



American Prosecutors
Research Institute

The Role of the Sexual Assault Nurse Examiner

in the Prosecution of
Domestic Violence Cases

National District Attorneys Association

American Prosecutors Research Institute
99 Canal Center Plaza, Suite 510
Alexandria, VA 22314
www.ndaa.org

Thomas J. Charron

President

Roger Floren

Chief of Staff

Jennifer Gentile Long

Director, National Center for the Prosecution of Violence Against Women

David LaBahn

Director, NDAA Research and Development Division

2007 by the American Prosecutors Research Institute, the research and development division of the National District Attorneys Association.

This project was supported by Grant No. 2004-WT-AX-K047, awarded by the Office on Violence Against Women, Office of Justice Programs, United States Department of Justice. This information is offered for educational purposes only and is not legal advice. The points of view, opinions, findings, conclusions, and recommendations expressed in this publication are those of the author and do not necessarily reflect the official position of the Office on Violence Against Women, the U.S. Department of Justice, or the National District Attorneys Association and the American Prosecutors Research Institute.

The Role of the Sexual Assault Nurse Examiner

in the Prosecution of
Domestic Violence Cases

August 2007

Jenifer Markowitz, ND

TABLE OF CONTENTS

I	Introduction
3	Role of the Forensic Nurse
5	The Domestic Violence Medico-Legal Examination
	Emphasizing the Medical
	The Medico-Legal Record
	<i>Medical history</i>
	<i>History of the assault</i>
	<i>Physical assessment</i>
	Wound Terms
	<i>Treatment plan</i>
	<i>Discharge plan</i>
	National Standardization
13	Using the Forensic Nurse as an Expert Witness
	Areas of Expertise
	Predicate Questions for Forensic Nurses as Experts:
	Laying the Foundation
	Common Defense Strategies
23	Interdisciplinary Collaboration and Program Development
	Conceptual Basis for Establishing a Forensic Nursing
	Domestic Violence Program
	Program Development
	Implementation
27	Beyond SART: The Multidisciplinary Approach to
	Victims of Domestic Violence
29	Appendix A: Sample Forensic Nurse Examiner
	Job Description
31	Appendix B: Scope of Practice in Intimate Partner
	Violence Nursing
33	Appendix C: Overcoming Crawford Issues
37	About the Author

INTRODUCTION

Sexual Assault Nurse Examiners (SANEs) are specialists in one of the most well-known fields within the arena of forensic nursing. However, many SANEs are moving beyond sexual assault patients, using their education and experience to expand their clinical practices to accommodate victims of other forms of interpersonal violence. In the past several years, more experienced SANEs have extended their practices into the care of victims of domestic violence. These specially-educated nurses can be a valuable resource to prosecutors, particularly in cases where the victim may be unwilling or unable to testify. This monograph will examine the basic components of the domestic violence medico-legal examination; the potential for using findings from the medico-legal examination in prosecutions; and the role of the prosecutor and other Sexual Assault Response Team (SART) members in expanding forensic nursing programs to include care of the domestic violence victim.

ROLE OF THE FORENSIC NURSE

Forensic nursing is commonly defined as “the application of the forensic aspects of health care combined with the bio/psycho/social/spiritual education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of violence, criminal activity, and traumatic accidents.”¹ Although SANEs have been most visible to sexual assault prosecutors, with programs in operation since the 1970s, forensic nurses can be found at any point along the continuum where health care and the legal system intersect: correctional nursing, psychiatric-mental health nursing, death investigation, legal nurse consulting, and trauma nursing, which involves working with victims of interpersonal violence. The International Association of Forensic Nurses (IAFN), established in 1992, is the professional organization representing forensic nurses around the world. In 1995, the American Nurses Association (ANA) formally recognized forensic nursing as a specialty area in the United States.²

¹ Lynch, V. (2005). *Forensic Nursing*. Elsevier Mosby, St. Louis, MO, p. 3.

² *Scope and Standards of Forensic Nursing* is currently being revised by the IAFN and ANA and will be available for purchase through the IAFN: www.iafn.org/store/storeHome.cfm.

THE DOMESTIC VIOLENCE MEDICO-LEGAL EXAMINATION

Nationally, clinicians are seeing domestic violence victims across health care settings. Hospital emergency departments are still frequently the entry points for acute cases of domestic violence, although increased awareness has resulted in more frequent identification in primary health care settings. While emergency departments have become more adept at screening for and documenting domestic violence in presenting patients, there is still much that can be improved upon.

The national push for specialty sexual assault care embodied by SANE programs is a model which can be expanded to enhance care of victims of domestic violence. “We can do better” has been a mantra employed by clinicians across the country as an impetus for establishing SANE programs. That mantra is applicable to domestic violence as well. Specialty educational programs have been created to expand clinician knowledge about the medico-legal care of domestic violence victims, and the International Association of Forensic Nurses has published standards of domestic violence nursing care.³ Furthermore, forensic nursing programs have formally expanded their programs to include care of domestic violence victims in many states across the nation. Unfortunately, these programs are still the exception, rather than the rule. And there is some inconsistency among the existing programs with regard to type and quality of documentation and practice philosophy.⁴

³ *Standards of Intimate Partner Violence Nursing Practice* can be purchased from the International Association of Forensic Nurses: <https://www.iafn.org/store/storeHome.cfm>.

⁴ Practice philosophy generally divides itself into two schools of thought: forensic nursing as a specialty medical service versus forensic nursing as an arm of law enforcement. While this monograph will not debate the merits of either school of thought, it will concentrate on forensic nursing as a specialty medical service since this outlook makes for a more flexible expert witness and can be generalized to other clinicians who may treat victims of domestic violence but not have specific forensic education (e.g., emergency medicine physicians).

