

**REASONABLE DOUBT:
The Use of Health Records in Legal Cases of
Violence Against Women in Relationships**

WOMAN ABUSE RESPONSE PROGRAM

**BRITISH COLUMBIA'S WOMEN'S HOSPITAL AND
HEALTH CENTRE**

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Executive Summary

The purpose of this study, supported by the Law Foundation of British Columbia, was to undertake a preliminary examination of the use of health records in criminal and civil cases involving violence against women in relationships. The authors and Advisory Committee hoped to learn how health records were being used to influence legal processes and outcomes for women in cases of assault, custody and access, and child protection. The primary research question related to whether notes relating to women found in health records are used in litigation to reach positive legal outcomes for abused women or whether they are used to discredit women and their claims.

Both legal and qualitative studies were undertaken to examine how health records are being used in relevant civil and criminal cases. A significant theme running through both studies is that violence against women in relationships is an important equality issue with serious legal, health, social, and economic implications.

The Legal Framework provides both an overview of the legal concepts relating to disclosure and production of health records pre-trial, and the legal concepts which apply to their introduction at trial – relevance, hearsay, self-serving and opinion evidence, privilege, and prejudice. It is clear that health records may be read by persons engaged in legal disputes and that they may in some circumstances be offered into evidence. This has significant ramifications for the makers of such records, the lawyers using them, and most importantly, for the people who are the subjects of such records.

As well the Legal Framework contains a survey of Canadian case law in which records have been used either to support women or to discredit them. Analysed in the context of academic commentary on the subject, the results of that survey suggest that persons alleged to have assaulted their partners are in a particularly good position to seek production of health records since they are likely to be aware of their existence, that in many cases hospitals and record holders did not take a formal position in legal cases, for example, by opposing the release of health records, and that records were sometimes, but not often, used to support allegations of abuse, for a number of reasons, including the operation of the hearsay rule. A particular dilemma for record keepers is the fact that silence about an allegation in a record may be construed to mean the allegation is false, while on the other hand, notes may be used to discredit women on the basis of inconsistencies or on the basis of casual comments or assessments.

Support for a focus on equality was found in this aspect of the research, since legislation, case law, and much academic commentary reflected a concern about the impact of production and use of records on the equality and privacy rights of women.

In the qualitative study, 90 interviews were conducted with legal and health professionals, advocates for abused women, and women in rural and urban centres across the province of British Columbia. This research is the first of its kind in Canada and noteworthy because it includes the perspectives of key stakeholders who are directly involved in the creation and use of health records.

This aspect of the study provided empirical reinforcement for the concern expressed in legal sources about the equality implications of the use of health records in the legal system. Uninformed and even discriminatory views of gender-based violence may filter the information reaching the legal system through women, health care providers, and legal professionals. Many factors operate to determine what questions are asked, what notes are made, how information is expressed in those notes, how it is determined who has access to those notes by the record keeper, and what use is made of notes in court.

The First Filter – The Abused Woman

The potential for creating discriminatory records exists because of the context in which women themselves decide to tell or not to tell a health care worker. Women who have been abused may explain the abuse through a cultural and social lens that holds women responsible for the abuse, minimizes the effects of the abuse, or shows disregard for women's safety and well-being.

No matter what their own understanding of the abuse is, women make decisions about how much, if any, information to share. Women may recognize that health care providers are part of a larger social context, with legal limits and responsibilities. The barriers to disclosure include lack of trust, retaliation, a sense of powerlessness and isolation, threats of child apprehension, fear of disbelief, prejudiced reaction, inappropriate or unsafe interventions, loss of confidentiality and privacy, and a desire to protect her abuser. Thus, judges and lawyers should not assume that a woman will disclose abuse at the first opportunity.

The Second Filter – The Record Keeper

Health professionals do not always accurately record what they are told. They may be influenced by assumptions, including gendered and racial assumptions, about violence against women. As a result, the objectivity, relevance, or non-prejudicial nature of records within the health sector should not be taken for granted. Other influences include a lack of understanding of the influence of a health professional, of how the records can be used in the legal context, and of how records can be used differently in criminal and civil cases. As a result, the filters through which health professionals conceptualize and record, or alternatively, do not properly document women's experiences of abuse have the potential to contribute to women's inequality because they may be used as reliable records in the legal system to represent objective truth.

The Third Filter – The Legal System and Lawyers

The very act of seeking access to records has implications for access to justice. In either criminal or civil cases, the alleged abuser may request production of records in anticipation that the victim will then drop the claim or refuse to testify. Lawyers reported that the concept of relevance in the legal system is broadly interpreted and thus it cannot be assumed that the law effectively protects the equality and privacy rights of patients.

If the record is produced, the alleged abuser's lawyer may argue that the woman is not a credible witness either because of her psychiatric or drug use history, or because an incomplete or inaccurate note of a statement is inconsistent with her subsequent statements. This study reveals significant potential for such use, against the woman's interests. Fact finders may require expert evidence to interpret the lack of disclosure, e.g., that she would not necessarily disclose the cause of an injury to the health care provider.

In contrast, some lawyers reported that documentation, when done properly, can be beneficial in legal proceedings. The challenge for both health and legal systems is to evolve in a way that allows truly relevant information in records to be created and used appropriately without causing further harm and subjecting women to unjust proceedings and outcomes.

Background

The purpose of this study was to undertake a preliminary examination of the use of health records in criminal and civil cases involving violence against women in relationships.¹ We hoped to learn how health records were being used to influence legal processes and outcomes for women in cases of criminal woman assault charges, custody and access decisions, and child protection (children who witness abuse). The primary research question related to whether notes relating to women found in health records are used in litigation to reach positive legal outcomes for abused women or whether they are used to discredit women and their claims, thus repeating the harms to women through the legal process.

Over the course of developing a hospital-based response to violence against women at British Columbia's Women's Hospital and Health Centre, the issue of how to document woman abuse on health records has been frequently raised. We investigated such practices in other jurisdictions in North America to inform our protocols. The findings were less than satisfactory. Little research had been conducted on this question beyond the energetic directive to "document everything" – all physical injuries, suspicions of abuse, assessment of character, verbatim statements, behavior and demeanor, and the interventions offered to the woman. (Ferris et al. 1997; Heilig et al. 1998; Sheridan 1996). Little attention had been paid, it seemed, to how to document appropriately and the impact of documentation both in the health care and legal systems.

The link between what is documented in health records, how it is documented, and possible harm is not well understood by health care providers in cases of woman abuse. More significantly, lawyers may not fully understand the record keeping practices of

¹ For the purposes of this study, we have adopted the definition of violence against women developed by the Attorney General of British Columbia, set out in the policy on Violence Against Women in Relationships. See <http://www.ag.gov.bc.ca/vawc/policy.htm>, retrieved June 27, 2002.

"For the purposes of this policy, violence against women in relationships is defined as physical or sexual assault, or the threat of physical or sexual assault of women by men with whom they have, or have had ongoing or intimate relationships, whether or not they are legally married or living together at the time of the assault or threat. Other behaviour, such as intimidation, mental or emotional abuse, sexual abuse, neglect, deprivation and financial exploitation, must be recognized as part of the continuum of violence against young and elderly women alike.

The term 'violence against women in relationships' encompasses common-law and dating relationships, and has been chosen after much debate and concern expressed over the use of gender neutral terms which fail to identify that the overwhelming majority of victims of violence within relationships are female. The term 'spouse assault' is used in the British Columbia Crown Counsel Policy Manual and in most police policies. It is recognized that throughout Canada various terms are used, such as woman abuse, wife assault, family violence, conjugal violence, domestic violence, and relationship violence.

In addition to addressing violence against women in heterosexual relationships, the policy is intended to prompt action to eliminate violence against males in homosexual relationships, against vulnerable males in heterosexual relationships, and against women in lesbian relationships. Therefore, this policy also applies where the victim of relationship violence is male or both partners are of the same sex and where the same dynamic described above exists."

health professionals, leading to assumptions that health records are, in fact, more reliable than they actually are. For example, the harms caused by abuse to a woman by her partner can compound her “health and personal problems” (Campbell 1995; Plichta 1992; Ratner 1993). Paradoxically, this can make her more vulnerable to discrediting diagnoses and documentation by health professionals and then to discrediting treatment in the legal domain.

The possible shortcomings of the health and legal systems to support the equality rights of women form the basis of this research. It is hoped that women experiencing abuse, advocates for abused women, health care providers, and lawyers will all benefit from this research. Without a conscious commitment to applying an egalitarian filter, health records may be created that are potentially prejudicial. Thus, while our foremost objective is to inform legal professionals about the creation of health records and raise concerns about the potential misuse of records, we anticipate that this research will assist health care professionals to develop standards that will, at minimum, do no harm, and ultimately support women's equality rights.

I. Introduction

In the past 15 years, there has been a growing trend to use the personal records of women victims of sexual assault and violence within intimate relationships in criminal and civil litigation. Such personal records include health records. Research to date in this field has focused on women victims of sexual assault. Among the observations that have been made is that it is almost exclusively in cases involving sexual violence that personal records of women are appropriated, raising a concern about gender inequality. The reality facing female victims of sexual crime within a court of law when personal records are used has been effectively described by Justice L'Heureux-Dubé:

[Victims] must contemplate the threat of disclosing to the very person accused of assaulting them in the first place, and quite possibly in open court, records containing intensely private aspects of their lives, possibly containing thoughts and statements which have never even been shared with the closest of friends or family (*O'Connor* at 54).

Aside from sexual assault cases, little research has been undertaken to understand how health records are used in criminal and civil cases specifically involving violence against women in relationships. In general, there is a lack of consensus over how useful health records are for women who experience abuse or violence. On the one hand, there has been a push to improve medical documentation so that it becomes more useful in a court of law (Health Canada; Issac and Enos 2000). At the same time, there is a growing concern about how health records are being used in legal settings, and in particular, if they are being used to help women in court or alternatively as tools for unfairly discrediting them and creating unjust outcomes (Goldman et al. 2000).

The debate is further complicated by the fact that the creation and use of such records directly affects a wide range of stakeholders. These include health professionals (record keepers), lawyers, advocates, the women who experience abuse and who are the subject matter of the records, and the accused (who often use records to question a woman's competence or credibility). In response to this emerging debate, we developed a research study to further our knowledge about the use of health records in legal proceedings. Our approach to the study of health records is unique because it includes the perspectives of 90 key stakeholders affected by this issue. By selecting a broad range of views, we were able to gather a variety of perspectives. The results are also applicable and have the potential to raise awareness across the entire range of key stakeholders. It has been argued by others that in the area of health records “clients, agencies and health and social service providers require further education on issues concerning confidentiality, its implications, and the particular protections they may be afforded by the laws” (Denike and Renshaw 1999: 46). Most importantly, we included in the research project the voices of women survivors and their advocates. This has been pointed out as a necessary element in understanding the complexity of health records as a policy issue. As Goldman et al. (2000: 10) argue, “all efforts to provide greater protections should involve the input of battered women and domestic violence advocates.”

As evidenced by the following descriptions derived from our study, the various stakeholders see the purpose of health records through different, often conflicting lenses:

Lawyers:

The majority of lawyers see health records as a form of evidence to be used in legal proceedings. In family law, the leading reasons reported for accessing health records have to do with: substantiating or dismissing claims of abuse – *“Records are helpful to exonerate and likewise confirm experiences of abuse – they work for both sides;”* determining relevant health and medical issues relating to spousal support and child custody – *“When there is a suggestion of a mental health issue that affects self-sufficiency... and ability to care for children;”* and for determining consistency and reliability in recall of female patients. Less than 20% reported that they do not access records. The reasons given included that *“they don’t reflect an accurate record at all.”*

Health Professionals:

According to all the health professionals interviewed in our study, the primary purpose of keeping health records is to document health care treatment and follow-up, to be able to *“communicate among a health care team for continuity of care,”* and also for issues of professional liability, which appear to be increasingly significant, as highlighted by one respondent: *“Now, people see [health records] as a way to protect themselves. This is a change in the past five or six years...covering self legally...It started because people were being called into court more often, records were being subpoenaed,”* *“What’s drilled into us at school is the legalities of practice – that’s a main purpose for documenting.”* Just over half saw health records as being created to assist patients, and specifically those who have been abused. As one physician reported, *“The woman is generally [here] because she wants the doctor to bear witness to the injuries. I would measure the bruises and describe the situation. I know that a record could be used to corroborate her report to the police.”* In turn, women expect that *“judges will see the facts and the history.”*

Women:

There were two main themes that emerged from interviews with women survivors. The first is that most are under the impression that health and health records are completely confidential. As one woman explained: *“I never thought at the time that my health records might not be completely confidential,”* and *“You just assume that they [doctors] are not going to talk to anyone about that stuff. It’s your private stuff and it’s nobody’s business, and you just kind of assume that.”* Secondly, women are often under the assumption that all documentation is not only helpful but also essential to support their reports of abuse. Many women expect that once they disclose to their doctor, that the *“doctor will sprinkle magic dust and validate personally and legally the abuse.”* Physicians’ reports substantiated this.

Advocates:

Advocates have been an important force in the debate over personal records, including health records. For the most part, they see records as harmful and prejudicial. As a result, there has been a growing trend to modify record-keeping practices, especially by sexual

assault service providers. In our study, advocates reported that they see health records as pathologizing women who are abused. The response of one of the advocates underscored this: *“suicidal and depressed was what was written in the chart. This left out the fact that the husband was having an affair and had taken the baby and refused to return the baby.”* Inappropriate judgements of abused women by health professionals were also reported. As another example: *“A Vietnamese woman was admitted to Riverview [Hospital]. The woman was not mentally ill, but the husband interpreted and he had proven that she was mentally ill. He got custody and all the property. The practitioners completely trusted what he had said. Everything was used against her.”* Finally, advocates emphasize that health records are often silent on issues that are critical because women fear disclosing abuse and violence and seeking medical attention. One advocate explained: *“[There is] fear of telling how bad her situation is for fear of having her children apprehended. So women aren’t getting medical attention because of the fear and not trusting the system. We can’t expect records to help women if we’re silencing them because of the possible impact of telling.”*

II. Bridging the Disparate Objectives and Interpretations

At first glance, there appears to be a fundamental difference between how each of these groups views health records. Upon closer analysis, however, there is some common ground. Legal and health professions, for example, share some basic values and practices, reinforced by law, professional responsibilities, and cultural assumptions. Privacy is extremely important in both fields. As well there is a common need to obtain and keep records containing what may be highly sensitive information relating to the purpose of the contact between the woman/patient and the professional. An obvious example, therefore, is the duty to keep legal and health information confidential (subject to legal obligations to disclose).

In turn, the duty of confidentiality is part of a larger framework of ethical obligations governing legal and health professions. Ethical principles requiring the preservation of confidentiality are found in various codes of ethics, as well as in the law itself. The Canadian Medical Association (CMA) has very clearly set out such standards of ethical behaviour in its Code of Ethics (CMA 1998). The first general responsibility of any physician is: "Consider first the well-being of the patient."

In terms of confidentiality, there are a number of relevant sections of the Code:

22. Respect the patient's right to confidentiality except when this right conflicts with your responsibility to the law.
23. Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

And in terms of responsibilities to society:

33. Refuse to participate in or support practices that violate basic human rights

In addition, the CMA has developed a Health Information Privacy Code (approved by the CMA Board of Directors, August 15, 1998) that articulates principles for protecting the privacy of patients, the confidentiality of their records, and most importantly to protect the trust and integrity of the doctor-patient therapeutic relationship. The CMA acknowledges that "many laws, practices, and initiatives, may not withstand the kind of scrutiny deemed necessary and reasonable for the protection of privacy and the trust and integrity of the therapeutic relationship." The code is specific with respect to the right to privacy, as defined below:

Principle 1: The Right to Privacy

The right to privacy is fundamental in a free and democratic society. It includes a patient's right to determine with whom he or she will share information and to know of and exercise control over use, disclosure and access concerning any

information collected about him or her. The right to privacy and consent are essential to the trust and integrity of the patient-physician relationship. Nonconsensual collection, use, access or disclosure violates the patient's right of privacy. The right of privacy is important and worthy of protection, not just for the good of individuals in society but also for the good of society as a whole. (CMA 1998)

The code goes on to emphasize that "even consensual...disclosure or access may erode the right to privacy and the trust and integrity of the therapeutic relationships. Therefore it must only occur with due consideration of possible negative impacts and with measures designed to maximize privacy protection" (Principle 3: p. 7). In the case of abused women, this would require a third party who is requesting health information to demonstrate that "patient vulnerability will not be exploited" (3.7: v: p. 10).

Where a contrast may be drawn, however, is with respect to the fundamental values governing issues relating to law and health. The law that governs the use of health records, like any other law, must conform to the values of the *Canadian Charter of Rights and Freedoms* (the "*Charter*"), which can be broadly described as including the rights to a fair trial, privacy, security of the person, and equality. For example:

Section 7 guarantees the right to life, liberty, and security of the person and the right not to be deprived thereof except in the accordance with the principles of fundamental justice.

Section 8 guarantees that everyone has the right to be secure against unreasonable search or seizure.

Section 12 guarantees the right not to be subjected to any cruel and unusual treatment or punishment.

Section 15 (1) guarantees that every individual is equal before the law, and has the right to equal protection and equal benefit of the law without discrimination and in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, sexual orientation or mental or physical disability.

Section 28 guarantees that notwithstanding anything in the *Charter*, the rights and freedoms referred to in it are guaranteed equally made to males and females. (Canadian Human Rights Reporter *Constitution Act, 1981*)

* The Supreme Court has now determined that a person's expectation of privacy in therapeutic records is an aspect of liberty or security protected under Section 7 (See *R. v. O'Connor*, [1995] S.C.R. 411, 130 D.L.R. (4th) 235.

These are the values that are particularly significant with respect to the use of health records in legal cases. It can at least be seen as desirable for any public institution to act in conformity with these values. The legal question of whether a publicly funded hospital is required to act in conformity with the *Charter* with respect to the creation and sharing of health records is more complex. It is arguable whether the *Charter* applies to this particular function of health care workers. More significantly, a posture of conscious attention to *Charter* values may not be part of the culture surrounding the creation and use of health records.

Thus, lawyers dealing with health records should be aware that the makers of health records may not consciously see themselves as required to respect the constitutional rights of their patients. What may be foremost in the minds of record makers may be issues of liability and the need to write as much information as possible (Issac and Enos 2001). Many want to do everything possible to avoid involvement in legal proceedings and court cases. To be fair, many are also concerned with maintaining medical standards for patients. The duty of confidentiality is considered both consistent with the foundational principles and sound practices of conscientious health care. As noted earlier, ethical duties of confidentiality are codified, for example by professional organizations such as the CMA.

Further, record makers should be aware that while the law and lawyers operate under an umbrella of fundamental values that should ensure alertness to possible problems of discriminatory use of records in violence against women in relationships cases, it cannot be assumed that health records will be used in the patient's interests in the legal system. Nor can it be assumed that attention will be paid to how their legal application may violate or undermine equality rights. It has been observed, for example, that the main reason personal records have been sought by defense counsel in sexual violence cases is to attack complainants' credibility, motive and character (Busby 1998). The tactic has been described elsewhere as "whacking the complainant" (Schmitz 1988: 22). Their usage has little to do with protecting the health and well-being of abused women.

The lack of an explicit (in the case of health professionals), reliable (in the case of lawyers), and consciously nurtured commitment to such values as equality may have significant ramifications with respect to the recording of health information influenced by social location, with respect to, for example, gendered violence in relationships. There may be considerable acceptance of the view that violence against women is at odds with Canada's commitment to equality. However, it may not be well understood that the production and use of health records may in fact contribute to the inequality experienced by women attempting to leave violent relationships. As it stands, it is difficult for women abused by an intimate partner to disclose the abuse due to feelings of fear of retaliation, powerlessness, isolation and fear that they will not be believed. This may be further compounded by fear that when they do disclose, their records may be used in court. As a result, women may forego medical treatment altogether, may not disclose their abuse, and may be discouraged from reporting instances of violence and proceeding with related legal proceedings. If they do disclose and seek medical treatment, information about their abuse and indeed the context of their lives may be transmitted through various

inegalitarian filters. This affects what questions are asked, what notes are made, how information is expressed in those notes, how it is determined who has access to those notes, and how these notes/records are used in legal disputes, especially by a party adversarial in interest to the original patient.

In this report, we hope to illuminate the issues surrounding the use of health records in legal cases involving violence against women in relationships. The report itself is divided into three sections. One section focuses on the laws governing access to and use of health records in legal disputes. In the next section, an overview of the empirical study is provided – including the rationale, purpose and methodology, and presentation of the data results from interviews with 90 key stakeholders. The final section of the report is an analysis and discussion of the findings.

III. The Legal Framework

A. An Overview

There are various ways in which the courts and parties to legal disputes may have access to health records. Once they do have access, there are various ways in which records may be introduced in evidence, either for or against the interests of the original subject of the records.

It is recognized in legislation, case law, and academic commentary that health records contain private information. For example, the definition of “record” in section 278.1² states that the concept “means any form of record that contains personal information for which there is a reasonable expectation of privacy and includes...medical, psychiatric, therapeutic...” Health care information is “perhaps the most intimate, personal and sensitive of any information maintained about an individual.”³

With respect to personal records more broadly, it has been stated that “even an order for production to the court is an invasion of privacy. The records here in question are profoundly intimate, and any violation of the intimacy of the records can have serious consequences for the dignity of the subject of the records and, in some cases, for the course of his or her therapy.”⁴

Because it is so important that patients be able to trust their health workers⁵ with private information, the recognition of privacy is in turn reflected in the legal⁶ and ethical obligation placed on health practitioners to keep information confidential, subject to certain legal exceptions, such as the duty to report child abuse.⁷

However, it is important to note that confidentiality and privilege are not the same thing. Privileged information will rarely be ordered disclosed in court, even though it is relevant. Solicitor-client privilege protects confidential communications to a lawyer, reflecting the importance to the administration of justice of protecting the lawyer-client

² *The Criminal Code*, R.S.C. 1985, Chap. C-46 (the *Criminal Code*).

³ Gostin L.O.et al. “Privacy and Security of Personal Information in a New Health Care System” (1993), 270: 20 *Journal of the American Medical Association* 2487, at 2487.

⁴ *R.v. O’Connor*, [1995] 4 S.C.R. 411, at para. 151, *per* L’Heureux-Dubé J.

⁵ It is important to note that while the health practitioner has a duty of confidentiality in relation to third parties, patients have a right of reasonable access to information contained in their own medical records. If the health practitioner believes a patient or others will suffer substantial physical or emotional harm because of information contained in the record, access may be denied. The onus lies on the health practitioner to justify an exception to the general rule of access. *McInerney v. MacDonald* (1992), 93 D.L.R. (4d) 415 (S.C.C.)

⁶ In the case of *Mammone v. Bakan*, [1989] B.C.J. No. 2438 (S.C.), a family physician was found in breach of an implied term of his contract with his patient when he released contents of her clinical file above and beyond what he was ordered to release by order of the court e.g. he included material from a time period before that specified in the order.

⁷ There are certain exceptions to the basic principle of confidentiality. For example, there is a duty to report child abuse. See section 14 of the *Child, Family and Community Service Act*, R.S.B.C. 1996, C.46.

relationship. However, there is no similar “class” privilege⁸ protecting confidential communications to a health practitioner or health records. Confidential health information may or may not be privileged depending on the circumstances, with this being decided on a “case-by-case” basis. Thus no health professional can guarantee that patient information will never be released.

B. Disclosure, Production and Admissibility

In criminal cases, the Crown must as part of the process of “disclosure” provide defence counsel with all relevant, non-privileged documents in its possession. Defence counsel is entitled to review them in order to defend the accused. Aside from sexual offences, where specialized rules apply, relevant health records in the possession of the Crown will therefore be disclosed to the defence.⁹

In cases where the record is in the possession of a third party, such as a family physician, on application, a civil or criminal court can also order the release of the records under a “production” order.

The applicable legal tests which apply to pre-trial production will depend on the type of case:

- In criminal cases which do not involve a sexual offence, the common law (or case law) will generally be applied as set out by the Supreme Court of Canada in *O'Connor*.
- In criminal cases which do involve a sexual offence, *Criminal Code* provisions 278.1 to 278.91 will generally apply.
- In civil cases the court will generally apply the applicable rules of court governing civil procedure and the test for case-by-case privilege as set out by the Supreme Court of Canada in *M. (A.) v. Ryan*.¹⁰

These procedures are discussed more fully below.

If the plaintiff, defendant or Crown counsel has the records when the trial begins, they may try to use them as evidence in the case.¹¹ Just because records are “produced” by court order, however, does not necessarily mean they will automatically be admitted as evidence at the trial. The general rules regarding the admissibility of evidence will then

⁸ In cases where class privilege applies, the whole category of communications that occur within a certain relationship is deemed to be privileged. Even this form of privilege can be overridden in exceptional cases where the privileged information is necessary for the accused to make full answer and defence.

⁹ *R.v. Stinchcombe* (1991), 68 C.C.C. (3d) 1 (S.C.C.). In sexual offence cases, where the record falls within the definition contained in section 278.1 of the Criminal Code, the record would not be released to defence without the victim expressly consenting to this, under section 278.2(2). The section 278.1 definition excludes investigatory or prosecutorial records.

¹⁰ [1997] 1 S.C.R. 157.

¹¹ This will not always be the case. In some circumstances the records may simply be used to cross-examine the witness or as a source of further information about them.

apply. In order to be admitted, information contained in the records must be found relevant to an issue in the case and not subject to any rules of exclusion.

It is thus clear that health records may be read by persons engaged in legal disputes and that they may in some circumstances be offered into evidence. This has significant ramifications for the makers of such records, the lawyers using them, and most importantly, for the people who are the subject of such records. While some further information about disclosure, production and admissibility is provided below, it is not the purpose of this study to analyse in detail all the rules relating to these matters. Rather, after a brief description of the law relating to pre-trial production and admissibility, attention will be focused on some critical issues which came to the fore in a survey of the case law.

C. Production in Criminal Cases

1. R. v. O'Connor

The leading case of *O'Connor* brought the issue of defence access to health and other private records to public attention in a dramatic manner, taking eight years to work its way through the courts. Bishop O'Connor, a principal at St. Joseph's Mission School, was charged with raping and indecently assaulting four Aboriginal women, employees and former students of the school.

The case drew attention to the issue of whether O'Connor should be entitled to production of the complainants' counselling, therapeutic, psychological, psychiatric, school, and employment records in order to defend himself against the criminal charges. This raised the question of what procedure should be followed to determine whether pre-trial production should be granted.

In *O'Connor*, the Supreme Court of Canada for the first time articulated principles and procedures governing the pre-trial production of third party records (such as health records in the hands of persons other than those directly involved in a criminal case). Partly because of intense public interest in the issue of defence access to such records, the rules developed by the Court have now been changed with respect to sexual offences by an amendment to the *Criminal Code*, now contained in sections 278.1 - 278.91. But *O'Connor* is still the leading authority in other criminal cases where the defence wishes production of third party records, including medical records.¹²

In legal terms, the main legacy of *O'Connor* is the two-step process it lays out to decide whether third party records will be released to the defence, in non-sexual cases:

¹² See Barrett, Joan M. *Balancing Charter Interests Victims' Rights and Third Party Remedies* (Scarborough Ont. Carswell, 2001). The criminal charges commonly associated with violence against women in relationships are criminal harassment, threatening and the different levels of assault.

Step One – The Threshold Test

The defence must satisfy a judge that there is a reasonable possibility that the information contained in the records is likely relevant to an issue in the case or the competence of the complainant to testify. The onus on the defence to show “likely relevance” is not onerous. It is described by the Court as a way of preventing the defence from engaging in speculative, fanciful, disruptive, unmeritorious, obstructive, and time-consuming requests for production. The situations in which third party records might be found likely relevant under this test are very broad.

Step Two – The Balancing Test

If the first test is satisfied, the judge reviews the records, to see whether and to what extent they should be produced to the defence. The judge considers the following factors:

1. The extent to which the record is necessary for the accused to make full answer and defence.
2. The probative value of the record.
3. The nature and extent of the reasonable expectation of privacy vested in the records.
4. Whether production of the record would be premised upon any discriminatory belief or bias.
5. The potential prejudice to the complainant’s dignity, privacy, or security of the person that would be occasioned by production of the record.

2. The O’Connor procedure

To start the process, the defence must file with the trial judge a formal written application for the records. The application is, unless this requirement is waived by the judge, supported by an affidavit (a sworn statement) setting out the specific grounds for production. The custodian of the records and anyone with a privacy interest will be served with the application documents (generally a notice of motion and subpoena). The record holder is not required to release any records on being served with the subpoena. It merely requires the record holder or their lawyer to attend court on the date and time set out for the hearing where the judge decides about release of the records.

3. The role of the health practitioner at the hearing

Both the record holder and the subject of the records have the right to appear and make submissions about relevance and/or privilege, which can be through a lawyer, at the hearing. Neither the record holder nor the subject of the records can be compelled or required to give oral evidence at the hearing. What role should the health practitioner play? First, it seems clear that the health care practitioner’s duty of confidentiality (subject to any other exceptions) continues to apply unless the court orders health records released after the hearing. Some may consider the logical extension of this duty of confidentiality to involve the health practitioner (or their lawyer) actively asserting that the records be found irrelevant, or else privileged by the court on a case-by-case basis.

With respect to relevance, especially with respect to gender-based crimes, such as sexual assault, a concern has been raised about the role of judicial assumptions and beliefs.¹³ Questions have been raised about whether the use of the complainant's health records is being justified on the basis of discriminatory beliefs or biases about women and about women victims in particular. One of the purposes of this study is to explore how records are being used specifically in violence against women in relationships cases.

Given this context, the health practitioner may choose to try to preserve client confidentiality by showing that the information in the records is irrelevant to the case or if it is relevant, that its usefulness is outweighed by the negative effects of releasing it. For example:

- The treatment was unrelated to the assault,
- The medical record contains highly sensitive information, and
- Releasing the information would negatively affect the patient's mental or physical health.

