including what the clinician saw, heard, and did. On the other hand, the clinician may be qualified as an expert witness, in which case their primary role is to educate. Witnesses are qualified as experts based on their knowledge, skills, experience, education, and/or training. In addition to

testifying about the patient encounter,<sup>55</sup> the clinician may be asked to render an opinion or provide more detailed educational testimony that delves into information such as current practice standards or the state of the science (e.g., frequency of injury findings; common examination techniques).<sup>56</sup> In certain instances, some clinicians may serve in both roles. Clinicians should seek clarification from the party calling them if they are unclear about their role.

The following graphic provides an overview of the general flow of testimony at trial.



(Adapted from [International Association of Forensic Nurses, 2020](#))

A subpoena will be issued if a clinician’s testimony is required at trial. Subpoenas will be handled differently depending on the facility. Some organizations channel them through the legal department

<sup>55</sup> In some cases, the clinician may act as expert witness despite having no involvement in the patient’s care. This type of expert witness is in court to testify about the care the patient received and/or to render an opinion or provide additional educational information related to the state of the science.

<sup>56</sup> A specific rule—Federal Rule of Evidence 702—outlines what qualifies an individual to be an expert witness. Most states and military courts base their rules on the Federal Rules of Evidence, and therefore use a similar, if not the same, standard: A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: (a) the expert’s scientific, technical, or other specialized knowledge will help the trier of fact [judge or jury] to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case (<https://www.rulesofevidence.org/article-vii/rule-702/>).

and distribute from there. Smaller organizations and practices may have subpoenas delivered directly to the clinician. Regardless of the clinical setting, subpoenas should be sent to the clinician's professional address, not their home address. If possible, clinicians should establish a process with their legal and health information management departments to ensure timely receipt of any subpoenas and access to relevant medical records for review prior to testimony.

A pretrial meeting with the subpoenaing attorney<sup>57</sup> can enhance witness confidence by clarifying the scope of testimony. It also provides an opportunity for counsel to clarify any questions that may arise from the medical evidence. Ideally the pretrial preparation process should take place face-to-face, but even a phone meeting is preferable to no pretrial preparation whatsoever. The clinician should contact the attorney listed on the subpoena to schedule a meeting as soon as possible after receiving a subpoena. In addition, if they have not done so already, the clinician should provide counsel with a current copy of the clinician's [curriculum vitae](#) at the time of the meeting. In the absence of an opportunity to prepare with counsel, the clinician should, at a minimum, ensure they have reviewed the patient's record thoroughly, as well as any literature upon which they are relying.

Upon receiving a subpoena, the clinician should have the opportunity to meet with counsel for pretrial preparation. Even for an experienced witness, a pretrial meeting allows counsel and the clinician to ensure they have a similar understanding of the facts and are clear on what is both needed and expected of the clinician as a witness. Because of discovery rules, the attorney generally will not provide a written list of questions that will be asked. The pretrial preparation process should result in answers to the following questions:

- Is the clinician testifying as a fact witness, an expert witness, or both?
- What key information does counsel want the factfinder to learn from the clinician's testimony?
- What are the anticipated questions that will be asked during the testimony on direct examination?

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<sup>57</sup> Clinicians may also be required to speak with opposing counsel. Clinicians should be prepared to discuss the factual components of their participation in the case and their knowledge base, including the source of any opinions that counsel intend to elicit during direct examination. In cases involving IPV, if you are being called by the plaintiff's attorney or the prosecutor and you are contacted by defense counsel, it is important to let the plaintiff's attorney or the prosecutor know so they can make best efforts to ensure the clinician is not conveying information to the defense that could harm crime victims' rights.

- Should the clinician bring anything with them to court, including records or photographs?
- What is the timeframe for the trial or proceedings and when will the clinician be expected to testify?
- Will the clinician be expected to listen to other testimony?
- What are the anticipated areas of cross-examination?

(Adapted from [Office for Victims of Crime, n.d.-c](#))

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### **What is expected from clinicians at trial?**

When the clinician is subpoenaed to testify about the patient encounter for an IPV medical forensic examination, the goal is to provide honest, objective facts to the judge or jury. To be most effective, clinicians should strive to:

- Apply their expertise, education, and knowledge fully to the case, regardless of who requested the testimony (i.e., prosecution, plaintiffs, or defense). No guarantee exists that a clinician will testify for a particular side. Testimony grounded in science and practice standards should not change, regardless of which side has issued the subpoena.
- Ensure testimony, generally, and opinions, specifically, are not crafted with the purpose of advocating for one particular side. Although clinicians are patient advocates in the clinical setting, in the courtroom, their primary role is clear: to testify as to events or facts about which they have personal knowledge and educate the judge and factfinder as necessary.
- Ensure any opinions rendered are grounded on the best available evidence-based science, practice standards, and their own relevant experience. Just as patient care is based upon widely accepted scientific principles and practice, the testimony stemming from patient care should also be built upon these fundamentals.
- Be clear about the boundaries of their own testimony and resist pressure from counsel to testify to information that exceeds their scope. This may include clarifying that specific questions fall outside the clinician's scope of practice.

([American Medical Association, 2016](#); [Office for Victims of Crime, n.d.-c](#); [Paul et al., 2017](#))

## Subpoenas for Medical Records

At the time the patient receives care, they may choose to sign a consent allowing release of medical forensic records and associated documentation. However, not all patients will opt to consent to release their records. Upon receipt of a subpoena for medical records, the clinician should know:

- **Is there a signed consent to release by the patient on file?**

If so, releasing the information outlined in that consent technically may occur without delay.