Emphasizing the Medical

Domestic violence is a health care issue. Multiple studies have catalogued the health consequences of domestic violence⁵ and the ill-effects of domestic violence on national health objectives.⁶ Domestic violence now exists within the curricula in nursing, medical, and dental schools across the nation and in a variety of medical residency programs.⁷ Almost every professional health care association has a position statement about its members' responsibilities in working with victims of domestic violence in the various health care settings.⁸ The role of the forensic nurse can be viewed as a specialty health care service that provides patients with the most appropriate and focused care for their presenting condition. This is similar to how we view other medical specialties, such as orthopedics. A patient presenting to an emergency department with a fractured leg will receive general treatment by the department staff, as well as specialty treatment specific to the fracture by the orthopedic clinician. Forensic nurses should ensure that medico-legal examinations prioritize specialty medical care over physical evidence collection, and prosecutors should emphasize this on direct examination to help mitigate accusations of a biased witness. Although

⁵ While there have been many excellent research articles on this topic by Ann Coker, Dr. Jacqueline Campbell, and others, a single source for an overview of the scope of domestic violence's health consequences can be found in the Family Violence Prevention Fund's curriculum, *Making the Connection: Domestic Violence and Public Health*. The printed curriculum, along with the PowerPoint presentation, can be obtained through its Web site: www.endabuse.org/health.

⁶ "Healthy People 2010" is a list of national health objectives created by the U.S. Department of Health and Human Services. The Family Violence Prevention Fund's examination of the impact of domestic violence on these objectives can be found in its report, *Intimate Partner Violence and Healthy People 2010 Fact Sheet*: www.endabuse.org/hcadvd/2003/tier4.pdf.

⁷ The American Medical Association has a formal policy in support of domestic violence education for medical students and resident physicians: "The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient." (H-295.912 Education of Medical Students and Residents about Domestic Violence Screening. <http://www.ama-assn.org/>.)

⁸ For instance, the position statement on domestic violence by the American Nurses Association includes:

- *Universal, routine assessment and documentation of abuse for all women in any health care facility or community setting.*
- *Principles of intervention and care that include: partnership between the clinician and the victim, assurance of confidentiality, culturally sensitive care, and problem solving within a framework of choice and safety planning.*
- *Education of all nurses and health care providers in the skills necessary for detection, prevention, or initial intervention in situations of violence against women.*
- *Inclusion of content related to violence against women in all undergraduate nursing curricula.*

(Position Statement on Violence Against Women <http://www.ana.org/readroom/position/social/scviol.htm>.)

the history and injuries documented and the evidence collected by the forensic nurse may be useful in the investigation and prosecution of domestic violence, the record itself should be medically focused, with careful attention paid to specialty treatment and discharge planning. There should be no expectation of ancillary evidence collection, such as lab work for drugs of abuse, unless there is a prevailing medical reason to obtain such information, such as loss of consciousness or patient impairment secondary to possible head trauma.

The Medico-Legal Record

Although universally accepted documentation forms do not exist, there are certain components to the examination which should readily be found in any medico-legal record. These include:

Medical history

- Allergies
- Date of last menstrual period (LMP)
- Pregnancy history
- Chronic illnesses (e.g., depression; asthma; diabetes)
- Acute illnesses (e.g., bronchitis; urinary tract infection)
- Current medications

Medical history is essential information for any clinician. It helps the forensic nurse prioritize care by identifying potentially emergent issues unrelated to or exacerbated by the domestic violence incident. It can also provide information about clinical presentation that may appear to be related to the acute assault, but is in all actuality related to an underlying medical condition or medications a patient may be taking. The simple existence of this section can be useful to prosecutors when making the argument that forensic nurses are not an arm of law enforcement. After all, crime scene technicians and forensic photographers do not obtain a health history before obtaining buccal swabs for a DNA standard or documenting injury at the scene of an assault.⁹

⁹ See Appendix C, “Overcoming *Crawford* Issues.”

History of the assault

- Date and time of assault
- Location of assault
- Name of assailant and relationship of assailant to patient
- Mechanisms of injury
- Patient narrative of the assault (patient's history of the assault in her words)

The documentation of the patient's history of the assault should be narrowly proscribed, with strict limitations placed on any information not necessary for the treatment and diagnosis of the patient. Previous incidents of physical and sexual violence should be documented in the assault history, although not necessarily as a component of the patient's narrative. Such information is relevant as it impacts the physical and mental health of the patient. Additionally, previous incidents or ongoing concerns related to threats or stalking should be carefully outlined in the discharge notes. Any issues that may compromise safety or well-being are appropriate to detail as a part of the larger discharge plan for the patient.

Although knowing the name of the assailant may not necessarily be a key component of the medical treatment and diagnosis of the patient, the relationship of the assailant to the patient is crucial. After all, the patient being discharged following an assault by a current or former intimate partner will have very different safety concerns than the patient being discharged after being assaulted on the street by an unknown assailant. Any clinician caring for a patient must have some knowledge of what safety issues may exist for that patient prior to discharge from the hospital. This is not unique to victims of violence; a patient treated for a fractured leg, for instance, would not be discharged until the treating clinician had obtained information about the environment to which that patient would return, including obstacles to mobility which would increase the likelihood of the patient either re-injuring the affected leg or incurring new injury.

