

**BETWEEN EVIDENCE AND ERASURE: THE CASE
FOR RECOGNIZING PERPETRATOR
IDENTIFICATION AS A COMPONENT OF
TREATMENT UNDER PA RULE OF EVIDENCE 803(4)
IN CASES OF INTIMATE PARTNER VIOLENCE**

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ABSTRACT

In *Commonwealth v. Smith* (1996), the Pennsylvania Supreme Court reaffirmed a restrictive interpretation of Pennsylvania Rule of Evidence 803(4), holding that statements identifying a perpetrator are inadmissible under the medical-treatment exception to the hearsay rule. This Article argues that *Smith* should be revisited to recognize a limited exception for statements identifying an intimate partner as the source of injury. In cases of intimate partner violence (“IPV”), perpetrator identification is not merely ancillary to medical diagnosis—it is integral to effective treatment, safety planning, and the prevention of recurrent harm. Drawing on developments in federal and sister-state jurisprudence, as well as contemporary understandings of trauma-informed care, this Article contends that the rationale underlying *Smith*—that identity is irrelevant to medical care—is both medically and socially obsolete. By acknowledging the medical relevance of perpetrator identification in IPV cases, the Pennsylvania Supreme Court can align its evidentiary framework with modern therapeutic practice and affirm the law’s role in protecting survivors rather than perpetuating their marginalization.

INTRODUCTION

Intimate partner violence (“IPV”)¹ and sexual violence represent not only widespread public health crises but also fundamental

1. This Article uses the term “intimate partner violence” (“IPV”) throughout. The U.S. Department of Justice’s Office on Violence Against Women defines “domestic violence” as “a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, psychological, or technological actions or threats of actions or other patterns of coercive behavior that influence another person within an intimate partner relationship. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.” *Domestic Violence*, U.S. DEP’T JUST., OFF. ON VIOLENCE AGAINST WOMEN, <https://www.justice.gov/ovw/domestic-violence> (on file with Syracuse Law Review)(last visited Jan. 22, 2026). Similarly, the Centers for Disease Control and Prevention defines IPV as “abuse or aggression that occurs in a romantic relationship. Intimate partner refers to both current and former spouses and dating partners. IPV can vary in how often it happens and how severe it is. It can range from one episode of violence to chronic and severe episodes over multiple years.” *Intimate Partner Violence*

violations of human rights.² According to the World Health Organization, roughly one in three women globally has experienced either physical or sexual violence by an intimate partner or sexual violence by a non-partner at some point in their lives.³ The vast majority of this harm occurs within intimate relationships: nearly 27% of women between the ages of 15 and 49 who have been in a relationship report experiencing physical or sexual abuse from a partner.⁴ In the United States, about 47.3% of women and 44.2% of men experience contact sexual violence, physical violence, or stalking by an intimate partner during their lifetime, and rates in Pennsylvania are comparable, with 37.1% of women and 30.4% of men affected.⁵ While intimate partner violence inflicts profound harm on individuals, it also carries enormous societal costs. Over a lifetime, the combined burden on the American economy—including medical care for IPV-related injuries, lost workplace productivity, criminal justice expenditures, and related expenses—has been estimated at \$3.6 trillion.⁶

Each year in the United States, nearly seven million women and 5.6 million men experience rape, physical violence, or stalking by an intimate partner, and a substantial percentage of these incidents result

Prevention, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/intimate-partner-violence/about/index.html?CDC_AAref_Val=https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html (on file with Syracuse Law Review) (last visited Jan. 22, 2026). Although this Article focuses specifically on IPV, it bears noting that domestic violence can and does occur outside of intimate partnerships, including between family members, household members, and other non-intimate relationships. Child abuse, for example, is often treated as its own legal and medical category. Importantly, the arguments advanced here—that survivor statements identifying perpetrators are “reasonably pertinent to diagnosis or treatment” within the meaning of Pennsylvania Rule of Evidence 803(4)(A)—could apply equally in cases of abusive non-intimate partnerships and child abuse, for all the reasons developed in this analysis. For clarity and specificity, however, this Article confines its primary focus to statements made by survivors of IPV.