If the court orders the records produced, the health practitioner can also play a key role in suggesting that conditions or limits be put on their release to minimize possible harm to the patient.¹⁴ These conditions might include:

- Only part of the record will be released,
- A copy of the records rather than the original will be produced,
- The record will only be viewed at the court office,
- The record is not to be copied,
- Information about any person named in the record, such as their address and other contact information will be deleted.

Finally, the health care practitioner should carefully review the contents of the order for production. In many cases, only a portion of the clinical file will be subject to the order. Only those records specified should be released.

¹³ See Busby, K. "Third Party Records Cases Since R.v. O'Connor." (2000), 27 *Manitoba L. J.* 355-390; Busby, K. "Discriminatory Uses of Personal Records in Sexual Violence Cases". (1996), 9 *C.J.W.L.* 148; Feldberg, G. "Defining the Facts of Rape: The Uses of Medical Evidence in Sexual Assault Trials" (1997), 9 *C.J.W.L.* 89; Bond, S. "Psychiatric Evidence of Sexual Assault victims: The Need for Fundamental Change in the Determination of Relevance" (1993), 16 *Dalhousie L.J.* 416. In this context gender-based crime refers to crimes in which the overwhelming majority of victims are female and the perpetrators male. In *R. v. Osolin* (1993), 86 C.C.C. (3d) 481, the Supreme Court of Canada described sexual assault as a gender-based crime. For an interesting analysis of the larger power and dynamics involved see: Light, L. *Nature and Dynamics of Violence Against Women, Children, Seniors and People with Disabilities*. Victim Services Division Ministry of Attorney General Victoria BC (2000).

¹⁴ See for example the case of *R. v. Chisholm* (1997), 34 O.R. (3d) 114 (Gen. Div.) in which the complainant's psychologist made submissions regarding the negative implications on her patient's health and continued treatment of having the complete file contents released. The court ordered partial production only and attached stringent conditions to the material which was released.

4. Sexual offence records cases

The *Criminal Code* amendments regarding records were passed in 1997 after *O'Connor* was decided, in response to strong concerns expressed by women's groups and victim service providers that the *O'Connor* test for relevance was too broad and that medical and other personal records about complainants were being used excessively and inappropriately in sexual offence cases.¹⁵

Many of the steps in the *Criminal Code* are similar to the *O'Connor* process: the defence must make a written application for release of the records and must serve documents on the record holder, the subject of the record, and anyone having a privacy interest in the record. There will be a hearing about the records and the record holder can make submissions.

There is, however, greater recognition of the complainants' privacy and equality rights. For example:

- Under *O'Connor*, the fact that the victim's right to equality might be affected by release of records is not a consideration.¹⁶ Under the *Criminal Code* (the Preamble to Bill C-46) equality rights are explicitly acknowledged.
- Under *O'Connor*, if Crown counsel already has the medical records they are presumed to be relevant and will normally be disclosed to the defence. Under the *Criminal Code*, if the Crown has the records they will not be released unless the complainant expressly agrees to this.
- Under *O'Connor*, the judge does not consider the victim's privacy rights before reviewing the records. Under the *Criminal Code*, the judge must consider the rights of the accused and the complainant before the judge sees the records.
- Under *O'Connor*, the test for relevance is fairly broad and the onus on defence fairly easy to satisfy. Under the *Criminal Code* insufficient grounds to establish relevance are listed in section 278.3(4). These assertions on their own will not be enough to establish relevance.

The stricter procedure for gaining access to third party records in sex offence cases can be justified on a number of grounds:¹⁷

- The need to encourage reporting;
- The recognition that compelled production may deter complainants from reporting to police or seeking necessary treatment;

¹⁵ See the majority judgment of the Supreme Court of Canada in *R. v. Mills*, [1999] 3 S.C.R. 668.

¹⁶ Unlike the majority judgment, the dissent in *O'Connor* does include a consideration of equality rights.

¹⁷ These grounds are included in the Preamble to the amending legislation: *Criminal Code*, R.S.C. 1985, c.C-46, ss. 278.1 to 278.91 [ad. 1997, c. 30, s.1].

- The recognition that the work of those who provide services and assistance to complainants is negatively affected by compelled production;
- While production may be necessary for an accused to make full answer and defence, that production may also breach the complainant's right to privacy and equality, and therefore decisions about production would be subject to careful scrutiny.

While the discriminatory use of personal records in violence against women in relationships cases has not been examined in the same way as it has been for sexual assaults, in terms of what is known about the dynamics of violence against women, many of the above concerns apply equally to cases of non-sexual spousal abuse.¹⁸

D. Production in Civil Cases

1. Whether records are privileged will be decided on a case-by-case basis

Criminal charges are not the only legal process associated with incidents of spousal abuse. The woman may launch a civil suit for damages for assault. Or there may be a civil action which appears unrelated to any acts of violence but which on closer examination has spousal abuse as an underlying element, for example, a custody and access dispute after separation due to violence or a child protection proceeding based on emotional harm to children in situations where they have witnessed the abuse of their mothers.¹⁹ Release of third party medical records can also be an issue in many of these cases.

In civil as in criminal proceedings, issues of relevance of health records may arise. Similarly, there is no blanket privilege for communications between health practitioner and patient. However, privilege may be applied on a case-by-case basis. The applicable principles are set out in the case of *M. (A.) v. Ryan*.²⁰

2. The M. (A.) v. Ryan issue – Are the records privileged?

Here the plaintiff sued her former psychiatrist, Ryan, for damages she suffered as a result of his sexual conduct towards her during treatment. Ryan sought production of records of another psychiatrist, Parfitt, to whom the plaintiff had gone for treatment. Parfitt agreed to release to the court the reports she made to the family doctor but made a claim for privilege with respect to her own notes.

The claim of privilege was denied at all court levels until it was partially successful at the British Columbia Court of Appeal. This court, later upheld by the Supreme Court of

¹⁸ See Light, *supra* note 12.

¹⁹ Repeated court proceedings, such as custody and access variation requests, can be used by an abusive partner to harass his ex-wife. See Braun "Custody Order or Disordered Custody?" (1999), *BCIFV Newsletter*, Vancouver BC. Under the *Child, Family and Community Service Act* the fact of the child having witnessed the abuse of its mother may be used as grounds to launch a child protection investigation. See Ruebsaat, G. *Developing a Dialogue: A Preliminary Discussion Paper on Child Protection Issues in Cases Involving Violence Against Women and Children*. Prepared for the BC Association of Specialized Victim Assistance and Counselling Programs et al. (2000).

²⁰ *Supra* note 9.

Canada, ordered release, subject to strict conditions,²¹ of Parfitt's reporting letters and notes recording discussions between her and the plaintiff. The court did not order release of Parfitt's personal notes which she used to make sense of what her patient was telling her. The majority of the Supreme Court ruled that four conditions must be met before communications such as these would be privileged. These conditions are often referred to as the Wigmore test:

1. It is expected that the communications are confidential.
2. Their confidentiality is essential to the relationship in which the communication arises.
3. The relationship must be one that should be "sedulously fostered" in the public good.
4. The interests served by protecting the communications from disclosure outweigh the interest of pursuing the truth and preventing an unjust verdict.

The Court found that in relation to the communications in question, the first three of the Wigmore criteria were met. With respect to item four, it was found that while the interest in preserving confidentiality was compelling in this case, the documents in question might be expected to bear on a critical issue, that is, the extent to which Ryan's actions, as opposed to other factors, caused the plaintiff's psychological difficulties.²² For this reason they must be disclosed.

3. Partial privilege

The Court in *Ryan* thus used the idea of partial privilege to restrict access to some of Parfitt's records and to attach strict conditions to others:

In some cases, the court may well decide that the truth permits of nothing less than full production. This said, I would venture to say that an order for partial privilege will more often be appropriate in civil cases where, as here, the privacy interest is compelling. Disclosure of a limited number of documents, editing by the court to remove non-essential material, and the imposition of conditions on who may see and copy the documents are techniques which may be used to ensure the highest degree of confidentiality and the least damage to the protected relationship, while guarding against the injustice of cloaking the truth.²³

E. Civil versus Criminal Cases

1. The need to prove damages in civil cases

Before *Ryan*, it was generally believed that in civil cases where damages for personal injury were claimed by the plaintiff, their health became an issue. This meant that almost

²¹ The documents were to be revealed only to Ryan's lawyers and expert witnesses and were to be used only for the purposes of the litigation. Only one copy was to be made.

²² In applying the fourth Wigmore criterion the Court held that the following factors should be considered:

- the injury to the plaintiff's ongoing relationship with her psychiatrist and her future treatment
- the effect a finding of no privilege would have on the ability of other persons suffering from similar trauma to obtain needed treatment and of psychiatrists to provide it
- the privacy and equality interests of the person claiming privilege.

²³ *Ryan*, supra note 9, per McLachlin J. for the majority at para. 33.

all health records would have to be produced. The Court in *Ryan* firmly rejected this approach:

It remains to consider the argument that by commencing the proceedings against the respondent Dr. Ryan, [the patient] has forfeited her right to confidentiality. I accept that a litigant must accept such intrusions upon her privacy as are necessary to enable the judge and jury to get to the truth and render a just verdict. But I do not accept that by claiming such damages as the law allows, a litigant grant her opponent a license to delve into private aspects of her life which need not be probed for the proper disposition of the litigation.²⁴

The Court went on to suggest that in civil cases, access to third party records might be more limited than in criminal cases. This was because there was less at stake for the defendant – in a civil suit he stood to lose money and reputation; in a criminal case he stood to lose his liberty. In effect the Court found that civilly, the privacy interest of the plaintiff might more easily outweigh the defendant's interests in production of records.

But this analysis should be put into a larger context: civilly, the plaintiff must prove not only the specific acts which are alleged, but also the damages caused by these acts. The practical result is that the scope of what is material may be broader than in a criminal case. It may be that a wider range of records will be produced civilly but that there will be greater latitude for editing of the records under the direction of the court.

2. In civil cases the court may not screen the records before they are produced to defence

In *Ryan*, the majority ruled that in civil cases, the court could make a decision about production of the health records to the defendant without having reviewed them. There would be no judicial screening of records to separate the relevant information from the irrelevant. The judge's decision could be based on affidavits describing the nature of the information and its expected relevance. This procedure is different from the criminal process whereby once the first test of relevance is established, the judge will further screen the records for relevance.

One of the judges in *Ryan*, Madame Justice L'Heureux-Dubé, dissented in part. She ruled that the judge must screen any documents not subject to partial privilege before they are released to the defendant. This would ensure the removal of any information which was not likely relevant or was otherwise exempt from production. Madame Justice L'Heureux-Dubé's approach offers greater protection for a plaintiff's privacy interests. It has been suggested that the majority decision in *Ryan* does not rule out the adoption of this approach in future cases involving sexual offences.²⁵

²⁴ *Ibid*, at para. 38.

²⁵ Ross, J. "Partial Privilege and Full Disclosure in Civil Actions: *M. (A.) v. Ryan*" (1997), 35 *Alta. L.R.* 1067. Ross points out that once produced, the records in a civil case can be used for questioning of the complainant during examination for discovery – a process which occurs outside of immediate controls which might be imposed in a criminal courtroom by the trial judge.

3. The role of the health practitioner during the production process

Whether the case is civil or criminal, health practitioners may wish to consider consulting a lawyer, assisting the lawyer in preparing arguments, providing information on why all or some of the information is privileged or irrelevant, and formulating possible conditions or limits which can be attached to production and being able to justify them.

Given the fact that judicial screening is less likely in the civil process, it is even more critical that the health practitioner, in consultation with a lawyer, carefully review the health records to identify which parts may be withheld on the grounds of privilege or irrelevance.²⁶ Health practitioners can play a key role by protecting the confidentiality of their relationship with patients to the fullest extent permitted by law.

Addressing this issue more broadly, with respect to all legal contexts, respondents in the empirical study emphasized that health professionals should take very seriously any request to release their patients' records. These results are discussed below.

More discussion is required about when it is appropriate to release medical information, in what form it should be released, and how third parties can potentially harm the patient who is the subject of the information. Dickens and Cook (2000: 390) have recommended that "with time for reflection, physicians may consult with licensing bodies or their professional associations to resolve apparent conflicts between the law and ethics of patient confidentiality."

A number of strategies for releasing records were recommended:

The first pertained to considering how much information should be released. As one advocate urged, "*Doctors need education not to release a whole file. It can undermine a woman's case.*"

Others emphasized the development of special forms or records to ensure that third parties can only access information necessary to substantiate a claim of violence. A number of advocates offered the following suggestions:

"Special records should be produced for the court."

"The medical field should create records they need to attend to women's health. If the court needs records, they should pay health care providers to produce special records for that purpose."

²⁶ See, e.g., Busby, *supra* note 12. It appears that in the Court of Appeal decision in *Ryan*, the court contemplated a role for Parfitt in organizing her records into the following categories: 1) notes which record discussions between her and the plaintiff, 2) reporting letters to the plaintiff's doctor, and 3) notes to herself which were an attempt to make sense of what the patient told her. Only records in categories 1 and 2 were ordered produced in part on the grounds that they were analogous to the notes made by a physician in treating a physical illness in which they set down the patient's account of their symptoms. *M. (A.) v. Ryan*, [1995] 1 W.W.R. 677 (B.C.C.A.)

“The Attorney-General needs to give direction and provide a way for doctors to give information to the courts. Perhaps health care practitioners need a particular form to add to a medical file when they suspect or confirm violence. But the onus should not be on doctors, they are not responsible for the functioning of the legal system.”

In any case, record makers need to be clear with their patients what their position is vis-a-vis health records, including how they and/or their institutions may respond to an application for release.

F. The Admissibility of Health Records at Trial

1. Background

Specific legal principles come into play when attempts are made to introduce third party records as evidence during a criminal or civil trial. At this stage health records can be used as evidence to support a plaintiff’s/complainant’s case, for example, to prove the existence of injuries in a prosecution for assault. Records can also be used against her, for example, as evidence of mental instability in cases where she has a psychiatric condition, or to attack her credibility on the basis of previous inconsistent statements to health practitioners about what caused her injuries.

The basic test for the admission of evidence is relevance. For example, some sexual history evidence may be irrelevant in sexual assault trials.²⁷ Generally speaking, one fact is relevant to another if its existence makes the second fact more probable than it would be without the existence of the first.²⁸

However, relevant evidence may be excluded from the fact-finding process on a number of grounds. For example, evidence may be excluded if it is privileged, as discussed above, if it is hearsay, if it is a statement of opinion presented by a layperson, or if it is overly prejudicial. A brief overview of the key principles is provided below.

2. Hearsay

Generally, out of court statements used to prove the truth of what they assert are inadmissible in evidence as hearsay. This includes written or oral statements or communicative conduct.²⁹ The reason for excluding hearsay is its inherent unreliability. Unlike oral testimony in court, hearsay is not subject to specific safeguards such as the requirement of an oath, cross-examination, or a potential perjury charge.

In relation to health records, the question of hearsay arises when the records contain a statement made by the patient and an attempt is made to have the records – including the statement – introduced as evidence at trial to prove the truth of the statement. For example, a statement of a patient to a nurse that the patient’s partner caused her injuries

²⁷ See section 276(1) of the *Criminal Code*.

²⁸ Sopinka J., Lederman S.N. and Bryant A.W., *The Law Of Evidence in Canada* (Second Edition) (Toronto, Butterworths, 1999) at para. 2.35 (Sopinka).

²⁹ *Ibid.*, at para. 6.2.

offered to help prove that the partner did indeed cause the injuries would be hearsay. This would be the case if the statement were contained in a record, was repeated by the nurse in testimony, or was repeated in court by the patient herself.

Over time, our courts have developed a number of exceptions to the hearsay rule. A useful example in this context is the “admission” exception, which (subject to the principled approach mentioned below) allows any statement by a party to litigation to be received into evidence. As well, a relatively informal legal procedure is adopted with respect to some types of legal issues, and thus hearsay may be admitted, e.g., at bail and sentencing hearings (in contrast to criminal trials themselves where the rules are much more rigid) and child protection hearings.

More recently, the courts have also developed what is called the “principled approach” to hearsay. Here evidence which does not fall into any hearsay exception may be admitted if it is necessary and there are sufficient indicia of reliability. In terms of the application of this approach to health records, the leading case is *Ares v. Venner*.³⁰

In this medical negligence case the Supreme Court of Canada ruled that hospital records, including nurses’ notes, should be received in evidence. This is provided that the notes were made contemporaneously by someone having personal knowledge of the matters then being recorded and provided the note taker was under a duty to make the entry or record. In *Venner* the Court quoted with apparent approval the Wigmore view that the “necessity” requirement was met in relation to hospital records. Requiring oral testimony from every doctor or nurse who attended a patient would seriously interfere with hospital management. Reliability was indicated by the fact that life and death decisions were made on the basis of these records. The Court also noted that the nurse note takers were present during the trial and that it was open to the parties to challenge the accuracy of the records by calling the nurses. This strengthened the Court’s view of the notes as being “generally trustworthy.”

Ares v. Venner suggests that statements made to health practitioners and included in health records may be admissible under the necessity and reliability principles. However, there may be other objections, such as the following.

3. Self-serving evidence

Self-serving evidence is generally not admissible to support a witness’ credibility unless their credibility has been made an issue in the case.³¹ This rule applies to out-of-court statements made by a witness on earlier occasions which are consistent with their testimony at trial. Thus the fact that a patient told a nurse that her partner caused her injuries would not usually be admissible to bolster the patient’s credibility when she is testifying at a later trial.

The rationales for this rule are that:

³⁰ [1970] S.C.R. 608.

³¹ Sopinka, *supra* note 27, at para. 6.2.

- Due to the risk of fabrication, a witness should not be permitted to create their own evidence, and
- The repetition of a statement does not make it more trustworthy.³²

Specific exceptions to the rule against self-serving evidence may come into play when the witness' credibility is being challenged. For example, a prior consistent statement may be admitted to rebut an allegation that the witness fabricated the story after the fact. Such a statement may also be admitted when the witness' credibility is attacked on the basis of silence when it would have been natural to speak.³³

Historically, another exception to the rule against self-serving evidence was applied in cases involving certain sexual offences. Evidence that the victim made a previous complaint about the incident shortly after it occurred could be used to support her credibility. This rule was based on the now discredited notion that a sexual offence victim's credibility was effectively always in doubt unless she made a hue and cry about the attack at the earliest opportunity. Silence was taken as a "virtual self-contradiction" of the sexual offence victim's story.³⁴ The introduction of a previous complaint, therefore, was needed to bolster the victim's credibility.

The special rules respecting recent complaint were "abrogated" by an amendment to the Criminal Code in 1983.³⁵ While this may change the approach taken in sexual offence cases, it does not affect the general principles of the law of evidence, including those that apply to prior consistent statements. There is some authority for the view that counsel can still cross-examine the complainant on the lack of a prior complaint, taking the risk of the Crown introducing a prior complaint in response.³⁶

However, it is still a matter of debate whether and under what circumstances a negative inference about credibility can be drawn from silence (such as failure to complain of sexual assault to a health practitioner). It is therefore possible for a recorded complaint of sexual assault to be helpful to a complainant whose credibility is attacked on the basis she did not complain at a reasonable opportunity.

4. Relevance, probative value and prejudicial effect

Even where evidence is relevant and not subject to specific exclusionary rules, such as hearsay, judges have the discretion to exclude evidence if its prejudicial effect outweighs its probative value.³⁷ This discretion can be exercised not only in the interests of the defendant but to avoid distortion of the truth-seeking process generally.³⁸ For instance,

³² *Ibid.*, at para. 7.1.

³³ *Ibid.*, at para. 7.12.

³⁴ *Ibid.*, at para. 7.21.

³⁵ S.C. 1980-81-82-83, c. 125, s. 19 [s. 246.5]; now see R.S.C. 1985, c. C-46, s. 275 [am R.S.C. 1985, c. 19 (3rd Supp.), s. 11]

³⁶ Sopinka, *supra* note 27, at para. 7.28.

³⁷ *Ibid.*, at para. 2.57.

³⁸ *R.v. Seaboyer; R.v. Gayme*, [1991] 2 S.C.R. 577.

this general discretion could be used to argue that psychiatric history evidence should be excluded in specific cases or that the use made of it during trial should be restricted.³⁹

The principle of *R.v. Osolin*⁴⁰ is illustrative. The Court ruled that the right to cross-examine a sexual assault complainant on her health records was not unlimited and must be guided by principles of relevance in relation to probative value, as well as by equality rights enshrined in the *Charter*:

Despite its importance, the right to cross-examine has never been unlimited. It must conform to the basic principle that all evidence must be relevant in order to be admissible. In addition the probative value of evidence must be weighed against its prejudicial effect....

Relevance and probative value must be determined in the context of the purpose for which evidence is tendered.... In the context of sexual assaults, this limitation on cross-examination has been recognized to prevent its use for improper purposes....

Both [*Seaboyer*] and the new provisions [s.276] of the Code suggest the factors which should be considered in limiting the scope of cross-examination of a complainant in a sexual assault trial....

The provisions of s.15 and s.28 of the *Charter* guaranteeing equality to men and women, although not determinative should be taken into account in determining the reasonable limitations....

Generally, a complainant may be cross-examined for the purpose of eliciting evidence relating to consent and pertaining to credibility when the probative value of that evidence is not substantially outweighed by the danger of unfair prejudice which might flow from it. Cross-examination for the purposes of showing consent or impugning credibility which relies upon “rape myths” will always be more prejudicial than probative.⁴¹

G. Emerging Questions and Concerns

1. The cases reviewed in this study

This section of the study explores violence against women in relationship cases addressing the production and use at trial of health records. The study includes a variety of legal proceedings such as:

- Criminal prosecutions for assault and sexual assault
- Civil suits involving assault and sexual assault
- Custody and access disputes involving abuse of the mother

³⁹ Bond, *supra* note 12, at pp. 439-40.

⁴⁰ (1993), 26 C.R. (4th) 1 (S.C.C.)

⁴¹ *Ibid.*, at paras. 27-35.

- Child protection proceedings involving abuse of the mother
- Criminal prosecutions for murder or manslaughter in which the abused woman is charged and claims self-defence
- Criminal sentencing hearings involving the abused woman who is convicted
- Criminal sentencing hearings involving a convicted abuser

In the legal literature, much has been written about the use of records in sexual assault cases.⁴² The literature also deals with the general question of when health practitioners are required to release their records in a variety of legal proceedings.⁴³ Less appears to have been written on the use of health records in violence against women in relationships cases which may or may not involve sexual assault.

Much of the analysis related to the sexual assault records cases examines the criminal law area. It links the rise of applications for records (including health records) with the imposition of restrictions on questioning the complainant regarding her sexual history.⁴⁴

While the law regarding the admissibility of past sexual history has changed in Canada, the attitudes that resulted in its admission in the past have not. These same attitudes will result in the admission of psychiatric history evidence.⁴⁵

The literature also identifies a link between current records applications and special rules of evidence that once applied in rape cases. These rules have since been abrogated and it is now widely acknowledged that many of them were based on gender-based stereotypes about women who allege rape – the primary one being that women often make false allegations. Concerns are now being raised that records applications are used to revive or reinvent rape myths, e.g., she is suspect, not because she is a woman, but because she may have a psychiatric disorder.

Less is known about the use of third party records in violence against women in relationships cases.⁴⁶ With respect to the nature and dynamics of the abuse, there are certain parallels between sexual assault and violence against women in relationships cases: the violence is an abuse of power and a method of social control, victims are primarily women, and there is often a reluctance to report or to testify once a report is

⁴²See, for example, Bond, *supra* note 12; Busby, *supra* note 12; Feldberg, *supra* note 12, Gold, A. & Lacy, M. “Therapy and Other Records In Sex Cases: Some Illustrations” (1998), *Collection of Criminal Law Articles on Quicklaw*; Pringle, L. (1999-001) “Third Party Record Applications” (1999-2001), *Ontario Criminal Lawyers Association Papers*.

⁴³ See, Dawson, J. “Compelled Production of Medical Reports” (1998), 43 *McGill L. J.* 25; Renke, W. “The Confidentiality of Health Information in the Criminal Law” (1998), 6 *Health L. Rev.* University of Alberta, No. 3, 3-11; Byrce, G. *The Legal Duty of Clinical Counsellors to Report Violent Crimes*, Paper Prepared for the BC Association of Clinical Counsellors. Victoria B.C. (1994).

⁴⁴ See Busby, *supra* note 12; Bond, *supra* note 12; Feldberg, *supra* note 12.

⁴⁵ Bond, *supra* note 12, at p.422.

⁴⁶ Ross, *supra* note 24; Niman, H. & Pirie, J. “How to Deal with Allegations of Spousal Assault in the Family Law Case” (1999), *SFLRP*; Isaac, N. & Pualani, E. *Medical Records as Legal Evidence of Domestic Violence*, Domestic Violence Institute Northeastern University School of Law (2000).

made.⁴⁷ Part of the purpose of this case review is to explore the issues emerging in violence against women in relationships records cases. The discussion will focus on the following questions: What rationale is being used to claim access to the records? What type of information is being looked for? How is the information being used, e.g., is it being used to support the woman's claim/case or to attack her credibility?

To identify cases, a search of Canadian jurisprudence was conducted using electronic research tools, including QuickLaw, Lexis-Nexis, the eCarswell Abridgment, E-Journals, and traditional index searches such as LegalTrac and the Social Sciences Index. Many keyword combinations were used. Keywords included: disclosure, abuse, health records, third party records, spousal, wife, clinical notes, hospital records, domestic assault, violence, conjugal, evidence, and sex.⁴⁸

Cases emerging from this search were reviewed to determine if they dealt with health records in the context of violence against women in relationships. This screening process eliminated many of the cases which dealt with sexual assault outside of the context of an intimate relationship or with non-health records. The 20 remaining violence against women in relationships cases were analyzed in the context of the literature. The major cases or cases illustrating a significant trend are discussed below. In some instances, key sexual assault cases (outside of the 20 violence against women in relationships cases reviewed) are also mentioned to illustrate a specific point.

2. Cases in which the records are being sought to support the woman's claim

i) Background

A key issue for health practitioners is the extent to which they should consciously adopt a goal of assisting an abused woman to document her case. From a legal perspective there are some barriers limiting the effectiveness of this approach, in particular the hearsay exclusionary rule discussed earlier, which may prevent a record being introduced which repeats an out-of-court statement. More significantly, a conscious adoption of a legally-supportive stance and a purpose that may be seen as not directly health-related, may have an impact on the admissibility and credibility of the record.

Despite these concerns, some commentators have argued that such a stance be adopted with some attention being paid to possible legal implications. A recent American study prepared for the National Institute for Justice, for example, suggests that health practitioners can play a crucial role in supporting an abused woman by carefully documenting details about the incident and any statements made by the woman about it:

With minor modifications to documentation practices, many more abused women's medical charts would contain the elements necessary to allow their statements about abuse to be introduced in court as "excited utterances." Such evidence can allow a prosecution to proceed even when

⁴⁷ Bala, N. "Legal Response to Domestic Violence in Canada and the Role of Health Care Professionals". (2000), *SFLRP/2000-004*.

⁴⁸ For more details on the word combinations used please refer to the methodology section of this report.

the woman is unwilling to testify against her abuser in court due to fear or for other reasons....

Many providers are recording significant details regarding injuries and health conditions in abused women's charts. If these practices were consistent, and symbols and abbreviations were standardized, this type of documentation could act as effective corroborative evidence in court.⁴⁹

This approach is based in part on a specific American case which held that statements contained in a record that identify a patient's abusive partner and his abusive behaviour are admissible pursuant to a hearsay exception for statements made for the purposes of medical diagnosis or treatment.⁵⁰ It is also based on interviews with lawyers specializing in women's advocacy, again in the American context, who reported frequent use of health records to corroborate that an abusive incident occurred and to demonstrate the impacts of it on the complainant.

In Canada, this type of approach has been advocated by Nicholas Bala, a recognized legal scholar in the area of violence against women and children:

If any statements are made relating to abuse, these should be carefully noted. A statement by a victim that she has been abused may be used to refute a later allegation that she "fabricated" a claim of abuse to gain tactical advantage in divorce proceedings, or to cast doubt on a later recantation by the victim.⁵¹

Of the cases reviewed in this analysis, in only six was an attempt made to use health records to support the woman's version of events. In two of these cases the attempt failed. The records in question were either not producible or were ultimately used against the woman. The cases are outlined below.

ii) Case review

In *R. v. Bird*,⁵² the accused was charged with 14 criminal offences including sexual assault. He and the victim (with respect to 13 of the 14 charges) had an ongoing relationship. Following her complaint of sexual assault, the woman went to the hospital and was examined by nursing staff. She also spoke with a hospital social worker. The complainant later recanted. From the evidence it was assumed that she had "reconciled" with the accused. She was arrested and still refused to testify even after receiving legal advice of the consequences of taking this position.

As an alternative to having the victim testify, the Crown attempted, relying on *Ares v. Venner*, to support its case by introducing verbal statements made by the complainant to the nurses which were included in the medical record. In applying *Venner*, the

⁴⁹ Isaac & Pualani, *supra* note at p.6.

⁵⁰ *State of Washington v. Sims* 890 P.2d 521 (1995. Wash. App. Div 1)

⁵¹ Bala, *supra* note 47, at para. 109.

⁵² (1999), 185 Sask. R. 102, affirmed 2000 SKCA 72 (C.A.)

Saskatchewan Court of Appeal said that in order for hospital records to be admissible it must be determined if the recorded observations of the record maker, who is not called to testify, are necessary and reliable. With respect to the statements of others recorded in the records, it must be determined if those also are necessary and reliable. This was because if the record makers were called to testify, they could not relate hearsay evidence unless it fell within a hearsay exception.