Physical assessment

- Vital signs
- Head-to-toe findings, including visible injury and other remarkable findings (e.g., decreased range of motion secondary to pain)
- Photographs and/or body maps

The physical examination section of the medico-legal documentation will often provide the most obvious material for investigators and prosecutors to use in building their case. However, interpreting the medical record can be challenging for non-clinicians. The following should provide some clarity regarding terminology found in the examination findings of the record:

<i>Directional Term</i>	<i>Definition</i>
Lateral	Toward the side
Medial	Toward the middle
Anterior	Toward the front of the body
Posterior	Toward the back of the body
Superior	Toward the top of the body
Inferior	Toward the bottom of the body
Dorsal	Along or toward the vertebral surface of the body
Ventral	Along or toward the belly surface of the body
Caudal	Toward the tail
Cephalad	Toward the head
Proximal	Toward the trunk
Distal	Away from the trunk or point of attachment
Visceral	Toward an internal organ; away from the outer wall
Parietal	Toward the wall; away from the internal structures
Medullary	Refers to an inner region
Cortical	Refers to an outer region

*Wound Terms*¹⁰

Abrasion: The rubbing or scraping of the surface layer of cells or tissue from an area of the skin or mucous membrane

Contusion: Bruise; an injury transmitted through unbroken skin to underlying tissue causing rupture of small blood vessels and escape of blood into the tissue with resulting discoloration

Cut: A wound made by something sharp

Erythema: Abnormal redness of the skin due to capillary congestion (as in inflammation)

Hematoma: A mass of usually clotted blood that forms in a tissue, organ, or body space as a result of a broken blood vessel

Laceration: A torn and ragged wound

Petechiae: A minute reddish or purplish spot containing blood that appears in skin or mucous membrane as a result of localized hemorrhage

Treatment plan

- Medical interventions (e.g., sutures; lab work; x-rays)
- Collection of physical evidence (e.g., swabs of bite wounds; bloody or torn clothing)
- Medications
- Referrals for other specialty care (e.g., obstetrics for pregnancy monitoring)
- Mandatory or patient-sanctioned reporting (e.g., law enforcement; Children's Services Bureau)¹¹

Discharge plan

- Recommended medical follow-up
- Safety plan
- Other referrals (e.g., shelter services; victim witness programs; faith-based services)

¹⁰ All definitions courtesy of Medline Plus On-line Dictionary: <http://www.nlm.nih.gov/medlineplus/plusdictionary.html>.

¹¹ See www.ndaa.org for information on reporting domestic violence.

National Standardization

Unlike sexual assault medico-legal care, which is guided by both state and national protocols, similar tools do not exist for domestic violence. Some states, such as California, have created standardized forms for health care providers to use in order to create more uniform medico-legal documentation.¹² Other states, including Ohio, have at minimum, drafted guidelines for the care of domestic violence victims in the health care setting.¹³ These do not necessarily provide guidance around medico-legal care. However, they do underscore the issue of domestic violence as a significant health care problem and the responsibility of clinicians to respond to domestic violence in their practices.

¹² Formally known as the Forensic Medical Report: Domestic Violence Examination. OES 502. Available at www.oes.ca.gov.

¹³ The Ohio Domestic Violence Protocol for Health Care Providers: Standards of Care was created in conjunction with the Family Violence Prevention Fund's National Health Care Standards Campaign. See www.odvm.org. A summary of model practices from the 15 states participating in this project can be obtained from the Family Violence Prevention Fund: www.endabuse.org, in the Health Care section of the Web site.

USING THE FORENSIC NURSE AS AN EXPERT WITNESS

Of the many medical professionals prosecutors will encounter, forensic nurses are perhaps the most willing to go to court because of the nature of their role. Prosecutors can elevate the quality and stature of the forensic nurse witness through careful preparation prior to court and through some simple steps during direct examination that will help juries see the forensic nurse as a peer and colleague of, not a handmaiden to, the physician.¹⁴

- Address your witness with the appropriate title. “Nurse” is a job description, not a title. “Mr.” or “Ms.” is the appropriate title to use with your witness, unless the witness has a doctoral degree, in which case “Dr.” is the appropriate title. Referring to your witness as “Ms. Jones” or “Dr. Jones” rather than “Nurse Jones” reminds the jurors they are hearing from a professional health care provider and may help undermine any stereotypes defense counsel attempts to perpetuate.
- Review the documentation carefully with the forensic nurse prior to trial. Discuss what you believe to be significant in the medico-legal record and ensure that the forensic nurse agrees with you. Even when you discover that components of the documentation do not contain evidence as strong as you may initially have believed, the information can still serve to enhance your witness’s credibility. For instance, you may see photographs of a patient with extensive bruising and believe this is irrefutable evidence of assault. However, the forensic nurse may find bruising less significant because of medications the patient is taking which increases the likelihood of bruising from unintentional contact. Knowing this beforehand allows prosecutors to address the issue during direct examination, and gives the forensic nurse the opportunity to discuss the impact of medication on the patient’s presentation. This immediately underscores the medical nature of the forensic nursing role and clearly identifies the witness as an objective health care provider, not an arm of law enforcement attempting to

¹⁴ For a more complete discussion of this topic, see Teresa P. Scalzo, “Tips for Testifying as an Expert Witness in a Violence Against Women Prosecution,” in *THE VOICE*, Vol. 1, No. 6 (2006).

over-inflate examination findings. In addition, ask the forensic nurse what she believes to be significant in the medico-legal record. There may be some aspects to the case which are more medically significant than you may have realized. Drawing those out on direct examination again underscores the medical role of the forensic nurse.

- During direct examination, discuss the protocols and standards of practice that guide the forensic nurse's clinical approach to patients. You can also discuss state nurse practice acts which guide all nursing practice in every state. Defense counsel often tries to paint forensic nurses as renegades practicing medicine without a license, or as politically-motivated victim advocates making up practice rules as they go along. By drawing out professional organizations' standards of practice and position statements (such as the International Association of Forensic Nurses and the Emergency Nurses Association),¹⁵ local and state protocols for care of victims of domestic violence, and state nurse practice acts which allow for this type of specialized health care by registered nurses, these types of defense arguments may be less effective.