However, in the interest of instituting a patient-centered process, the organizations may establish a policy stating that, when possible, an attempt will be made to contact the patient for consent or notification before releasing any records. It is important to understand that if the patient declines to give consent, there may still be a legal obligation to release the records, but at minimum the patient will be informed with details about the request. In the absence of a signed release by the patient, organizations should consult with their legal counsel or risk management official about how to appropriately respond, including whether a requirement exists to inform the patient about the subpoena.

- **What is being requested?**

Only records delineated in the subpoena should be released. This requires attention to dates noted in the subpoena to ensure release of the appropriate documentation rather than the entirety of the patient's medical record (particularly if they have been treated by the clinician or organization on multiple occasions). It is important to note whether the subpoena specifically requests photographs and radiographic images, laboratory reports, and other components not necessarily contained within the documentation of the medical forensic record.

- **Is a record being maintained of the disclosures?**

HIPAA requires that all covered entities track protected health information disclosures. "Individuals have a right to an accounting of the disclosures of their protected health information by a covered entity or the covered entity's business associates" ([U.S. Department of Health and Human Services, 2013](#)).

Before releasing medical records, HIPAA outlines specific patient notification requirements. Reasonable efforts must be made to show that:

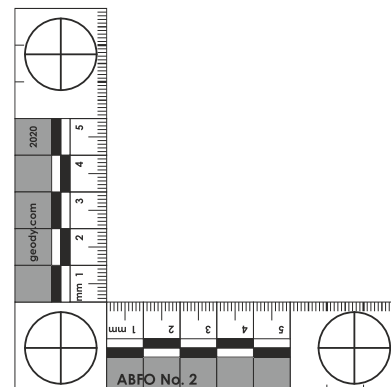
The patient has been notified so they have the opportunity to object to the disclosure, or they may “seek a qualified protective order from the court”. ([U.S. Department of Health and Human Services, 2020](#))



## Glossary

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**ABFO Ruler:** A standardized 8-cm x 8-cm, L-shaped reference scale developed by the American Board of Forensic Odontology (ABFO). Inclusion of three circles across the scale allows for identification and compensation for image distortion resulting from an oblique camera angle. Measurements can be calculated using the 1-cm and 1-mm imprinted gridlines. These gridlines allow for compensation of distortion resulting from non-parallelism between the planes of the camera lens/sensor and the object being photographed. The alternating 1-cm black and white grids are useful for approximating measurement from high-light/low-light images ([CFNE International, n.d.](#)).



**Anatomical inventory:** Sometimes known as an organ inventory, it is a process by which clinicians can document and track the presence or absence of specific organs in the health record along with any surgical procedures ([Grasso et al., 2021](#)).

**Arraignment:** The first step in criminal proceeding where the defendant is brought in front of the court.

**Burnout:** A state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations. Symptoms may include depression, cynicism, boredom, loss of compassion, and discouragement ([Office for Victims of Crime, n.d.-d](#)).

**Community-based advocate:** Individuals either employed or serving as volunteers at a community-based program who provide support and assistance to victims of crime ([CFNE International, n.d.](#)).

**Confidentiality:** The legally required process and ethical practice of not disclosing to the public or other unauthorized persons any private or identifying information regarding a patient or client that may be collected while providing services ([CFNE International, n.d.](#)).

**Crepitus:** When palpating a part of the body, eliciting a crackling sound or sensation. In strangulation, specifically, crepitus can be of concern when identified during palpation of the neck, as a sign of subcutaneous emphysema (infiltration of air under the dermal layer of skin). Its absence can also be concerning, as when palpating the larynx, where laryngeal crepitus is normally felt when the larynx is moved from side to side with a slight posterior pressure. Following strangulation and other mechanisms of injury that cause laryngeal trauma, crepitus may be absent upon examination ([Hansen, 2001](#)).

**Current Procedural Terminology (CPT) codes:** The preferred system for coding and describing healthcare services and procedures in federal programs (Medicare and Medicaid) and throughout the United States by private insurers and providers of healthcare services ([Dotson, 2013](#)).

**Curriculum vitae (CV):** A catalogue of one's professional accomplishments, a CV provides a thorough review of a clinician's education, experience and credentials, similar to a resume, but much more extensive. Where a resume is meant to market an individual with professional highlights, the CV is

meant to provide a comprehensive history or *course of life* (the literal translation of the term curriculum vitae).

**Disability:** A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). There are many types of disabilities, such as those that affect a person's vision, movement, thinking, remembering, learning, communicating, hearing, mental health, and social relationships. Although "people with disabilities" sometimes refers to a single population, this is actually a diverse group of people with a wide range of needs. Two people with the same type of disability can be affected in very different ways. Some disabilities may be hidden or not easy to see ([CDC, 2020](#)).

**Dyspareunia:** Recurrent or persistent pain with sexual intercourse

**Dysphagia:** Difficulty swallowing

**Dyspnea:** Difficult breathing; shortness of breath

**Gender:** Gender refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviors and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time ([WHO, n.d.](#)).

**Gender-based violence:** Gender-based violence can take many forms, and it is rooted in structural gender inequalities and power imbalances. It includes the use or threat of physical violence and coercive control toward an intimate partner (including domestic and dating violence), sexual assault, and stalking, human trafficking, online abuse and harassment, and child sexual abuse ([U.S. Department of Justice, 2022](#)).