The court in *Bird* found that the necessity criterion had been established. All reasonable efforts had been made to obtain the complainant's evidence in court and it was not possible to obtain her evidence other than through her out-of-court statements contained in the medical record. However, the court did not find that the reliability requirement had been met, at least not in terms of the records of the complainant's verbal statements. The court was not satisfied that medical personnel would make efforts to ensure that any verbal statements were recorded fully and accurately. The court felt that they might simply paraphrase the patient's statements. For this reason, the complainant's out-of-court verbal statements were not admissible.

Records of the dates of hospital visits, observations of medical personnel about the condition of the complainant, and the treatment provided were admissible under the *Ares v. Venner* criteria.

With respect to the social worker's records in *Bird*, the court made an interesting ruling. The fact that the complainant was seeing the social worker in relation to a report of sexual assault and that sexual assault was *not* discussed was found admissible, as it was not hearsay. The court viewed this evidence as consistent with fabrication of the sexual assault allegation.

In five other cases in this review, the victim's records were sought in an effort to support her case. In *R.v. Lavallee*,⁵³ the accused was charged with murdering her partner. She was acquitted on the basis that she suffered from battered woman's syndrome and was acting in self-defence. Hospital records⁵⁴ as well as expert evidence were used to support her defence. It is interesting to note that in *Lavallee*, unlike in *Bird*, the Court acknowledged that this type of victimization is characterized by a reluctance to disclose the beatings to others, including medical personnel. Perhaps this was because in *Lavallee* the Court had the benefit of expert evidence on the nature and effects of violence against women in relationships. This evidence helped overcome potential credibility problems related to the health records, namely, the fact that while Ms. Lavallee did get treatment for physical injuries which were documented in her dealing with hospital personnel, and she also attempted to mask the cause of these injuries.

⁵³ [1990] 1 S.C.R. 852; In a somewhat similar case, *R.v Whitten*, [1992] N.S.J. No 105 (S.C.), the woman pled guilty to manslaughter in the death of her abusive husband. Hospital records were used to establish the abusive relationship with the deceased, the fact that she acted in self-defence, and showed remorse. The court concluded that this was an exceptional case in which rehabilitation and reformation, rather than deterrence, should be the guiding principle in sentencing.

⁵⁴ It is important to keep in mind that hospital records appeared to play only a part in the outcome, which was primarily based on a psychiatric assessment prepared in anticipation of trial. It appears that the pre-existing hospital records were used to bolster the expert opinion regarding the battered woman's syndrome.

In *R.v. B.G.B.*⁵⁵ the accused husband pled guilty to two breaches of probation and assault causing bodily harm. The woman's health records regarding the injuries she suffered were entered at the sentencing hearing. It is unclear what role this evidence played in the sentencing decision, however.

*R.v. Baker*⁵⁶ is interesting in a few respects. In this case the hospital applied for an order refusing a Crown application for production. The Crown attempted to get access to records to establish the dates on which the assault occurred. There was some doubt whether the complainant would be able to testify about this fact given the lapse of time involved. Also the Crown sought the evidence to rebut a possible defence allegation of recent fabrication. The Crown was not successful in its efforts to get access to the records to strengthen its case.⁵⁷ The court found that there was no evidentiary basis for ordering production. Unlike many of the other cases in this review, the hospital took a formal position in the production process and was represented by counsel.

*MacKay v. Buelow*⁵⁸ is the only civil case in this review in which records were used in support of the woman. This was a claim for damages for harassment and intimidation. An expert assessment was conducted to support the woman's claim for damages for emotional suffering. In his evidence, the medical expert referred to the records of the woman's doctor which indicated that prior to the incidents in question, the woman had a high level of functioning. This case resembles *Lavallee* in that the medical expert appears to use the regular doctor's records to support the expert opinion.

The small number of cases in which health records were used to support the woman, and *Bird*, in contrast, raises questions about appropriate note-taking for health practitioners. While Professor Bala's suggestion of documenting information for possible use in response to an allegation of fabrication is significant, this study does not provide support for the suggestion that detailed note-taking is helpful. If in practice such statements are not being admitted in evidence – either as an alternative to the woman's testimony or as a way of corroborating her story – then it may not be helpful to document this on file, particularly if it is not required to treat her medical condition, and particularly if there is a risk of statements being used as prior inconsistent statements.

The criminal cases such as *Lavallee* and *R.v. B.G.B.*, in which abused women are charged, suggest that concise documentation of injuries (as opposed to statements) may play an important role in later legal proceedings to help demonstrate a pattern of abuse which contributed to the woman's later acts of violence. Such documentation would be necessary in any case in order to deliver medical services effectively and avoid liability.

The use of the family doctor's records as the basis for expert assessments which are then used in court (*Lavallee* and *MacKay v. Buelow*) raises some concerns. Does this mean

⁵⁵ [1999] A.J. No. 1079 (Prov.Ct.)

⁵⁶ [1995] N.J. No. 318 (Prov. Ct.)

⁵⁷ The application was held in abeyance pending further assessment of the documents.

⁵⁸ [1995] O.J. No. 867 (Ct. Justice)

that by requesting or submitting to an assessment the woman is potentially opening her complete medical file for review? Will she be advised of this possibility before the assessment is undertaken?

Some of the potential concerns that can arise here are illustrated in *Smith v. Smith*,⁵⁹ a custody and access dispute. In that case, a court-ordered custody and access report was used as an indirect way of getting access to personal therapy records about the mother to allege recent fabrication of the abuse on the basis that the therapy records made no reference to the abuse.⁶⁰

It is noteworthy that in only one case did the hospital (or record-holder) appear to take a position on production of the records. In that instance it seemed to work against the woman's interests. Results obtained as part of this study indicate that not all health practitioners and their employers fully appreciate the important role they can play in protecting the confidentiality of their relationship with patients. This raises important questions: Are health practitioners leaving it to the woman to oppose production and awaiting an outcome in the form of a court order? Or are they actively asserting claims for privilege or advocating for restricted release on the grounds of irrelevance?

In *Bird*, the fact that the hospital social worker's record did not include reference to the sexual assault was viewed as consistent with recent fabrication. The fact that an existing medical record does not include documentation of abuse was also used against the woman in two other cases in this review: *R.v.Q.*⁶¹ and *Smith v. Smith*. In a third case, the fact that no hospital records even existed which documented her injuries worked against the woman.⁶²

The non-recording of a sexual assault in another type of record – the complainant's diary – is an issue in a British Columbia Court of Appeal case heard by the Supreme Court of Canada with the reasons not yet released. In *R.v.Shearing*,⁶³ the Court of Appeal held that the non-recording had no presumptive relevance because there is no expectation that someone would record events accurately or fully in a diary.

It will be interesting to see whether this aspect of the ruling is upheld. *Shearing* was not a case. Nor did it deal with health records. Nevertheless, the Supreme Court of Canada's decision with respect to the possible relevance of non-recording in a diary will have implications for the health records cases being considered in this study. The question

⁵⁹ [1997] S.J. No. 483 (Q.B.) The custody and access report listed the mother's therapist as a source. It did not indicate to what extent the report's findings were based on the information provided by the therapist. The father wanted to use the therapist's records to allege recent fabrication. Production of the therapist's clinical notes was ordered.

⁶⁰ See also *Birks v. Birks*, [1999] B.C.J. No. 2215 (S.C.) This was a custody dispute in which the alleged abusive father sought access to the mother's health records to refute what was in the senior family justice counsellor's report, prepared in anticipation of the litigation.

⁶¹ As cited in Gold, *supra* note 42.

⁶² *Wheeler v. Wheeler*, [1993] N.J. No. 57 (S.C.)

⁶³ [2000] B.C.J. No. 235 (C.A.), leave to appeal granted [2000] S.C.C.A. No. 108.

arises: If a diary's silence regarding a sexual assault is not relevant, what about the silence of a medical record regarding relationship abuse?

3. Cases in which the records are being sought to discredit the complainant

i) Background

A number of commentators have questioned the underlying assumptions about women and sexual violence that often drive the request for production or admission of records⁶⁴ – the most common of these misapprehensions, perhaps, being the idea that women commonly fabricate or exaggerate allegations of sexual or physical violence committed against them by male partners. Some commentators maintain that implicit in the request for records in many cases is the notion that the woman's credibility is inherently suspect:

The increased use of personal records and therapy evidence in sexual assault cases found in this study raises a large number of concerns. All of these concerns must be read in the context of a legal environment where sexual assault reform has expanded categories of sexual assault but has not challenged discursive beliefs within the legal system or wider society. Mental health records are used by defence counsel to shrink the margins of who is rapeable. The reasons given for this defence are not based in the language of the credibility of the primary witness but rather in the credibility of her account. However, the effect is still to presume that all women's accounts need to be carefully scrutinized.⁶⁵

This viewpoint also cautions that while health records are often viewed as objective evidence,⁶⁶ they may in fact reflect sexual stereotypes and that even an attempt to use them to benefit the victim may have the unwanted effect of further "syndromizing" women's behaviour:

[Professional utterances] may also contain elements that support myths that women precipitate assaults and theories that "medicalize" and "psychologize" women's behaviour because it is different from "men's." Where professional social constructions match dominant norms and the experiences of the person hearing them, they are more likely to be uncritically accepted. Where these accounts contain judgments presumed to be based in norms that are not dominant (e.g., the assessments of feminist therapists) or are foreign to personal experience, professional

⁶⁴ See, for example, Bond, *supra* note 12; Busby, *supra* note 12; Feldberg G., *supra* note 12, Kelly K. "You Must Be Crazy if You Think You Were Raped": Reflections on the Use of Complainants' Personal and Therapy Records in Sexual Assault Trials." (1997), 9 *CJWL* 178.

⁶⁵ Kelly, *ibid.*, at p.193.

⁶⁶ In their article on the use of third party records in defence work, for example, Gold and Lacy, *supra* note 42, comment on the importance of their use given the absence of other "objective" evidence. In each case summarized third party records were essential in securing an acquittal, withdrawal or discharge. Records were useful in establishing the tainting of memory, improper therapeutic techniques, previous inconsistent statements, exaggeration, fabrication and ulterior motives in cases where objective evidence to disprove the allegations was otherwise not available.

conclusions are more likely to be regarded critically and to be less likely to sway those determining the facts at hand.⁶⁷

The implication of such analysis is that health care practitioners and lawyers should make every effort to evaluate the release of health records since they may be used unfairly to discredit women. Concern about invasion of privacy, inegalitarian or stereotypical record keeping, and misuse of records in legal proceedings is consistent with constitutional values, the common law controls on production, and the more rigorous legislative controls on production in sexual assault cases. Nevertheless, production is often ordered and records can sometimes be used in evidence, including for testing serious allegations in criminal trials. The concern about misuse, coupled with the reality of use, presents both record makers and lawyers with challenges. Record makers may wish to consider confining their documentation to matters falling within their professional expertise, including specific and detailed observations of injuries. Lawyers need to be aware of the limitations of, and variations in, record keeping, as well as the potential risks and benefits of their use. It is hoped that the following case review may be helpful in that respect.

ii) Case review

Of the 20 cases reviewed in this study, 14 involved production applications launched with a view to discrediting the subject of the records or her version of events. Justifications for seeking production of the records included:

- To show she may be unfit to care for a child
- To show she has a psychiatric disorder and is therefore a discredited witness
- To show alcohol and drug abuse affecting memory
- To show inconsistencies between her evidence regarding injuries and what is said in the health records
- To show that she has an animus against the accused
- To defend the husband against attacks on his reputation and character arising from the woman's allegation of abuse

Outlined below are some illustrative cases.

*R. v. White*⁶⁸ is a sexual assault case involving former partners. Initially the defendant obtained production of records relating to drug and alcohol counselling that the victim received around the time of the assault. Among the records released was a clinical summary prepared by a social worker. It stated that the victim had been diagnosed with Munchausen Syndrome. The defence used this information to cross-examine the complainant at the preliminary inquiry. The supervisor at the clinic where the social worker practiced indicated that their staff are not qualified to make such diagnoses. The maker of the records was now overseas. It is unclear what information, if any, the purported diagnosis was based on. The trial court commented that the Munchausen Syndrome statement might have been speculative.

⁶⁷ Kelly, *supra* note 65, at p. 193.

⁶⁸ (1998), 132 C.C.C. (3d) 373 (Ont. C.A.)

On the basis of the note, the defendant made a further production application. Production of five years worth of psychiatric records was ordered despite the fact that evidence suggesting she has the Syndrome is described by the court as "...so thin as to be almost non-existent." Nothing in any of the records produced showed that she'd been treated for Munchausen Syndrome.

Two years later the same complainant launched a civil action for damages for sexual assault. She sought summary judgment.⁶⁹ The defendant made a motion for production of the complainant's entire medical history, once again on the basis that she suffered from Munchausen Syndrome. He alleged that this psychiatric disorder is characterized by fabrication, self-infliction, and exaggeration or exacerbation of medical ailments.

In this case the Ontario Court of Appeal ruled that the defendant's request for production of further documents was not a sufficient basis for refusing the plaintiff summary judgment. The court agreed with *Ryan* that the interest in disclosure of health records is less compelling in the context of a civil action for damages than in a criminal trial. The court distinguished the facts in the current case from those in *Ryan*, however. In *Ryan* the victim's privacy claim arose from her need for treatment for the harm she suffered as a result of the assault. In the current case, the records related to the victim's pre-assault history. For this reason, the court ruled that the claim for privilege must fail.

The court then applied the Ontario Rules of Civil Procedure to the production process. They require that the party seeking production establish that the documents are relevant to a material issue and that it would be unfair to require them to go to trial without discovery of the document. The court found that neither test had been satisfied. They did not, however, rule out a further application based on fresh material.

Unlike the *Franco* and *White* cases, *R.v. E.R.*⁷⁰ involved a simple assault charge. A similar issue arose, however, in terms of the accused having knowledge of records from one proceeding and using it to attempt to get access to additional records in another. In this case the complainant and defendant were also involved in matrimonial litigation at the time the criminal production application was made. The complainant had provided Crown with substantial amounts of material related to the family law case including affidavits, notes of persons she met with, letters and reports from psychologists, and memoranda from her civil counsel. Since these had been disclosed to Crown, *Stinchcombe* was applied and the records were disclosed to defence regardless of their private nature. The defence then applied for production of additional material to attempt to show that past psychological difficulties and a change in the complainant's medication levels may have affected her perception of events. This was partially successful.

*In each of R.v. Q.*⁷¹ and *K.H.P. v. R.P.*,⁷² the victim's credibility was challenged on the ground of discrepancies between what the complainant said caused the injury and what

⁶⁹ *Franco v. White*, [2001] O.J. No. 847 (C.A.)

⁷⁰ [2000] O.J. No. 5083 (Ct. Justice)

⁷¹ As cited in Gold and Lacy, *supra* note 42, at para. 22.

⁷² [1997] B.C.J. No. 1166 (S.C.)

the medical record indicated caused the injury. In *Q.* even though the injuries she reported in evidence did correspond in part with the type of injuries noted in the medical record, the doctors were called and testified that the cause of the injuries was not an assault by the accused. In an article on the use of third party records, Gold and Lacy describe the case outcome this way:

The third party records demonstrated that the complainant was either grossly exaggerating or was in fact lying. The accused testified but his credibility was seriously undermined. In his reasons for judgment, Justice S. considered the complainant's claims in light of the medical evidence. Although he did not believe the accused's denial and thought that he had probably committed the offence, he found that in light of the inconsistencies between the injuries the complainant suggested were caused by the accused and the objective medical information he was left in doubt about his guilt. He therefore acquitted.⁷³

In *K.H.P. v. R.P.*, an action for divorce and custody, the mother said that her first husband abused her. Her doctor's medical chart indicated that it was her current boyfriend. This discrepancy contributed to the court's conclusion that she was an untruthful witness.

In *Smith v. Smith*, a custody and access dispute, the father applied for full disclosure from professionals who had provided counselling and therapy to the mother and children. The mother alleged she had been abused. The court ruled that production was relevant to issues of credibility and to the husband's defence of his character and reputation.

The *White* and *Franco* cases raise a number of key issues. They illustrate the potentially serious consequences for the patient of one "speculative comment" contained in a single record. This single statement resulted in a kind of quest to discredit the complainant on the basis of the possibility that someone at sometime may have diagnosed her as having Munchausen Syndrome. These two cases also demonstrate some of the limitations involved in using records in situations where the maker of the record cannot be called to help contextualize the comment. The medical source of the speculative comment was never identified despite years of litigation.

Franco appears to limit the application of case-by-case privilege to situations where the records relate to treatment for the harm suffered as a result of the crime. Pre-assault medical history, therefore, would not be covered by any form of privilege. This distinction may be particularly significant in violence against women in relationships cases that do not involve a sexual offence. In these cases the woman may not be as likely as a sexual assault victim to seek psychiatric counselling as a result of the crimes.

The accused's prior knowledge of the existence and contents of records is a particular concern in some of the violence against women in relationships cases reviewed. In violence against women in relationships cases the complainant and defendant will generally have had some history together. Some of the records may even be joint, e.g.,

⁷³ Gold and Lacy, *supra* note 42, at para. 24.

family therapy. The defendant can use this prior knowledge to improve his chances of establishing relevance and obtaining a production order. In *Smith v. Smith*, for example, the father deposed to a conversation he had with the mother's therapist two years before the litigation. The therapist had apparently told him that no abuse allegation had been made during the therapy and this information was used to allege that the records were relevant to possible fabrication.

In her paper on records cases since *O'Connor*, Karen Busby,⁷⁴ a legal scholar specializing in this area, raises the issue of prior knowledge. In the cases she sampled, Busby found that most records production cases involve defendants who are related to the complainants (most commonly their fathers) or professionals who have worked with the complainants. She points out that defendants rely on their personal knowledge of information about the complainants to determine that records exist. Often, these defendants already have access to some of the records in question. In her analysis Busby concludes:

The majority's assertion in *O'Connor* that "generally speaking, an accused will only become aware of the existence of records because of something which arises in the course of the criminal case" is clearly wrong. Rather it is the rare case that a defendant could truthfully assert that he does not know anything about the existence of records on the complainant. Indeed, in the usual case, he already knows her intimately and moreover, has easy access to additional information about her.⁷⁵

The reviewed cases involving discrepancies between the woman's evidence as to what caused the abuse and the records' assessment of the cause raise questions about how the courts view the two types of evidence. Can it be assumed that the medical record is truly objective? Can it be assumed that it is accurate? Are courts taking into account what is known about the dynamics of violence against women in relationships, for example, the fact that the woman may be reluctant to disclose the abuse and may lie about the cause of injuries?

In *Smith v. Smith* the mother alleged she had been abused in the context of a custody and access dispute. The father was entitled to fairly broad disclosure in part to defend his character and reputation. Does this mean that whenever abuse is alleged, getting access to records is viewed as a necessary prerequisite to an effective defence?

These cases also raise questions about the role of health practitioners. They do not appear to be playing an active part in the production process, for example, by informing the court of the potential harm to the victim if sensitive information is released, by making a claim for privilege on a case-by-case basis, or by raising questions about the relevance of the information.

⁷⁴ Busby (2000), *supra* note 12, at para. 4.

⁷⁵ *Ibid*

Of particular concern are cases such as *R.v.Q.* in which the patient provides police with a consent for the release of records. In most criminal violence against women in relationships cases, once material is provided to the Crown or police, it is presumed relevant and will be disclosed to defence. This initial disclosure can then be used to try to get access to more records, as was done in *R.v. E.R.* It is critical that the patient understands the possible legal implications before she signs such a release.

H. Gender-Based Violence and the Fact-Finding Process

1. Background

Sexual offences and violence against women in relationships cases both involve gender-based crimes. This affects the way issues regarding relevance and the admissibility of evidence are resolved by the courts. In her article on the use of psychiatric evidence of sexual assault victims Sadie Bond argues:

If sexual assault trials are inherently credibility contests, it is not because the offence is usually committed in private (although that may be true) but because of the gendered nature of the offence. Because sexual assault is a crime committed by men against women, the contest is between the credibility of men as men and the credibility of women as women.⁷⁶

Bond maintains that the rationale for the introduction of psychiatric history evidence is based on the belief that the complainant's credibility is in effect always suspect. This in turn is based on the now discredited myth of the high number of false allegations of sexual assault.

The rise in *O'Connor*-type applications and the controls on the use of sexual history evidence suggest that records are an indirect way to introduce personal history evidence which would otherwise be excluded as irrelevant or unreliable. In civil cases the use of personal records to challenge the accuracy of the victim's memories may be associated with attempts to minimize or deny the prevalence of historical sexual abuse in the face of the rising number of claims.

This study focuses primarily on violence against women in relationships cases, many of which do not involve a sexual assault. Nevertheless, in spousal assault cases some of the underlying social dynamics are similar to those present in sexual offence cases, namely:

- The vast majority of victims are women
- The violence reflects and perpetuates larger social inequalities within society
- Victims are often reluctant to reveal the abuse to anyone

In violence against women in relationships cases the reasons for reluctance may include:

- Fear of retaliation from the offender or his family

⁷⁶ Bond, *supra* note 12, at p.420.

- Feelings of helplessness
- Fear or mistrust of health and justice response systems based on cultural or historic factors
- Pressure from social or cultural community not to speak out
- Fear that children may be removed by child welfare authorities
- Economic insecurity

Historically, in sexual assault cases, societal myths and stereotypes about the victimized woman were reflected in special rules of evidence. Canadian courts have now recognized the danger of such beliefs distorting the fact-finding process. The fact that similar myths may come into play in spousal assault cases was acknowledged in the *Lavallee* case:

Laws do not spring out of a social vacuum. The notion that a man has a right to “discipline” his wife is deeply rooted in the history of our society. The woman’s duty was to serve her husband and to stay in the marriage at all costs “till death do us part” and to accept as her due any “punishment” that was meted out for failing to please her husband. One consequence of this attitude was that “wife battering” was rarely spoken of, rarely reported, rarely prosecuted, and even more rarely punished. Long after society abandoned its formal approval of spousal abuse, tolerance of it continued and continues in some circles to this day.

Fortunately, there has been a growing awareness in recent years that no man has a right to abuse any woman under any circumstances.... However, a woman who comes before a judge or jury with the claim that she has been battered and suggests that this may be a relevant factor in evaluating her subsequent actions still faces the prospect of being condemned by popular mythology about domestic violence. Either she was not as badly beaten as she claims or she would have left the man long ago. Or, if she was battered that severely, she must have stayed out of some masochistic enjoyment of it.⁷⁷

Certain justifications for the use of records in sexual and spousal assault cases reflect a reliance on misinformation about women who are victimized. Lawyers and health care providers involved in such cases can play an important role by helping to ensure that when decisions are made about the possible use or relevance of personal information such decisions are based on an informed understanding of the dynamics of gender-based violence.

This section of the study explores this issue and considers possible approaches suggested primarily by the violence against women in relationships cases reviewed. Where appropriate, examples from key sexual assault cases are also included.

⁷⁷ *Lavallee*, at paras. 33,34.

2. Relevance, probative value and prejudicial effect

In *Shearing*, one of the issues was the defence counsel's right to cross-examine one of the complainants regarding her failure to make an entry in her diary about the sexual abuse. The defendant already had a copy of the diary so the question at this stage was one of admissibility of evidence at trial and not pre-trial production.⁷⁸ The complainant's counsel successfully argued that there was no probative value in the lack of a complaint in the diary and that to allow cross-examination and argument on the issue was premised on discriminatory belief or bias. This argument was accepted at trial and upheld by the Court of Appeal. The court agreed that the proposed line of questioning was "discriminatory." The court ruled that the decision of the Supreme Court of Canada in *Mills* "...shifted the balance away from the primary emphasis on the rights of the accused"⁷⁹ and quoted *Mills* as follows:

It is clear that the right to full answer and defence is not engaged where the accused seeks information that will only serve to distort the truth-seeking purpose of a trial, and in such a situation, privacy and equality rights are paramount. On the other hand, where the information contained in a record directly bears on the right to make full answer and defence, privacy rights must yield to the need to avoid convicting the innocent.... Full answer and defence will be more centrally implicated where the information obtained in a record is part of the case to meet or where its potential probative value is high. A complainant's privacy interest is very high where the confidential information contained in a record concerns the complainant's personal identity or where confidentiality of the record is vital to protect a therapeutic relationship.⁸⁰

Information which can only serve to distort the search for truth can be seen as irrelevant. In other cases, the judicial discretion to exclude evidence may come into play as outlined above in *Shearing*. This discretion can be exercised in situations involving potential prejudicial effects interconnected or indeed unrelated to gender. For example, a general assumption that a witness is unreliable because of a mental condition can also be challenged if relevance is solely based on stereotypes related to disability.

This issue arose in *R.v. Miller*,⁸¹ a sexual assault case. Crown counsel disclosed some materials. They revealed that at the time of the alleged assaults, the complainant had been diagnosed with and was receiving treatment for Personality Disorder and Bi-polar Disorder. Defence counsel then made an application for production of the complainant's hospital records. In support of the application, the defence attached excerpts from psychiatric texts including information on the general features of these conditions. The court held that the defence had not satisfied the requirement to show that the records were

⁷⁸ Please note, however, that issues related to production were raised on appeal to the S.C.C. in this case. See the factum of the intervenor, the Women's Legal Education and Action Fund.

⁷⁹ *Shearing*, at para. 93.

⁸⁰ *Ibid.*, at para. 96.

⁸¹ [1997] N.J.No. 207 (Prov.Ct.)

likely relevant.⁸² The court ruled that the threshold for likely relevance was more than mere possibility or speculation based on textbook generalities without reference to circumstances relating to the victim. The court also made reference to the dangers of relying on stereotypes to establish relevance:

However, one must avoid the stereotyping of witnesses or complainants. One such stereotype might be the consideration that simply because a person is receiving or has received psychiatric treatment or indeed, has been assigned a general diagnosis, that that person automatically cannot be relied upon to tell the truth in a judicial proceeding. I find this to be the situation before me.⁸³

In reaching this conclusion the court was assisted by affidavit evidence from a physician. This evidence described a general diagnosis of Personality Disorder and Bi-Polar Disorder as covering a very broad range of problems, not all of which would involve credibility weaknesses. Both the Health Care Corporation and the complainant were represented by counsel.

Both the *Shearing* and *Miller* cases suggest that under certain circumstances judges will use their discretion to exclude prejudicial evidence. Lawyers and health practitioners can play a key role by ensuring that hidden assumptions are made visible to the court. Where they are based on stereotypes, they can be challenged. In some cases this may require the use of expert medical evidence such as the doctor's affidavit in *Miller*.

3. Issues related to the use of out-of-court statements to support the complainant

It was earlier noted that on occasion attempts were made to have the woman patient's out-of-court statements introduced to support her account of events. Health practitioners and their counsel who choose to adopt this approach may encounter legal barriers including the hearsay exclusionary rule and the rule against self-serving evidence.

One context in which prior consistent statements contained in a record can be useful however, is in response to an allegation of recent fabrication. The statement contained in the record could be introduced to rebut an allegation that the woman made up her story after the fact. The cases reviewed in this study did not reveal a situation where this argument was used successfully. In *Baker*, an attempt by Crown counsel to get access to health records to rebut a possible defence allegation of recent fabrication was unsuccessful.

Another potential use of the record to support the woman would be to introduce it as an alternative to having her testify on the basis of the necessity and reliability criteria articulated in *Ares v. Venner*. Again Crown counsel unsuccessfully attempted to do this in *Bird*.

⁸² The court did not rule out the possibility that the defence could establish likely relevance at trial through questioning of the complainant about her diagnosis. That would involve a separate application for production at that time.

⁸³ *Supra* note 81, at para. 10.

It may be that advocating for the admission of out-of-court disclosures of abuse will assist the complainant in specific situations. But this could well be the exceptional case. It assumes that:

1. The complainant generally makes full disclosure to the health practitioner.
2. The health practitioner fully and accurately documents the disclosure without adding potentially damaging or irrelevant speculation or commentary about the patient.
3. The patient's disclosure is informed in the sense that she understands that the information provided by her may be used as evidence.

Item one does not correspond with what is known about the dynamics of violence against women in relationships. Items two and three place high expectations on health practitioners both in terms of the time it takes to make detailed notes and the understanding of how these notes might be used in violence against women in relationships cases. It may not be realistic to expect this of hospital staff or doctors.

The court in *Bird* did admit specific records related to dates of admission, treatment, and observations regarding the patient's condition. In doing so, the court was acknowledging the expertise of health practitioners. The court also recognized that the recording of the patient's verbal statements fell outside this area of expertise. For that reason notes paraphrasing the statements were excluded as unreliable. The ruling in *Bird* suggests a potentially useful approach: that health practitioners focus on keeping records relevant to their particular functions, diagnosis, continuity of care, treatment (which could of course include information, or opinion, about the source of injuries since it may well matter for medical purposes, for instance, whether an injury is a falling injury or a beating injury). A disciplined focus on recording information for medical purposes would increase the possibility of records being seen as reliable by a court.⁸⁴

Some support for less rather than more documentation can be found in the empirical study that follows this legal overview. Suggestions included the following:

"Doctors should be recording the minimal amount that is needed to work professionally, respectfully." (advocate)

"Keep minimal 'tombstone data.' This date, this hospital, injuries sustained. Facts only, nothing subjective." (advocate)

⁸⁴ See Dalton, C. "Domestic Violence, Domestic Torts and Divorce: Constraints and Possibilities" (1997), 31 *New England L.Rev.* 319, suggesting the inclusion of specific and detailed records of injuries plus noting if the woman's explanation is inconsistent with the physical symptoms. This approach is distinct from screening for domestic violence in which the health practitioner asks the woman directly whether she has been abused and then documents the response.