Areas of Expertise

Many prosecutors feel comfortable using forensic nurses to testify to the facts of the case. However, forensic nurses are often overlooked as accessible (and in some cases, free) expert witnesses, providing testimony in cases with little or no specialty medical documentation. Prosecutors can use forensic nursing expert testimony in several ways outside or beyond the facts of the case:

- *Common Patient Presentations:* Forensic nurse examiners have seen many victims of violence in their careers. They can address issues such as delayed reporting and ranges of trauma reactions. Depending upon their education and experience, they may also be able to testify about such topics as the cycle of violence, power and control issues, and lethality indicators. Meeting with the forensic nurse examiner program administrators ahead of time will allow the prosecutor to determine

¹⁵ The Emergency Nurses Association position statement about domestic violence and the role of emergency nurses can be found on their Web site: www.ena.org/about/position/pdfs/domesticviolence.pdf.

which nurses will be able to provide testimony on the aforementioned topics. The program may also assist the prosecutor with identifying other helpful experts available in the community with whom they work.

- *Mechanisms of Injury and Wounds:* Assessing and documenting wounds are key areas of expertise for the forensic nurse. As a witness, she should be able to educate juries about mechanisms of injury, such as strangulation, consistency of wounds with the patient's accounts of the assault, and injury patterns.
- *Absence of Injury:* As with sexual assault cases, lack of injury does not mean lack of assault. Forensic nurses can articulate why this occurs and discuss other types of signs and symptoms of injury not readily documented with photography, such as decreased range of motion and pain with palpation. For instance, only about half of strangulation cases have visible injury. Forensic nurses can help juries understand the physiologic processes that occur with strangulation and what other non-injury symptoms the patient exhibited which would correlate with the report of strangulation.
- *Additional Clinical Expertise:* Most forensic nurses work in other areas of nursing in addition to their roles as examiners. Additionally, many have years of experience working in trauma, critical care, emergency nursing, obstetrics and gynecology, and mental health/substance abuse nursing. Prosecutors should explore this background to determine if there are other ways in which the witness may be able to help educate the jury. For example, a victim whose credibility is being attacked because of her use of a psychotropic medication could provide the opportunity for a forensic nurse with relevant experience to discuss how psychiatric drugs work and why this defense argument is invalid.

In addition to their testimony, forensic nurses can also assist prosecutors by reviewing medical records prior to trial and identifying relevant or remarkable components of the documentation. This is not limited to domestic violence cases. Forensic nurses can be an excellent resource for information

about any unusual or confusing health care issue in a criminal or civil case, including medications, adverse drug interactions, medical procedures, and physical and mental health diagnoses.¹⁶

Predicate Questions for Forensic Nurses as Experts: Laying the Foundation

The following questions can be used to lay a foundation for the forensic nurse as an expert witness.

Occupation

- What is your occupation?
 - How long have you been employed in that capacity?
 - Describe the responsibilities of your position.
 - How long has the program been in existence?
 - What services does your program offer?
 - Do you supervise?
 - Do you train staff?
 - What is the total number of staff?
 - Do you currently work in any other area of nursing in addition to your forensic nursing role?
- Forensic Nursing Employment
 - How many domestic violence patients does your program see annually?
 - How many medico-legal examinations have you done in your career?
 - Of those, how many of them were for domestic violence cases?
 - Do you have other duties besides clinical ones?
 - What percentage of your time is spent seeing patients?

¹⁶ Some jurisdictions also permit the forensic nurse to testify about common victim behavior.

■ Program Services

- Are your services solely for victims of abuse?
 - Are your services solely for women?
 - How many persons are served by this program yearly?
 - How are patients referred to your program?
 - How long do you have direct contact with an individual patient?
 - After your initial examination, is there ever repeated contact with that patient?
- What kind of records does your program maintain?
- Are you required by your hospital to maintain these records?
 - Is there a quality assurance or peer review process for those records?
 - Who is responsible for this process?

Previous Nursing Experience (if relevant)

- What was your previous occupation?
- How long did you perform those duties?
 - What were your responsibilities?
 - Did you have direct contact with victims of domestic violence?
 - What was the nature of the contact?
- Have you had any other experience working with patients with wounds/injuries/trauma?

Education

- What is the highest degree you have obtained?
- What was your area of concentration?
- Do you hold any professional certifications or licensures (including those unrelated to forensic nursing)?
- Are you required to obtain continuing education to maintain those certifications or licensures?

Professional Affiliations

- Do you belong to any professional organizations in the area of nursing?
- What is the nature and purpose of those organizations?
- Do you belong to any county, state, or national organizations which specifically address forensic issues?
- What is the purpose of those organizations?
- Are you involved with any committee work of these organizations?
What are they?

Training

- When you began your work at your program, did you receive any training in the area of domestic violence?
 - Please describe that training.
 - Have you received any additional training in domestic violence issues?
 - Please describe that training.
- Have you conducted any trainings yourself?
 - For whom did you conduct the trainings?
 - For what purpose were the trainings designed?
 - How many attended the trainings?
 - How often do you conduct such trainings?
- Have you ever published on the topic of forensic nursing or domestic violence?

Conferences

- Have you attended state or national forensic nursing conferences?
- Who sponsored the conference?
- What was the purpose of the conference?
- When and where was the conference?

- Did you attend any workshops relevant to domestic violence issues?
- Have you conducted any workshops or presentations at these conferences?

Previous Expert Testimony¹⁷

- Have you testified previously in court?
- Was it a criminal or civil case?
- How many times?
- For the defense or the prosecution?
- Have you ever been certified as an expert witness?
- In what counties?

Common Defense Strategies

Certain defense tactics are to be expected when a forensic nurse testifies as an expert witness:

- “Isn’t it true you’re just a nurse?”