**Guardian ad litem:** A lawyer appointed by the court to advocate for the best interests of a child and to ensure that the child's concerns and preferences are effectively advocated ([Tennessee Bar Association, n.d.](#)).

**Memorandum of Understanding (MOU):** A statement of intent between the participating organizations to work together and often states goals, objectives, or the purpose for the partnership; details the terms of and conditions for the agreement; and outlines the operations needed to achieve the goals or purpose ([Computer Security Resource Center, n.d.](#)).

**Metoidioplasty:** A gender-affirming procedure using clitoral tissue to construct a penis ([Crane, 2016](#)).

**Odynophagia:** Painful swallowing

**Privilege:** A legal rule prohibiting the disclosure of private information against someone's will ([Aiken & Confidentiality Institute, Inc., 2015](#), p. 1).

**Ptosis:** Drooping of the upper eyelid

**Quality assurance (QA):** A process that measures compliance against certain necessary standards, typically focusing on individuals ([Office for Victims of Crime, n.d.-a](#)).

**Quality improvement (QI):** A continuous improvement process focused on processes and systems ([Office for Victims of Crime, n.d.-a](#)).

**Reproductive coercion:** Behaviors that interfere with contraception use (birth control sabotage) and/or pregnancy (pregnancy pressure and coercion) ([Chamberlain & Levenson, 2013](#), p. 6).

**Safety plan:** A plan for maintaining safety in anticipation of future violence or abuse.

**Secondary trauma/stress:** See Vicarious trauma

**Sequelae:** The consequence of a disease or injury.

**Subconjunctival hemorrhage:** Burst blood vessels under the conjunctiva (the clear membrane that covers the surface of the eye).

**Subpoena:** A written order to testify in court. See also *subpoena duces tecum*, which is a court order to produce documents relevant to specific proceedings ([Cornell Law School, n.d.](#)).

**Systems-based advocate:** A term referring to victim advocates who are employed by non-community-based organizations (e.g., police departments, courts, universities, and federal agencies). System-based advocates may provide limited (i.e., system specific) services therefore often collaborate with community-based advocates to ensure victims have access to all available resources. System-based advocates usually do not hold privilege and confidentiality protections in the same manner as community-based advocates ([CFNE International, n.d.](#)).

**Telehealth:** The delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services, and self-care via telecommunications and digital communication technologies ([NEJM Catalyst, 2018](#)). It is a broader term than *telemedicine* in that it encompasses more than just direct clinical care.

**Vaginoplasty:** A procedure to construct or repair a vagina ([Meltzer, 2016](#)).

**Vicarious trauma:** An occupational challenge for people working and volunteering in the fields of victim services, law enforcement, emergency medical services, fire services, and other allied professions, due to their continuous exposure to victims of trauma and violence. This work-related trauma exposure can occur from such experiences as listening to individual clients recount their victimization; looking at videos of exploited children; reviewing case files; hearing about or responding to the aftermath of violence and other traumatic events day after day; and responding to mass violence incidents that have resulted in numerous injuries and deaths ([Office for Victims of Crime, n.d.-d](#)).

**Victim advocate:** A member of the multidisciplinary team whose focus is to provide support and assistance to victims of crime, either through a community-based organization (*community-based advocate*) or through a law enforcement agency (*systems-based advocate*).

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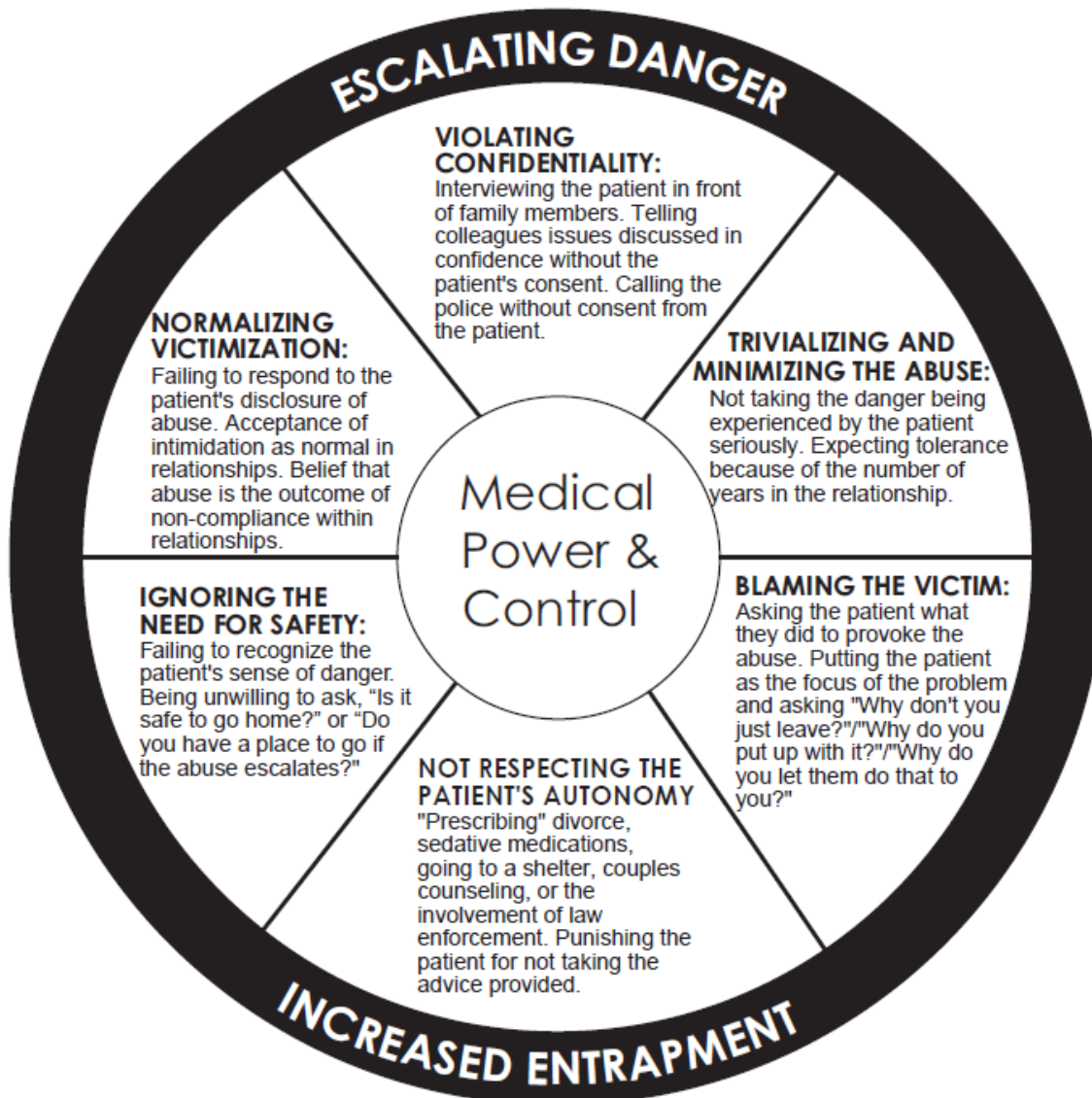
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## Appendix A – Medical Power and Control Wheel