2. See WORLD HEALTH ORG., GLOB. STATUS REP. ON VIOLENCE PREVENTION 2014, 2–3 (2014).

3. See *id.* at 14.

4. See *Violence Against Women Fact Sheet*, WORLD HEALTH ORG. (2025), <https://www.who.int/news-room/fact-sheets/detail/violence-against-women> (on file with Syracuse Law Review).

5. See Kathleen C. Basile et al., *The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Sexual Violence* (2022); see also *Intimate Partner Violence in PA*, PCADV IPV DATA & VISUALIZATIONS (2020), <https://pcadv-ipv-pasdc.hub.arcgis.com/> (on file with Syracuse Law Review).

6. See Cora Peterson et al., *Lifetime Economic Burden of Intimate Partner Violence Among U.S. Adults*, 55 AM. J. PREVENTIVE MED. 433, 438 (2018).

in injuries requiring medical treatment.⁷ Approximately 15% of women and 4% of men report IPV-related injuries, and half of those injured seek medical care as a direct consequence.⁸ Emergency departments (“ED”), in particular, serve as a primary point of contact:⁹ as many as 14% of female patients present with IPV-related conditions, and between 5% and 38% of women seen in the ED report experiencing IPV within the past year.¹⁰ Survivors also tend to have higher medical expenses, more unmet health care needs, and repeated visits for injury-related complaints,¹¹ including, in some tragic cases, encounters shortly before being killed by an intimate partner.¹²

These figures underscore the scale of the problem and the imperative for medical and legal systems to identify and respond to survivors effectively. The medical profession has recognized its duty to identify patients at risk of violence and to incorporate that knowledge into treatment decisions.¹³ If medical professionals are ethically and clinically obligated to ask about and act upon IPV, then the information that survivors provide about their abusers should be understood as “reasonably pertinent to diagnosis or treatment” within the meaning of Pennsylvania Rule of Evidence 803(4)’s exception to hearsay.

This Article argues that Pennsylvania courts should re-evaluate *Commonwealth v. Smith* and recognize that statements identifying the perpetrator of intimate partner violence may fall within the scope of Rule 803(4)’s medical diagnosis or treatment exception. The traditional exclusion of perpetrator-identifying statements rests on an outdated and artificially narrow conception of medical treatment that fails to account for the realities of intimate partner violence. Unlike an accidental injury, IPV requires a treatment plan that extends beyond physical healing to encompass mental health care, patient safety, and

7. See Michele C. Black et al., *The National Intimate Partner and Sexual Violence Survey: 2010 Summary Report* 38 (2011).

8. See *id.*

9. See Wendy G. Goldberg & Michael C. Tomlanovich, *Domestic Violence Victims in the Emergency Dep’t*, 251 J. AM. MED. ASS’N 980, 980–83 (1984).

10. See Stacey Beth Plichta, *Interactions Between Victims of Intimate Partner Violence Against Women and the Health Care System: Policy and Practice Implications*, 8 TRAUMA, VIOLENCE, & ABUSE 226, 228 (2007).

11. See *id.* at 228–29.

12. See Marie L. Crandall et al., *Predicting Future Injury among Women in Abusive Relationships*, 56 J. TRAUMA, INJ., INFECTION, & CRITICAL CARE 906, 906 (2004).

13. See Danielle M. Davidov et al., *United States Emergency Dep’t Visits Coded for Intimate Partner Violence*, 48 J. EMERGENCY MED. 94, 99. (2015).

access to social services. By admitting such statements, the Pennsylvania courts would not only align evidentiary practice with modern trauma-informed medical standards but also correct the gendered inequities embedded in current doctrine, which afford greater evidentiary protection to child abuse survivors than to IPV survivors. Recognizing perpetrator identification as medically relevant under Rule 803(4) is thus necessary to ensure that the evidentiary rules serve both the truth-seeking function of trials and the broader imperative of survivor-centered justice.

