

3. Documentation by Health Care Personnel

Recommendations at a glance for health care providers to complete needed documentation:

- Ensure completion of all appropriate documentation.
 - Ensure the accuracy and objectivity of medical forensic reports by seeking education on proper report writing.
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Ensure completion of all appropriate documentation. Examiners are responsible for documenting forensic details of the exam in the medical forensic report, according to jurisdictional policy. This report usually includes patient consent forms related to evidence, the medical forensic history, and documentation of exam findings.¹⁵⁶ (The medical forensic history and documentation of exam findings are discussed in more depth in later chapters in this section.) The only medical issues documented in this report are findings that potentially relate to the assault or preexisting medical factors that could influence interpretation of findings. If the case is reported, the criminal justice system will use the medical forensic report, along with collected evidence, photographs and video images, and victim/witness statements, as a basis for investigation and possible prosecution. If examiners are required to testify in court, they will use the report to recall the incident.

Separate medical documentation by examiners and other clinicians follows a standard approach of addressing acute complaints, gathering pertinent historical data, describing findings, and documenting treatment and followup care. Forensic examination records should be maintained separately from other records to avoid inadvertent disclosure of unrelated information and to preserve confidentiality. The medical record is stored at the exam site. The exam site should have clear policies about who is allowed access to these records.¹⁵⁷

The medical record is not part of the evidence collection kit and it should not be submitted to the crime lab. Much of the record is not relevant to case prosecution, and releasing it infringes upon patients' privacy rights and could be used against patients. Although all or part of the medical record may be subpoenaed, if patients do not consent to its release, it is ultimately up to the court to decide whether such information is pertinent to the case and should be released.

Educate examiners on proper documentation. It is vital that the exam documentation be thorough, precise, and accurate. It is essential that examiners receive education on the importance of proper documentation and on report writing that fits their role and is unbiased.

Involved law enforcement representatives and advocates should understand the importance of examiner documentation and be able to convey that importance to patients.

Ensure the accuracy and objectivity of medical forensic reports. It is suggested that examiners within an exam site, jurisdiction, or region, devise an appropriate review process tailored to their needs. Consider having a clinical director or supervisor at the exam site systematically review documentation related to the exam. (In some jurisdictions, review of nonphysician examiner's documentation by a medical director/supervisor is required.) These reviews can serve to increase the overall effectiveness of the examiner program by ensuring that reports are filled out according to policy, assessing staff training needs,

¹⁵⁶ Documentation on exam findings should include patients' demeanor and statements related to the assault not already recorded on the medical forensic history. Such documentation can be admitted as evidence at trial in most States. Local prosecutors can provide more detailed information on this type of documentation.

¹⁵⁷ Mechanisms to restrict access to records related to the exam are particularly important in small communities where health care facility employees may be acquaintances, friends, and family members of patients or suspects.

considering adjustments needed to paperwork, troubleshooting for potential problems, and identifying trends in presenting issues of patients. All identifying patient information should be removed when a document is copied for a review. The clinical director or supervisor can also be involved in broader multidisciplinary quality assurance efforts related to the exam process.