# MEDICAL POWER & CONTROL WHEEL



This gender-neutral wheel was adapted by International Association of Forensic Nurses from the Medical Power & Control Wheel developed by: The Domestic Violence Project, Kenosha, WI, adapted from the original wheel by the Domestic Abuse Intervention Project; Distributed by the [National Center on Domestic and Sexual Violence](#). An accessible explanation is provided below. Note: This wheel assumes the patient is without a disability, but for patients with disabilities, other examples within the wheel include screening the patient for IPV in front of their personal care attendant; making mobility aids or other assistive devices inaccessible throughout the patient encounter; and refusing to provide the patient with IPV-specific referrals.

## Description of Graphic

Medical power and control are comprised of a variety of elements, all of which signify escalating danger and increased entrapment. In no particular order, these elements include:

1. Violating Confidentiality
  - a. Interviewing the patient in front of family members
  - b. Telling colleagues issues discussed in confidence without the patient's consent
  - c. Calling the police without consent from the patient
  
2. Trivializing and Minimizing the Abuse
  - a. Not taking the danger being experienced by the patient seriously
  - b. Expecting tolerance because of the number of years in the relationship
  
3. Blaming the Victim
  - a. Asking the patient what they did to provoke the abuse
  - b. Putting the patient as the focus of the problem and asking "Why don't you just leave?" "Why do you put up with it?" or "Why do you let them do that to you?"
  
4. Not Respecting the Patient's Autonomy
  - a. "Prescribing" divorce, sedative medications, going to a shelter, couples counseling, or the involvement of law enforcement
  - b. Punishing the patient for not taking the advice provided
  
5. Ignoring the Need for Safety
  - a. Failing to recognize the patient's sense of danger
  - b. Being unwilling to ask "Is it safe to go home?" or "Do you have a place to go if the abuse escalates?"
  
6. Normalizing Victimization
  - a. Failing to respond to the patient's disclosure of abuse
  - b. Acceptance of intimidation as normal in relationships
  - c. Belief that abuse is the outcome of non-compliance within relationships

## Appendix B – Sample Medical Forensic Examination Consent Form

Patient Name:	
DOB:	DOS:
MRN:	

### Medical Forensic Examination

\_\_\_\_\_ I **consent** to a medical forensic examination. I understand that I am able to decline any portion of the examination at any time during the process of the examination.

\_\_\_\_\_ I **authorize** the release of a copy of the medical forensic examination documentation to law enforcement.

### Photography

\_\_\_\_\_ I **consent** to having photo documentation conducted during the medical forensic examination. I understand that I am able to decline any portion of the photography during the process of the medical forensic examination.

\_\_\_\_\_ I **do not** consent to having photo documentation conducted during the medical forensic examination.

\_\_\_\_\_ I **authorize** the release of photographs obtained during the medical forensic examination to law enforcement, excluding anogenital photographs and photographs deemed sensitive in consultation with the clinician, which will be released only with the receipt of a subpoena.

### Evidence Collection

\_\_\_\_\_ I **consent** to having evidence collected during the process of the medical forensic examination. I understand that all collected evidence will be sealed and submitted to the appropriate agency of the law by the collecting clinician. I understand that if I have not chosen to release my medical forensic examination records and/or photographs, they may still be subpoenaed by an investigative agency.