This Article proceeds in three parts. Part I provides background on Rule 803(4), including its text, rationale, traditional scope, Pennsylvania precedent, approaches in other jurisdictions, and other hearsay pathways commonly used in domestic violence cases. Part II analyzes why perpetrator-identifying statements in IPV cases are medically relevant, critiques *Commonwealth v. Smith*, and explores ethical, public health, and doctrinal considerations supporting their admission. Part III proposes a framework for evidentiary reform and situates the discussion within broader advocacy and survivor-centered justice goals.

I. BACKGROUND: RULE 803(4) AND ITS LIMITS

A. Rule 803(4): Medical Diagnosis or Treatment Exception

In Pennsylvania, hearsay is “a statement that (1) the declarant does not make while testifying at the current trial or hearing; and (2) a party offers in evidence to prove the truth of the matter asserted in the statement.”¹⁴ “Hearsay is not admissible except as provided by [the Rules of Evidence], by other rules prescribed by the Pennsylvania Supreme Court, or by statute.”¹⁵ However, a statement made for medical diagnosis or treatment is not excluded by the rule against hearsay.¹⁶ The exception contemplates:

Rule 803(4). Statement Made for Medical Diagnosis or Treatment.

(4) *Statement Made for Medical Diagnosis or Treatment.* A statement that:

14. PA. R. EVID. 801(a), (c).

15. PA. R. EVID. 802.

16. PA. R. EVID. 803(4).

(A) is made for—and is reasonably pertinent to—medical treatment or diagnosis in contemplation of treatment; and

(B) describes medical history, past or present symptoms, pain, or sensations, or the inception or general character of the cause or external source thereof, insofar as reasonably pertinent to treatment, or diagnosis in contemplation of treatment.¹⁷

The commentary to Pennsylvania Rules of Evidence 803(4) emphasizes two key differences from its federal counterpart. First, Pennsylvania requires that statements be made not just for diagnosis but also in contemplation of treatment; statements offered solely for litigation purposes fall outside the exception.¹⁸ This reflects the rule's core rationale: patients have a strong incentive to be truthful when seeking medical care, but that same reliability is absent when speaking only for legal advantage.¹⁹ Second, the rule has been applied flexibly to statements made not only to physicians but also to other medical providers, such as nurses.²⁰

Finally, Pennsylvania courts have consistently found that the medical treatment exception is “well-rooted” for Confrontation Clause purposes.²¹ Statements properly admitted under Rule 803(4) therefore satisfy both federal and state constitutional requirements without the need for further guarantees of trustworthiness.²²

B. Traditional Scope and Pennsylvania Precedent

1. Early Precedent

The critical inquiry—whether a declarant made a statement for the purpose of obtaining medical diagnosis or treatment—is subjective: it is not enough that a physician or other medical professional may find the information useful in diagnosing or treating a condition; the declarant must have made the statement with the intent of facilitating medical care.²³ Courts have emphasized that the rationale

17. *Id.*

18. *See id.*

19. *See id.*

20. *See id.* (citing *Commonwealth v. Smith*, 681 A.2d 1288, 1291 (Pa. 1996)).

21. DANIEL J. ANDERS, *OHLBAUM ON THE PENNSYLVANIA RULES OF EVIDENCE* § 803.04[12] (2016) (citing *Idaho v. Wright*, 497 U.S. 805, 820 (1990)).

22. *See id.* (citing *Commonwealth v. Sanford*, 580 A.2d 784, 791 (Pa. Super. Ct. 1990)).

23. *See Commonwealth v. Blackwell*, 494 A.2d 426, 437 (Pa. Super. Ct. 1985).

underlying the exception is the patient's strong motivation to be truthful when seeking treatment. As early as 1884, the Pennsylvania Supreme Court stated that "nothing is better settled than that statements of a patient to his physician, as to the character and seat of his sensations, made for the purpose of receiving medical advice, are competent evidence . . ." ²⁴ Conversely, statements made in contemplation of litigation, or to individuals retained solely for forensic purposes, fall outside the exception because the same guarantees of reliability are absent. ²⁵