Defense counsel obviously is trying to place the forensic nurse on the defensive with this question while at the same time trying to undermine her level of credibility. Preparing forensic nurses for this type of question can help them maintain a neutral response and affect. Questions on direct examination related to the witness’s level of specialized education, clinical experience, and adherence to protocols and the state nurse practice act will establish her capacity as an expert in this field and help juries understand why a nurse would be the appropriate clinician for the domestic violence patient. Drawing out the role of the forensic nurse as a medical specialist, similar to cardiologists or neurologists with unique educational requirements and practice guidelines, further underscores the credibility of the witness while also tempering further defense attacks regarding nurses practicing medicine without a license.

¹⁷ The prosecutor should also prepare the expert for a question like, “When you are subpoenaed to testify in a trial, is it standard practice for you to meet with the attorney who subpoenaed you in advance of trial?” The forensic nurse should explain that she meets with anyone who subpoenas her—prosecution or defense—before testifying at trial.

■ Forensic nurse as arm of law enforcement¹⁸

Attempting to discredit the forensic nurse by designating her as an arm of law enforcement is to be expected. This includes aligning her with crime scene investigators and painting her as an exclusive prosecution witness. During direct examination, the prosecutor must emphasize that the SANE is not an arm of law enforcement. The SANE and the prosecutor, however, must be aware that defense counsel will highlight a variety of areas in order to strengthen his or her point:

- Prior testimony experience—especially the number of times the witness has testified for prosecution. This can easily be thwarted on direct examination by asking the forensic nurse about prior defense testimony. Even if a nurse has not testified for defense previously, she may have a member of her team who has, or she may have been subpoenaed by the defense in the past but not had the opportunity to testify because the case pled. If neither has occurred, the prosecutor should highlight that the SANE has not testified for the defense simply because she has never been consulted by defense counsel, but would of course do so if asked.
- Program funding—programs which receive any type of local, state, or federal examination reimbursement or program funding may be targeted as being aligned with law enforcement and prosecution. Prosecutors should explore whether or not these same monies would be available to hospital emergency departments or other medical specialties if they were to provide the same care for victims of violence. This will illustrate the medical nature of the forensic nursing role and help juries understand that forensic nurses are simply one type of clinician who might care for this patient population.
- Photography and evidence collection—the fact that these exist within the medico-legal examination will be used to underscore alignment with law enforcement. The forensic nurse should concede that neither is medically necessary in the care of the domestic violence patient. However, photography is a standard way in which to document many

¹⁸ See Appendix C, “Overcoming *Crauford* Issues.”

different types of remarkable findings in health care today. Photographs are frequently employed in documenting wound healing, skin changes from pathology, and other significant medical findings. Cameras are not only the purview of the forensic nurse.

Evidence collection usually has no medical relevance. However, it is done at the same time as the medical examination as a courtesy to patients. It is unnecessary to require patients to go through a thorough medical examination and then a second, separate forensic examination when both could be completed simultaneously. And because the forensic nurse has the specialty education required to effectively collect and preserve this evidence, she is the appropriate health care professional to complete this task. Discussing the priorities of the forensic nurse—health and well-being of the patient first with evidence collection and photography as secondary—will emphasize this point. It can be underscored further by asking the forensic nurse if patients would still receive care from the treating facility even if they refused photography or evidence collection. The answer should be yes.

■ Forensic nurse as victim advocate

Defense counsel often will ask if forensic nurses are victim advocates. Although the obvious answer is “no,” forensic nurses should be given the opportunity during direct examination to clarify their advocacy role. Forensic nurses, like any health care provider, are advocates for their patients. However, the inherent role of patient advocate within every health care professional’s responsibilities is significantly different than that of victim advocate. Patient advocacy centers on the clinician’s concern that patients receive the most appropriate and effective health care within the hospital or clinic system. A victim advocate is a person who aligns herself “with the patient, providing emotional support, referral services for follow-up, contact with social services, legal assistance, arrangements for transportation, presence in court, and for other needs.”¹⁹

¹⁹ From the Glossary of Forensic Terms: Sexual Assault Forensic Examination Technical Assistance (SAFE TA) Web site. <http://www.safeta.org/library/libGlossary.cfm>.

■ “Isn’t it true you believe all of your patients?”

The implication of this question is that the forensic nurse assumes that the patient was victimized by this defendant.²⁰ This misses the central issue for any health care provider. Patients are not required to prove their chief complaint prior to receiving appropriate health care. A patient complaining of chest pain does not have to prove the veracity of the chest pain in order to receive the full evaluation that would be provided to any patient presenting with this symptom. The same holds true of victims of violence. They are treated according to their presenting complaint like any other patient. The medical hearsay exception emphasizes this—patient statements are deemed inherently credible when made for the purposes of medical diagnosis and treatment because it is in a patient’s best interest to be honest with the treating clinician.

²⁰ The prosecutor should object to this on grounds that it is commenting on credibility, which is impermissible. See also F.R.E. 803(4).

INTERDISCIPLINARY COLLABORATION AND PROGRAM DEVELOPMENT

Prosecutors and other collaborating disciplines can participate in the domestic violence program development process in ways similar to SARTs. Although these programs need to be health care driven, support from stakeholders is crucial in the success of the services. Examining policies, procedures, and documentation and referral processes can provide health care professionals with feedback regarding the utility of their patient interventions beyond the health care setting. The following sections outline some of the core facts behind the establishment of domestic violence nurse examiner programs and the process for program development:

Conceptual Basis for Establishing a Forensic Nursing Domestic Violence Program

- Victims of domestic violence do not always feel comfortable or safe disclosing violence in their homes or relationships, especially in hospital emergency departments.
- Failing to disclose violence frequently results in victims remaining in violent relationships with little awareness or use of area victim support services available to them.
- Failing to disclose violence results in an increased use of emergency department resources for vague pain complaints, gynecologic problems, and mental health-related issues.
- Providing a dedicated forensic nurse for domestic violence victims results in increased use of area victim support services, increased prosecution of domestic violence-related crime, and decreased use of emergency department resources, especially clinician time.
- The existence of a forensic nursing program for domestic violence victims creates a point for hospital and community coordination of services.