“The less written down the better.” (lawyer)

“Accuracy and brevity are important.” (lawyer)

The development and implementation of practice protocols regarding note taking in such cases would help to ensure that if health records are used in court, that they are of assistance in the search for truth. Again, and unsurprisingly, the empirical study provides support:

“We need guidelines and standards in place, so everyone is using similar formats and judges and lawyers are used to seeing the same formats.” (advocate)

“There is value to standardizing procedures and using consistency when you make records.” (lawyer)

“Don’t use medical shorthand. Write so that anyone could understand the notes.” (lawyer)

“Doctor’s writing should be legible.” (lawyer)

An issue more fundamental than practice protocols, however, is that of the legitimacy of inferences about credibility. The most disciplined and focused record-keeping practices will not prevent the exercise of what is sometimes called “common sense” in legal fact-finding. If legal fact finders are prepared to draw a negative inference about credibility from silence about certain matters in health records, then legal pressures may distort the record-keeping process. Ideally, record keeping focused on medical functions and a critical legal stance towards assumptions about silence would both help to avoid discriminatory fact-finding.

4. Expert opinion evidence

Additional challenges are presented by cases in which there are inconsistencies between what the patient told the health practitioner (or what was recorded) and what she says in court. The reviewed cases indicate that such inconsistencies often work against the complainant. Either they are used by the defendant to limit the extent of available damages or to avoid liability or accountability entirely.

Expert evidence may sometimes be of assistance in explaining inconsistencies. In *Lavallee*, the expert psychiatrist testified that “fabrication” was typical of battered women. The Court adopted much of this analysis:

Apparently another manifestation of this victimization is a reluctance to disclose to others the fact or extent of the beatings. For example, the hospital records indicate that on each occasion the appellant attended the emergency department to be treated for various injuries she explained the cause of those injuries as accidental. Both in its address to the jury and in its written submissions before this Court the Crown insisted that the

appellant's injuries were as consistent with her explanations as with being battered and, therefore, in the words of Crown counsel at trial, "the myth is, in this particular case, that Miss Lavallee was a battered spouse." In his testimony Dr. Shane [the psychiatrist] testified that the appellant admitted to him that she lied to hospital staff and others about the cause of her injuries. In Dr. Shane's opinion this was consistent with her overall feeling of being trapped and helpless:

...But basically the manner in which, I think, she would be prevented from telling the doctors or other people about the beatings was related to the fact that this whole process would repeat itself. He would want forgiveness and tell her he would love her and it would never happen again and she would feel grateful. She would feel a little loved. It would help her self-esteem again and she would feel a little safer for a while too. It would allow her to have a sense, a window of security for a period because she felt so trapped in this relationship.⁸⁵

In giving weight to the expert's opinion, the Court in *Lavallee* noted the fact that the psychiatrist considered sources including police statements and hospital records. It appears that despite the fact that the defendant lied to hospital staff about the cause of her injuries, the records were of assistance to her in that they documented the physical injuries she suffered. The Court was also influenced by corroborative evidence from one of the emergency room doctors. He testified that he doubted the defendant's explanation of the cause of her injuries at the time.

As an alternative to expert evidence, the fact that women who genuinely have been abused by their intimate partners would not reveal this to a health care practitioner, or might lie about the cause, may now have become such a matter of common knowledge that it is appropriately the subject of judicial notice.

5. The need for empirical data

Legal case analysis and attention to the literature on gender-based violence can only provide part of the picture. This study turns now to empirical data collected through interviews with lawyers, health practitioners, women, and advocates to add more dimensions to the emerging picture.

⁸⁵ *Lavallee*, at para. 84.

IV. The Empirical Study

A. Rationale for the Study

The purpose of this study was to undertake a preliminary examination of the use of health records in criminal and civil cases (custody and access decisions and child protection, children who witness abuse) involving violence against women in relationships. The question underpinning the research was whether health records and their contents are used in litigation to produce fair, equitable, and just legal outcomes or, alternatively, if they are tools to unfairly discredit women and their claims, thus further victimizing women. Because this is a nascent field of inquiry, we were keenly interested in gathering and analyzing the perspectives of stakeholders from the health and legal systems who could contribute to this emerging body of knowledge. We also interviewed women and advocates for abused women as they are subject matter of the records and have been most affected by the creation, production, and use of their records in legal proceedings.

The research was overseen by an Advisory Committee, comprised of professionals representing health care, legal, and anti-violence sectors. The research was conducted by two principal investigators with the assistance of three research assistants experienced in the field of violence against women. Academic and legal guidance was provided by a UBC Faculty of Law Professor, a provincial family violence organization, and two family law practitioners.

B. Methodology

This research was approved by UBC Ethics Review Committee and British Columbia's Women's Hospital and Health Centre Ethics Review Committee. To accomplish our objectives, 90 key respondents from across British Columbia were interviewed for this study in person or by telephone. Researchers traveled to four rural communities in BC to interview stakeholders and conducted research by telephone in one remote community in BC. The key respondents were comprised of:

- 30 lawyers (Crown counsel, defense and family lawyers);
- 30 physicians and nurses;
- 10 women survivors of relationship abuse (subjects of health records); and
- 20 advocates of abused women, representing anti-violence women's organizations.

While the samples were not random, we attempted to avoid biases of perspectives by including individuals with a wide range of perspectives. For example, in the case of legal professionals, we included lawyers who work for the Crown and defence, plaintiff and defendants, and complainants. The participants were recruited from five communities representing the northern, coastal, interior and lower mainland.

The methods of recruitment were varied. The Committee constructed a preliminary list of lawyers and health care professionals. The research project's legal consultants provided direction for this process. Two lawyers who are well-recognized as representing fathers

rights were contacted, but declined to participate in the study. A number of strategies were utilized to recruit Crown Counsel in the lower mainland, but ultimately Crown Counsel did not agree to participate in this study. Two Crown Counsel from other regions of the province did agree to be interviewed. Additional professionals were identified through the research interviews. Women were recruited through various means including newspaper ads, posters in community centres, women's centres, and British Columbia's Women's Hospital and Health Centre (see Appendix C for the poster). Criteria for participation in the project included: being a woman who had been abused by her intimate partner and was aware of having health records created and used in legal proceedings (criminal or family). The original plan did not include interviews with advocates, but because of the narrow criteria for participation in the study for women, we were unable to locate 30 participants for the study. Therefore, we interviewed 10 women who had experienced abuse and had their health records used in legal proceedings and 20 anti-violence advocates. All study participants were given letters describing the study and its objectives, as well as consent forms (Appendix B).

C. Results

In the following section the detailed data findings from the interviews are presented. Standardized open-ended interviews were utilized (See Appendix A for the interview guides) and data were analyzed in accordance with qualitative research methodology. Once the interviews were completed, they were written-up and coded according to emergent themes and patterns. Qualitative analysis is inductive. It is also iterative in that the researchers formed categories from the data and then returned to the data to test the generalizability of their categories of analysis. The objective was to generate detailed and rich information about the use of health records from those who have direct experience with them. The perspectives of those who we interviewed therefore inform all stages of the analysis, beginning with the detailed interview data in the next section to the discussion at the end of the report.

From these interviews we obtained a better understanding about how health records are currently being created and for what purposes. We also learned more about what medical documentation is potentially usable and helpful and what is harmful in these cases. Finally, as presented in the discussion, we hope that the study provides useful insights for lawyers considering the production and admission of health care records as well as information to health care providers about the creation and use of health care records.

1. Legal professionals data analysis

Demographic information:

Twenty-four lawyers, three police officers, two RCMP officers and one Adult Probation officer were interviewed. 40% were male, 60% were female. Their ages ranged from 32 to 57. Among the lawyers, almost 60% were in private practice. The others were Crown counsel (4), legal aid lawyers, and lawyers working for community organizations. Approximately one-third represented rural settings. The majority of legal professionals interviewed identified themselves as Caucasian. The remainder identified their ethnicity as being Aboriginal, Jewish, East Indian, and South Asian.

1. What experience do you have in any or all of these (cases involving assault, custody and access, and child protection) fields?

Most of the lawyers interviewed reported that their primary focus or a “good portion of their work” was in the area of family law including custody, access, family violence, and violence against women in relationships.

2. Within those areas, what experience do you have working with health records?

In terms of working with health records in their areas of expertise, the answers varied:

- 23% reported that they do not deal with health records often. As two family lawyers commented, “*I don’t find it a common issue at all,*” and “*It doesn’t come up that often.*”
- 18% reported that they have “some experience.”
- 23% reported that they work with health records on a “pretty regular basis.”
- 36% reported that they consistently use health records, that is, in more than half of all their cases: “*If there are medical records, I always try to get them for court reasons,*” and “*I ask for and examine health records in almost all cases.*”

3. Are there any types of cases where you seek access to your client’s, or opposing party’s, health records as part of your preparation for settlement discussions or litigation?

Forty percent sought access to health records to substantiate or dismiss claims of abuse:

“To ascertain if there has been an assault, the nature and severity of injury, and if the assault was reported.”

“The big thing is to show a continuity of domestic violence. The medical records need to show continuity to establish a history of abuse.”

“To document domestic assault in custody and access cases.”

“To confirm abuse in relevant cases. Records are helpful to exonerate and likewise confirm experiences of abuse – they work for both sides.”

“Defendant says that she made a false statement about me. I check her records. She claimed a ruptured eardrum and her medical records did not bear this out.”

Thirty-one percent sought access to health records to determine health and medically related issues:

“Only in cases where I believe that there is relevant medical history such as psychiatric treatment.”

“When there is a suggestion of a mental health issue that affects self-sufficiency (in terms of spousal support) and ability to care for children (in terms of custody).”

Seventeen percent did not seek access to health records:

“I try not to access records because they don’t reflect an accurate record at all.”

“I try not to request it because it costs \$500 for a medical legal report.”

There were a number of lawyers who also provided examples of when they would not seek access to health records:

“Custody cases where the woman says she lied to hospital to protect her partner. That’s an example of where I won’t get records.”

Nine percent sought access to health records because of issues of recall/reliability and four percent sought access because of settlement issues.

4. What factors would influence your decision to seek or not to seek access to such records?

Factors that influence whether or not records are sought differed, but for the most part had to do with whether they are relevant in terms of providing useful information and supporting evidence. Examples of responses include the following comments:

“The influencing factor would be the belief that there is something relevant in them. In my perspective the factors are: credibility, reputation for truthfulness, fitness to testify – some people are delusional. You can’t always rely on what people tell you – your own client included. There are potentially very material things in records. Objective evidence shows certain things didn’t happen. Objective evidence is also inconsistent with the ‘story.’”

“Generally, health records do not lie. A professional will not manufacture evidence.”

“In any fact pattern where we conclude there is an injury and that medical evidence would corroborate the complainant’s versions of the facts.”

“We need as much corroborating evidence as possible. You can’t have too much information, you can, however, have too little.”

Forty-six percent stated specifically that it would be when the records provided relevant information and evidence for substantiating or undermining claims of abuse.

“If I am representing an individual who has suffered domestic abuse or emotional or mental abuse, I almost always request the underlying clinical records to evidence the abuse being described. And if I am representing someone who is the alleged abuser, I request them as well.”

“In my case [identifying information], I am seeking medical records because I don’t believe that the woman who says she has been assaulted by her husband. It’s important for me to see what drugs she’s on. If she’s not lying, then she must have mental health issues because her story doesn’t make sense otherwise.”

Twenty-five percent reported that they would seek access if they thought that the production of records would in any way help their clients. As one lawyer explained, *“If I don’t get the records, the other side will bring out information during the examinations so it is better to get the records, vet them, and know what is coming so you can argue about it in context.”*

And here, some lawyers pointed out that deciding if records are helpful vs. potentially problematic is often a delicate balancing act. For example, evidence of a debilitating health issue may be helpful in a case involving a claim for spousal support, but at the same time such information could be extremely damaging in a child custody case. In the words of one lawyer *“I am very cautious because these records are often ‘scary,’ indicating mental health issues such as depression which can be used against women. If I think that the records may support an allegation that she is emotionally unstable then I will avoid them.”*

Twenty-one percent stated that they would seek records if they thought it would help settle disputed issues.

Five percent reported that it would be to ascertain any alleged health issues. As one lawyer explained: *“Impact of mental health of mother on the well-being of children is important. But, we are talking...it has to be a solid, serious psychological problem – not just something like anti-depressant pills. The more that we become acquainted with the psychological field, the more we know about psychological problems including anti-depressants. In fact, these people [taking anti-depressants] may be further along treating themselves and their problems appropriately.”*

The balance reported that there are no mitigating factors because they do not access records:

“Generally speaking I won’t seek records – they have no benefit at all. The records have generally been detrimental and an obstacle to overcome.”

5. What procedures have you used or observed for seeking access to health records?

All the lawyers mentioned that they begin with trying to get consent from their client or opposing counsel's client, and, alternatively, that they would apply to the court for release of such records (rule 26 in civil and 278.1 of the Criminal Code in criminal cases).

"I will ask my client to obtain medical records. Doctors are usually pretty good at releasing records."

"I always ask the client. I will ask the client to get records from the doctor, or to give them permission to access the records. I get this permission in writing."

"I get the woman to sign a medical release form and request records from the doctor or hospital. I always ask the person I am working for if they would mind if I got their medical records. And, I explain to them why I need them. I go through the whole process of what we need to get and how we're specifically interested in the records about the injuries received as a result of the assault, wanting to make sure they understand that completely."

A small number of lawyers – 13% – also mentioned that they vet records for irrelevant material before passing them over to the opposing counsel. A number of legal professionals also noted the high price charged for releasing health records. The reported range was between 100 and 500 dollars. According to one lawyer *"No health professional has ever refused to hand over records, but they've often charged a fortune for them."*

6. What factors seem to influence the success or failure of the procedures for accessing records?

The overwhelming majority (82%) reported that the key factor is that of relevance:

"My experience is that the test is relevance. If the records are relevant, they will be ordered."

"If there is a dispute over how things occurred connected to the case and the records are of 'probable value' that is what would influence the release – an agreement or order."

This means that lawyers need to provide *some* evidence as to why the record is needed. Many explained that it *"has to be more than a fishing expedition."*

Some lawyers explained that relevance is a broadly defined term whose interpretation depends on who is sitting on the bench on any particular case. One lawyer reported that *"The courts tend to release any information that may appear relevant, the records are released, and then the true weighing of evidence is done later."*

Another lawyer explained that although the test is supposed to be relevance, *“I have found that it is the tenacity of the counsel. If they are determined to get them [the records] they will. A determined counsel – they will ‘craft’ their application to the requirements of case law and then get the records.”*

Thirteen percent also reported that therapists, counsellors, or physicians do not want to release records and *“take it upon themselves to protect the client.”*

7. Have you worked on any cases where you found such health records to be helpful to your case?

Eighty-two percent reported that they have worked on cases where health records have been helpful. Their experiences are evidenced in the following:

“Traumatized women may not always remember, or what they remember is partial. The doctor’s records fill in the gaps.”

“Frequently helpful to determined what really happened.”

“In abuse cases and child custody [health records] are helpful because what happens is the records provide an objective record of a fact that is being alleged. Medical records substantiate claims of injury.”

“Medical professional’s opinion carries a lot of weight when it comes to domestic violence cases. Many of them are about one person’s word against another and when you can get any evidence to support what the victims is saying, it gives a lot of strength to the case.”

“Yes, but what they really are used for is to damage someone else. Records never really build a client’s case, they are used as a weapon against someone else.”

“They are helpful for doing justice. They protect the innocent, and prosecute the guilty. It is hard to prove you didn’t do it [in case of being accused of abuse/assault] in the current climate – there is increased prosecution, reporting, and awareness. The pendulum has swung. Records help you get the right result and bolster credibility.”

“Yes, because they exonerate and establish credibility. Especially in violence cases, health records are important. For example, if a woman claims that she has been abused and at one time this led to a broken arm – but there are no records, no marks – maybe she is not telling the truth.”

For the remaining 18%, health records have not been helpful:

“It is not just that women are being hurt – it is the entire justice system hurting.”

“There are other, better avenues for obtaining the evidence that you need.”

8. Have you worked on any cases where you found such health records to be harmful to your case?

At the same time, a majority (72%) also answered in the affirmative. This indicates that records have the potential to be *both* helpful and damaging.

Negative experiences were described in the following responses:

“I have acted on behalf of individuals who have denied such actions [assaults]. I have sought records and they did show that something happened.”

“I don’t believe records are very helpful in family law.”

“People are always more forthright with their physicians than with their lawyers.”

“Sometimes my clients are not as forthcoming. Doctor’s files follow through on abuse suspicions.”

“Defense would get the records which would have a lot of irrelevant material and use against her. For example – she is a practicing lesbian then she meets a guy. She faces questions and comments like – ‘you see more of your girlfriends than your husband.’ Defense discomposes the victim and there is no legal bar to it. In order for a judge to disallow such questions – they have to be asked, but once they are, the damage is already done.”

“I find that in cases where there is an Aboriginal woman and a Caucasian man, records are sought more frequently and they are detrimental. The record maker has ethnocentric eyes.”

“Yes, because they have been so scant as to be meaningless. Sometimes this is taken as being inconsistent with what the client says. I know that record keepers say little or nothing in records – such as in the cases of sexual assault centres. However, instead of being protective, the opposite is true.”

“Sometimes harmful when the records are totally illegible.”

“I’ve seen lots of records that have been useless because they’re equivocal or unclear or because the doctor will not have noted that the woman has disclosed abuse.”

“If there are discrepancies between the notes and what the client says, then the client is made to look like a fool and/or liar. The court doesn’t take into account that these records are often not taken in a session but written later, but the record taker (doctor or therapist) still used quotes to indicate a verbatim record. Record takers tend to be shoddy record keepers with no idea as to the extent to which they are sticking it to their clients.”

“Where the records indicate depression or anti-depression medication but there is no indication of what has contributed to the depression, e.g., the abuse.”

“If a woman says she goes to the hospital often and records do not show abuse but state she is a hypochondriac then her credibility is challenged.”

Twenty-eight percent answered that they had never worked on cases where records have been harmful.

“No, usually the point of getting records is to harm the other client, e.g., to support a claim of assault to the detriment of the accused.”

9. Have you worked on any cases where opposing counsel’s use of such health records was harmful to your case?

When asked if they had worked on any cases where opposing counsel’s use of health records has been harmful to their case, 70% answered yes and offered the following reflections:

“My client was not being candid with me and this was harmful. My client claimed abuse all the time and she claimed that she had gone to see a medical professional to report threats by her husband. She did go to a doctor, but there was nothing about the abuse. In fact, she said positive things about her husband that were on the record.”

“In sexual assaults in particular because records of medical professionals are used to cross-examine. If there is corroboration, nothing is raised. If anything is inconsistent that is what they focus on.”

“Everything that is said by third parties (e.g., doctors) carries more impact than the woman’s testimony.”

“There are always ways to use records against women.”

“But at the end of the day, what you get is the right results. The right result may not always be my client’s acquittal.”

In contrast, 30% answered no to this question:

“We do not see a lot of women’s credibility being attacked.”

When asked if the prospect of their use makes clients reluctant or unwilling to proceed, 20% answered in the affirmative and provided a number of examples:

“I have had complainants withdraw or want to withdraw after there has been an application for an entire medical history. The application process itself acts as a deterrent.”

“Sometimes my clients back down from moving forward. For example, they have told the doctor about a history of incest or substance abuse that is unrelated to the case at hand. It is too much to bear to have it raised.”

“I had one client who backed down because she didn’t want her breast augmentation to become public.”

“I can see how [a client] would want to back down. Some counsel do not necessarily violate rules of court, but when they are cross-examining they will intimidate and harass. This is all part of the strategy.”

One lawyer offered the following observation:

“I am aware that claimants say they won’t go to court (if the records are produced). In my experience, this is ‘overrated’ – they say they won’t go but they do.”

10. Have you any experience in making a claim of privilege with respect to health records?

Thirty-nine percent reported having some experience in making a claim of privilege with respect to health records:

“In cases where it has come up, there has been an attempt to stop records from being produced on the basis of privilege – the arguments that are made are that the materials produced are not relevant or that we should have no right to see them. Judges determine whether it is appropriate to have them released. In the majority of cases, they do release records. Sometimes they say, ‘I don’t see anything relevant or helpful.’”

“I have had a number of cases where a client has gone to their doctor and health professional seeking advice about a problem at home, e.g., some kind of historic childhood experience. I have claimed privilege, that is, this information is private to them and has nothing to do with the actual case. It is hard, however, to keep it out of custody and spousal support cases.”

“Medical records say everything about someone. There could be personal issues such as sexual diseases – this is an issue of privacy and potential embarrassment. There needs to be a balance between privacy and evidence.”

“Prior to O’Connor, people didn’t get medical records except for, say, in the case of AIDS – did she or didn’t she have AIDS before the assault. They were there just to prove injury or cause of death. O’Connor opened up medical records to defense counsel.”

Fifty-six percent reported having no experience with making claims of privilege. Some of the reasons provided included:

“Generally speaking, it is not raised as an issue.”

“Doctor patient relationship is not really privileged, but the lawyer and client are.”

“Once you win on ‘likely relevance,’ than the privacy issues becomes irrelevant.”

Five percent couldn’t recall.

11. Have you any experience with the use of health records as hearsay, using for instance the principled approach to hearsay?

Sixty-two percent have had experience with the use of health records as hearsay, 38% have not. A number of lawyers emphasized that *“health records are hearsay. We can file them without the record maker.”*

Others provided the following comments:

“Hearsay rule has been watered down so much.”

“It is very different in criminal and civil matters. It is less strict in family law and child apprehension.”

“If a patient complains of domestic violence, the doctor will tell the court what the patient said to them and that is hearsay. So whether or not a defense lawyer could have a whole record thrown out because of hearsay evidence is hard to say but it could happen. So that’s always a possibility.”

12. What are the risks/benefits of the use of health records in cases that you are familiar with?

The majority of respondents identified both risks and benefits in using health records in cases with which they are most familiar.

Risks were described in the following manner:

“Huge risks because the record maker uses a ‘group lens,’ e.g., an Aboriginal biased perspective when making records.”

“One’s private life is out in public view.”

“Open yourself to scrutiny.”

“The risk is that something that is relevant will not be disclosed – it will be kept from the court.”

“Emotionally risky for the client. I tell them that they will have a sense of lying down naked and being poked and prodded. There is also a serious risk of misinterpreting what is in the health records.”

“They can be used to show the weakness of a client, used against them to take away children.”

“Client is caught lying or differing in their recollection of events between what they say and what the doctor says.”

“It’s like any other evidence – it can be used a weapon.”

“They are more risky than beneficial. It kicks down a whole door and opens up an entire world. It includes all the presumptions and stereotypes of women and health from a medical model/male model.”

Benefits included the following comments:

“The court is entitled to know everything, all information.”

“Generally, it helps to get to the truth of what happened.”

“It substantiates a claim or complaint.”

“Supports the case of long-standing nature of abuse.”

“It brings in hard evidence for injuries and then the defense has to come up with reasons for why these injuries occurred other than what the woman has said. If

we have pictures of visible injuries, medical records plus a woman's statement then the case is much stronger, and can give you the edge to win."

"In spousal abuse cases, it is very rare for an abuser to say 'yes – that's what I did.' It is common to be abusive at home and not display this side in public. They are important tools for women to prove themselves."

Overall, however, 46% found that benefits outweighed the risks, whereas conversely, 33% reported that risks outweighed benefits: *"It is always a risk. If you can avoid it – please do."*

Twenty-one percent did not make any assessment of the balance between the two: *"It can go either way in allegations of abuse,"* and *"It is a double-edged sword."*

13. Do you have any comments or advice to makers of health care records to maximize their usefulness for health care purposes but minimize their harmful use in legal proceedings?

The advice offered by legal professionals included making clear to health professionals that they should not assume privilege – that counselling and therapy for instance are not covered by privilege. Doctors also need to be aware that records could be subpoenaed at any time and, as one respondent explained, *"Doctors have to realize that we live in a litigious world and not blame the clients when they need/want to use their records."* At the same time, most of the legal professionals emphasized that medical care – not possible litigation – should be paramount because health is more important than the law:

"I'm not so cynical to think they should record in a particular way because of litigation. Their responsibility is to help patients – that is their first priority."

"Do not look at making records from the point of view of making legal records but for their primary purpose and let the legal profession look after itself. If those records are accurate and you can recount accurately then let the 'chips fall where they may.'"

Overall, their advice to health professionals could be categorized as follows:

Writing in health records should be more legible.

"Doctors should write legibly."

"You can't read most doctors' handwritings."

When recording information, stick to medical facts and keep other things out.

“The less written down the better.”

“Just write down the facts.”

“Accuracy and brevity are important.”

“Better to leave relevant information out than to put prejudicial material in.”

This also included advice specific to counselling records:

“In counselling or psychologist/psychiatrist notes – no damning or cryptic comments about client.”

“In terms of psychological records – fair amount of minimalism would go towards protecting the patient/therapist relationship. One should keep privilege in a therapeutic relationship.”

Several lawyers also identified specifically the kinds of information that should be excluded:

“Keep out personal detail and make it less effusive, less subjective. Keep negative comments out of the record.”

“I think that makers of records need to keep certain things out of records like experimental behaviour such as drinking and drugs.”

“Avoid opinions, comments that can be perceived to be fact when they are merely ‘thoughts’ on an issue. Doctors don’t always remember what they ‘thought.’”

“Avoid pejorative or judgmental languages, avoid own speculation because you won’t remember – did the patient tell me this or did I think this. Avoid direct quotes.”

“My concern is that comments and conclusions are drawn without proper basis – record makers need to examine their own ethnocentricity.”

Provide more detail:

“Records should explain specifically what the injuries were.”

“It would help if there were some more detail instead of one-word or three-word comments.”

“If there is something about abuse allegations, make it complete not cryptic. This causes misinterpretation.”

“E.g., drawings, photos, sizes, dimensions or bruises, etc.”

“I am not a fan of minimalism. It hurts more than it helps.”

“Don’t just say ‘client depressed and thinking about leaving kids and husband.’ This could be easily used against her in a custody battle as it gives no context as to why she is thinking of leaving, why she is depressed. Make notes – patient concerns regarding violence.”

Use consistent recording style:

“There is value to standardizing procedures and using consistency when you make records.”

Use simple and clear language:

“Make use of more colloquial words so that the layperson can understand what the injuries were. When showing to the judge, they would understand what they injury was.”

“Don’t use medical shorthand. Write so that anyone could understand the notes.”

Educate health professionals around health records:

“There needs to be workshops for health professionals on how to keep records, how to deliver to courts and how to be cross-examined.”

“There is a need to educate medical practitioners about reports.”

Ask more questions:

“Doctors should ask more questions about what is going on, e.g., If a woman is telling 10 different stories about how she is getting hurt.”

“Thorough canvassing of suspicious injuries.”

“Doctors should take a more proactive approach to sign of violence – ask the patient.”

Question the release:

“Doctors should be aware that they can question the release. A lot of doctors don’t question the release, they just send off the whole record. I’ve never had a doctor question me, they just give me what I ask for.”

Other lawyers had this to say in terms of advice/comments:

“It is not the role of the doctor to be an advocate. It is to assist the client with health. They are not advocates – this is the role of the lawyers. Some doctors don’t reveal records. It is not their place to stonewall the process.”

“Doctors are notorious for not wanting to give evidence – they don’t like to substantiate or defend diagnosis.”

“They know what they are up to – it’s a matter of ethics and professionalism, standards that have to be met. Those who say – I don’t make records, I don’t know, or lie – they are despicable.”

14. Are you aware of any distinctive risks/benefits involved in the use of health records in cases involving violence against women in relationships?

In terms of distinctive risks and benefits in cases involving violence against women in relationships, legal professionals had the following to say:

Records can undermine women’s experiences of violence:

“At times, records may be overstated in their importance vs. the woman stating what happened herself.”

“If a woman is a making claim that there is violence but there is no evidence, courts will discount it.”

“If we can’t get the record, it doesn’t help.”

“When the client has lied to her doctor [to protect the abuser] then records can undermine her credibility.”

“Any inconsistencies in record – nothing but downside for person recounting their experience.”

“History is not medical information and should not be part of medical records.”

“The use of medical/social history should be tightened – protect against former relationships being brought up.”

“Having a clear insight into what women think is a tool, ammunition for abuser.”

“Problems arise when assailant has records in possession prior to legal action. Then there is no protection.”

Records are necessary to prove violence:

“You need more than just her word against his.”

“Medical records help avoid the he said/she said scenario. Medical report adds objectivity.”

Records are necessary for justice:

“You give me records – I am not out there to embarrass or humiliate. I am there to get to the truth. Health records have assisted me – any injustices as I perceive them well, the system does this, not the records.”

“My personal view is if you are making an incredibly serious allegation you would have to produce medical evidence to substantiate your story. Allegations are devastating on families and on children. There is often a tendency to exaggerate or not tell the truth. The benefits are that these records can assist in the truth, can determine the truth.”

Doctors need to recognize the role they are playing:

“Accuracy is important. If a woman says, my husband got angry and did ‘v’ then the ‘v’ needs to be recorded accurately.”

“Mom goes to the doctor because she is getting beat up. Doctor makes notations and records come back to haunt her. He questions her mental stability because she doesn’t leave and stay out of the relationship. There is not an understanding of the dynamic of violence against women. The doctor sees the woman as ‘lacking’ in parental and personal capacities.”

“Relevance” needs better perimeters:

“Who is judge of relevance? Judges need to take seriously the balancing act.”

One legal professional also pointed out that there are contradictory goals/objectives in terms of records for health professionals and lawyers:

“Objective truth is of little relevance when you are treating someone suffering from a psychiatric disorder. It is the patient’s truth that is important. It matters that you believe you were assaulted. The court system only cares – did it happen or not – [about] objective reality. So we have conflicting objectives and conflicting rights. But we as a society put a premium on not imprisoning the innocent.”