For the past 50 years, Pennsylvania courts have understood the medical treatment exception to the hearsay rule as having two essential requirements. First, the declarant must make the statement for the purpose of receiving medical treatment. ²⁶ Second, the content of the statement must be reasonably pertinent to diagnosis or treatment. ²⁷ Both elements reflect the underlying rationale for the exception: that a person seeking medical care has a strong incentive to be truthful about symptoms and the circumstances surrounding an injury, and that medical professionals reasonably rely on such information in formulating treatment (in cases involving child patient-declarants, courts have recognized that even if a child does not fully appreciate the medical purpose of the inquiry, the absence of an ulterior motive and the surrounding circumstances may suffice to demonstrate reliability). ²⁸

Historically, Pennsylvania law was restrictive in admitting statements of cause. Within this framework, admissible statements typically concerned the declarant's symptoms, pain, or sensations, whether physical or psychological. ²⁹ For example, Pennsylvania courts have long admitted statements reporting chest pain, ³⁰ bruises, ³¹ or other concrete symptoms. ³²

24. *Smith*, 681 A.2d at 1291 (first citing *Lichtenwallner v. Laubach*, 105 Pa. 366, 370 (1884), then citing *Cody v. S.K.F. Industries, Inc.*, 291 A.2d 772, 776 (Pa. 1972)).

25. See *ANDERS*, *supra* note 21, at § 803.04[2].

26. See *Lichtenwallner*, 105 Pa. at 370.

27. See *Cody*, 291 A.2d at 776.

28. See *Sanford*, 580 A.2d at 792.

29. See *Smith*, 681 A.2d at 1291 (first citing *JOSEPH, EVIDENCE IN AMERICA*, at 57 (1994), then citing *Cody*, 291 A.2d at 772).

30. See *Ferne v. Chadderton*, 100 A.2d 854, 855–56 (Pa. 1953).

31. See *Boyle v. Philadelphia Rapid Transit Co.*, 134 A. 446, 448 (Pa. 1926).

32. See *Foulkrod v. Standard Accident Ins. Co.*, 23 A.2d 430, 432 (Pa. Sup. Ct. 1942); *Turner v. Valley Hous. Dev. Corp.*, 972 A.2d 531, 537 (Pa. Super. Ct. 2009).

2. *Expansion of the Exception*

In 1972, the Pennsylvania Supreme Court marked a shift by allowing testimony about the cause of an injury when made in the context of medical treatment.³³ The court in *Cody v. S.K.F. Industries* recognized the admissibility of a decedent's statements to his treating physician describing a workplace accident.³⁴ The statements were admitted to show the causal connection between the trauma and the decedent's later death from a subdural empyema.³⁵ In unwitnessed cases where the injured party is deceased, the *Cody* court reasoned, statements about the cause of injury are not only necessary for medical diagnosis but also carry inherent reliability, given the declarant's condition and motivation.³⁶ In *Cody*, the court demonstrated its willingness to admit hearsay evidence of causation in order to bridge evidentiary gaps where direct testimony is unavailable. Thus, in addition to the requirement that the declarant speak with the motive of obtaining treatment, the excepted statement must also contain information that medical personnel reasonably rely upon in providing care.

The medical treatment exception was again broadened when the Pennsylvania Superior Court recognized that such statements could be admitted when made to nurses for purposes of treatment and diagnosis, not just to physicians.³⁷ Pennsylvania courts have likewise allowed treating physicians to rely on statements made by prior treating physicians if such information was pertinent to continuing diagnosis and treatment.³⁸ Treatment has also been understood broadly to encompass psychiatric care, meaning that statements made for the purpose of obtaining mental health evaluation or therapy may also qualify.³⁹

3. *Commonwealth v. Smith*

In 1996, the majority in *Commonwealth v. Smith* reaffirmed Pennsylvania's adherence to the two-part reliability test for the medical treatment hearsay exception.⁴⁰ There, the court drew a firm line between statements of cause and statements of fault. In *Smith*, a five-year-old burn victim told a nurse that her "daddy" had put her in the