\_\_\_\_\_ I **do not consent** to having evidence collected during the process of the medical forensic examination.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Clinician Name (Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Date/Time

## Appendix C – Sample Quality Assurance Tool for IPV Medical Forensic Examinations

Clinician Name: \_\_\_\_\_ Date of Exam \_\_\_\_\_  
 Date of Review \_\_\_\_\_ MRN: \_\_\_\_\_

Chart Components	Completed/ Documented			Chart Components	Completed/ Documented		
Patient demographics	Yes	No	N/A	Lab tests	Yes	No	N/A
Consent forms	Yes	No	N/A	Pregnancy test	Yes	No	N/A
Allergies and medications	Yes	No	N/A	Radiological imaging	Yes	No	N/A
Vaccinations	Yes	No	N/A	Medications administered	Yes	No	N/A
Past medical history	Yes	No	N/A	Photo documentation	Yes	No	N/A
Current medical history	Yes	No	N/A	Photograph log	Yes	No	N/A
Surgical history	Yes	No	N/A	Evidence collection - swabs per history	Yes	No	N/A
Gynecological history	Yes	No	N/A	Clothing/Other evidence collected	Yes	No	N/A
Sexual history	Yes	No	N/A	Safety planning	Yes	No	N/A
Current method of birth control	Yes	No	N/A	Domestic violence advocacy services	Yes	No	N/A
Psycho-social history	Yes	No	N/A	IPV victim service resources	Yes	No	N/A
Suicide assessment	Yes	No	N/A	APS/CPS report	Yes	No	N/A
History of current event of IPV	Yes	No	N/A	Report to law enforcement	Yes	No	N/A
Time and date of described IPV event	Yes	No	N/A	Chain of custody form	Yes	No	N/A
Danger assessment	Yes	No	N/A	Release of information	Yes	No	N/A
Strangulation assessment	Yes	No	N/A	All required signatures and dates	Yes	No	N/A
Physical assessment	Yes	No	N/A	Discharge instructions	Yes	No	N/A

### Specific Considerations for Patient Populations with Additional Needs

Patient	Additional Considerations/ Referrals/Resources	Completed/Documented		
Pregnant patients		Yes	No	N/A
Adolescent patients		Yes	No	N/A
Transgender or non-binary patients		Yes	No	N/A
LGBTQIA+ patients		Yes	No	N/A
Patients with limited English proficiency		Yes	No	N/A
Patients who are Deaf or Hard of Hearing		Yes	No	N/A
Patients with disabilities		Yes	No	N/A
Other:		Yes	No	N/A

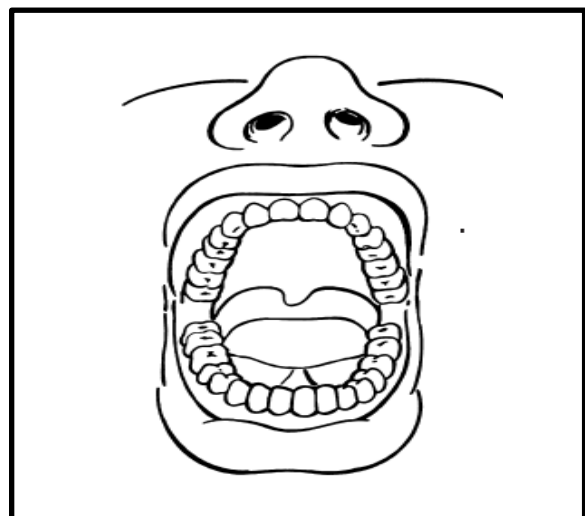
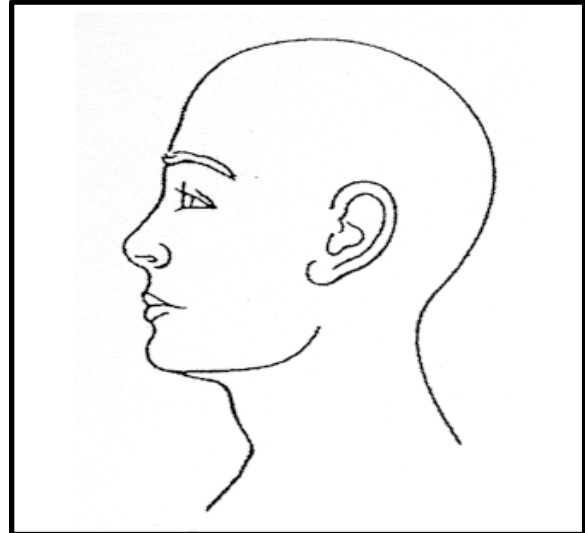
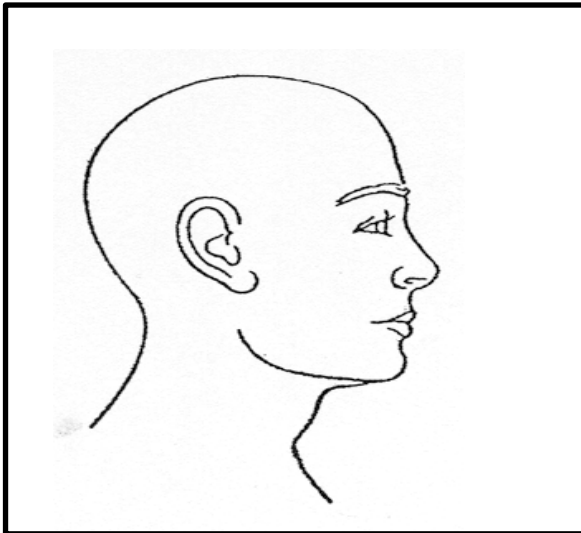
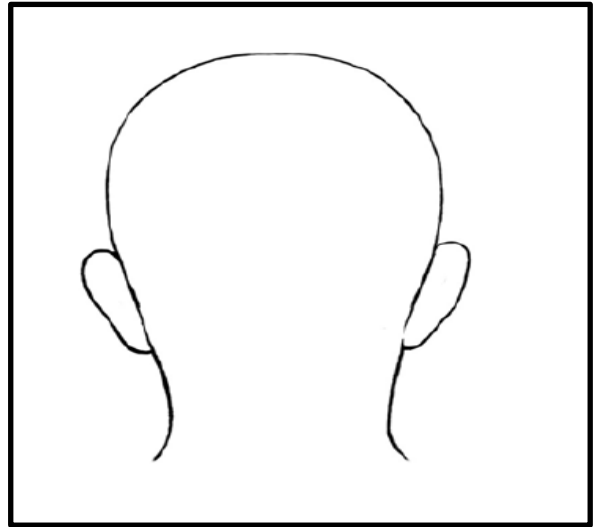
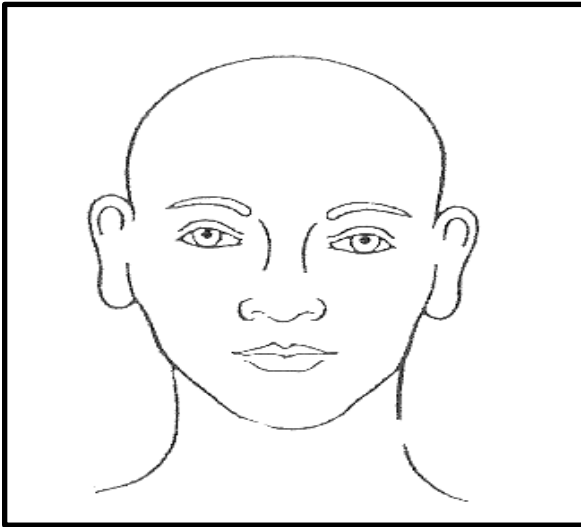
Photographs and Photo Documentation	Completed/Documented		
Consent for images	Yes	No	N/A
ID photo	Yes	No	N/A
Injury orientation	Yes	No	N/A
Close-up injury with and without scale	Yes	No	N/A
All injuries identified	Yes	No	N/A
Photo quality acceptable	Yes	No	N/A

