DOCUMENTING CLINICAL EVIDENCE OF ABUSE- "FIRST DO NO HARM"

BMC Domestic Violence Program, November 2020

This tip sheet was created to offer general guidance for medical providers in a variety of adult health care settings on how to effectively and safely document clinical findings and disclosures related to abuse in the medical record, weighing the benefits of documentation with the potential risks. ***Please note: Different practices may apply when the patient is under 18, 60 or older, or a person with disabilities, as well as in cases involving sexual assault. Additionally, information about abuse in the record of a patient who is not the victim (for example when a patient's spouse or a child's parent discloses abuse to you) can pose a risk to the victim, especially when the abuser has legal access to the record.*** In these cases, please consult with the Domestic Violence Program, Child Protection Team or the Office of General Counsel as appropriate before signing the note.

Introduction

A well-documented medical record supports continuity and quality of care for any patient, especially in a setting where a patient may see many different providers over time. For victims of abuse, the medical record can additionally serve as a valuable source of legally recognized evidence of abuse, whether the patient chooses to disclose the abuse or report it to authorities now or in the future. However, in the age of electronic medical records and patient portals such as MyChart, even *appropriately* documented medical information has potential to be viewed by those far beyond the intended audience, including an abusive partner or family member with access to the patient's portal. The potential harm caused by *inappropriately* documented information is even greater, given the much wider scope of visibility and accessibility by multiple providers over time.

As with all sensitive information, it is important to use your own judgment regarding what and how information should be documented in a patient's medical record, always mindful of why you are documenting what you do. Anything you document should be relevant to the patient's current state of health or well being and to the care you are providing. Let your patient know how you will be documenting disclosures of abuse and any other sensitive information, and be sure to take a patient's concerns about privacy or safety seriously. ***If your patient uses MyChart, be sure the patient knows they can request the note, result, or other sensitive information be withheld under the "Privacy" exception. As the provider, you may also withhold notes or results under the "Preventing Harm" exception, if you feel that releasing the note, result, or other information may result in physical harm to the patient or anyone named in the record.***

1. History

Document patient's responses to screening questions objectively and without judgment; additional detail will depend on your role and clinical setting, as well as what the patient has disclosed. **(refer to p. 2 for examples).** When a patient reports an actual incident of violence/abuse (particularly if it is the cause of presenting injuries) a notation about the disclosure and minimal, relevant details may be helpful, but keep in mind that in the event of a sexual assault, documentation should be limited to clinical findings and care so as not to contradict a survivor's statements to law enforcement or a SANE. Details about a past history of abuse, if shared by the patient, should be documented with caution, considering your reason for documenting, the clinical relevance and need, weighing potential risks to the patient, and ensuring that the patient is aware and comfortable with what you are writing.

2. Physical Findings

Include your observations of the patient's appearance, behavior and demeanor, describing them objectively. Describe what you observe, including whether or not the patient's report of what happened is medically feasible/consistent with your clinical findings. *(Please note: This is not to imply disbelief of patient, but rather to record clinical evidence whether or not patient discloses abuse.)*

Be sure to name and describe physical wounds using proper terminology including size, location and description.

Keep in mind- As a medical professional you are not expected to determine whether injuries were caused by abuse, by self-defense, or by some other mechanism. However, by examining the patient carefully and documenting patient disclosures and clinical findings accurately, you will be able to provide the highest quality care to your patient, and will also provide a quality medical record that may serve in the future as legally recognized evidence of abuse that has occurred.

3. Follow Up Plan and Referrals

Describe the plan of care that you are setting forth, including your efforts to support, follow up with, and offer additional resources and referrals to the patient. ***Please note: for the safety of the patient and any advocates working with them, do not include in the record names/numbers of DV advocates or Rape Crisis Counselors who may have responded, nor any details of safety planning, the extent or nature of any follow-up patient has with a DV or Sexual Assault program. Use caution making reference to abuse in any discharge notes; discuss with patient whether it is safe to take written materials/resources in case the person hurting them may see them.*** Additional documentation will depend on your clinical role, setting, and the health issues you are addressing with the patient. For more information, contact the BMC Domestic Violence Program at 617-414-7734. For safety concerns you can also call the National DV Hotline at 1-800-799-7233, which offers consultation to providers as well as assistance to people experiencing abuse.

 **Avoid legal terms or those that imply disbelief or judgment**	 **Use terms that are objective, descriptive if helpful**
-Patient *alleges* that her boyfriend burned her with a curling iron.	-Patient *states* that her boyfriend, Robert, grabbed her curling iron out of her hand and held it against her neck.
-Patient *denies* that boyfriend burned her, *claims* that she burned herself.	-Physical findings of a burn are of size and shape consistent with report that it was caused by a curling iron. Severity and location of the burn *appear inconsistent with patient's report* that she burned herself.
-Patient *became hysterica*l while describing the incident.	-Patient *cried and was shaking uncontrollably* while describing the incident.

In summary, documentation of notes related to abuse should include:

- Patient's ***responses to screening questions and minimal, relevant details*** if more information is shared;
- Your ***objective observations*** of the patient's appearance, behavior and demeanor;
- ***Detailed and accurate clinical findings*** and descriptions of any injuries/wounds;
- Your plan of care, recommendations for medical follow-up, and efforts to provide additional resources and referrals ***without including details of work with Advocates and safety planning***.
- ***Consideration of whether any notes should be withheld under the Preventing Harm exception, advising the patient they can also request that notes be withheld under the Privacy exception.***