33. See *Cody*, 291 A.2d at 772.

34. See *id.*

35. See *id.* at 774.

36. See *id.* at 777.

37. See *Blackwell*, 494 A.2d at 426.

38. See *King v. Stefanelli*, 862 A.2d 666, 674 (Pa. Super. Ct. 2004).

39. See *Smith*, 681 A.2d at 1288, 1292.

40. See *id.* at 1288.

hot water, and the prosecution introduced this identification at trial under the medical treatment exception.⁴¹ Although the trial court and Superior Court admitted the statement, the Supreme Court reversed, holding that the child's attribution of responsibility did not fall within the exception.⁴²

The *Smith* court explained that while statements describing the cause of an injury—such as “I was put in hot water”—may be pertinent to diagnosis and treatment, statements identifying the perpetrator—“Daddy did it”—serve no medical purpose.⁴³ Knowledge of how the injury occurred might affect a physician's ability to treat scalding burns, but the identity of the person inflicting the harm has no bearing on medical care.⁴⁴ The court rejected the Commonwealth's broader argument that identification of the abuser could be relevant to psychological or emotional treatment, reasoning that such an approach would effectively erase the “pertinent to treatment” requirement and turn the exception into a vehicle for admitting accusatory hearsay.⁴⁵

Justice Castille's dissent in *Smith* took sharp issue with the majority's refusal to admit the child's identification of her father as the abuser.⁴⁶ While acknowledging the general rule that statements of fault are outside the medical treatment exception, he asserted that child abuse cases present a fundamentally different context.⁴⁷ Unlike most injuries, child abuse inflicts both physical and deep psychological harm, and effective treatment requires attention not only to immediate somatic injuries but also to the child's ongoing safety and emotional well-being.⁴⁸ In such cases, the identity of the abuser—particularly when the perpetrator is a household member—is integral to formulating a comprehensive treatment plan.⁴⁹

Drawing on authority from other jurisdictions and federal precedent, Justice Castille noted that many courts had already recognized that a child's identification of an abuser to medical personnel can be “reasonably pertinent” to treatment.⁵⁰ He pointed out that physicians

41. *Id.* at 1290.

42. *See id.* at 1292.

43. *Id.*

44. *See Smith*, 681 A.2d at 1292.

45. *Id.*

46. *See id.* at 1293.

47. *See id.*

48. *See id.* at 1293 (first citing *State v. Nelson*, 138 Wis. 2d 418, 434 (1987), then citing *United States v. Renville*, 779 F.2d 430, 437 (8th Cir. 1985)).

49. *See Smith*, 681 A.2d at 1293 (citing *Nelson*, 138 Wis. 2d at 433–34).

50. *Id.*

must often determine whether returning a child to a potentially abusive home environment will exacerbate the injuries, and thus knowing who inflicted the harm is inseparable from the treatment process.⁵¹ On these grounds, he concluded that the nurse's testimony repeating the child's statement should have been admitted under the medical treatment exception.⁵²

In retrospect, Castille's dissent reads as an early acknowledgment of what is now widely accepted: trauma cannot be compartmentalized as purely physical, and effective medical care for abuse victims requires integrating physical, psychological, and safety considerations. His opinion seemed to foreshadow later developments in trauma-informed advocacy and healthcare. Yet, despite this broader recognition, Pennsylvania evidence law maintains the traditional boundaries of the medical treatment hearsay exception: symptoms and medically relevant circumstances are admissible, while statements of blame or legal responsibility are not.

C. Other Jurisdictions

Pennsylvania's approach thus remains firmly traditional, tied to the "cause, not fault" formulation. But elsewhere, the law has evolved. Many jurisdictions have recognized that identity may be reasonably pertinent to medical treatment, that identifying the abuser is not a matter of blame but a critical piece of medical treatment in cases of child abuse, domestic violence, and sexual assault. This broader consensus offers a persuasive model for rethinking *Smith* considering effective trauma-informed care that requires integrating safety, prophylaxis, and psychological recovery into diagnosis and treatment.