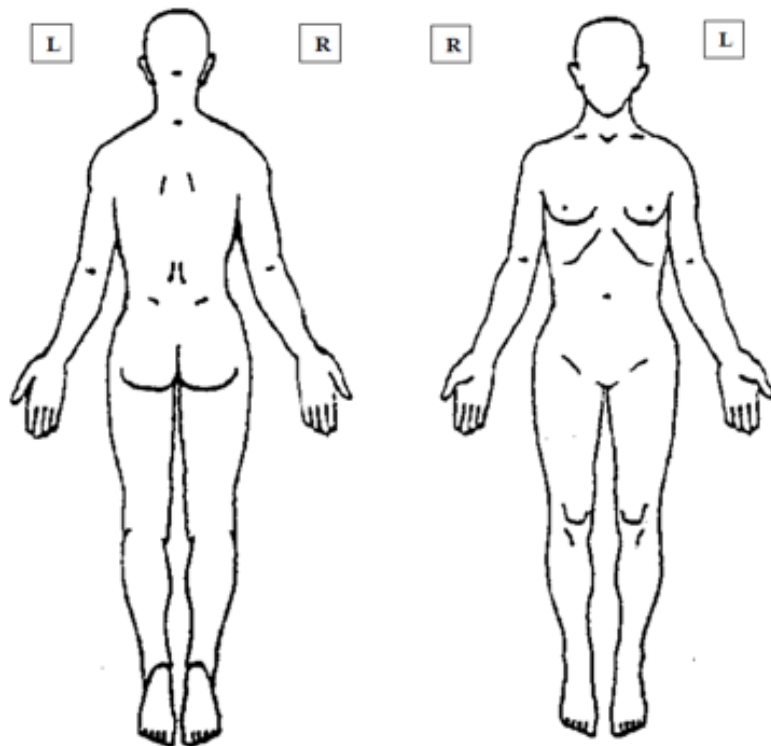
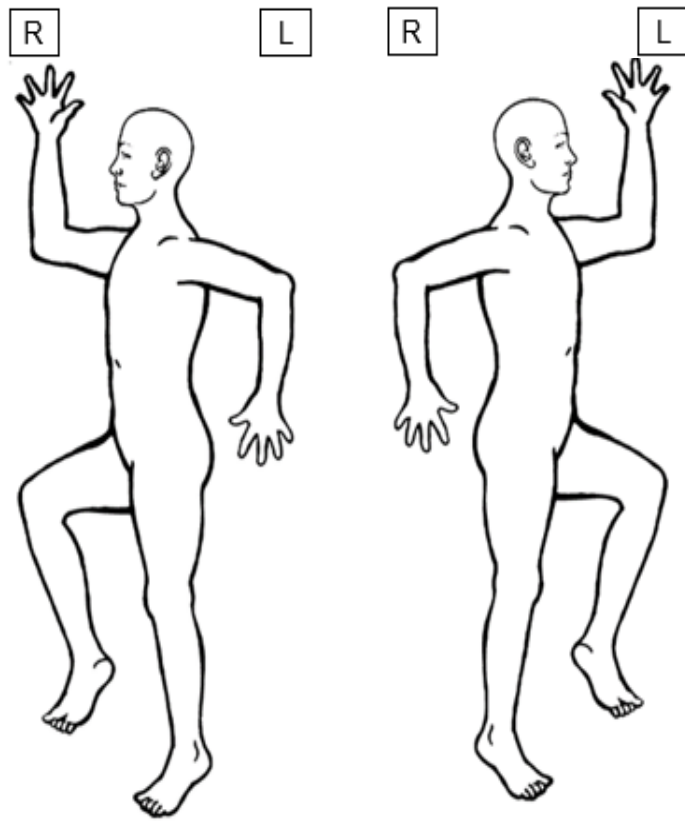
### Recommendations for Improvement