Program Development

In order to successfully integrate a domestic violence program into an existing forensic nursing program, all stakeholders need to come together to plan. The following organizations should participate in an advisory capacity:

- **Advocacy groups:** This should include shelter services, rape crisis services, victim assistance services, legal advocacy services, and any other services that fall into this category.
- **Law enforcement:** Optimally this includes members from all of the law enforcement agencies your program serves. At the very least, it should include members of the biggest agencies, including police, sheriffs, and highway patrol if relevant.
- **Prosecutors:** Both felony and misdemeanor prosecutors are useful to have at the table since the court process can differ depending on the level of charges in a given case. Each group has a unique perspective that can be helpful to forensic nurses creating and growing programs.
- **Judiciary:** At least one judge should consider serving in an advisory capacity. However, it is useful to have judges from common pleas, domestic relations, and municipal courts advising the program if possible.
- **Hospital administration:** Representatives from emergency medicine, emergency nursing, social work, and other interested parties should be included in the advisory committee. Hospital-based programs will impact hospital policies, so it is important to have key administrators present as the program evolves and takes shape.

The existence of a formalized advisory committee that meets on a regular basis can help solidify the program's place in the community. The advisory committee can play a key role in the development and clarification of:

- Policies and procedures
- Documentation tools
- Referral services
- Legal questions
- Physical plant issues
- Staffing (including qualifications, educational requirements, etc.)
- Witness testimony

As with sexual assault, having a multi-disciplinary response team in place benefits everyone involved. The advisory committee is one of the first steps in assuring inter-agency and inter-disciplinary consultation and cooperation.

Implementation

Implementing a domestic violence program in a hospital-based forensic nursing program involves a series of steps, which are overlapping and continuous:

- Agree upon the need for a forensic nursing program that includes victims of domestic violence by presenting the benefits of such a program to key community and hospital stakeholders. Include ideas for funding, staffing, and dedicated examination space.
- Construct the program from a strong foundation with active participation by key stakeholders through regular meetings and open communication.
- Begin seeing patients, taking care to note the level of collaboration among professionals involved.
- Evaluate the efficacy of the services, the impact they have on other professionals, and their identifiable deficits.
- Share results of evaluations with stakeholders, adapting the program as challenges arise.

BEYOND SART: THE MULTIDISCIPLINARY APPROACH TO VICTIMS OF DOMESTIC VIOLENCE

Many communities have implemented multidisciplinary, coordinated responses to domestic violence. This has been accomplished through the creation of community response protocols, formalized collaborative networks, and most recently, domestic violence fatality review teams.²¹ The goal in these efforts is to increase consistency of services to victims of domestic violence while enhancing communication among collaborating organizations and agencies. As with the SARTs, this model can create a foundation for increased:

- Community education and public awareness
- Evaluation of coordinated responses
- Interdisciplinary education and professional role development
- Standardized responses at the state level
- Strategic planning for sustainability
- Collaboration with military or tribal communities

Several states, such as New York, have formalized their coordinated response at the state level through coordinating councils and state agencies.²² Both prosecutors and forensic nurses have roles to play in this type of multidisciplinary approach, particularly in efforts to create or enhance appropriate and accessible community resources and to identify gaps in existing services. By combining efforts and resources, the domestic violence victim can receive the level of care that she needs in order to become a domestic violence survivor.

21 For a state-by-state matrix of domestic violence fatality review activities, visit the National Domestic Violence Fatality Review Initiative Web site: <http://www.baylor.edu/ndvfri/index.php?id=37955>.

22 See the New York Office for the Prevention of Domestic Violence (OPDV), established in 1992: <http://www.opdv.state.ny.us/index.html>.

APPENDIX A:

SAMPLE FORENSIC NURSE EXAMINER JOB DESCRIPTION²³

Basic Function:

Provide comprehensive medico-legal examinations, and timely and accurate collection of forensic evidence; and collaborate with physicians, local law enforcement, city and county prosecutors, and victim advocates to provide complete care for patients, ensure safety, and maintain chain of evidence.

Minimum Qualifications:

- Registered nurse with current licensure to practice nursing in this state.
- Three years experience as a registered nurse.
- Personal nursing liability insurance with a \$1,000,000/\$3,000,000 coverage amount.
- Successful completion of the Sexual Assault Nurse Examiner Training and additional didactic and clinical hours related to the domestic violence medico-legal examination.
- Successful completion of Forensic Nurse Examiner Orientation Program.
- Approved to practice through the Hospital Credentialing Department.
- Four continuing education units in forensics completed annually after the first year of work with the forensic nursing program.

Special Qualifications:

- Possess a thorough knowledge of the management of the sexual assault patient, the medico-legal examination, and the collection of forensic evidence.
- Able to work collaboratively and effectively with physicians, victim advocates, local law enforcement agencies, city and county prosecutor's office, and the Bureau of Criminal Identification and Investigation.
- Able to work independently.
- Demonstrate organizational skills.
- Willing to attend continuing education specific to forensics with a minimum of four hours per year.

²³ Used with permission of the DOVE Program, Summa Health System, Akron, OH.

- Demonstrate commitment to forensic nursing program by willingness to participate in on-call rotation with minimum number of __ call shifts per month.
- Possess clear and concise written documentation skills.
- Demonstrate good communication skills.
- Assume accountability for demonstrated behaviors consistent with customer service policy.
- Participate in professional organizations including the International Association of Forensic Nurses.