Across jurisdictions, three patterns stand out in authority that depart from Pennsylvania's rigid "cause versus fault" line. First, courts show a broad willingness to admit perpetrator identification under the medical treatment hearsay exception in child abuse cases, recognizing that knowing the abuser's identity is often essential to treatment. Second, many courts extend the same reasoning to sexual assault, where identifying the assailant can shape immediate clinical decisions. And third, in cases of intimate partner violence, courts have begun to acknowledge the medical relevance of identification, though the application remains uneven.

51. *See id.*

52. *See id.* at 1294.

1. Child Abuse Contexts

The most consistent thread in the comparative material is that courts confronted with child-abuse cases are often willing to treat a child's identification of an abuser as reasonably pertinent to diagnosis or treatment. Several federal and state courts admit a child's statements identifying a family member when those statements are integrated into a treating clinician's assessment, safety planning, or therapeutic regimen.

In *United States v. Renville*, the Eighth Circuit confronted whether a child abuse victim's statement to her physician identifying her stepfather as her sexual abuser could be admitted under Federal Rule of Evidence ("FRE") 803(4).⁵³ The defendant argued that the hearsay exception excludes statements of identity or fault because they are usually irrelevant to treatment.⁵⁴

The court began with the two-part test from *Iron Shell*: (1) the declarant's motive must be consistent with promoting treatment, and (2) the statement must be the type reasonably relied upon by a physician in treatment or diagnosis.⁵⁵ Normally, identity statements fail both prongs because a patient doesn't name an assailant to receive treatment, and physicians typically don't need that information to provide care. Importantly, *Renville* noted that neither *Iron Shell* nor the Advisory Committee flatly barred fault-identification statements—they only said such statements are "seldom" or "not ordinarily" relevant to treatment.⁵⁶ It reasoned that a child abuse victim's identification of a household member as the abuser is a special case, distinct from what the Rule's drafters had in mind, and therefore should be admissible under Rule 803(4).⁵⁷

The *Renville* court distinguished *Iron Shell* on several grounds. First, it emphasized that *Iron Shell* never directly addressed whether statements identifying an abuser fall within Rule 803(4); rather, it considered only a child victim's description of the course of events and the assailant's conduct during the attack.⁵⁸ Second, while the defendant in *Iron Shell* was not a member of the victim's household, the defendant in *Renville* was, making the abuser's identity directly relevant

53. See *Renville*, 779 F.2d at 430.

54. See *id.* at 435–36.

55. See *id.* at 436 (citing *United States v. Iron Shell*, 633 F.2d 77, 84 (8th Cir. 1980)).

56. *Id.*

57. See *id.* at 436–37.

58. See *Renville*, 779 F.2d at 438.

to the physician in devising a treatment plan and ensuring that the child was not returned to a dangerous environment.⁵⁹ The circuit court emphasized that medically treating child sexual abuse involves not only somatic injuries but also psychological harm, which is deeply tied to the identity of the abuser.⁶⁰ State reporting duties further connect identity to the physician's treatment role.⁶¹

Finally, *Renville* explained that the two-part *Iron Shell* test supported admissibility in the unique context of child abuse cases.⁶² Ordinarily, statements of fault are excluded because patients do not expect that naming a perpetrator will aid their medical care—however, where a physician makes clear that identity is important to diagnosis and treatment, a child victim has the same motive for truthfulness as when recounting symptoms or describing the assault.⁶³ In this way, the *Renville* court treated statements of identity in household-abuse cases as both medically pertinent and trustworthy, squarely within the rationale of Rule 803(4).⁶⁴

Several state courts have followed the *Renville* rationale to extend the medical treatment hearsay exception to statements identifying the perpetrator of child sexual abuse where the identification is sufficiently tied to diagnosis, treatment, and protection.