Section	Recommendation



Appendix D – Diagrams







0022



0022



0022



0022



0022



0022

## Appendix E – Sample Anatomical Inventory

### Breasts

- Present
  - Absent
    - Chest reconstruction
    - Bilateral mastectomy
    - Unilateral mastectomy, R
    - Unilateral mastectomy, L
    - Breast augmentation/implants
- 

### Uterus

- Present
  - Absent
    - Hysterectomy-cervix removed
    - Hysterectomy-cervix remains
- 

### Ovaries

- Present
  - Absent
    - Bilateral salpingo-oophorectomy
    - Unilateral salpingo-oophorectomy, R
    - Unilateral salpingo-oophorectomy, L
- 

### Vagina

- Present
- Absent
  - Colpocleisis-closure of the vagina
  - Vaginoplasty

### Cervix

- Present
  - Absent
- 

### Penis

- Present
  - Absent
    - Phalloplasty/penile implant
    - Metoidioplasty
    - Erectile device
    - Penectomy
- 

### Testes

- Present
  - Absent
    - Testicular implant(s)
    - Bilateral orchiectomy
    - Unilateral orchiectomy, R
    - Unilateral orchiectomy, L
- 

### Urethra

- Present
  - Absent
    - Urethral lengthening
- 

### Prostate

- Present
- Absent
  - Prostatectomy

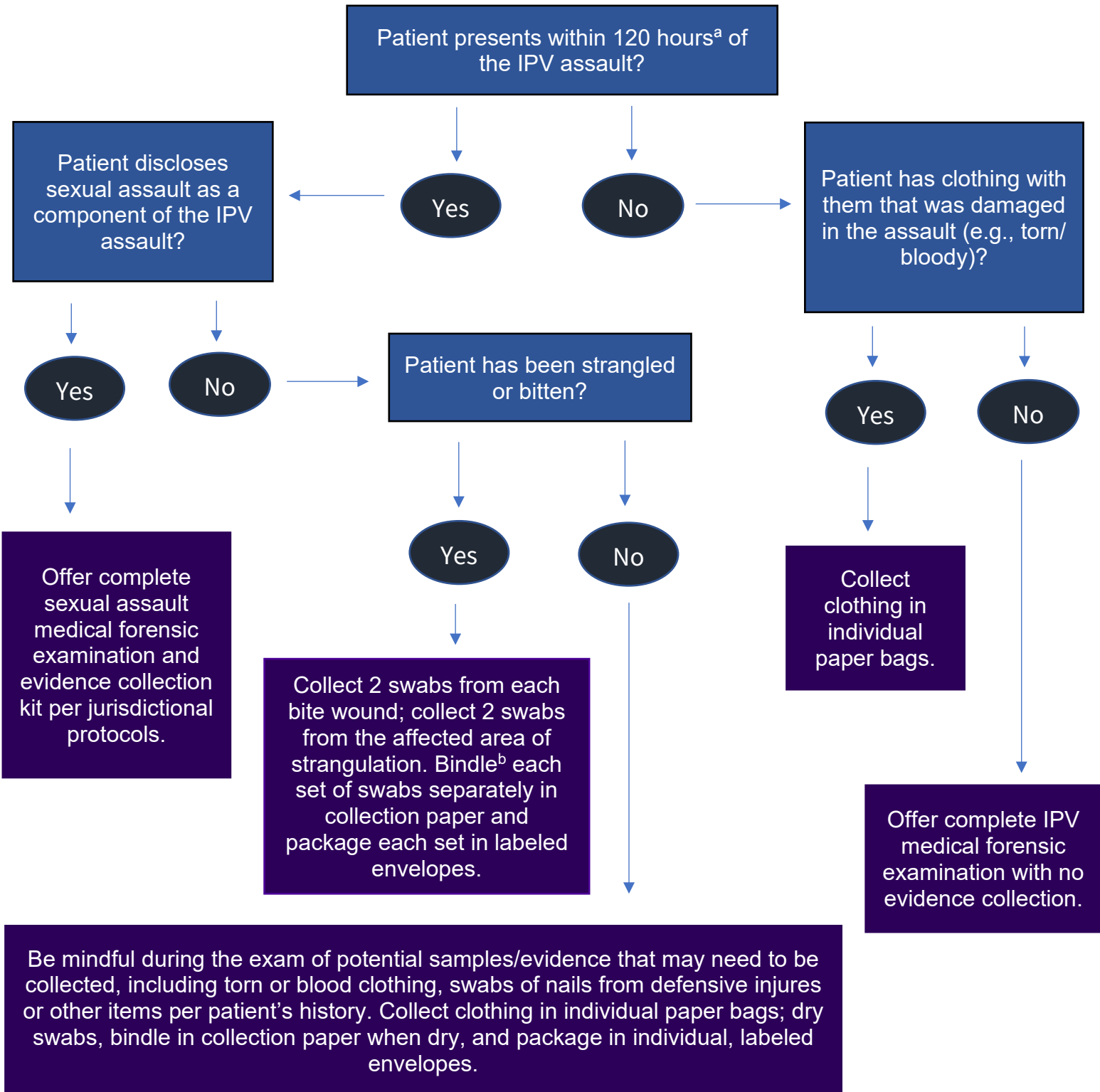
(adapted from [Grasso et al., 2021](#))