Description of Work:

- Collaborate with the Forensic Nurse Examiner Program Coordinator, hospital clinicians, local law enforcement agencies, and area victim advocates in the comprehensive care of sexual assault and domestic violence patients.
- Perform a complete medico-legal exam of the sexual assault and/or domestic violence patient.
- Demonstrate ability to appropriately use equipment, including cameras and colposcope, in the documentation of injury and collection of evidence.
- Make appropriate community referrals for the sexual assault and/or domestic violence patient.
- Identify emergency medical conditions and make appropriate referrals.
- Communicate with the emergency department staff when transferring patients for evaluation and treatment.
- Facilitate communication between hospital staff, patient, victim advocates, and law enforcement agency when patient is transferred to another hospital department.
- Perform quality assurance functions to include: maintenance of chain of evidence, appropriateness of documentation, appropriateness of referrals, and preparing and interpreting reports as needed.
- Provide court testimony as needed.
- Participate in a yearly evaluation with the program coordinator.

APPENDIX B: SCOPE OF PRACTICE IN INTIMATE PARTNER VIOLENCE NURSING²⁴

Two levels of practice are recognized for the intimate partner violence nurse—general practice and advanced practice. The following Scope of Practice applies.

Intimate Partner Violence Nurse

Nurses in intimate partner violence nursing practice provide health care to individuals in a variety of settings. Unique areas of practice are currently found in forensic nursing in collaboration and conjunction with law enforcement agencies, victim advocacy, domestic/intimate partner violence shelters, medico-legal, judicial, and correctional facilities. Ongoing areas of practice are within emergency/rescue, trauma, medical-surgical, psychiatric, routine women's health care, OB/GYN, labor and delivery, pediatrics, health care agencies, and community health.

Nurses are in a unique position to identify and assist survivors who present following an intimate partner violence episode. This type of violence is frequently not identified as the causative agent of injuries seen in these settings. The unique role of the nurse is in identification, assessment, diagnosis, intervention, referral, safety planning, and counseling support for the survivor in these settings and for the offender in the correctional facilities and community counseling settings.

The American Nurses Association Code for Nurses states, “The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by considerations of social or economic status, personal attributes, or the nature of the health problem.”²⁵ The roles and functions of the nurse providing care in an intimate partner violence setting vary depending on the identified needs of the individual and community.

²⁴ Excerpted with permission from *Standards of Intimate Partner Violence Nursing* (2002).

International Association of Forensic Nurses. Available online: <https://www.iafn.org/store/storeHome.gfm>.

²⁵ See http://www.med.howard.edu/ethics/handouts/american_nurses_association_code.htm.

As educational preparation and expertise in the nursing profession expand, the same trend will become a reality in intimate partner violence nursing practice. The nurse employed in intimate partner violence nursing must be a registered nurse due to the depth of theoretical basis, range and depth of practice expertise needed, as well as assessment and referral skills included in this highly independent area of nursing practice. The practice includes a full range of nursing skills including the nursing process, prevention, recognition and treatment of survivor as well as assailant, physical and triage assessment, counseling, and community referral and follow-up care. In addition, the nurse must have advanced knowledge and expertise in forensic and criminal investigation, forensic pathology, documentation (including basic photography), judicial process, and victim advocacy. Clinical experience prior to employment in intimate partner violence is preferable and training by the facility/agency through specific orientation, in-service education, clinical experience, and continuing education is necessary.

Intimate partner violence nursing practice is primary health care as defined by the American Nurses Association, which states that primary care is: “(1) the care the consumer receives at the point of contact with the health care system; and (2) the continued care of the individual as a health care consumer. The care is two-dimensional: (1) the identification, management, and/or referral of the health problems; and (2) the maintenance of the consumer's health by means of preventive and promotive health care action.”²⁶

²⁶ *Id.*

APPENDIX C: OVERCOMING CRAWFORD ISSUES²⁷

It is not uncommon for prosecutors to encounter *Crawford*²⁸ objections from the defense when presenting a SANE's testimony regarding statements made by a victim who is unavailable to be cross-examined at the time of trial. Several examples of common defense objections and recommended prosecutor responses are set forth below:

- **Defense objection: Government Agent**—Prosecutors generally introduce victim statements made during a SANE examination under the medical diagnosis and treatment exception to the hearsay rule.²⁹ Because a SANE fills the dual role of providing medical treatment and gathering evidence, the defense may object to the admission of the patient's statements under this exception. The defense will argue that testimonial statements are those provided to a government agent, and the SANE is essentially a government agent because her primary purpose is to collect evidence for future prosecution. Therefore, all statements made to the SANE are for the purpose of prosecuting the alleged assailant. As a result, all victim statements to a SANE should be deemed testimonial and therefore inadmissible.
- **Prosecutor's in-court response:** SANEs are not an arm of law enforcement. A SANE's primary purpose is to administer medical treatment.³⁰ Moreover, there is no reason for a victim to believe that

²⁷ For a more complete discussion of this topic, see Allie Phillips, "I Have an 'Owie' – Health Care Providers' Roles after Crawford, Davis, and Hammon," in *THE VOICE* Vol. 1, No. 5 (2006).

²⁸ *Crawford v. Washington*, 541 U.S. 36 (2004), and *Davis v. Washington*, 126 S. Ct. 2266 (2006), held that testimonial statements of an unavailable witness can be admitted at trial only when the defendant has had a prior opportunity to cross-examine that witness; to do otherwise would violate the Confrontation Clause. The Court stated that testimonial statements are not admissible in court unless: (1) the witness testifies; and (2) there is an opportunity for the defendant to cross-examine the witness. However, if the witness is unavailable at trial but there previously was an opportunity to cross-examine the witness, all admissible hearsay statements previously made by the witness may be introduced at trial since the defendant's right of confrontation was satisfied by the prior cross-examination.