2. Health professionals data analysis

Demographic information:

Fifteen nurses, 15 physicians and one health records manager were interviewed. Twenty-six respondents were female, five were male. Their ages ranged from 29 to 56. Slightly more than one-third represented rural settings. Four respondents identified themselves as Aboriginal, five were immigrant and visible minority, and 22 respondents interviewed identified themselves as Caucasian

1. For what different purposes do you keep health records?

There was consensus among health care respondents about the primary purposes of making and keeping health records. The purposes include: ensuring continuity of care from visit to visit, including diagnoses and treatment, tracking progress or changes in health conditions, sharing information with colleagues, documenting the relationships between the patient and the provider, protecting against legal liability, and maintaining quality assurance. The respondents explained:

“It’s a way to monitor natural course across lifespan and life events, and trajectory of diseases.”

“It’s a method of communicating among a health care team for continuity of care.”

“Now, people see [health records] as a way to protect themselves. This is a change in the past 5 or 6 years...covering self legally...It started because people were being called into court more often, records were being subpoenaed.”

“The system itself is more open. Records are going to standards of care and audit committees for review.”

Records are also kept for patients as a record of accountability – to determine if the care they received was appropriate. Several respondents stated that this is a shift in record keeping that reflects a more open policy for patients to have access to their records.

“Information ‘belongs’ to the patient.”

“The patient can use it to show absence of care or things done.”

In addition to creating records for the purposes of health care, legal liability, and medical accountability, 56% of the respondents identified that health records are kept for legal purposes. These respondents gave consideration to the potential uses of charts beyond their own system or their own health care practice with respect to women patients, and asked themselves, “Who might these records be used by and for what purposes?”

“When I write in a chart I ask myself, ‘How might the records be used in court to substantiate or challenge a woman’s story, what would the implications be if this patient saw her chart, how might these records be used in court?’” (physician)

“If the patient doesn’t want me to keep notes, I won’t. I’m careful to couch terms in case the record is read by someone else.” (psychiatrist)

“I think of these records for advocacy – creating evidence to support her, substantiate her story/claims.” (nurse)

“The assumption is that medical charts only get subpoenaed to find out about medical mismanagement. There’s no focus on women needing the records, or records being used against a patient.” (nurse)

Respondents were aware that their records are sometimes used in legal situations to justify or corroborate claims, such as worker's compensation or vehicle accidents insurance (ICBC). In these cases they identified that they record keeping changes because of an awareness of creating material evidence for court.

2-4. What types of medical information go into a patient’s chart and how do you determine what kind of information you record?

Responses to this question focussed both on the general *content* of the records (what types of notes are contained in the charts), the *quantity* of material in the charts (how much is recorded), and the *quality* of the records (the reliability of the material contained within the records). Responses reflected a range of perspectives about each.

In general, respondents agreed that health care charts could include: physician notes, nursing notes, plan of care, treatments, consultations, lab results, social work and mental health consultation notes, ethnicity, spiritual orientation, family history and social/lifestyle history (employment, marital status, education, leisure, addictions, gambling, other lifestyle issues). Usually a signed consent form from the patient giving permission to share information with other health care practitioners would be in the chart.

Two types of charting frameworks were identified by 67% of respondents. Thirty-three percent did not refer to any particular charting framework. The frameworks frequently cited were Focussed Charting (structured charting of variances from the expected norm) or SOAP (subjective, objective, assessment, and plan) to record medical data, assessment, and actions taken or recommended.

“Charting should be descriptive – what you did, what was the effect, action, plan. This can then include the woman’s social context and situation and her input. A tick box can’t reflect the relationship between the woman and nurse.” (nurse)

“Charting is idiosyncratic. Although most of us use SOAP as a framework, and have received some education, there are so many decisions made about what goes onto a chart and what doesn’t. That’s left to clinical judgement.” (physician)

Respondents had differing views about how much information to record in a chart.

“I keep scant records because research has shown that family physicians are reluctant to read notes if they are more than one page long.” (psychiatrist)

“I want to ensure that the patient’s record is boring – what mode of therapy I’ve used, the drugs prescribed, etc. Also, because it’s typed, it’s easy to read and interpret. There’s no ambiguity.” (psychiatrist)

“I see lots of patients, so it’s imperative that I write stuff down. Lots of docs only write on the non-fee-for-service patients because there’s more time. Record keeping is more economically-driven than concern for confidentiality or safety.” (physician)

“Physicians never record everything! It just depends on what I think is medically relevant.” (physician)

“While training in psychiatry is to take a complete history and record that, in reality there isn’t any conceivable way to do that. One impediment is time and the other is that in recording you are always making selective choices. That kind of history is very much biased by one’s theoretical perspective. It guides the kinds of questions asked, what kind of responses are recorded and how they are interpreted.” (psychiatrist)

Forty percent of respondents stated that they considered the patient’s requests when deciding how much information to put in the notes.

“Hospital notes are more extensive because I am communicating with other staff. My own office notes have the least information. I am told many things by my patients that I don’t put in the chart. In the event that material might be subpoenaed I don’t want that information misinterpreted and used against my client. In mental health, I’ve seen this happen far too often, especially in a small town.” (psychiatrist)

“Unless a woman says, ‘don’t write that down,’ I write it down.” (physician)

“I used to chart everything I could. I never checked with a woman about any of this. Now I see that that dishonoured her and also my own principles. I focus on her now, ‘what can I do with her and only her, what can I expect of her and can she follow through.’” (nurse)

All respondents spoke about recording information based on what they considered relevant and these views varied significantly.

“It’s only medically relevant when you can do something about it. For example, if a woman comes in tearful, I assess for depression. If there are organic symptoms, I treat with anti-depressants – I do something. If it’s situational, I might talk to her about some support options, but it’s not medically relevant because I didn’t treat it.” (physician)

“We need to spell out why we are documenting anything social. It’s such a habit among professionals to write things like ‘family stress’ or ‘doesn’t appear to be coping’ without questioning the relevance. We need to keep talking to women about their social lives to increase awareness, but most of this shouldn’t be on the charts.” (nurse)

“What you take for a medical history and what you write are two different issues. For example, in the case of a sexual assault, you might need to know when her last period was, if she is on birth control, any allergies – these are all medically relevant. But when we write a legal report, these are not relevant and shouldn’t be on a legal report.” (physician)

“Health and legal don’t have same measure of relevance, e.g., A bruise that goes away is medically irrelevant or an incidental finding that wouldn’t be charted, but if it’s caused by an assault or accident, it may be legally relevant.” (physician)

“For a woman being beaten up, she’s seen as a mental health patient and the violence is irrelevant. In my experience that crucial fact is ignored by doctors and lawyers.” (nurse)

“There is constant tension between decision-making about relevance versus communication versus the rights of the woman. My own orientation is that the choice for the woman is paramount so I check with her about what’s in the chart, care plans, who else will see the information.” (nurse)

All health care respondents stated that their records should reflect objective information, but, like relevance, what constituted “objectivity” varied widely. For example, some felt that verbatim quotes were objective while others stated that direct patient quotes were subjective. Sixteen percent of respondents observed that verbatim quotes were used against women or served no purpose. Forty percent of respondents explained the difficulties in recording verbatim quotes accurately while 60% felt that verbatim quotes were a useful way of recording data.

“Sometimes we revert to writing verbatim statements from the patient because we don’t know how to interpret what they’re saying. I have written things that the patient has told me and I disagree with, but wrote it the way she said.” (nurse)

“I’m careful to record what a patient tells me but not to write it as if it were a fact, only my observation.” (physician)

“I try to quote people as much as possible.” (psychiatrist)

“There is a valid concern about accuracy. When I was teaching at the university we did training with medical students where they tape recorded a session, then wrote notes and compared them with the tape. They were given lots of time, which isn’t the norm in the real world, and still there was a lot of discrepancy between the tape recorded version and the notes.” (psychiatrist)

Seventy-six percent of respondents expressed skepticism about how objective records really are, despite the ability to record some medical information objectively.

“Assessments of behaviour can be far-ranging and not objective, but when they are written by a professional, they appear objective. Differences in values and training among health care professionals leads to different assessments.” (mental health nurse)

“We’re all trained to work with symptoms, but we’re not trained to respond or cope with psycho-social issues. How do we trust records if professional judgement isn’t consistent? It may appear to be based on objective data – symptoms – but it isn’t really.” (physician)

“Inference and speculation on the chart may appear as fact or objective, e.g., obese vs. 20% over ideal body weight. These claims are junk science but they sound like facts.” (physician)

“For example, I wouldn’t write down that a woman thinks she created the break-up of her relationship because of her substance use. I would use a fuller analysis of the problem because I think I have had an opportunity to understand the context of her addictions.” (physician)

“Objectivity is a myth in people but not in charts. If you write ‘A drunk guy hit her from behind at a red light’ and it turns out that he wasn’t drunk or wasn’t a red light, the patient can look like a liar and I can look like an idiot. You can only write that the patient has a strained this and a pulled that and was treated for it and not worry about the legal interpretations.” (physician)

“The assumption is that no matter who a woman was examined by, the same facts would be written. It would be the same record. In fact, this is true for many medical conditions, but not when it comes to assessments that involve psycho-social dimensions of a person. Then it’s really a convergence of our own values, experience and a little training in some cases.” (physician)

“We have training on Focussed Charting, a documentation framework that describes variances - tick box. For quality charting a tick box doesn't give room for interpretation of data, or provide opportunities to describe the woman's context. So it helps to record medical information, but social documentation is missing. For example, we might tick off that there is a variance in her 'adaptation to motherhood' in postpartum and that sounds like it's evidence-based, but really, it's a thinly veiled judgement of what 'bonding' should look like according to a white, middle-class standard.” (nurse)

“The issue is what is missed as much as what's in the chart. We don't connect the dots. See something that's not expected, but we don't investigate. When we do investigate issues, we find ways to prove our assumptions. It's like the petals of a flower – the issue is in the middle but the petals get charted.” (nurse)

“You have to steer an objective path in this profession. I just keep objective records and hope I never need them in a legal dispute.”

“Health records get credibility through the guise of objectivity.” (physician)

Credibility – of both female patients and female record keepers – was linked to discussions of objectivity. Forty percent of respondents expressed that they were concerned about the gendered assumptions on this issue.

“Women are not seen as credible if they have a mental health diagnosis. This is often enough evidence for them to lose their children, and often these diagnoses aren't objective – they're based on values and assumptions.” (physician)

“I would write 'patient states that...' I never write 'patient claims or alleges...' because it sounds like I don't believe her.” (physician)

“I wasn't seen as credible because I wasn't 'objective.' I'm an advocate for my patients, and that meant that my credibility could be challenged.” (physician)

“I was an expert witness on some of these cases. Then my own history of abuse was brought into court, and my credibility was challenged. It's a reflection of how easily one's credibility can be undermined in the legal context.” (nurse)

5. Have you ever received any education/training in how to document health records?

Forty-three percent of health care providers stated that they had received formal education during training or received information about new modes of documenting through training at the hospital. Thirty-three percent of respondents pursued training on forensic documentation as part of their continuing education.

“Our hospital provides some training, but it's still ad hoc.” (nurse)

“Occasionally, there are letters from the College providing guidelines about documentation, but nothing consistent.” (physician)

“Psychiatrists are trained in record keeping, but typically not very good training. There is a tendency to collect a lot of irrelevant information that is either interpretive or theoretical. One’s theoretical perspective guides what kind of questions are asked and what responses are recorded and how they are interpreted. This determines what I record.” (physician)

“We get no education on forensic documentation. We have no training on legal issues – may be two hours on legal documentation. In mental health we’re often asked to be expert witnesses, or provide medical reports in legal proceedings – it’s not fair.” (nurse)

“Training in health care follows what’s happening in the legal system by a few years.” (physician)

“There was nothing in med school except the assessment, physical exam, the pattern of dictation. It’s different now because students are more trained with respect to legal fears. Now med schools have lawyers come in to train med students.” (physician)

“Doctors are trained to record in a way that covers them legally.” (physician)

“I did a six week forensic training course and part of that dealt with writing reports for court. I also have done lots of Mental Health Act training, at least one day a year over the past 10 years.” (nurse)

“What’s drilled into us at school is the legalities of practice – that’s a main purpose for documenting. But all respondents felt that they weren’t taught how to document for legal purposes, just emphasized that they needed to document for liability issues.” (nurse)

“Most of my training was done during my practicum. The instructor would review all our charting and assessed the charting. There was lots of guidance from preceptors and instructors. The supervisor would ask if the notes were too judgmental or not enough information, etc.” (nurse)

“I was once told by an instructor, ‘don’t ever put down on paper that which you wouldn’t be comfortable with reading aloud while sitting to the left of a judge.’” (physician)

Thirty-three percent of respondents had sought out training related to documenting sexual assault and /or relationship abuse.

“I’ve attended two violence against women conferences, so I know more about it. But that’s because it’s of interest to me, and I seek out professional development on this.” (physician)

“None before working in the Sexual Assault Service. I have become a lot more educated since joining SAS.” (physician)

“It’s not in any guidelines, but I know that lots of time, in my judgement and the desire of my patient is to not document. It’s the interactions that must be safe and respectful and that must be most important. This is clinical judgement and I guess you can teach some of the basic premises of safe care, but a lot depends on the physician to be sensitive. I sure didn’t learn that in med school.” (physician)

“At the time, I thought med school training was adequate. Once I got into practice, I saw lots of habits become ingrained. You start to unlearn good habits to be quicker. I gained the most useful knowledge through a women’s health and violence conference in Vancouver two years ago.” (physician)

6. When you suspect that a woman is experiencing violence or when a patient has disclosed abuse, does this affect in any way the kind of information you record?

Seventy-six percent of respondents answered affirmatively, stating that knowledge or concern about a woman in an abusive relationship would affect the kind of information they recorded.

“If there are injuries and she told me they were caused by her partner, I would record the injuries carefully and record verbatim her statements about who caused the injuries.” (physician)

“The woman is generally there because she wants the doctor to bear witness to the injuries. I would measure the bruises and describe the situation. I know that record could be used to corroborate her report to the police.” (physician)

“Knowing about abuse shouldn’t change our charting but it probably does. If I know a chart could be subpoenaed, I’m a little more careful about what I put down.” (physician)

“For one thing, I’m careful not to go into graphic details unless it might be helpful to her.” (nurse)

“No, except I will ask if she wants me to put it down. I will put down facts about what happened, and may write down her response to the event, how she’s feeling.” (physician)

Respondents also addressed the subject of how much to record specifically related to violence against women. Only 23% of health care respondents stated that they document everything – the remaining gave consideration to a number of factors before documenting woman abuse. Forty-six percent explicitly stated that they write as little as possible.

“I’m careful to record, but not in much detail. I don’t want my notes to conflict with what the patient says in court. I might write ‘patient reports she was assaulted by husband multiple times’ and leave it at that.” (nurse)

“People have no idea the impact their notes will have in court. I’ve seen terrible consequences for women for documenting too much. I keep my short and to the point, avoiding labels and judgements.” (psychiatrist)

“If a woman discloses abuse, I try to find out if she’s safe, discuss options and give her referrals. I document all of that enthusiastically unless she said she was really scared and didn’t want me to write anything.” (physician)

“If there are injuries, we write lots. But we tend to be less detailed about other facts relating to the abuse – secondary issues like depression, medication, etc.” (physician)

Obtaining consent from the patient – the subject matter of the records – to record information about abuse was a practice that 56% of health care providers followed. An additional 23% write as if the patient were going to see her record. Twenty percent offered no comments about obtaining consent to document.

“I pay more attention to how I write, as if she was going to see the record. On the other hand, in these cases, I have less time to write because I’m usually dealing with the immediacy of her situation and her safety.” (physician)

“If a woman tells me about abuse, I would be double-checking myself about documenting. I’d check everything with her on the chart. I’ve seen how health care has been affected by these kind of disclosures. Before I thought I would have been helpful to chart. My interpretation could be completely inaccurate. The same observation can have many interpretations ‘partner supportive, present throughout labour’ vs ‘partner hovering, making decisions, interfering with a woman’s health care.’” (nurse)

“Speaking as a physician, the power dynamics inherent in the medical model will disenfranchise the disenfranchised. It’s a mind set of control – I wasn’t quite so imbued with this from the university training I got, but still isn’t nearly progressive enough. We have to deeply examine our motivation – is it to control or to facilitate our patients’ autonomy? My role is to facilitate, and part of that is having the consent for documenting abuse.” (physician)

“In domestic violence I ask whether she wants it recorded. One woman asked me to write it down and I have done that. She did that because she feels safer that I know and she told her husband that she disclosed to me.” (physician)

Recording information about woman abuse was described as a complex issue by over 75% of respondents. To illustrate the complexity, respondents offered a number of scenarios that highlighted the potential contradictions or conflicts between the interests of the health care providers, lawyers, and women – the subject matter of the records. These scenarios include: the record is silent on the subject of woman abuse; the record is inconsistent on the subject of woman abuse; the record contains (mis)interpretations of woman abuse; and/or the record keeper is aware of the dynamics of woman abuse.

The record is silent on the subject of woman abuse:

“Charting doesn’t affect violence against women cases because it doesn’t present as violence against women in relationships. Therefore, most of the records that go to court won’t have been kept for the purposes of documenting violence against women by a partner. That can be good because it doesn’t show a bias, but then, we probably make lots of assumptions that are wrong because we don’t have the full picture. Then our notes can be misinterpreted, first by us and then by the courts.” (physician)

“We trust the patient. We try to create an environment of trust and openness. She may still choose not to share information and we respect that. Nothing would appear in our records, especially not speculation about abuse without a discussion with her.”

“I find the WAST screening tool for domestic violence ineffective, even though I was part of the SOGC committee that encouraged its use. The information shouldn’t be on the charts. I had a patient who was very sick and her husband refused to bring her for treatment. By the time she got to hospital, she needed two litres of blood. He’s never hit her, but he almost killed her. It would have been documented that he wasn’t abusive if we relied on women answering those questions.” (physician)

“Lawyers believe that medical records are written for medical reasons not for legal purposes. That means sometimes that bruises are truly not medically relevant because it probably doesn’t require any treatment. If it’s strained, sprained, broken – it doesn’t matter. It needs an intervention and that would be recorded. If I don’t know it’s from an assault, and I probably don’t, I wouldn’t record anything. But if I ask her if the bruises are from an assault and she says no I might not record anything.”

“The only protocol we have in our hospital is to ask a woman if she wants police involvement. Otherwise nothing else changes.” (nurse)

“I don’t think so. The patient has a disease or condition – that always gets recorded. Just the factual stuff. Knowing about her home situation may change how I interact with a patient, but not what I record.” (physician)

“It’s a dilemma. I want to call a spade a spade, and not make veiled illusions about the abuse. On the other hand, you can’t be sure it won’t be used against them, either by their husband, who often has access to our therapy notes if their children are receiving therapy, or by the courts.” (psychiatrist)

“If she told me about past abuse, I wouldn’t write that down.” (physician)

The record is inconsistent on the subject of woman abuse:

“Really, I’ve never seen a woman who doesn’t recant her story and then later says ‘I wish it hadn’t happened.’ This really jeopardizes her credibility because recanting is misinterpreted.” (nurse)

“Noting that a spontaneous disclosure was given adds to believability in cases of sexual abuse, but delayed disclosures are seen as problematic from a legal perspective. It’s not appropriately interpreted. Women don’t just come in and disclose abuse. It takes time to develop a therapeutic relationship for those disclosures. Yet courts will challenge women on why they didn’t tell anyone about the abuse when it occurred. This compromises the disclosure, and because I work with women in the mental health system, the credibility of an abuse disclosure is questioned even more.” (psychiatric nurse)

“If a woman doesn’t disclose, I usually ask questions about abuse. If she denies the abuse, I would note that I asked and her response was ‘no’ and sometimes put in a note that I suspect domestic violence.” (physician)

The record contains (mis)interpretations of woman abuse:

“There is dangerous practice in mental health. Once a diagnosis is made, it colours professional perception. It’s hard to ignore the label – even 50 years later! No question, it’s an incontrovertible fact. The diagnosis becomes the seed for all further diagnoses. For example, a woman being beaten up is often seen as a mental health problem rather than domestic violence.” (nurse)

“It’s a problem, medicalizing social problems. For example, a diagnosis from the DSM appears as fact and then verified and then everything is interpreted from this. Of course women get depressed when they get abused. Most women are on tons of anti-depressants which don’t help their functioning.” (psychiatrist)

“MDs just don’t realize anything else is going on. Then conclusions or inferences are made, drawing on the fact that she’s on medications. I’ve seen women come to me saying they had delusional disorder, and they’ve been terrorized by an

abusive husband. She's been made to think she's nuts by her husband and by her psychiatrist." (psychiatrist)

"There's the issue of content. Of course you would record injuries and leave it to the woman to say whether she wanted the cause of the injuries recorded. But my worry is the characterization of women – interpretations of demeanour, medications, mental illness, substance use, social history, compliance – these judgements are always found in charts, and even more so in cases of woman abuse. These are women with multiple problems because of the abuse." (nurse)

"You're damned if you do, damned if you don't. If I write 'woman reports pain, gave tylenol,' 'next visit, still complaining of pain,' the physician notes could say, 'I question the presence of pain' or 'she's med-seeking.' But it could also say 'chronic and persistent pain due to ongoing abuse by partner.' Now, you'd think that would be more helpful, but then defense could ask, 'If it was such a problem, why did she stay?'" (physician)

"In a sexual assault, I wouldn't chart demeanor or presentation because I wouldn't want it to be misinterpreted. But documenting visits for domestic violence is different because often it isn't known so I might make notes on her presentation or demeanor. To me, it would be part of the assessment puzzle, but I usually wouldn't be considering domestic violence as the problem. I guess that's a problem." (physician)

"If a nurse thinks it's domestic violence, she's bound to write 'query domestic violence' in the notes. This makes it so it's not inference or evidence-based." (physician)

"I have trouble seeing how recording her injuries could hurt her. It could hurt her more by the stereotypes of what proper women should and shouldn't do. Like having an abortion, or staying with an abusive partner. That's more likely to get used against her than the actual record of assault." (physician)

The record keeper is aware of the dynamics of woman abuse:

"For me, any history of previous trauma is relevant to the care I give to a woman. It affects her health, her ability to follow medical advice, the health outcomes and overall experience of her health care. If she's fearful or mistrusting, that is the first issue for me, but that's not everyone's approach. Some would say that this is completely irrelevant. But, this information needs to be handled and charted carefully – legally, there is no such thing as confidential and women need to know this." (nurse)

"I know what is medically relevant in prenatal care and in my office practice and there would be a fair amount of agreement among doctors about this, even though we might record it differently. With relationship abuse, even those of us who are

interested, have attended courses and see patients who are suffering abuse, I really don't know what to record. There is a lot that is medically relevant, but should we always be identifying the cause as the abuse? I don't know." (physician)

"I really try to avoid any judgements. If I make a statement about her emotional state, like calm, distant or distracted I would be very careful to attach it to a context or a cause. Instead of saying she was coping, I would say, 'She is visiting with friend and has lots of support.' It may be minor, but it really changes our view of the woman depending on how we record our observations." (nurse)

The scenarios described above reflect the broad range of approaches to documenting, or not documenting, information about woman abuse. Understanding the diversity of record keeping can assist lawyers to evaluate the reliability of health records with respect to cases of violence against women.

7. Do you distinguish between violence against women in relationships and violence outside relationships in your record keeping?

Forty-three percent of health care respondents answered "no" to this question while 37% responded that their record keeping changed. A smaller number of respondents explained that it depended on what they were told (14%), and 6% stated that they didn't know.

"Only that if she says who the assaulter is and wants it written down, I will do so." (nurse)

"In sexual assault cases, the records are very complete, thorough, they go through the history and the examination in a very step-by-step way. In domestic violence, there is no process like in rape. This documentation is very normal and it varies from practitioner to practitioner. Certain doctors are always better at documentation. Some are very sketchy." (physician)

"I pay particular attention in DV cases because I'm more concerned for the women when I know the abuse is ongoing and not a random, one-time act. But this doesn't change my record keeping." (physician)

"If she's being assaulted by her husband, we want to know that so we have some idea of the risks. We'll be asking and documenting that." (physician)

8. What is your understanding of how health records documenting violence against women in relationships may be used by the legal system or elsewhere?

Approximately one-third (33%) of respondents identified that they understood health records could be used to help women in legal cases of abuse by documenting injuries or verifying her reports of the abuse. The remainder (76%) felt records were more harmful than helpful for women because they can manipulate reality or discredit the woman's

story. The responses were often mixed, with respondents hoping that their records could be helpful, but fearful that they would be used against her.

Helpful (33%):

“Charts are used to provide verification of what really happened. They need to show that the story didn’t change from the time when a patient was first treated to when she went to court. It shows a history of abuse.” (physician)

“Lawyers rarely want the entire file. They only want the part of it relating to the DV injury or accident. I go through it to make sure it’s appropriate.” (health records manager)

“She may use her health records to prove that she disclosed to a health practitioner.” (physician)

“Sometimes it’s used to verify woman’s facts or to find discrepancies between her story and mine. So vague, only need important things for medical treatment. Don’t need to know or record details.” (physician)

Harmful (76 %):

“I’d assume that if records would be used, it would depend on whether the lawyer was acting on behalf of the victim or the abuser. They’ll use records to suit their purposes. They can use the records to discredit women in a custody and access case for example. Records are often used in a bad way.” (physician)

“They can subpoena anything they want. Whatever’s written can go against her. Charts can be manipulated for anyone’s purpose. I could write that a woman is trying to get out of her relationship and is living in poverty. A ministry [child protection] lawyer could twist this into putting the child at risk in their living conditions rather than protecting the child from an abusive partner.” (physician)

“My understanding is if a woman decides she wants to press charges, they pick apart every single word you put down, or didn’t put down. My experience is that record keeping in any court situation is always inadequate. I don’t think you could ever write enough.” (nurse)

“I wouldn’t have thought about this a whole lot until recently. Now it will be part of my thought process in creating records if she has to go to court.”(nurse)

“We’ve never had a bad experience that we know of... The fear is to not make judgements about a person or of their past history, i.e., drug use or mental health issues – this can end up harming women and making them look bad in their chart.” (physician)

“The last thing people want in their charts are words like ‘prickly,’ ‘angry,’ or ‘uncooperative.’ So I might write ‘stress in relationship’ in order to contextualize her behaviour. Now that I’m thinking about it, that’s probably not helpful, and may be harmful to her.” (physician)

“Medical charts totally influence child protection/apprehension, not just against women in violent relationships. Like mental health issues, these can be used against women and they are, in health care and legal.” (nurse)

“Child apprehension worries. In sexual assault cases of relationship rape, a woman will be really reluctant to tell because they worry about social work involvement, especially women who have had involvement with systems.” (nurse)

“Judges are not experienced at interpreting medical records. I’m disillusioned with the law. It’s ‘who has the most money and power,’ not justice or safety for women and children. Judges are hoodwinked along with the best of them.” (psychiatrist)

“I see it as abuse and harassment. I am furious at lawyers for what kind of harm they do to women.” (physician)

“If a woman has sustained injuries and we documented that, it may be used to support her, but it can also be used by the other side. But they also want to know her emotional state and that can be used to discredit her. We shouldn’t be ascribing motives to moods or feelings, just facts. This is a concern, especially in court but also in care.” (psychiatrist)

“Credibility is a huge issue in the mental health field as well as the violence field. It’s common for women to change their story or recant, and this can be really damaging. Lawyers have a field day with recanting.” (psychiatrist)

“I believe it’s used against women. Women don’t do well in court. They’re made to go through lots of hoops and not necessarily with good outcomes. I don’t think that caring for abused women is very high on the agenda of the legal system or the medical system.” (physician)

“My records have been challenged. The attempts to discredit my records were because I’m seen as an advocate for my patients. Somehow this isn’t objective, as if other records were.” (Mental health nurse)

9. Have you changed your record keeping practices for any reason over the last five years?

Fifty percent of respondents explained that they have changed their practice as they became aware of violence against women and the legal implications. A number of respondents pointed to the *O'Connor* case as changing the perception and reality of access to personal records. Computer systems have created a less confidential health care environment.

“Our standards get updated every three years. We’ve had conversations [about a recent case] and wondered about whether we’d hold back on writing info because of fear of a subpoena. The case did influence us a little, i.e., we tried to be careful not to put in too much hearsay and we’re more succinct in our notes.” (physician)

“I became aware of issues of violence and legal implications. Medical charts can totally influence child protection, not just with violence against women but also mental health concerns. Any issues can be misinterpreted and used against women – and they are. They are used against women in their care and for legal purposes.” (nurse)

“I look at the way I used to record on the chart and saw the ways I was so punitive in my language. Now, I see every record as subpoenaeable data and everything is open to patients. I’ve changed by language so it’s not punitive. For example, rather than saying ‘vague’ or ‘difficult’ I say ‘short reply.’ Her mental capacity should never be questioned – that’s not our responsibility or right. It’s a major challenge to change how physicians think about their female patients.” (physician)

“We know of Dr. McGregor’s research that showed that cases of sexual assault where injuries are well-documented are more likely to get convictions. There isn’t any similar research for relationship abuse, but we assume that it helps so we try to be very factual and thorough with those cases.” (physician)

“I don’t know if our service has refused to send documents when they’ve been requested. Our [health] service used to fight the release of records, but not anymore.” (psychiatrist)

“It used to be that I would be asked for reports where the doctor gives a professional opinion in context. Now, I’m getting requests for charts that are fishing expeditions. I deplore that practice, and it’s changing how I chart. I write less now, especially anything supratentorial (above the brain).” (physician)

Concerns about not being able to assure confidentiality within a health care context were specifically raised by respondents regarding the use of records in the legal system.