For example, Texas Rule of Evidence 803(4) mirrors its federal counterpart. In *Tissier v. State*, the Texas Court of Appeals, relying on *Renville*, upheld the admission of a treating physician's testimony that a child had identified his mother's significant other as the source of his injury.⁶⁵ The court emphasized, relying on *Renville*, that statements identifying a perpetrator in child abuse cases differ from ordinary statements of fault because they are reasonably relied upon by physicians for diagnosis or treatment.⁶⁶ Such reliance is justified by the legal duty to prevent an abused child from being returned to an unsafe environment.⁶⁷

59. See *id.* (citing *Iron Shell*, 633 F.2d at 80–81).

60. See *id.* at 438.

61. *Id.*

62. See *id.* (citing *Iron Shell*, 633 F.2d at 83–84).

63. See *Renville*, 779 F.2d at 438.

64. See also Robert R. Rugani Jr., *The Gradual Decline of a Hearsay Exception: The Misapplication of Federal Rule of Evidence 803(4), the Medical Diagnosis Hearsay Exception*, 39 SANTA CLARA L. REV. 867 (1999) (discussing federal courts' expansion of *Renville*'s "household" or "family member" criteria).

65. See *Tissier v. State*, 792 S.W.2d 120, 125 (Tex. Crim. App. 1990).

66. See *id.*

67. See *id.* (quoting *Renville*, 779 F.2d at 437).

Nebraska has also repeatedly admitted child-victim identifications made to treating clinicians so long as the evidence “satisfactorily demonstrate[s] that the circumstances under which the statement was made were such that the declarant’s purpose in making the statement was to assist in the provision of medical diagnosis or treatment, that the declarant’s statement was reasonably pertinent to such diagnosis or treatment and, further, that a doctor would reasonably rely on such statement.”⁶⁸ The *Vaught* court did not require direct evidence that the child-declarant consciously understood, “I’m telling the doctor this so they can help me.”⁶⁹ Instead, the court allowed inference of the declarant’s state of mind from context; because the statement was made during a medical exam, it was reasonable to infer that the child was speaking to assist diagnosis or treatment.⁷⁰ The Nebraska medical exception statute itself does not distinguish between children and adults, and the *Vaught* court declined to presume that children are less truthful or less motivated by medical concerns when speaking with doctors.⁷¹ However, the court recognized that, with very young children, it may take more evidence about the setting (e.g., who was present, how the doctor explained the exam, what the child understood) to show that the child’s statement falls within the purpose of the medical treatment exception.⁷²

In Mississippi, even before its holding in *Hennington v. State*, the state supreme court recognized the *Renville* two-part test for the medical treatment exception to apply: 1) the declarant’s statement is reasonably pertinent to treatment; and 2) the statement is therefore reasonably relied upon by a treating physician.⁷³ In *Hennington*, the court held that the motive for telling a treating physician about sexual abuse aligns with facilitating treatment, since a doctor cannot address a patient’s needs without knowing the complaint.⁷⁴ Preventing further abuse is part of treatment, so identifying the perpetrator also serves this purpose. Under Mississippi’s medical treatment hearsay

68. *State v. Vaught*, 682 N.W.2d 284, 289 (Neb. 2004). *See also* *State v. Max*, 492 N.W.2d 887, 891 (Neb. Ct. App. 1992); *State v. Roenfeldt*, 486 N.W.2d 197, 202 (Neb. 1992).

69. *Vaught*, 682 N.W.2d at 289.

70. *See id.*

71. *See id.*

72. *See id.*

73. *See Hennington v. State*, 702 So. 2d 403, 413 (Miss. 1997) (citing *Young v. State*, 679 So. 2d 198, 203 (Miss. 1996); *Doe v. Doe*, 644 So. 2d 1199, 1205–06 (Miss. 1994); *Jones v. State*, 606 So. 2d 1051, 1056 (Miss. 1992); *Mitchell v. State*, 539 So. 2d 1366, 1366 (Miss. 1989)).