²⁹ See F.R.E. 803(4), which allows, "Statements made for the purposes of medical diagnosis or treatment and describing medical history, or past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof insofar as reasonably pertinent to diagnosis or treatment."

statements to a SANE will be used for anything other than treatment, particularly when no law enforcement officials were present during the examination.³¹ The SANE is providing a service to the victim by only making her undergo one exam rather than two.

- **What the prosecutor should do pre-trial:** Talk to the SANE about her primary duty: diagnosing and treating the patient. Ask about medical protocols and any discussions the SANE may have had with the victim outside the direct scope of medical treatment. At trial, the prosecutor will then be able to emphasize that the SANE's duty is to treat the patient, even if at the same time evidence is collected that is later provided to law enforcement.³²

■ **Defense objection: Identity Not Admissible**—The defense will argue that the identity of the assailant is irrelevant for purposes of medical treatment and diagnosis.

- **Prosecutor's in-court response:** Identity is relevant for medical treatment to ensure the safety of the victim when she is released from the hospital. SANEs generally would not want to release a victim to an individual who is going to harm her. However, if the victim insists upon returning to her assailant, the victim's treatment plan would likely involve a safety plan. A treatment plan involving follow-up instructions for the patient is a standard part of medical treatment for any purpose, and would be done by the SANE for the victim as part of her medical treatment. If the victim knows her assailant, the victim could be in additional danger upon release from the hospital or health clinic.

³⁰ See *Commonwealth of Virginia v. Brown*, 2006 Va.App. LEXIS 152 (Va. Ct.App. 2006). The Virginia Court of Appeals noted that the SANE report was not created for the benefit of prosecution and that the medical examination was conducted before a suspect was even identified.

³¹ See *Ohio v. Lee*, 2005 Ohio 996 (2005). There is no reason to believe that a victim would believe her nurse is acting as an investigatory arm of the state when questioning the victim about details of the crime for treatment purposes.

³² However, if the prosecutor is faced with a health care provider who is primarily or exclusively working with a governmental multi-disciplinary team or with law enforcement for purposes of gathering evidence of criminal activity *and* if the health care provider does not engage in diagnosis or treatment of the victim, then the statements made by the victim during the examination will likely be deemed testimonial and will not properly fit under the medical diagnosis/treatment hearsay exception.

- **What the prosecutor should do pre-trial:** Talk to the SANE to determine the circumstances in which the perpetrator's identity was revealed. The prosecutor should review case law in her jurisdiction to determine prior cases in which the assailant's identity was revealed pursuant to medical diagnosis and treatment testimony. The prosecutor should then file a motion in limine to introduce the testimony.

- **Defense objection: Statements Relating to Past Abuse**—Statements are testimonial when the primary purpose of the interrogation is to establish or prove past events potentially relevant to later criminal prosecution. When SANEs ask about the history of abuse between a defendant and victim, they are clearly trying to learn about information that could be relevant in a later criminal case. Therefore, the statements should be considered testimonial and not admitted into evidence in the victim's absence.

- **Prosecutor's in-court response:** The questions asked by the SANE were not posed in order to establish or prove past events potentially relevant to later criminal prosecution. First, the SANE is not a prosecutor; her primary goal is to treat the victim. Second, learning about past events is part of obtaining the patient's medical history, which will hopefully lead to the correct diagnosis and treatment of the victim. For example, if the victim has been assaulted previously and has broken bones before, that information would be medically relevant if the patient presents with new fractures. Asking for medical history is part of all medical examinations.

- **What the prosecutor should do pre-trial:** It is important for the prosecutor to acknowledge a SANE's testimony can be limited to admissible matters if portions are deemed testimonial by the court. Trial courts can recognize the point at which, for Confrontation Clause purposes, statements in response to interrogations become testimonial. Through in limine procedure, they should exclude the portions of any statement that have become testimonial as they do, for example, with unduly prejudicial portions of otherwise admissible evidence.³³

³³126 S. Ct. 2266 (2006).

ABOUT THE AUTHOR

Jenifer Markowitz was, until December 2004, the Coordinator of Victim Services for the DOVE Program (Developing Options for Violent Emergencies) in Akron, OH, overseeing forensic services for victims of sexual assault, intimate partner violence and elder abuse. She is currently a special consultant for DOVE, concentrating on issues of program development and clinical education. She is also the project director for a CDC-funded grant received by the International Association of Forensic Nurses focusing on sexual violence primary prevention and is project manager for the SANE Sustainability Technical Assistance Project for the National Sexual Violence Resource Center.

A forensic nurse examiner since 1995, she is a past president of the Ohio Chapter of the International Association of Forensic Nurses. Her recent national activities include working with the Office on Violence Against Women to develop a national protocol and training standards for Sexual Assault Forensic Examinations (SAFE) and with the American Prosecutors Research Institute, teaching at their National Sexual Violence Prosecution Institute. She is also a member of the advisory board for the National Sexual Violence Resource Center. In 2003 her first book was released, *The Color Atlas of Domestic Violence*, published by Mosby.

Dr. Markowitz received a B.A. from Case Western Reserve University in Cleveland, Ohio. She completed her women's health nurse practitioner (WHNP) certification and clinical doctorate in nursing (ND) at the University of Colorado Health Sciences Center in Denver. In 2004, she was the recipient of the International Association of Forensic Nurses' Distinguished Fellow award.



National District Attorneys Association
American Prosecutors Research Institute
99 Canal Center Plaza, Suite 510
Alexandria, Virginia 22314
Phone: (703) 549-9222
Fax: (703) 836-3195
<http://www.ndaa.org>