“I have great concern about the computerized record keeping systems. It has many flaws particularly impacting confidentiality. Any professional can now access a patient’s records. Now I shall be putting less information in the records for protection of my patients, and to a smaller extent, my own protection. This compromises the quality of the notes.” (psychiatrist)

“I never tell women the records are confidential. I try to explain the possible uses of them, and make sure women are aware of the contents of the files. Women can have input and make changes in the file. This isn’t usual practice among professionals I don’t think.” (mental health practitioner)

“The problem is taking records out of context. Notes are reminders to physicians, not legal evidence of anything. If a professional has a query, it should be safe for the patient to note this on the chart without considering how it could be used against her in the future.” (physician)

“There is no one to whom a person can go to express concerns and have confidentiality assured. This is very creepy.” (physician)

10. To your knowledge, have your health records ever been requested or subpoenaed in a criminal, civil or administrative tribunal matter? Please elaborate.

Twenty percent stated that they had never had their charts subpoenaed.

“No, my charts didn’t show she’d been abused. If you keep short, brief records, you don’t get involved in lots of hassle. I’m for low stress. Mental health work is high stress so the more I can get through it with the least hassle, the better I can serve my patients.” (psychiatrist)

Ten percent identified that they had charts subpoenaed, but not for violence against women cases.

“My records have often been called into court, but mostly for child protection or access issues related to substance abuse with women.” (psychiatrist)

“I got a piece of paper in the mail with an official stamp on it. It was a writ or something. It didn’t have anything to do with domestic violence. This is how I know that there are rarely convictions, because I’ve never had a request for health records having to do with domestic violence.” (psychiatrist)

The remaining 70% of respondents had charts subpoenaed for cases of violence in relationships, sexual assault, or child abuse.

“My records have been examined by the coroner for a death of a woman in an abusive relationship and also a suicide.” (psychiatrist)

“They were used in a custody battle. The woman’s lawyer asked for them, but they were of no help. She had a lot of health problems and they questioned her ability to parent. I did have records of her statements of the abuse.” (physician)

“My records are fairly regularly called, mostly MVAs and injuries, and some for domestic violence. Not so many with DV because women go to emergency when it’s really bad.” (physician)

“It’s usually the husband who’s requesting them. Not challenging the extent of injuries, he’s challenging that he never did anything. Doctors’ records can’t be used as evidence against these claims. We’re not in the business of creating evidence for or against our patients.” (physician)

“Most lawyers ask for charts on behalf of clients so they can be pre-emptive, not because they’re useful. Even so, it’s better to take the chance and not have charts subpoenaed.” (physician)

“Yes, once in England. It was a custody and access case where the woman had been abused in the relationship. The records were subpoenaed by the husband’s lawyer.” (psychiatrist)

a) How were the records requested from you?

The 21 respondents who had records requested for cases of violence against women identified five main ways that records were requested. These included: police or Crown (25%); women or their lawyers (20%); partner’s lawyer (25%); child protection ministry lawyers (20%); request came through hospital health records (10%).

b) Did you resist disclosing your records?

Fifty-five percent did not resist at all and provided information that was requested. More than half of these respondents felt that they had no option: *“I can’t resist when I get a subpoena,”* and one commented that *“I didn’t resist because I knew it would be a positive outcome for the woman.”*

“Once I got a subpoena and I panicked and sent it off to the other side before I had really read it carefully. Fortunately, it wasn’t related to woman abuse, and I sure learned my lesson.”

Forty-five percent sought consent from the patient before releasing records. One-third of these respondents are part of the sexual assault service and always obtain a patient's consent prior to recording the assault and releasing to police and/or Crown. Examples that respondents provided to illustrate the process of releasing records with women's consent include: "get consent from the woman over the phone;" "go through the charts to pick out 'relevant' parts together with the woman;" "never accept a release by fax;" and "never send out records without a woman's permission." Three respondents said that they released records so that the woman would look cooperative to the courts.

Only 20% actively resisted release of records:

"A lawyer requested my records and I along with three other practitioners had to go before the judge to tell him why our records shouldn't be used. We were all arguing that this was an unwarranted invasion of privacy and would be harmful to our patient." (physician)

"I've seen fishing expeditions to get records. Of course, because we see children in therapy, often both parents are aware of the records – so he can get the records as easily as the woman could. I need to protect both children and women from this abuse of records and I have successfully resisted releasing my records on a number of occasions." (physician)

"If it helps a woman, I would release. But there are definitely times that I have asked my institution to fight the release of records and we have won." (mental health nurse)

c) Were you required to give evidence? Please elaborate.

Seventy percent (21 out of 30) of respondents answered this question. Of those 21, 58% were required to give evidence.

"I appeared one time for an assault case. I called the woman to my office and we went through her file so she could pick out exactly what she wanted released." (physician)

"I went to court and gave details of the sexual assault. I see my role to corroborate a woman's evidence and to support the woman. I only take cases for Crown because I see myself there for the truth and justice." (physician)

"My role is to help the judge find the truth. Our job as expert witnesses is to act like a camera – to focus on the injury and not to add subjective things." (physician)

"Women appreciate that I'm appearing as an advocate, but I see my words twisted and used against the woman." (psychiatrist)

“The testimony is really vital. If you believe the patient, then your records should show this. Don’t ask too much – don’t fact-find because that can get her and me in trouble. I get on the stand and then know too much. You just need to write what you saw and what you did and then report that. You don’t want them to think you’re hiding something, and if you ask too many questions you will be.” (nurse)

“I’ve always gotten out of testifying in court. I tell lawyers I will provide extensive, long dictated notes and I would have nothing to add by appearing in court. That’s always worked.” (physician)

Forty-two percent were not required to give evidence.

“I was subpoenaed by MCFD, and I resisted showing up because I felt I couldn’t add anything that wasn’t in my records and my testifying would harm our therapeutic relationship.” (mental health nurse)

“Got out of it, told them they’d have to pay him to read his affidavit verbatim.” (physician)

d) How do you view your role in appearing in court as third party?

Fifty-two percent (12 out of 23) stated that they saw themselves as advocates for women by appearing in court.

“I’m interested in the safety of children and keeping the confidence of my women patients.” (psychiatrist)

“She’s my patient, my role is to protect their interests, and maintain good health.” (physician)

“It brings you up short. It’s been a variable experience for me and depends a lot on the judge. Half seen through defense lawyers, discrediting women, trying to discredit me as an expert witness, allegations that were not true, but the sexist beliefs about women. It’s very demoralizing and intimidating.” (psychiatrist)

“I’ve testified in custody and access cases as an expert witness. But now, because my views about women’s equality are well-known, I have to tell clients that my testifying is the kiss of death for their case.” (physician)

“I’m an advocate – that’s how I’d be appearing for my patients.” (physician)

A number of respondents felt that they were unprepared for court and could not provide support for women because they did not have the training.

“It’s criminal to call us into court. We have no coaching or sense of what to do.” (nurse)

e) Did you have difficulties in recalling/interpreting your notes?

Fifty-seven percent (17 out of 30) of respondents answered that they did not know if they had difficulties recalling or interpreting their notes. Thirteen percent of respondents answered “no,” and 30% answered “Yes, most of the time.”

“Varies. In most cases no. Most times I’m appearing as an expert witness and I know that I’m being asked to record for purposes of being an expert witness, in which case I’m paid to be damn clear.” (psychiatrist)

“I always go to court with the original records. The forensic report is dictated within 48 hours after the assault, so it’s well-documented.” (physician)

“People have no idea the impact their notes will have in court. I’ve seen terrible consequences for women from writing too much.” (physician)

f) Are you aware of the laws that govern the release of health records?

Thirty-seven percent (11 out of 30) of respondents answered “yes.”

“I think most physicians are aware of the laws, it’s not complicated – they go to nobody unless courts demand.” (physician)

“Ultimately, the medical record is the property of the patient – we only safeguard it.” (physician)

“Depends for what. Anybody can access their own charts – that happens a lot. Criminally, can be subpoenaed and no longer requires patient consent. The gray area is civil stuff. My sense is that the patient must provide release.” (physician)

“I think I have some familiarity with it. You say no to anyone but the patient. The patient owns the information and the physician owns the paper it’s written on.” (physician)

Fifty-seven percent of respondents answered “no,” while 6% answered “not sure.”

“I don’t have a copy of the law. I know there’s no privilege and that I have to release the records if they are requested. I have to show that I’ve been maintaining the records for at least 7 years (by law) or 10 years (College requirements). I’m also aware that the records are mine and that the patient can have a copy but I’m required to keep the original record and their access can be censored.” (physician)

11. If your health records were used in a criminal, civil or administrative tribunal matter, would they be easy to interpret without your presence?

Fifty percent of respondents answered “yes.”

“They’d be very easy to interpret – they’re deliberately made that way. Generally, a file is made up of a series of letters to the GP. There are some hastily scribbled notes, but they are not meant for other people.” (physician)

“For the most part, yes. It depends on penmanship, mood, reaction. If there’s not a lot of jargon, what you see is what you write. Then it should be easy.” (physician)

“I think it would be okay because they are detailed on injuries but there’s not a lot of hearsay included. We outline major issues, treatment, and follow-up.” (physician)

“Yes, the nurses’ notes are quite detailed. It would depend on the woman and her willingness to have the nurse document the abuse. We give our patients as much control as we can – that’s what health care usually takes away from patients. We try to give that back – to empower women to make their own choices.” (physician)

“Yes, I’ve become more clear, concise and I’ve at times edited myself prior to making a permanent record. I’ve thought about things more. It’s been due to wanting to increase a woman’s chance of an improvement in her situation in a legal case, help her in continuity of her care and prevent further victimization.” (nurse)

Twenty percent of respondents answered “no.”

“I always keep in mind that the doctor is going to read my notes, but I don’t think about court so much.” (nurse)

“I have terrible handwriting. Sometimes that protects me. I usually have to get my notes transcribed.” (physician)

“No but they can make all kinds of assumptions. For example, I was seeing a woman on a weekly basis and rather than interpreting that as positive because she was receiving support for the abuse she and her children suffered, they stated ‘this person hasn’t made any progress if you’re still seeing her after three years.’” (psychiatrist)

“Judges aren’t trained to interpret medical information. It’s not enough just to relay what’s in the notes. You have to have a context for the information, and I

don't think it happens accurately. Just like, I read legal decisions and can't interpret it the way lawyers do.” (psychiatrist)

Thirty percent of respondents answered that they were not sure.

“Anyone can misconstrue written notes if you're not present. I've already interpreted the problems and then they will be re-interpreted. That's a lot of interpreting and not a lot of safeguards.” (psychiatrist)

12. If you were required to give evidence, would you foresee any difficulties with recall and interpretation?

Forty-two percent (10 out of 24) answered “yes,” while 58% (14 out of 24) answered “no.”

“Some nurses were taught to document everything. But with focused charting, if there is no change in the patient's condition, then there's not much in the record. For new nurses who have only done focused charting, the first time a legal thing comes up and they have to testify, they are really worried because there's not much in the chart to refer back to.” (nurse)

“I would say in terms of documentation that more is better because as soon as you know there's going to be a court case and nurses and physicians are involved, some of the most common concerns are ‘I know this happened but there should have been more documented.’ It often appears there's a missing link. Especially if the nurse or doctor is liable.” (nurse)

“It's usually so long after the fact that the notes may not be specific enough to trigger your memory.” (physician)

“I've been to court twice – once for domestic violence. They ask things like ‘what did the bruises look like? And how did the patient appear?’ I wasn't expecting that and my notes didn't help.” (physician)

“With a few exceptions, my feeling is that there is never enough information in a record because there is never enough time to write them. I always feel a little inadequate in this regard.” (physician)

13. Do you have any recommendations about the documentation of abuse and/or how those records might get used in legal proceedings?

Consider women's needs:

"Think about possible uses of coercion that could happen – and it could very well happen. Do what the woman wants – it's her only safeguard." (physician)

"Women have no control over the creation of those charts. Why should it be used against her in court?" (physician)

"Charts should be something that women had a part in creating." (physician)

Protocols:

"Use this report to develop protocols. It's a very important, and poorly understood issue." (physician)

"Be as objective as possible. Describe what you see and hear, don't make value judgements or speculate. Describe behaviours. Avoid psychologically loaded words." (nurse)

"Health care providers should resist production." (physician)

"Over and over again I see women who will sign consent to release their medical information assuming that only the relevant parts having to do with the assault of the injuries will be released. This isn't the case. I always tell a woman never to sign a blanket consent form. They need to be aware of what exactly is going to be released and to whom. They also need to be more aware of what's in the records in the first place." (physician)

Training and education:

"There should be more training. There is no place to get experiential training because you can't experiment with vulnerable women." (nurse)

"We need provincial standards and training." (physician)

"Documentation should be part of continuing medical education courses." (physician)

"Testifying in court and writing legal documents isn't taught and it should be." (physician)

Information:

“Family physicians need to be better informed. It would be good to get something written up in the College of Physicians and Surgeons newsletter on domestic violence. Every physician in the province reads that newsletter.” (physician)

“Health care providers need the basics of the legal process – and also need to understand violence against women policy and dynamics.” (nurse)

“People have no idea the impact their notes will have in court. I’ve seen terrible consequences for women from writing too much. They need to know more.” (physician)

“Disseminate this information. Like the material we learned through the Sexual Assault Service, this is really valuable for my practice.” (physician)

“Don’t write abuse unless you actually know. Don’t write ‘suspect’ or ‘alleged’ because women’s credibility is already in jeopardy in the courts.” (nurse)

14. Do you have any final thoughts?

“These are two systems that come up against each other, with two different goals. Health is the restoration of being right with ourselves and our environment and legal is deciding who’s right and wrong. A health document may be a legal document but I use it to help improve health. I want it to convey useful, comprehensive information for the assistance of the person. As a caregiver and a recorder, I want to record the truth – it doesn’t mean it’s all the facts.” (physician)

“I feel 50/50 about whether or not the records should be used in court. I would like there to be enough evidence to make the charges stick in criminal cases but not at the expense of making women look bad or unstable because she has depression or STDs in her record. A chart contains a lot of things – I think that only information relevant to the assault should be released, if anything. Assault should be documented always.” (nurse)

“My relationship with a woman will set the tone for how I report. What you write can come back to haunt you so I try to be objective and just put facts down, but if I know the situation, I try to be sensitive to the woman.” (physician)

“Women’s biggest barrier to accessing care is child apprehension. If women are worried their records are going to be used, they won’t come for care. Threatening to take records out of context revictimizes women.” (physician)

“I am troubled that the legal representation for the people involved is inadequate. In my experience, when there are good lawyers and good judges, then the system works pretty well. My records or my testimony are only as good as the judge.”
(physician)

“I’ve learned over time that as a physician, when you enter a patient-physician relationship, when you support a healing relationship – a non-judgmental therapy is sometimes the only thing you can offer. If you come from a life where you’ve always been put down, it’s not therapeutic to hear that from your doctor as well. Then, so find out that relationship is being made public and used against you – it’s outrageous.” (physician)

3. Women and their advocates data analysis

Demographic information:

Women

Ten women in abusive relationships were interviewed, ranging in age from 33 to 54. Seven women were from urban centres and three were from rural areas of BC. Five women identified themselves as white or Caucasian, two as Canadian, and the other three as each French, Hindu and Metis.

Women were in their abusive relationships for between 8 months and 13 years (mean = 6 years). Two women were in more than one abusive relationship. Women's experiences of abuse included: physical, emotional, verbal, mental, financial, sexual, violence towards pets, abuse in front of children, violence towards children, control in custody and access disputes, legal harassment, criminal harassment, criminal assault, and attempted murder.

For health care related to the abuse, women saw family physicians (88%), emergency room providers (44%), psychiatrists (44%), counsellors (22%), walk-in clinics (10%), alcohol and drug treatment (10%), and dentists (10%).

Women's court cases were criminal (67%), custody and access (44%), child apprehension (10%), small claims (10%), restraining order (10%), divorce (10%), and criminal injury compensation (10%).

Advocates

Twenty advocates participated in the study, with ages ranging from 28 to 59. All of the respondents were women. Ten were from urban settings, nine from rural and one represented both (province-wide). The majority were Caucasian/white, with three Aboriginal women, and two South-Asian women.

For the purposes of presenting this data, the interview guide of the advocates will be used, with the analysis of women survivors' responses embedded within the same framework.

1. What is your position and what do you do?

All of the advocates address women's or First Nations issues as the focus of their work. Violence against women is part or all of the work these women do, in roles that include Violence Against Women in Relationships Coordinator, Stopping the Violence counsellor, Specialized Victim Assistance worker, Aboriginal Victim Assistance worker, transition house support worker, rape crisis centre worker, crisis line counsellor, sexual assault counsellor, and social worker. Around the issue of violence against women, advocates are involved in providing education and training, support groups, accompaniment, advocacy, counselling, court support, assistance with application to criminal injuries compensation, resource referrals, program development and supervision, coordination of community agencies around violence against women, crisis lines, transition shelters, and policy direction.

2. Do you work with clients who have had their health records used in court? How often and what is the nature of their cases?

Although advocates see a great number of women who are, or who have been, in abusive relationships, they seldom see health care records used in criminal proceedings related to violence against women. However, an interesting finding arising from interviews with advocates and survivors was that records are more often used in family court matters. Paradoxically, records containing evidence of injuries resulting from an assault can be used as corroborating evidence, yet advocates report that this rarely occurs.

Advocates and women offered their perspectives on why health records were not used in criminal proceedings. Reasons include: women may decide not to proceed with legal action, the police may decide not to pass a case onto the Crown, or the Crown may decide not to prosecute. Advocates explained:

"It's very seldom [that a woman's case will go to court]. It's quite a process to even happen." (advocate)

"It's usually the discretion of police officers to not pass [a woman's case] onto Crown, based on credibility, witnesses and injuries." (advocate)

"Most [cases] are pled down, though, where the abuser pleads guilty to a lesser charge, usually a Peace Bond." (advocate)

"Crown doesn't see sexual assault against a domestic partner as a risk to the public." (advocate)

In addition, whether a woman's case goes forward may be influenced by issues of race and class:

"First Nations' cases are only investigated to a point, then not forwarded to Crown. Individuals see that and say 'What's the use?'" (advocate)

“One woman was assaulted by her ex-partner, robbed, and stuck with a needle. He was a heroin addict. Because she has a diagnosis of schizophrenia, they say she’s not a credible witness. So, they’re not going ahead with the case. She lives in poverty and it shows, and she’s in recovery. Schizophrenia is the excuse, but all those other things mean it won’t go ahead.”(advocate)

Advocates did report that health records, and what they may or may not contain, can prevent a woman's case from going forward to court:

“Before a record even gets to court, police are making judgements about women [from their charts]. If a woman has a medical history that includes prostitution, drug treatment programs, abortion, or STDs, it can change the way police look at the attack.” (advocate)

“It’s a Catch-22. Women seek medical care after an assault, and get a forensic exam. But, if there’s no forensic evidence because the bruises haven’t shown up yet or the injuries aren’t visible, the police don’t go forward with the case. They take the fact that there’s no forensic evidence as evidence that there was no assault. I’ve actually seen police reports that say ‘no evidence of injury or sperm, so no assault.’”(advocate)

Advocates and survivors provided a number of concrete reasons as to why health records documenting abuse may not exist, or if they do, that they may not accurately reflect women's experiences. These explanations echoed many of the observations made by health care professionals about the unreliable nature of records.

Women avoid disclosing to health care or the legal system, usually out of fear and shame:

“Women are afraid to reveal information, they’re afraid for their safety.” (advocate)

“The woman doesn’t reveal that her partner sexually assaulted her when she goes to the hospital. She’ll tell us two days later at the shelter when she feels safe.” (advocate)

“A woman and her physician don’t always have a relationship that allows her to feel safe enough to tell the truth. The risk of the truth needs to be understood.” (advocate)

This may be further complicated by issues of race and/or culture:

“Some of the younger First Nations women will maybe disclose, because we’ve been working on prevention. But older women think it’s no one’s business. They have problems with the health care system anyway, because of its lack of understanding. They don’t volunteer any information.”(advocate)

Instead of disclosing abuse, they make up other reasons for their injuries:

“I said I fell down the stairs.” (survivor)

Women’s fear of disclosing or getting proper medical attention is often specifically linked to the possibility of their records being used against them in court:

“Fear of telling how bad her situation is for fear of children being apprehended. So, women aren’t getting medical attention because of the fear and not trusting the system. We can’t expect records to help women if we’re silencing them because of the possible impact of telling.” (advocate)

“I don’t think I told her [the doctor] very much because at the time I was afraid she would make me call the police, and I wasn’t ready.” (survivor)

“I don’t feel safe going back to the psych ward. It was used against me. I will never go back.” (survivor)

Issues of age, race, geographic location, and class also are reported as factoring into women's fear of disclosing:

“For marginalized women, the medical system has a history of not supporting women with mental health issues or aboriginal women. Women were institutionalized and shackled. Lots of women won’t go to the hospital, they don’t feel it is a safe place.”(advocate)

“In rural areas, confidentiality is a fear for women. Doctors socialize with others, and women see that. You do hear about work getting out.” (advocate)

“It began while I was in high school. I didn’t feel safe enough at the time to ask for help. You are in so much fear...anything you do becomes suspect, you’re the guilty party.” (survivor)

Health care providers minimize or misunderstand women's experiences of abuse. The resulting documentation is unlikely to reflect women's experiences of abuse accurately, in a way that would support them in court.

“Some doctors really minimize what they’re going through. ‘It’ll get better. If it doesn’t, let me know.’ They give medications and recommend anger counselling for the man.” (advocate)

“The doctor didn’t think much about the strangling.” (survivor)

“They just really don’t want to know.” (survivor)

“Women were telling health professionals before anyone else, or being more up front about what’s wrong. She’s not necessarily calling it abuse, but saying he’s pissed off at her. But the doctor is maybe not reading between the lines, they might say they’ve never seen abuse. It may be seen as a problem between peers. I’ve had doctors tell me they called in a man and gave him heck.” (advocate)

“I was depressed from the abuse in my marriage. I disclosed to my doctor and he made me get blood work to make sure it wasn’t hormonal or thyroid. I was pleading to see a psychiatrist and they wouldn’t refer me. I lived in fear.” (survivor)

“I disclosed to the psychiatrist...When I talked to my psychiatrist he said it was because he [my boyfriend] loved me so much. It was me who was the questionable one. I remember the psychiatrist said there was a home for wayward girls.” (survivor)

“(Speaking of a recent encounter with plastic surgeon, using CIC to repair scar from knife wound from abuse.) “He was extremely rude to me. When I told him that I might be emotional around the surgery because of the connections with the abuse, he said ‘Don’t you come up to my office being emotional. You get some Valium or something and get under control.’” (survivor)

“I spoke to my family doctor about the mental disability arising from the trauma and stress of the abuse. They just don’t get it. If they can’t see it, they don’t think there is anything wrong.” (survivor)

“A young, First Nations woman was sexually assaulted. She went to hospital, the doctor refused to do a physical exam because she had tracks on her harm. He decided the forensic exam wasn’t necessary. She begged him for drugs for STDs and the morning after-pill. He refused. What did those records say?”(advocate)

“I got a call from the hospital that a woman was drunk and needed to go to a transition shelter. She had been beaten up by her son. When I talked to her I found out that she was diabetic and that she needed to go home and get her insulin, but she was scared. The woman hadn’t had a drink for years. What did that nurse write down? I had to advocate to get the doctor to get her a shot [of insulin].” (advocate)

“A First Nations woman hadn’t had an internal exam in 10 years because the doctor didn’t want to touch her. How does that get justified in the charts? The woman was so upset, she wanted me to come to the doctor with her.”(advocate)

“Defense lawyers are trying to prove mental illness and some records are suggestive of that. In this case, he was reporting that she was crazy and coming after him with a knife. There was an injury documented in his records.” (advocate)

“The whole family sees the same physician. The doctor gave all the information to the husband. ‘Suicidal and depressed’ was what was written in the chart. This left out the fact that husband was having an affair and had taken the baby and refused to return the baby. The doctor calls the couple to come in on Monday to talk about things.” (advocate)

“The woman got 30 sleeping pills. Ten days later, went back to get a refill. The husband was the one who had used them. Doctor never questioned her safety or suicide. And it’s on her chart.” (advocate)

“Women can make a statement and it can be interpreted and put in many contexts. They run the risk of judgements and assumptions.” (advocate)

“I was watching what my doctor wrote down the other day, and couldn’t believe it. That’s not what I said. I made him re-write it. If they’re not listening or not understanding, it can change a woman’s file.” (advocate)

“For some women, they trust that the doctor kept records about what she told him about the abuse. Then she gets slapped in the face when there is nothing there, or that she’s ‘histrionic.’ It’s the worst. Women are devastated when they thought something was recorded out there, but it’s not.” (advocate)

“The psych ward seemed supportive and understanding and yet their records didn’t reflect that when a nurse was called to testify.” (advocate)

3. Have you ever had a woman you worked with personally have her records used in court? Did it help/harm her case?

4. In your experience, when women have their records used in court, does it generally help their case or create negative outcomes for them?

As evidenced by the following, where there was an incidence of assault and a resulting physical injury, documentation of the injury can help a complainant.

“Of the cases I’ve seen, one went okay. There was a physical assault, and the doctor did lots of documentation. The offender was convicted.” advocate)

“Emergency Room Admissions that document abuse are used to enhance Crown’s case.” (advocate)

“I don’t agree to just a forensic-based approach, but the nurse-practitioner program in [location], which has a forensic approach to evidence collection, has resulted in an increased number of convictions out there. In forensic kits there is a picture of the human body where health care practitioners can record observations, rather than what they heard the woman say. So, it’s not as subjective and the defense lawyer can’t attack that. The picture is more

compelling as evidence. It is free of personal bias and improves the file.”
(advocate)

“In extreme cases, such as assault, records helped her.” (advocate)

Some stated that the usefulness is dependent solely on the type of record being used:

“It depends on the type of records. In sexual assaults, medical forensic exams tend to support and substantiate story. But mental health records, drug and alcohol counselling records are bad. When records are specifically produced because women are seeking help because of violence against women, those are okay if the author of the records is informed and using guidelines to limit what they write down. But historical, peripheral health records are used in negative ways to discredit women.” (advocate)

However, a substantial number also acknowledged that any kind of record is potentially harmful:

“If no evidence is found through the forensic kit in the hospital, it can undermine a woman’s case.” (advocate)

“In sexual assaults, medical evidence usually does not corroborate force or assault if the perpetrator was the partner. Even if sperm is present, it shows sex, not assault. If the assailant is known to the victim, consent is difficult to prove.”(advocate)

“In cases where women are sexually assaulted by their partners, DNA evidence is not useful because, of course, he is known to her.” (advocate)

“We tracked a file where a woman went to hospital with a broken jaw. The hospital lost her medical records. She wanted Crown to have the records so he would go to jail. She was seen as a troublemaker, raised hell. There was a huge custody and access battle, allegations of sexual assault. The woman was arrested for not appearing in court, so the proceedings were staid. In this case, she believed the records would help her. They didn’t. She lost her kids, and that’s what killed her. Things were not written in, or not written right. The records said ‘hooked on Tylenol 3s.’ RCMP wanted her records. Why? Not to help her.”
(advocate)

“One case going to court now, the woman had serious injuries from a previous assault and had to have a hysterectomy. This second assault created similar injuries. Crown is telling her that the first assault will be brought up and used against her in court because the injuries are so serious.” (advocate)

“Forensic exams are precise, but if a woman instead told her family doctor who wrote down what she said and the injuries, a defense lawyer will ask the doctor, ‘Could these injuries have happened if she walked into a wall?’ and will question the origin of the injury.” (advocate)

“Defense used the inconsistencies between the third party record and the medical record, even though they were very detailed. This was used against the woman and she lost the case.” (advocate)

Where the records are silent about the abuse, it is often taken as evidence that there was no abuse. Questions about the woman's truthfulness are also raised:

“One woman saw a doctor for five years for health reasons related to the abuse, but she didn't tell so there was no health record of it. That was used against her.” (advocate)

“A woman sees a doctor several times, related to the abuse but she didn't tell the physician specifically about the abuse. Then, police are involved and they say, ‘Why didn't you come forward sooner?’ Well, I did go to my physician, she says. The reference to violence by her partner isn't made clear, so the interpretation can be ‘she lied to her physician about not being abused,’ and now she's seen as lying. It affects her credibility. Or a woman tells her physician about abuse, but says ‘I provoked it,’ then in court tells the truth, and this is used as evidence against her.” (advocate)

“Too often, medical records are used to say that nothing happened if there's nothing in them.” (advocate)

“In Criminal Injuries cases, it's asked, ‘Did you get pictures?’ If no, then it's seen as inadequate records.” (advocate)

Another important theme that arose was the point that the impact of abuse is not just physical and that the other non-visible dimensions may not be properly interpreted or documented.

“Women always say that bones and bruises may heal, but emotional abuse will last forever. We're not doing women any justice by treating them as two separate issues.” (advocate)

“They need to understand the mental stuff can be worse than the physical stuff. It's a hundred times more painful. The bruises and stuff, you get over, but it takes a long time to get over the other stuff and they don't really get it.” (survivor)

“Emotional well-being affects physical health. It's a whole person, we need to look at everything.” (advocate)

Records that contain information about the impacts of violence or women trying to cope with the impacts – such as STDs, abortion, counselling, mental diagnoses, prescription medication use, substance use, drug treatment, etc. – are frequently used to discredit women.