## Appendix F - Sample Photograph Log

Patient Name: \_\_\_\_\_  
 Patient MRN: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 DOS: \_\_\_\_\_

Photo/JPEG #	Photograph Description (e.g., injury description, measurement)

## Appendix G - Flowchart for Sample/Evidence Collection



a. The *National Best Practice for Sexual Assault Kits: A Multidisciplinary Approach* informs that samples/evidence should be collected up to 120 hours or longer after the assault and is considered best practices recommendations. Where jurisdictional protocols differ, please adhere to jurisdictional protocols ([National Institute of Justice, 2017](#)).

b. **Bindle**: (also referred to as *bindle paper*) Clean paper folded to use to contain trace evidence ([National Institute of Justice, 2009](#)).

## Description of Graphic:

Is the patient presenting to healthcare within 120 hours<sup>a</sup> of an IPV assault?

If not, does the patient have clothing with them that has been damaged in the assault? (e.g., torn, bloody). If clothing is present, collect it in individual paper bags. If clothing is not present, offer a complete IPV medical forensic examination with no evidence collection.

If the patient is presenting within 120 hours of an IPV assault, has the patient been sexually assaulted? If so, offer a complete sexual assault medical forensic examination and evidence collection kit.

If the patient has not been sexually assaulted, have they been strangled or bitten? If so, collect 2 swabs from each bite wound; collect 2 swabs from the affected area of strangulation. Bindle<sup>b</sup> each set of swabs separately in collection paper and package each set in labeled envelopes.

If the patient has not been sexually assaulted and has not been strangled or bitten: Be mindful during the exam of potential samples/evidence that may need to be collected, including torn or bloody clothing, swabs of nails from defensive injuries, or other items per the patient's history. Collect clothing in individual paper bags; dry swabs, bindle<sup>58</sup> in collection paper once dry, and package in individual labeled envelopes.

- a. The *National Best Practice for Sexual Assault Kits: A Multidisciplinary Approach* informs that samples/evidence should be collected up to 120 hours or longer after the assault and is considered best practices recommendations. Where jurisdictional protocols differ, please adhere to jurisdictional protocols ([National Institute of Justice, 2017](#)).
- b. **Bindle:** (also referred to as *bindle paper*) Clean paper folded to use to contain trace evidence ([National Institute of Justice, 2009](#))

## Appendix H – Sample/Evidence Collection Supply Checklist

- Paper bags
- Saline solution or distilled water
- Sterile swabs
- Self-sealing envelopes
- Nail clippers
- Scissors
- Collection paper
- Evidence tape or other method for sealing paper bags such as patient labels
- ABFO ruler or other measuring device



## Appendix I - Sample Chain Of Custody Form

Patient Name: \_\_\_\_\_

Patient MRN: \_\_\_\_\_

DOB: \_\_\_\_\_ DOS: \_\_\_\_\_

Hospital/Clinic Name: \_\_\_\_\_

Hospital/Clinic City: \_\_\_\_\_

### Items Included:

Clothing Bag

Clothing Bag 1: \_\_\_\_\_

Clothing Bag 2: \_\_\_\_\_

Clothing Bag 3: \_\_\_\_\_

Clothing Bag 4: \_\_\_\_\_

Swabs

Swab 1: \_\_\_\_\_

Swab 2: \_\_\_\_\_

Swab 3: \_\_\_\_\_

Swab 4: \_\_\_\_\_

Other

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Items Secured by:

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Print Name

### Items Released by:

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Print Name

**Items Received by:**

\_\_\_\_\_  
Law Enforcement Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
Agency/Badge Number

## Appendix J - Victim Services Resource Reference List

Resource Agency	Contact Information	Advocates Available?
<b>Local Forensic Nurse/SANE Program</b>		
<b>Local Domestic Violence Center</b>		
<b>Local Rape Crisis Center</b>		
<b>Local Domestic Violence Services</b>		
<b>Domestic Violence Shelter</b>		
<b>LGBTQIA+ Services</b>		
<b>Tribal Domestic Violence Services</b>		
<b>Homeless Youth Services and Shelters</b>		
<b>Homeless (Adult and Family) Services &amp; Shelters</b>		

Resource Agency	Contact Information	Advocates Available?
<b>Local Child Advocacy Center</b>		
<b>Local Immigration Services</b>		
<b>National Immigration Services</b>		
<b>Language Interpretation Services</b>		
<b>Deaf and Hard of Hearing Services</b>		
<b>Blind and Visually Impaired Services</b>		
<b>Civil Legal Services</b>		
<b>Prosecution Victim Witness Advocates</b>		
<b>Law Enforcement Victim Advocates</b>		

## Appendix K – Participants in Protocol Development

### Individuals participating in the Protocol development process:

*(These individuals participated in the Advisory Committee, the Subject Matter Expert Focus Groups, Individual Virtual Consultations, and/or Protocol draft reviewers. This list does not include representatives of any federal agencies that were involved. It is important to note that the development of this protocol was significantly enhanced from the input of all involved individuals, but the views expressed in this publication do not necessarily reflect the views of all individuals participating in the process.)*

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- Civil Rights Division, Criminal Section
- Office of Justice Programs:
  - Access to Justice Office
  - National Institute of Justice
  - Office for Victims of Crime

Department of Defense

- Family Advocacy Program
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