“Cases that don’t go well are those where lots of emotional abuse and counselling records are used... You go to counselling to get help and you’re seen as an unfit mother and can lose your children.” (advocate)

“One woman believed she lost custody of her baby because she was on anti-depressants. The baby was a month old. Another woman believed she lost custody because she was being prescribed several medications, so it looked like she had a prescription medicine dependency. This was held against her.” (advocate)

“The partner convinced the doctor to commit a woman to the psych ward. An advocate appealed with the help of the hospital social worker and got the woman to a transition house down south.” (advocate)

“The amount of pills prescribed to abused women is huge. So many Father’s Rights groups are using women’s psych histories to discredit women.” (advocate)

“A Vietnamese woman was admitted to Riverview. The woman was not mentally ill, but the husband interpreted and he had proven that she was mentally ill. He got custody and all the property. The practitioners completely trusted what he had said. Everything was used against her.” (advocate)

“My counselling records were summoned and I went with the record... The spouse was trying to prove that the woman was seeing me because she had suicidal ideation. She thought about suicide, but always did something to prevent herself from following through with it. If the spouse had not been as irresponsible as he had been – he had a criminal record, no job, and used drugs – they would have taken her children away.” (advocate)

“I lost my child in a custody dispute after checking myself into the psych ward. I felt like I was having a nervous breakdown [due to the abuse]... I was in a psych ward for a couple of days then checked myself out. The psychiatrist gave ‘expert’ testimony. He saw me for 45 minutes and he put a report into the court that was used to prove how unstable I was. My family physician said that I was stable and able to care for my children. His testimony was not considered expert and wasn’t taken into court.” (survivor)

“I went to [place] [for drug and alcohol treatment] and had been clean for a year. This was used against me by the courts. The records were mainly used by his lawyer. I agreed to have them released and thought they would help to see how I felt about my children, that I was trying to get help and get my life straight. Instead I was painted as emotional and unstable.” (survivor)

“Women’s histories are often used against them. A woman may be in a drug treatment program, which is an integral part of taking care of herself, but defense lawyers use this, or the fact that a woman had an abortion, against her.”
(advocate)

“There is a huge gap in civil court. Anything and everything gets used against women. It’s often based on health, mental health, and the behavior of women. It doesn’t talk about the impact of victimization, so it continues the cycle of abuse.”
(advocate)

And as one survivor so aptly put it:

“His past doesn’t matter to the courts – like that he killed our pet – but mine was absolutely used to punish me by taking away my children and giving them to him.” (survivor)

Respondents were also clear that while sometimes records can help a woman in criminal court, those same records can be used against her in family/custody and access cases to discredit her ability to parent.

“In a woman’s victim impact statement was documentation that she did not have a lot of energy to get out of bed to help her children. May get a conviction in criminal court, but then the same information is used against the woman in family court to show that she’s an unfit mother.” (advocate)

“If you had doctor’s records that go in her favor, it’s good for her criminally, but it’s custody where it’s a problem.” (advocate)

In sum, as reflected in the following quotes, all respondents noted that the whole process of using women's health records in court can revictimize women, adding to the trauma of the abuse they have endured.

“Women receive the notice of the motion that health records are sought to be released, and they’re extremely traumatized by that. It’s another layer of victimization.” (advocate)

“It was like I was the one who had done something wrong and not him. Maybe if I had gone to the doctor and reported when he hit my head, maybe that would have made it easier, maybe they would have believed me. It was like I was the one that was on trial and even though he lost in the end, it was hard.” (survivor)

“It always comes down to the woman having to prove that he’s hurting her or the kids. It always comes back to her. Even though she’s the victim, she’s the one on trial, and health records reflect that.” (advocate)

“The woman got access to her psychiatric profile on herself and her family. We reviewed the health records together. There was lots of mental health stuff, they discussed her ability to mother. There was no consent from her. It was devastating for the woman. She couldn’t understand how psychiatrists could write that about her. It’s what put that woman over the edge.” (advocate)

For the women in the study who had partners involved in criminal cases, conviction rates were low, and sentences were minimal. Of three cases of assault leading to charges, one perpetrator got 12 months probation, one had charges staid, and in the other, the woman agreed to a Peace Bond. In the criminal harassment case, the abuser got 18 months probation. In the small claims case, the woman won the money he owed her, but not with the profit promised. The woman who went to court for criminal injuries compensation won on appeal. All of the women involved in custody and access cases lost their children, except in one case which is still ongoing.

“He [the abusive partner] stood up in court and ranted and raved at me. I thought the judge would give it to him after seeing how he really was, but he only got probation.” (survivor)

Advocates also spoke about conviction rates and sentences:

“Of the women I see at the transition shelter, 20 to 30% go to court. On a very serious recent case where there was lots of police involvement, he got three months probation. It was the most serious case we’ve seen in the past years. Sometimes women report to police but most fully expect no sentence or a minimal sentence.” (advocate)

“She initially won, he appealed and won and she didn’t have the money to continue.” (advocate)

5. In general, what are your views about how health records should be used in court?

Health records should not be used in court because it revictimizes women.

“I don’t think records should ever be used in court. If women seek medical attention, it’s not about facts. Health records are produced for the provision of health care. They are not to be scrutinized. Everybody in different professions speak different languages.” (advocate)

“Records have no business in court.” (advocate)

“Not all doctors are good or sympathetic, and health records used by his lawyers can do more damage than if they were never used at all.” (advocate)

“Let’s not introduce one more piece of extraneous evidence that can be used against women. Rather, let’s use and believe what the woman herself is saying.” (survivor)

“Anything that gets out can be twisted against the woman. What happens normally is that men are the ones with the money, so they can hire a good lawyer. She can’t afford to hire a lawyer, and there’s no more legal aid, so she has no legal representation. It’s not an even playing field in courts. With records being used, he now has more ammunition to use against her. Until there’s a level playing field, I don’t think records should be used, unless the woman wants. It’s stacked against the woman to begin with.” (advocate)

“Histories being opened to courts are harmful. If a woman said something in confidence, it shouldn’t be used in court.” (advocate)

In addition to harm actually caused by using health histories and records in litigation, advocates recognized that even the threat of using records could prevent a woman from seeking necessary health care.

“[The possibility of records being subpoenaed] undermines women’s medical care.” (advocate)

“If women know that their records could be subpoenaed they may not want to seek assistance or help. It’s a Catch-22.” (advocate)

“With First Nations people, they’re already very closed about what they speak about. With records being disclosed, it deters them from seeking help if records can be subpoenaed for court and used against them.” (advocate)

“Records being used scares away individuals. Women need and want services, then the information gets into the court system.” (advocate)

“One woman was an adult survivor of child sexual abuse and was in long-term counselling. In the civil case against her abusive partner, defense counsel wanted access to records to discuss in court all the history of her child sexual abuse. The accused was also a lawyer, he got hold of her records and sent them to people in her family – her aunt, cousins and grandmother. It was horrendous. She initially won and he appealed and won. She didn’t have the money to continue. She had to stop counselling because she was terrified that every service she was seeking where records are made, he would get a hold of them.” (advocate)

“I don’t believe records should be used in court. There has to be another way. It makes people unsafe and they won’t disclose, especially First Nations women, who won’t talk a lot anyway.” (advocate)

One recommendation that came out of the interviews is that only "relevant" medical information should be requested. Information about a woman's past, or other "peripheral" information should be understood in the context of the dynamics of abuse.

"It would be great if there was a law that no past records could be used unless relevant to the current case. Why do they need to know past anti-depressant use or attempted suicide? I have a hard time understanding how this is relevant. She's the victim. Why does it matter if she has schizophrenia or an addiction?" (advocate)

"If used at all, records used specifically for the court, not the whole medical file, so unrelated stuff is not in there. Minimal, case-related information. 'Tombstone' data. For example, this date, this hospital, injuries sustained, facts only, nothing subjective." (advocate)

"Crown Counsel needs to be told to not subpoena whole medical files. Just specific dates and events. Otherwise, it can undermine a woman's case." (advocate)

"If a woman is a victim for years, and is now going through healing, need to see the strides she's making. A support group can be seen as positive or negative – need to see women's strengths, not problems." (advocate)

"Anything with a woman's past history shouldn't be used against her, especially if years have gone by and she's now on a good track of making a life for herself. It works against women, discredits them." (advocate)

"Only relevant medical records should be requested. For example, only sexual assault records for a sexual assault charge. They need an understanding of the context of domestic violence. So often the context is missing. Records don't necessarily help women if the judge doesn't see the context. It makes her look worse. Her decisions look stupid. Health records completely depend on the level of education you have about the issue." (advocate)

"In civil and family court, need more in the sense of how dynamics of the relationship affected women's behaviour, in the home and as a parent. Instead of judging her harshly, they might come to an understanding of the impacts of abuse. Need more contextual information." (advocate)

If the trend towards using health records continues, respondents suggested that records be created specifically for legal purposes when requested, preserving health records for providing health care.

"Special records should be produced for the court." (advocate)

“The medical field should create records they need to attend to women’s health. If the court needs records, they should pay health care providers to produce special records for that purpose.” (advocate)

“The Attorney General needs to give direction and provide a way for doctors to give information to the courts. Perhaps health care practitioners need a particular form to add to a medical file when they suspect or confirm violence. But the onus should not be on doctors, they are not responsible for the functioning of the legal system.” (advocate)

6. In your experience, how knowledgeable are women about the impacts of disclosing abuse to their doctor or health practitioner?

In advocates’ experience, most women thought that their health records would be confidential:

“Women believe it’s completely confidential. That it’s money in the bank. She may not understand the risks she may be opening herself up to.” (advocate)

“They don’t know it could be subpoenaed. If they did know, they may not want to seek assistance or help.” (advocate)

“Women depend on the professionals that they go to for help to protect their privacy rights. If people knew [their records could be subpoenaed] they’d be more careful of what they say, but that’s not good either because we don’t want women to not get the help they need.” (advocate)

Women’s experiences support this. With the exception of sexual assault services, health care providers generally did not let them know that their records might not be confidential.

Of the five women who were able to answer the questions, none were aware that their health records may not be completely confidential, and none were aware that their records may be shared with other health care staff.

“I never thought at the time that my health records might not be completely confidential.” (survivor)

“I guess at the time that I spoke to them [emergency room doctors and social worker] I wasn’t really thinking about it. I think they are confidential but I agreed to sign the paper so they could use them, the police, I mean.” (survivor)

“They should be [confidential]. I guess in court they might use them, but at the time you’re not really thinking about it. You’re going to the doctor for help and it’s kind of embarrassing. They don’t talk to you about that. You just assume that

they're not going to talk to anyone about that stuff. It's your private stuff and it's nobody's business, and you just kind of assume that." (survivor)

According to advocates, some women are aware that records may be used in court, and either avoid disclosing abuse or disclose with the understanding that the records created from the disclosure would help her in court.

"In the beginning, when I was talking to my doctor about my ex's addiction, I stayed away from talking about the abuse because I knew it might be used in court. But later, I needed help, so I disclosed." (survivor)"

"In some cases, women think disclosures to doctors would be positive. They think 'Judges will see the facts and history'. In some files, women are discussing their own behaviors, and don't see this as negative, but the court can use it against them." (advocate)

Women were rarely fully informed of what they were giving consent to when they signed a release of their health records.

"I've seen women willingly sign away consent to their health records. The police have forms through which women sign away their whole health records. Women want to cooperate with the police and don't know that they are giving up access to their whole medical file, and that the defense can get access to it." (advocate)

"I don't remember signing a release...I guess there must have been one." (survivor)

7. How knowledgeable are you and your co-workers of the laws that govern disclosure of health records?

Sixty-three percent reported having some or little knowledge:

"Not very. We are somewhat, but not as knowledgeable as we could be." (advocate)

"A little bit. What we heard from the O'Connor case." (advocate)

"We know they can be used. There's nothing to stop them from being used." (advocate)

"Not that knowledgeable. I've seen records be subpoenaed, and people panicked. There's a lack of knowledge because it's unpredictable." (advocate)

Thirty-seven percent reported being very knowledgeable:

“We went through legal services to prevent records from being released. Three times. We won each time.” (advocate)

“We participate in a whole debate/discussion about records being used in courts. We supported other organizations that were having records subpoenaed and resisting.” (advocate)

“Extremely knowledgeable. We have records management guidelines for anti-violence workers across the province. Since 1998, we inspired front-line workers to develop their own policies. Community Violence Against Women Programs are very knowledgeable. Health care practitioners can get information from agencies in their communities.” (advocate)

8. In your experience, do women generally resist having their health records used in court? Why or why not?

All of the survivors who answered this question did not resist having their health records used in court.

In the experience of advocates, women don't resist because they don't understand the process or the outcome. For example: *“They don't understand the impact or the process. They're fairly agreeable to anything, especially if there's no advocate,”* and *“Mostly, I don't know if women know how to resist. Often women don't know when records will be used in court or how to stop that from happening.”* Or, women want the records used, believing they will help: *“Women don't resist if the record is the forensic at the hospital, not if she understands that this is what will back her up,”* and *“With sexual assault records, if the record helps, women want them used.”* Some even believe that agreeing to their release will prevent being labeled a vindictive partner.

Advocates also noted that in some instances, women do resist. As one woman explained: *“With past records, such as counselling, HIV, STDs, bipolar, etc. women often resist. They don't see how it's relevant. They're the victim. They know the defense and the accused get the information. They don't want the enemy to get information on all the struggles they've gone through.”*

9. Has the threat of your records being subpoenaed changed your agency's policy on keeping records of clients? Has the threat changed your personal record keeping methods?

Only one advocate said their record keeping hadn't changed. Her organization is two-years old. The remaining 19 advocates said their record keeping has changed, mostly to become more “minimal” and “objective.” They describe the changes in the following:

“We ask women if they want injuries documented and refer to [place].” (advocate)

“[The threat] definitely affects [our record keeping]. I encourage staff to keep ‘factual’ notes. No opinions, judgments, or observational notes. Keep specific to what we’re assisting women with. If issues come up, unless it’s directly related to the assistance we’re providing, records are not kept.” (advocate)

“Records are minimal, objective, not things that can harm a woman. Not her emotional state. Women used codes, our records are vague, not a lot of detail.” (advocate)

“Counselors are told to be careful. If records are too detailed, it can be used against women in court.” (advocate)

“In the counselling field, we keep our notes short. Only what you need to know to do the best job for the client.” (advocate)

Some advocates have created different strategies to protect women:

“Many sexual assault centres chose to not keep records. We chose to keep them, but to hide them. We were trying to get other centres to not rip up files. The history of violence against women is an important record. We didn’t want to lose the herstory of women fighting back. Our records are not legal documents. It’s in my words, not verbatim. I record what I heard her say and what I did. That won’t prove an attack happened.” (advocate)

“In my work, I let individuals know what I keep in the file, and ask them what they want to take with them.” (advocate)

10. What do you think would make records easier to use in court so they supported a woman’s case?

Health care providers and those in the legal profession need training and guidelines on this issue.

“Doctors need to get more education on this issue.” (advocate)

“Doctors should get more training about it, what happens to women when they get beaten up and when this stuff happens.” (survivor)

“Never in 25 years of working in health care have I had any information about abuse. I can’t believe how backward we are in terms of discussing these issues...the attitudes that doctors carry and get away with. The understanding is not there.” (survivor and health care provider)

“It seems like they need to have more education about [abuse] and they need to make sure they understand what it is that women are going through...that they see how hard it is.” (survivor)

“Before any record is produced, they need mandatory training to understand the implications of what you write down and how that may affect women in the future.” (advocate)

“Women assume the people they’re entrusting their lives with are professional enough to have training.” (advocate)

“The legal landscape is constantly changing. One minute, no sexual histories are allowed in court cases. The next minute, the Supreme Court says we can use sexual history. We need a provincial body with the responsibility to see that professionals are updated as the legal situation changes.” (advocate)

“We need guidelines and standards in place, so everyone is using similar formats and judges and lawyers are used to seeing the same formats.” (advocate)

“I’d like to see the judicial system involved in training, and have exposure to the complexity of women’s lives, especially when there is abuse or mental illness.” (advocate)

Among the potential things to be included in training:

Need to understand complexity/dynamics of abuse:

“Maybe doctors should have more information about abuse, then they could talk to you more. Maybe they need to take more time because it’s like you don’t really want to talk about it and then you can’t really just get it one time... You need more time but in a supportive way, not like you’re doing something wrong and maybe you are stupid for being there because you already feel stupid and that you’re the one who is wrong and then they say stuff about you leaving and you just feel worse.” (survivor)

“Doctors don’t know much about violence against women, especially the socio-political stuff.” (advocate)

“[In terms of violence] Doctors need to understand that the mental stuff can be worse than the physical stuff. It’s a hundred times more painful. The bruises and stuff you get over but it takes a long time to get over the other stuff and they really don’t get it.” (advocate)

“Need system-based education on dynamics of abuse.” (advocate)

Need to record briefly and objectively, without judgement:

“Should be recording the minimal amount that is needed to do work professionally, respectfully.” (advocate)

“Don’t need to put in that she’s drunk, if it’s not related to the physical symptoms. Or, the fact that she had tracks on her arms. It’s not part of the sexual assault. Health care providers only seem to write down observations that are negative for women, all the prejudices, only one view of things.” (advocate)

If peripheral information is included, record it with an understanding of the context/dynamics of abuse:

“Write in a way that sees women’s strengths, not their problems.” (advocate)

Let women know that health records may be used in court:

“[Health care providers] should let individuals know ahead of time. Be upfront that it may be used against them. Open communications about possibilities is very important.” (advocate)

Think about the purpose of records and who “owns” them and how records may be used in court:

“We must ask, why do we record? For the sake of the woman or for the sake of the practitioner?” (advocate)

“What the woman wants should be written down. She knows what will keep her safe.” (survivor)

“There is all this stuff that is out of your control...It’s as if you are no part of it, but you’re the patient, you’re the source of the information...they are your records.” (survivor)

“Doctors need education not to release a whole file. It can undermine a woman’s case.” (advocate)

“The information is owned by the woman. She has the right to control the information.” (advocate)

“There is still an attitude that this is our [the health care system’s] secret information and that you [women] can’t have it.” (survivor)

Doctors must recognize their power:

“Doctors have so much credibility, their statement has so much of an impact. They have to understand their power. Women can get labelled by their doctors... The reality is that my testimony [as a woman’s advocate] does not carry as much weight as a doctor’s. They’re seen as more knowledgeable, even though I work every day with women in this situation.” (advocate)

“It would be helpful for doctors to spend more time with clients. The doctor writes a report, has more weight than counsellors. Counsellors are not seen as credible because the doctors have more credentials.” (advocate)

“An important piece to remember is that when recording, what we are doing by nature is taking women’s experiences of their lives, and taking control over the interpretation away from them. We have to keep in the forefront our respect for women’s right to interpret their experiences in their own way.” (advocate)

“Women are not really seen as equal counterparts even as professionals...so, how are you going to be perceived as a woman patient, and as a woman being abused?” (survivor)

And finally, have lawyers argue against the use of abused women's health records:

“It’s important that survivors are referred to community-based programs and violence against women specialists, then her lawyer can argue against the disclosure of her records.” (advocate)

This completes the summary and analysis of data from the empirical study. A number of key issues that are highlighted by the study present challenging problems in terms of fair and egalitarian fact-finding that respects the privacy of abused women seeking health care. In addition there are communication challenges across health and legal professions/disciplines. Problems generated by records created in a health-oriented fact-finding process not attuned to gender equality implications may be compounded when the records are transferred to a legal process that is not sufficiently attentive to those implications.

V. Discussion

The purpose of this study was to undertake a preliminary examination of the use of health records in criminal and civil cases involving violence against women in relationships. We hoped to learn how health records were being used to influence legal processes and outcomes for women in cases of assault charges, custody and access decisions, and child protection (children who witness abuse). The primary research question was about whether notes relating to women found in health records are used in litigation to reach positive legal outcomes for abused women or whether they are used to discredit women and their claims, thus repeating the harms to women through the legal process.

Two significant themes run through the foregoing legal and empirical studies. One is that violence against women in relationships has serious legal, health, social, and economic implications, about which there are varying degrees of knowledge. Clearly, there are significant health implications, with health professionals often being the first to interact with abused women seeking help or assistance for the negative mental and physical consequences of interpersonal violence (Eyler & Cohen 1999; Coker et al. 2000; Varcoe 2002; Ratner 1993). Equally as clear are the significant legal implications, with violence against women in relationships leading to, or being a factor in, a range of legal disputes, both criminal and civil. This study focuses on an important point of intersection between these two fields, where records move from health care to litigation.

The second theme is that violence against women in relationships is a significant equality issue. While not so immediately self-evident, strong support for this theme can be found in legal sources, as discussed in the Legal Framework section of this paper. For instance, our definition of violence against women in relationships was drawn from the Attorney General's Violence Against Women in Relationships Policy (2000), which states, in relation to the dynamics of violence, that:

Violence is used by batterers to establish control over their partners. They use abusive tactics to control partners' actions. These tactics are often successful because of the fear and isolation a victim feels.

It may be difficult or impossible for a woman to leave the relationship because of love, cultural/religious values, socio-economic condition, fear or the denial of the violence in the relationship. Violence often escalates and may continue or worsen if the woman leaves the relationship. In addition, unique to the situation of violence in relationships, the accuser and accused usually reside within the same home, enabling the accused to further control or abuse the victim.

When abuse occurs, there is usually a power imbalance between the partners in the relationship. That power imbalance is perpetuated by societal and individual messages undermining the potential for women to gain control of their situations, and for men to be held accountable for their actions within a relationship.

Further, the Supreme Court of Canada has most clearly recognized the equality dimension of the use of private records in cases of sexual violence in *R.v.Mills*,⁸⁶ stating:

An appreciation of the equality dimensions of records production in cases concerning sexual violence highlights the need to balance privacy and full answer and defence in a manner that fully respects the privacy interests of complainants. McLachlin J. made this clear in *M.(A.) v. Ryan*, [discussed in the Legal Framework] at para. 30, while discussing the interests at stake in determining whether counselling records were privileged or should be produced in a civil action for damages allegedly caused by sexual assault:

A rule of privilege which fails to protect confidential doctor/patient communications in the context of an action arising out of sexual assault perpetuates the disadvantage felt by victims of sexual assault, often women. The intimate nature of sexual assault heightens the privacy concerns of the victim and may increase, if automatic disclosure is the rule, the difficulty of obtaining redress for the wrong. The victim of a sexual assault is thus placed in a disadvantaged position as compared with the victim of a different wrong. The result may be that the victim of sexual assault does not obtain the equal benefit of the law to which s. 15 of the Charter entitles her. She is doubly victimized, initially by the sexual assault and later by the price she must pay to claim redress – redress which in some cases may be part of her program of therapy.⁸⁷

It was suggested in the Legal Framework that sexual violence and violence against women in relationships overlap and have factors in common which point to a similar equality dimension in violence against women in relationships cases. This gives rise to the need to be attentive to avoiding discriminatory reasoning with respect to the production and use of health records.

It can be argued that private records, such as health records, should never be used in the legal system because of the danger of discrimination.⁸⁸ On the other hand, it can be

⁸⁶ (1999), 28 C.R. (5th) 207 (S.C.C.)

⁸⁷ *Ibid.*, at para. 91. The danger that a woman who experiences violence may be made to choose between treatment and prosecution has also been pointed out by Justice L'Heureux-Dubé: “the courts must take care not to create a class of vulnerable victims who have to choose between accusing their attackers and maintaining the confidentiality of their records” (*R.v.O'Connor*, [1995] 4 S.C.R. 411, at para 121).

⁸⁸ Such a position has been taken by the coalition including the Women's Legal Education and Action Fund (LEAF), the Canadian Association of Sexual Assault Centres (CASAC), the Aboriginal Women's Council of BC, and the DisAbled Women's Network as evidenced in the following quote:

“...until the devaluation of women and children, their word and integrity are addressed instead of reinforced by the law, the disclosure of complainants' personal records is so likely to reinstate sexism in the administration of criminal law, to deter reporting, to distort the fact finding process and to violate victims' integrity that affirmation of complainants' constitutional rights...requires that no personal records be

argued that some use is inevitable and that they may assist in the appropriate testing of serious allegations. Indeed, it can be further argued that they may perform a positive function for abused women.⁸⁹ While this study did not set out to test whether health records are actually misused in the legal system, it suggests that records are more likely to be of no use or to be used against women than to support them. At the very least the danger of revictimization means that caution must be exercised by both record keepers and lawyers with respect to the use of health records in legal cases involving violence against women in relationships.⁹⁰

In our view, the legal system should strive to avoid undermining the health or safety of women experiencing violence. At the most general level, safeguards need to be in place so women do not stop seeking help from the health care system because of the fear of possible misuse of their medical information. While record makers and holders “have an ethical responsibility to maintain public trust by treating health information in a confidential manner and should be accountable for the ways they use, maintain, and disclose information” (Goldman et al. 2000: 14), there has been little discussion about how these obligations are applied to information gathering and record keeping as it relates to violence against women.

The challenge for both health and legal systems is to evolve in a way that allows truly relevant information in records to be created and used appropriately without bringing further harm and subjecting women to unjust proceedings and outcomes. The objective is to mitigate the harms of abuse, not add to the burden for women. Because the harms inflicted on a woman, both physical and psychological, can result in further “problems,” this may have the effect of making her appear less credible to both the health care and

disclosed in any sexual offense proceeding.” (As quoted in Women’s Legal Education and Action Fund, *Equality and the Charter: Ten Years of Feminist Advocacy Before the Supreme Court*. Toronto: Montgomery Press, 1996.

⁸⁹ Some commentators have suggested that such documentation can be critical when abused women seek to demonstrate a history of violence. Health records may provide compelling legal evidence. This is particularly true in criminal proceedings. In the recent US study discussed earlier in the Introduction and the Legal Framework of this paper, it was emphasized that health records contain a variety of information useful in legal proceedings and that more attention needs to be paid to the accurate and comprehensive documentation by health care providers. The study’s authors recommend: documenting factual information rather than making conclusory or summary statements; photographing the injuries; noting the patient’s demeanor; clearly indicating the patient’s statements as her own; avoiding terms that imply doubt about the patient’s reliability; refraining from using legal terms; recording the time of day the patient was examined; and writing legibly. (Issac & Enos 2001:2).

⁹⁰ The need for caution is being raised in other jurisdictions. As a recent U.S. study has concluded, health care practice and policy in many areas has fallen short in implementing protections that address the health care, safety, and discrimination concerns of domestic violence victims (Goldman et al. 2000: 9). In the United States, some disturbing developments are taking place regarding the privacy of health records and protections for abused women. Currently, federal medical regulation is in place that requires patients to provide written authorization before their private health records can be shared, and patients can also request restrictions on how the records are actually used. The Bush Administration is reviewing the requirement of patients’ written consent. The Family Violence Prevention Fund is opposing this proposal. It has taken the position that “medical privacy is essential to keeping battered women safe, and the Administration’s proposed changes could harm battered women who may fail to disclose abuse to their health care providers if they know the information will be shared” (President Esta Soler, April 23, 2002).

legal systems. For example, the record keeper may portray a woman as having “not been harmed” where the record is silent, or “mentally unstable” where negative or prejudicial inferences have been drawn from her presentation to the record maker. Furthermore, the way these notes/records are used in legal disputes, especially by a party adversarial in interest to the original patient, can lead to further victimization of the woman.

The legal and empirical studies each provide support for the view that normative views of gender are upheld by the health and legal systems and can reinforce gender inequality, thus risking replication of the original gender-based violence. Furthermore, we observed that normative and stereotypical views of gender-based violence may act as filters for women, health care providers, and legal professionals. Many factors operate to determine what questions are asked, what notes are made, how information is expressed in those notes, how it is determined who has access to those notes by the record keeper, and what use is made of notes in court. What have we learnt about the operation of these filters which may help to ensure the informed and egalitarian use of records by lawyers and courts?

Below we address the three filters through which “facts” about abused women are found in the legal system: the woman herself, the record keeper, and the legal system/lawyers. However, these filters are all part of the broader societal context and may share certain features as well as bringing different perspectives to bear.

The First Filter – The Abused Woman

The potential for creating discriminatory records exists because of the context in which women themselves decide to tell or not to tell a health care worker. Women who have been abused may explain the abuse through a cultural and social lens that holds women responsible for the abuse, minimizes the effects of the abuse, or shows disregard for her safety and well-being. As an advocate in our study explained, “*a woman tells her physician about abuse, but says ‘I provoked it,’ then in court tells the truth, and this is used as evidence against her.*” Women often question and agonize over what it was about their behaviour, their manner, or even their appearance that may have provoked the abuse.

No matter what their own understanding of the abuse is, women make explicit decisions about how much, if any, information to share with their health professional about being abused. Women may recognize that health care providers are part of a larger system with legal limits and responsibilities and choose not to risk revealing abuse. Women's experience of violence leads to trauma and reluctance to disclose until a relationship of trust is established; judges and lawyers should not assume that a woman will disclose woman abuse at the first opportunity. The barriers women consider before disclosing abuse may include retaliation from her abusive partner, her own sense of powerlessness and isolation, threats of child apprehension, and a fear that they will not be believed. The underreporting of abuse is not limited to the health care sector. For example, according to Statistics Canada, only 6% of rapes are ever reported to the police (Rengetti & Curran,

1995: 306). Indeed, deciding to report a rape is a step most victims never take (Estrich 1987: 15).

Within the realm of health, women may also “fabricate” an explanation for an injury to avoid inappropriate or unsafe interventions, prejudicial reactions, or loss of confidentiality and privacy. They may also “lie” about causes of injuries to protect the abuser.

“A woman sees a doctor several times related to the abuse but she didn’t tell the physician specifically about the abuse. Then, police are involved and they say ‘why didn’t you come forward sooner?’ Well, I did go to my physician, she says. The reference to violence by her partner isn’t made clear, so the interpretation can be ‘she lied to her physician about not being abused’, and now she’s seen as lying. It affects her credibility.” (advocate)

Conversely, abused women may view health care encounters and the records relating to these encounters as private matters. Many women request that records not be kept about disclosures of abuse. They put their trust in a health care provider, assuming that all communications with their health care provider are privileged and will not be disclosed. Women may be led to believe that the record keeper is someone who is obliged to keep confidential information about the harms they have endured. The health care provider may not fully understand or be explicit about the limits to confidentiality.

Women who do disclose abuse may face detrimental health care responses and have records created from this disclosure that are prejudicial. Some women want their doctor to “bear witness” to the injuries and corroborate her report. Some women may assume that the health care provider will “do something” about the disclosure whereas the health care provider may not see the disclosure as sufficiently relevant to even record. Many women make disclosures not thinking about how the statement might be used in other proceedings. Some think that their attempts to obtain mental health services or other counselling services will be viewed as positive steps, whereas the court in a child custody or protection matter may view a mental health diagnosis as detrimental to both credibility and “parental fitness.”

The Second Filter – The Record Keeper

The woman’s often filtered account of the abuse, or absence of an account, passes through a second filter – the record keeper. An example can be as simple as the fact that health professionals do not always accurately record what they are told. *“I was watching what my doctor wrote down the other day, and couldn’t believe it. That’s not what I said. I made him re-write it. If they are not listening or not understanding, it can change a woman’s file.” (survivor)*

Record keepers are also influenced by assumptions about violence against women. These range from a lack of awareness of the problem to a lack of knowledge about the dynamics and health effects of violence against women. As a result, the objectivity, relevance, or

non-prejudicial nature of records within the health sector must be seriously questioned. Here the empirical data of the study illuminates the cross-section of individual and collective intentions, professional practices and obligations, values and knowledge, and how these factors influence the record keeper and record keeping. In fact, many health care professionals themselves questioned the reliability of records and cautioned legal professionals about taking health records at face value.

We also heard from record keepers and others about a number of key issues that lawyers should be alert to when evaluating health records. First, although violence against women is now, to some extent, understood to be a problem of enormous proportions with immediate and long-term physical and mental health effects for women, health professionals report that they have varying levels of awareness and knowledge, rendering their interpretation of health concerns suspect.

Health care providers are not uniformly aware of the dynamics of violence against women. Often they have not received adequate training regarding victim safety planning, health effects of violence, and appropriate documentation. The effect of lack of knowledge is that health care providers may rely on stereotypes of “battered women” in their assessments and recording of abuse. In the interviews with health care providers, references to health concerns were frequently limited to injuries. For example, record keepers may not make any record if there is no visible injury. This suggests that concomitant health problems caused by exposure to violence are not always considered related or “medically relevant.” As one woman explained, *“I spoke to my family doctor about the mental disability arising from the trauma and stress of the abuse. They just don’t get it. If they can’t see it, they don’t think there is anything wrong.”* Some doctors, such as the following respondent, even stated that there are fiscal reasons for not properly documenting abuse and violence: *“There is a reward for not making the diagnosis of domestic violence. You have a ten-minute billable patient visit when it’s broken ribs and you have a 30-minute visit if you ask about the cause and it’s domestic violence. That the MSP disincentive.”*

According to the interview participants, we must challenge the kinds of assertions made by Isaac and Enos (2001: 2) who claim that medical documentation “constitutes unbiased, factual information.” These assumptions about health records are also widely held by legal professionals. In the words of one family lawyer: *“Generally, health records do not lie. A professional will not manufacture evidence.”* The overarching problem with health records is any assumption that they are *necessarily* objective and comprehensive. In many cases, they are not. Numerous health professionals stated that there is no such thing as an objective standard for assessing and recording medical information. In the words of one respondent:

“Assessments of behaviour can be far-ranging and not objective, but when they are written by a professional, they appear objective. Differences in values and training among health care professionals lead to different assessments.” (mental health nurse)

It is important to recognize that health data can be filtered through the biases, values and standpoint of the practitioner. This is highlighted by a legal professional in the study who cautions: *“Treat health records with kid gloves. The language is so damaging and open to inference. For example you can have a woman who is crying because of violence and this is interpreted as depression and that she is blowing everything out of proportion.”* Another practitioner offers a similar caution:

“The assumption is that no matter who a woman was examined by, the same facts would be written. It would be the same record. In fact, this is true for many medical conditions, but not when it comes to assessments that involve psycho-social dimensions of a person. Then it’s really a convergence of our own values, experience, and a little training in some cases.” (physician)

To further complicate matters, according to many of the respondents racial meanings are constructed and reproduced in the production of health records creating further inequality.

There are other factors which may influence this filter, such as a lack of understanding of the influence of a health professional, of how the records can be used in the legal context, and of how records can be used differently in criminal and civil cases.

Record keeping practices may be influenced by a lack of awareness of how the information can be drawn upon and interpreted in a legal proceeding:

“Understand the implications of what you write down and how that may affect women in the future.” (advocate)

“People have no idea the impact their notes will have in court.” (psychiatrist)

As one health professional acknowledged, *“I wouldn’t have thought about this a whole lot until recently. Now it will be part of my thought process in creating records if she has to go to court.”*

As one advocate noted, what may be helpful in one context may also be detrimental in another:

“In a woman’s victim impact statement was documentation that she did not have a lot of energy to get out of bed to help her children. May get a conviction in criminal court, but then the same information is used against the woman in family court to show that she’s an unfit mother.” (advocate)

Some lawyers are well aware of the record-keeper filter. A small number of lawyers in the study observed that producing and keeping objective, non-prejudicial health records for the purposes of legal evidence is unrealistic.

“The court doesn’t take into account that these records are often not taken in a session but written later, but the record taker (doctor or therapist) still used quotes to indicate a verbatim record. Record takers tend to be shoddy record keepers with no idea as to the extent to which they are sticking it to their clients.” (lawyer)

“Doctors don’t always remember what they ‘thought.’ They ask themselves, ‘did the patient tell me this or did I think this?’” (lawyer)

In contrast, the data of the study demonstrate that health records do not necessarily contain “objective facts.” Despite this, a number of lawyers interviewed in our study commented that “*objective evidence [in records] shows certain things didn’t happen,*” and “*the records provide an objective record of the fact...of abuse,*” revealing the belief that health records are reliable accounts of the abuse.

Not surprisingly, the filters through which health professionals conceptualize and record or, alternatively, do not properly document women’s experiences of abuse have the potential to further contribute to women’s inequality because they may be used as reliable records in the legal system to represent objective truth regarding violence against women in relationships. Health care providers and their records are ordinarily considered to be credible documents – at least more so than the woman’s own account. The empirical and legal evidence suggests that lawyers and legal decision-makers should not view health records as objective records containing reliable expert opinion.

The Third Filter – The Legal System and Lawyers

Rules of evidence and the assumptions of both lawyers and fact finders are the third filter, and the one with which lawyers are most familiar. Feminists have long been concerned with the actual practices and processes of the law which give rise to variable and contested meanings and interpretation (Ehrlich 2001). Certainly this concern extends to violence against women and how it is interpreted and given meaning within the legal system. The stakes are high in this context because courts may give a lot of weight to data in health records if they are perceived as being objective.

“Everything that is said by third parties (e.g., doctors) carries more impact than the woman’s testimony.” (lawyer)

“Medical professionals’ opinion carries a lot of weight when it comes to domestic violence cases. Many of them are about one person’s word against another and when you can get any evidence to support what the victims is saying, it gives a lot of strength to the case.” (lawyer)

The very act of seeking access to records has implications for access to justice. In either criminal or civil cases, the alleged abuser may request production of records in anticipation that the victim will then drop the claim or refuse to testify. It cannot be assumed that the law effectively protects the privacy of patients. Lawyers consistently reported that the concept of relevance in the legal system is broadly interpreted and this is

consistent with the case law review. In the words of one lawyer: *“The courts tend to release any information that may appear relevant; the records are released and then the true weighing of evidence is done later.”*

This concern about effective screening has, in turn, implications with respect to the response of record keepers to applications for production. Some lawyers urged health professionals to take more seriously any request to release their patients’ records. For instance:

“Doctors should be aware that they can question the releases. A lot of doctors don’t question the release, they just send off the whole record. I’ve never had a doctor question me, they just give me what I ask for.”

Lawyers noted that there should be more of a discussion about when it is appropriate to release medical information, in what form it should be released, and how third parties can potentially harm the patient who is the subject of the information. A number of lawyers discussed how the mere prospect of having to disclose records acted as a deterrent:

“I have had complainants withdraw or want to withdraw after there has been an application for an entire medical history. The application process itself acts as a deterrent.” (lawyer)

“Sometimes my clients back down from moving forward. For example, they have told the doctor about a history of incest or substance abuse that is unrelated to the case at hand. It is too much to bear to have it raised.” (lawyer)

And others emphasized that there needs to be more discussion to determine whether there may in fact be some cases where record access/release may never be permissible. In the opinion of one lawyer: *“One should keep privilege in a therapeutic relationship.”*

If the record is produced, the alleged abuser’s lawyer may argue that the woman is not a credible witness either because of her psychiatric or drug-use history, or because an incomplete or inaccurate note of a statement is inconsistent with the victim’s subsequent statements. This study reveals significant concern about the potential for such use, against the woman’s interests.

Many lawyers for women who experience violence in relationships interviewed in this study advise against using health records: *“Records never really build a case, they are used as a weapon against someone else;” “I am very cautious because these records are often ‘scary’ indicating mental health issues such as depression which can be used against women;” “There are other, better avenues for obtaining evidence that you need;” “I’ve seen lots of records that have been useless because they’re equivocal or unclear or because the doctor will not have noted that the woman has disclosed abuse;” “If there are discrepancies between the notes and what the client says, then the client is made to look like a fool*

and/or liar;” and “There are always ways to use records against women.”

“I went to [place] [for drug and alcohol treatment] and had been clean for a year. This was used against me by the courts. The records were mainly used by his lawyer. I agreed to have them released and thought they would help to see how I felt about my children, that I was trying to get help and get my life straight. Instead I was painted as emotional and unstable.” (survivor)

As Estrich (1987: 15) has noted, victims who do not report rape are not deemed “legitimate victims by the ...justice system.” When women do not disclose abuse they are considered to have lied about their experiences of abuse or violence rather than having acted out of fear, shame, or lack of awareness. As one lawyer commented, *“When the client has lied to her doctor [to protect the abuse] this can undermine her credibility.”* The reluctance to disclose challenges the assumption held by several lawyers in the study that *“people are always more forthright with their physicians than with their lawyers.”* In civil cases the victim may resist production of the record because the content, e.g., psychiatric or drug use history, harms her claim for child custody.

There can be discrepancies between the record and a woman’s statements in a legal proceeding. Where the record is silent and a woman later reports the abuse, a common account for this discrepancy is to accuse the woman of fabricating the “alleged abuse.” Instead, the dynamics of abuse and the strategies that women employ to protect themselves and their children must be understood. Filtering “silence” in the records through the lens of “fabricating” reflects a lack of awareness of the dangerous pattern of abuse that women are subject to and the risks inherent in disclosing abuse. In *Lavallee* the Supreme Court recognized that fact finders may require expert evidence to interpret the lack of disclosure, e.g., that she would not necessarily disclose the cause of an injury to the health care provider.

Sexist and racist interpretations and meanings are also reproduced in the legal discourse through which the medical information is filtered, raising further doubts about the objective nature of records. In the words of one survivor: *“His past doesn’t matter to the courts – like that he killed our pet – but mine was absolutely used to punish me.”* One lawyer reported: *“I find that in cases where there is an Aboriginal woman and Caucasian man, records are sought more frequently.”*

In contrast, some lawyers support using the woman’s health records: *“...when you can get any evidence to support what the victim is saying, it gives a lot of strength to the case;”* *“Traumatized women may not always remember, or what they remember is partial. The doctor’s records fill in the gaps;”* and *“Health records substantiate claims of injury.”*

Several lawyers reported that documentation, when done properly, can be beneficial in legal proceedings:

“It [the record] brings in hard evidence for injuries and then the defense has to come up with reasons for why these injuries occurred other than what the woman

has said. If we have pictures of visible injuries, medical records plus a woman's statement then the case is much stronger, and can give you the edge to win."
(lawyer)

In conclusion, however, this study shows both that records are much more likely to be used against the woman than in her interests, and that the various "filters" through which health records pass may distort the legal fact-finding process. This can be the case even when the record is limited to the areas of professional expertise of the record keeper, i.e., the documentation of injuries and treatment. This is for the simple reason that, in an ideal and possibly often in the real world, health records are kept for health and not legal purposes. Even the recording of injuries can be problematic given that injuries that are relevant in legal proceedings, e.g., bruises or minor muscle strains, may not have medical significance and therefore not be recorded. Also emergency health care providers may not adequately assess and document the psychological harm caused by the trauma. Or the health care provider may inaccurately draw inferences from the traumatized demeanour of the patient at the time she receives emergency care. More complex concerns arise from a lack of protocols and research that can provide reliable guides to the rules and customs of record keeping. It is hoped that this study will provide some impetus to the development of such protocols and, in the meantime, provide insights into current practice for lawyers who work with health records. Also of necessity in the meantime, is for courts to exercise great caution in using health records to negatively assess a woman's credibility or truthfulness.

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Appendix A: Interview Guides

Interview Guide for Lawyers

Demographic Information

Date of interview:

Name:

Position:

Agency:

Nature of Services Provided

Geographic location (urban/rural):

Age:

Sex:

Ethnicity:

1. The focus of this research is on violence against women in relationships and in particular, on cases involving assault, custody and access and child protection. In general terms, what experience do you have in any or all of these fields?
2. Within those areas, what experience do you have working with health records?
3. Are there any types of cases where you seek access to your client's, or the opposing party's, health records as part of your preparation for settlement discussions or litigation?
4. What factors would influence your decision to seek or not to seek access to such records?
5. What procedures have you used or observed for seeking access to such records?
6. What factors, in your experience, seem to influence the success or failure of the procedure(s) you mention in obtaining access?
7. Have you worked on any cases where you found such health records to be helpful to your case?

If YES

In what way were they helpful? For example, is there any way they can be used to bolster credibility, to suggest possibilities for evidence gathering or overall strategy?

8. Have you worked on any cases where you found such health records to be harmful to your case?

If **YES** In what way were they harmful? Are there situations were you would avoid seeking access to health records?

9. Have you worked on any cases where opposing counsel's use of such health records was harmful to your case? Please provide as much detail as possible.

If **YES** In what way was it harmful? For example, did the prospect of their use make your client reluctant or unwilling to proceed, were they used to raise an issue of competency, or were they used to impeach credibility?

10. Have you any experience in making a claim of privilege with respect to health records? Can you identify any factors relating to the making of such records which might affect the success of such a claim?
12. Have you any experience with the use of health records as hearsay, using, for instance, the principled approach to hearsay?

Final Thoughts

13. What in your view are the risks and benefits of the use of health records in the types of cases with which you are familiar. Are there any particular risks associated with the use, either in preparation or evidence, of health records without their maker present to interpret them?
14. Are you willing to share any comments or advice, arising out of your experience, with the makers of health care records who wish to maximize their usefulness for health care purposes but minimize possible harmful uses in legal procedures?
15. Are you aware of any distinctive risks and/or benefits of the use of health records in cases involving violence against women in relationships?

Interview Guide for Health Professionals

Demographic Information

Date of interview:

Name:

Position:

Agency:

Nature of Services Provided

Geographic location (urban/rural):

Age:

Sex:

Ethnicity:

Questions

1. For what different purposes do you keep health records?
2. What types of medical information go into a patient's chart (e.g. physician notes, nursing notes, lab results, social work and mental health consultation notes, etc)?
3. Do you record any other information that does not appear with the patient's medical chart?

If YES - What kind of information and where do you record it?

4. How do you determine what kind of information you record?

- a) What principles guide your record-keeping?
- b) What customs guide your record-keeping?
- c) What professional protocols guide your record-keeping?
- d) What policies guide your record-keeping?

5. Have you ever received any education/training in how to document health records?

If YES – What type of education/training?

6. When you suspect that a woman is experiencing violence or when a patient has disclosed abuse, does this affect in any way the kind of information you record?

If YES – How?

7. Do you distinguish between violence against women in relationships and violence outside relationships in your record keeping? Please elaborate.

8. What is your understanding of how health records documenting violence against women in relationships may be used by the legal system or elsewhere?

9. Have you changed your record keeping practices for any reason over the last five years?

If YES. How and why?

10. To your knowledge, have your health records ever been requested or subpoenaed in a criminal, civil or administrative tribunal matter? Please elaborate.

If NO to question 10 go to 11.

If YES to question 10 – continue with following:

a. How were the records requested from you?

b. Did you resist disclosing your records?

c. Were you required to give evidence? Please elaborate.

d. How do you view your role in appearing in court as third party?

e. Did you have difficulties in recalling/interpreting your notes?

f. Are you aware of the laws that govern the release of health records?

If YES – Please elaborate.

11. If your health records were used in a criminal, civil or administrative tribunal matter, would they be easy to interpret without your presence?

12. If you were required to give evidence, would you foresee any difficulties with recall and interpretation?

Final Thoughts

13. Do you have any recommendations about the documentation of abuse and/or how those records might get used in legal proceedings?

14. Do you have anything else to add?

Was the abuse against you raised in court?

CHILD APPREHENSION Yes No IF YES,

Where did the court event take place (which court)?

How were you represented?

Who were the other parties involved?

Were your health records released to anyone involved in the case?
Yes No Not sure

Were your health records used in court? Yes No Not sure

Was the abuse against you raised in court?

OTHER CIVIL Yes No IF YES,

Where did the court event take place (which court)?

How were you represented?

Who were the other parties involved?

Were your health records released to anyone involved in the case?
Yes No Not sure

Were your health records used in court? Yes No Not sure

Was the abuse against you raised in court?

2. What was the outcome of the court event(s)?

Questions regarding relationship

3. How long were you in the abusive relationship?

4. What was the nature of the abuse?

5. During the relationship, did you ever visit a health practitioner for issues arising from the abuse in your relationship? Yes No

6. If yes, which health practitioner(s) did you visit?

- a. Family doctor
- b. Emergency doctor
- c. Walk-in Clinic doctor or nurse
- d. Community health nurse
- e. Mental health worker
- f. Other

- 7. If/when you saw a health practitioner, did you ever disclose the abuse in your relationship?
- 8. If you didn't disclose the abuse, were you visiting the health practitioner because of injuries or health concerns arising from the abuse?

Questions regarding health records

- 9. What was your understanding of how your health records would be used?
- 10. Were you aware that your health records may not be completely confidential?
- 11. Were you aware that your health records might be shared with other health care staff?
- 12. Did you ever agree to the release of your health records?
- 13. Do you recall ever signing a release of confidentiality so your health records could be used in court?
- 14. Did you ever resist having your health records used in court?
- 15. If your health records were used in court, what is your perception of how they were used? (*Prompts: Did it feel like the records helped or harmed your case?*)

Final Thoughts

- 16. Can you make any suggestions as to how health records can be used in a way that supports women through the court process in cases involving violence against women in relationships?

Is there anything else you'd like to add?

Appendix B: Letters of Information and Consent Forms

LETTER OF INFORMATION – LAWYERS

Preliminary Investigation of the Use of Health Records in Civil and Criminal Cases of Violence Against Women in Relationships

We are a group of researchers, working in Vancouver, British Columbia in collaboration with the Woman Abuse Response Program at BC Women's Hospital and Health Centre. We are conducting a research study examining the use of health records in criminal and civil cases involving violence against women in relationships.

As part of the project, we will be interviewing women consumers, lawyers and health professionals across the province of British Columbia. We hope to learn how health records may influence legal processes and outcomes for women in cases of criminal domestic assault charges, custody and access decisions and child protection (children who witness abuse). The primary question relates to whether the chronicles of the harms against women found in health records are used in litigation to reach positive legal outcomes for abused women or whether they are used to discredit women and their claims, thus repeating the harms to women through the legal process. The name of the project is at the top of this letter.

We hope that our work in this project will lead to developing effective protocols to guide the health and legal system. In addition, we hope that the findings help victims and survivors to understand the implications of consenting to the use of their health records as evidence in legal proceedings. We will try to reach women who have been abused by making the information available to the general public. We plan to publish the results of this research in academic and professional journals that will be read by lawyers, health care professionals and women's health care advocates so that they can better assist future clients.

At no time will it be necessary for us to know your name. We can use any other name or identification you choose. Your confidentiality will be protected. Care has been taken to ensure that any information you may choose to give us cannot be used to identify you. All information will contain only your pseudonym and no list will be kept with your real name. Information that is collected for this project will be protected at BC Women's Hospital by placing data in a locked file cabinet and destroyed after the project is finished.

The interview will take about an hour. We will do it in person in a location of your choice. If you would like, you can have a friend or supporter with you during the interview.

During the interview, if we ask any questions you would rather not answer, you can simply skip those questions. Please be assured that the interviewer will not try to pressure

you to answer any question. The interviewer will make every effort to help you feel comfortable during the interview.

We have included a consent form that we would like you to sign if you are willing to help us with this project.

This consent can be withdrawn by you at any time during the project if you wish.

Yours very truly,

Jill Cory
Provincial Coordinator
Woman Abuse Program
BC Women's Hospital and Health Centre

Olena Hankivsky
Post-Doctoral Fellow
Department of Political Science
University of British Columbia

LETTER OF INFORMATION – HEALTH PROFESSIONALS

Preliminary Investigation of the Use of Health Records in Civil and Criminal Cases of Violence Against Women in Relationships

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As part of the project, we will be interviewing women consumers, lawyers and health professionals across the province of British Columbia. We hope to learn how health records may influence legal processes and outcomes for women in cases of criminal domestic assault charges, custody and access decisions and child protection (children who witness abuse). The primary question relates to whether the chronicles of the harms against women found in health records are used in litigation to reach positive legal outcomes for abused women or whether they are used to discredit women and their claims, thus repeating the harms to women through the legal process. The name of the project is at the top of this letter.

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At no time will it be necessary for us to know your name. We can use any other name or identification you choose. Your confidentiality and anonymity will be protected. Care has been taken to ensure that any information you may choose to give us cannot be used to identify you. All information will contain only your pseudonym and no list will be kept with your real name. Information that is collected for this project will be protected at BC Women's Hospital by placing data in a locked file cabinet and destroyed after the project is finished.

The interview will take about an hour. We will do it in person in a location of your choice. If you would like, you can have a friend or supporter with you during the interview.

During the interview, if we ask any questions you would rather not answer, you can simply skip those questions. Please be assured that the interviewer will not try to pressure you to answer any question. The interviewer will make every effort to help you feel comfortable during the interview.

We have included a consent form that we would like you to sign if you are willing to help us with this project.

This consent can be withdrawn by you at any time during the project if you wish.

Yours very truly,

Jill Cory
Provincial Coordinator
Woman Abuse Program
BC Women's Hospital and Health Centre

Olena Hankivsky
Post-Doctoral Fellow
Department of Political Science
University of British Columbia

LETTER OF INFORMATION – WOMEN PARTICIPANTS

Preliminary Investigation of the Use of Health Records in Civil and Criminal Cases of Violence Against Women in Relationships

We are a group of researchers, working in Vancouver, British Columbia in collaboration with the Woman Abuse Response Program at BC Women's Hospital and Health Centre. We are conducting a research study to help us understand how health records are used in criminal and civil cases involving violence against women in relationships.

As part of the project, we will be interviewing women who have experienced abuse, lawyers and health professionals across the province of British Columbia. We hope to learn how health records may influence legal processes and outcomes for women in cases of criminal violence against women charges, custody and access decisions and child protection (children who witness abuse). The primary question relates to whether the what is written in health or medical charts helps women and their lawyers to reach positive legal outcomes for abused women or whether they are used to discredit women and their claims. The name of the project is at the top of this letter.

We hope that our work in this project will lead to developing effective guidelines for the health and legal systems. In addition, we hope that the findings help women survivors to understand the implications of consenting to the use of their health records as evidence in legal proceedings. We will try to reach women who have been abused by making the information available to the general public. We plan to publish the results of this research in academic and professional journals that will be read by lawyers, health care professionals and women's health care advocates so that they can better assist future clients.

At no time will it be necessary for us to know your name. We can use any other name or identification you choose. Your confidentiality will be protected. Care has been taken to ensure that any information you may choose to give us cannot be used to identify you. All information will contain only your pseudonym and no list will be kept with your real name except for the consent form that you will sign. This consent form will be kept separate from the information you provide to us during the interview. Information that is collected for this project will be protected at BC Women's Hospital by placing data in a locked file cabinet and destroyed after the project is finished.

The interview will take about an hour. We will do it in person in a location of your choice. If you would like, you can have a friend or supporter with you during the interview.

During the interview, if we ask any questions you would rather not answer, you can simply skip those questions. Please be assured that the interviewer will not try to pressure you to answer any question. The interviewer will make every effort to help you feel comfortable during the interview. We will also give you numbers you can call if you would like to talk to someone after the interview.

We have included a consent form that we would like you to sign if you are willing to help us with this project. You may sign it with your initials only, so that you can remain anonymous. This consent can be withdrawn by you at any time during the project if you wish.

Yours very truly,

Jill Cory
Provincial Coordinator
Woman Abuse Response Program
BC Women's Hospital and Health Centre

Olena Hankivsky
Post-Doctoral Fellow
Department of Political Science
University of British Columbia

LETTER OF INFORMATION – ADVOCATES

Preliminary Investigation of the Use of Health Records in Civil and Criminal Cases of Violence Against Women in Relationships

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As part of the project, we will be interviewing women consumers, lawyers and health professionals across the province of British Columbia. We hope to learn how health records may influence legal processes and outcomes for women in cases of criminal domestic assault charges, custody and access decisions and child protection (children who witness abuse). The primary question relates to whether the chronicles of the harms against women found in health records are used in litigation to reach positive legal outcomes for abused women or whether they are used to discredit women and their claims, thus repeating the harms to women through the legal process. The name of the project is at the top of this letter.

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This consent can be withdrawn by you at any time during the project if you wish.

Yours very truly,

Jill Cory
Provincial Coordinator
Woman Abuse Program
BC Women’s Hospital and Health Centre

Olena Hankivsky
Post-Doctoral Fellow
Department of Political Science
University of British Columbia

Preliminary Investigation of the Use of Health Records in Civil and Criminal Cases of
Violence Against Women in Relationships

CONSENT FORM – LAWYERS

I have read the letter from Jill Cory at the Woman Abuse Program at BC Women’s Hospital and Health Centre and Olena Hankivsky at the Department of Political Science at the University of British Columbia describing the project named above.

I understand that I am agreeing to participate in a research project investigating the use of health records in civil and criminal cases of violence against women in relationships. I understand that I will be participating in an interview of approximately 1 hour in length.

I understand that if I have any questions about the interview, the letter or anything else related to the project, I may call the researchers collect in Vancouver at 604-875-3717.

I understand that if I have any concerns about my rights or treatment as research subject, I may contact Dr. Richard Spratley, Director or the UBC Office of Research Services and Administration, at (604) 822-8598.

I agree to the researchers publishing the interview in a manner that does not identify me.

I understand that this consent can be withdrawn by me at any time simply by informing a member of the research team that I revoke this consent.

I have received a copy of this Consent form for my own records.

Signed by Name or Initials

Date

Preliminary Investigation of the Use of Health Records in Civil and Criminal Cases of
Violence Against Women in Relationships

CONSENT FORM – HEALTH PROFESSIONALS

I have read the letter from Jill Cory at the Woman Abuse Program at BC Women's Hospital and Health Centre and Olena Hankivsky at the Department of Political Science at the University of British Columbia describing the project named above.

I understand that I am agreeing to participate in a research project investigating the use of health records in civil and criminal cases of violence against women in relationships. I understand that I will be participating in an interview of approximately 1 hour in length.

I understand that if I have any questions about the interview, the letter or anything else related to the project, I may call the researchers collect in Vancouver at 604-875-3717.

I understand that if I have any concerns about my rights or treatment as research subject, I may contact Dr. Richard Spratley, Director or the UBC Office of Research Services and Administration, at (604) 822-8598.

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Signed by Name or Initials

Date

Preliminary Investigation of the Use of Health Records in Civil and Criminal Cases of
Violence Against Women in Relationships

CONSENT FORM – WOMEN PARTICIPANTS

I have read the letter from Jill Cory at the Woman Abuse Program at BC Women’s Hospital and Health Centre and Olena Hankivsky at the Department of Political Science at the University of British Columbia describing the project named above.

I understand that I am agreeing to participate in a research project investigating the use of health records in civil and criminal cases of violence against women in relationships. I understand that I will be participating in an interview of approximately 1 hour in length and that following the interview, I will receive compensation of \$25 as an honorarium. I understand that if I choose to end the interview at any time, I will still receive the \$25.00 honorarium.

I understand that if I have any questions about the interview, the letter or anything else related to the project, I may call the researchers collect in Vancouver at 604-875-3717.

I understand that if I have any concerns about my rights or treatment as research subject, I may contact Dr. Richard Spratley, Director or the UBC Office of Research Services and Administration, at (604) 822-8598.

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I have received a copy of this Consent form for my own records.

You may sign it with your initials only, so that you can remain anonymous.

Signed by Name or Initials

Date

Preliminary Investigation of the Use of Health Records in Civil and Criminal Cases of
Violence Against Women in Relationships

CONSENT FORM – ADVOCATES

I have read the letter from Jill Cory at the Woman Abuse Program at BC Women’s Hospital and Health Centre and Olena Hankivsky at the Department of Political Science at the University of British Columbia describing the project named above.

I understand that I am agreeing to participate in a research project investigating the use of health records in civil and criminal cases of violence against women in relationships. I understand that I will be participating in an interview of approximately 1 hour in length.

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I have received a copy of this Consent form for my own records.

Signed by Name or Initials

Date

Research on Medical Records and Woman Abuse

- **Have you left an abusive relationship?**
- **Have you gone through legal proceedings where your health records were used in court?**

The Woman Abuse Response Program at B.C. Women's Hospital is conducting a research project to understand how women's health records are used in criminal and civil cases involving violence against women in relationships. We would like to know if health records help women in court or if they are used to discredit women and create negative outcomes or decisions for them.

The research team is interested in speaking to women who have left an abusive relationship and are willing to share their experiences of both the legal system and medical services.

If you are interested in participating in this research, we would ask you for the following:

- to participate in one interview with a female researcher lasting approximately 1 hour
- to allow us to have access to your medical records if possible

In return for your participation, we are offering:

- A \$25.00 honorarium to cover travel and/or child care costs and to compensate you for your time
- Referrals to community resources (counseling and advocacy) if desired

For more information about the research or to sign up to participate, please call Laura Quilici at 255-6854 or Robin Cox.