74. *See Hennington*, 702 So. 2d at 413.

exception, such statements are relevant to treatment and reasonably relied upon by the physician. *Hennington* then unequivocally took the “opportunity to set forth definite guidelines regarding the admission of hearsay testimony under Miss. R. Evid. 803(4) as to the identification of the perpetrator in a sexual abuse case”:⁷⁵

[H]earsay testimony identifying the perpetrator is admissible under Miss. R. Evid. 803(4) regardless of whether he or she is a member of the child’s immediate household. The overriding question making the inquiry necessary is, “Will the perpetrator have access to the child in the future that would allow the sexual abuse to continue?” Because the inquiry is necessary for treatment, the answer is admissible under the Rule.⁷⁶

Wyoming courts also recognize the “special” nature of child abuse cases, “encompassing more than physical injury.”⁷⁷ Wyoming adheres to the *Renville* two-part test, and in *Blake*, affirmed the admission of a treating physician’s testimony, when it indicated that the physician “relied on the victim’s account of the circumstances surrounding the sexual assault, including the abuser’s identity, to determine how to treat the victim properly.”⁷⁸

In his 1997 law review article examining expert witnesses under FRE 703 and 803(4), L. Timothy Perrin noted that post-*Renville* courts regularly admitted children’s statements to psychologists and clinical social workers under Rule 803(4).⁷⁹ In these cases, the relevance of identifying the abuser lies not only in treating somatic injuries, but also in addressing the victim’s profound emotional and psychological trauma and in preventing further harm.⁸⁰ Moreover, knowing whether

75. *Id.* at 414.

76. *Id.* at 415.

77. *Blake v. State*, 933 P.2d 474, 477 (Wyo. 1997); *Goldade v. State*, 674 P.2d 721, 725 (Wyo. 1983). *See also Betzle v. State*, 847 P.2d 1010, 1019 (Wyo. 1993); *see also Owen v. State*, 902 P.2d 190, 195 (Wyo. 1995).

78. *Blake*, 933 P.2d at 479.

79. *See* L. Timothy Perrin, *Expert Witnesses under Rules 703 and 803(4) of the Federal Rules of Evidence: Separating the Wheat from the Chaff*, 72 *IND. L.J.* 939 (1997).

80. *See e.g.*, *State v. Nelson*, 406 N.W.2d 385, 434–35 (Wis. 1987); *People v. Wilkins*, 349 N.W.2d 815, 817 (Mich. 1984); *People v. Oldsen*, 697 P.2d 787, 788–89 (Colo. App. 1984); *State v. Tracy*, 482 N.W.2d 675, 681–82 (Iowa 1992); *People v. Brodit*, 61 Cal. App. 4th 1312, 1331 (1998); *State v. Muttart*, 875 N.E.2d 944, 953 (Ohio 2007); *State v. Craig*, No. 18 MA 0102, 2020 Ohio App. LEXIS, at *72 (Ohio Ct. App. 2020). *See also* Celina E. Contreras, *Has Florida Won or Lost the Battle by Eliminating Section 90.803(4) as an Alternative Tool in Prosecuting Child Sexual Abuse?*, 55 *U. MIAMI L. REV.* 533 (2001) (for a discussion of the admissibility of

the abuser is a household member meaningfully shapes discharge decisions, protective interventions, and follow-up mental-health care.⁸¹ Because mental health professionals rather, than physicians, often provide such care, courts have had to decide whether Rule 803(4) applies. Most have concluded that it does, noting both the advisory committee's recognition that the rule is not limited to physicians and the significant therapeutic need for the information. These courts, therefore, treat identity as part of the total picture of treatment rather than a mere accusatory fact.

2. *Sexual Assault Cases*

A second, albeit smaller cluster of decisions recognizes identity as medically relevant when it affects time-sensitive clinical choices—post-assault prophylaxis (e.g., sexually transmitted infection (“STI”) prophylaxis), coordination of forensic exams, or pregnancy prevention—and when it influences safety planning and counseling. The Eighth Circuit's *Renville* decision and several state decisions exemplify this logic: identity can be “diagnostic” when the clinician must evaluate risk of communicable disease exposure or implement a specific clinical protocol tied to the assailant's conduct or status.

In *State v. Max*,⁸² for example, a child's disclosure that her adoptive father had abused her was admitted under the medical diagnosis exception because it guided physicians in diagnosing genital warts, assessing mode of transmission, and preventing further harm. Other courts have made the same point more broadly: as the Court of Special Appeals of Maryland noted in *Cassidy v. State*, when there is a risk of communicable disease, identity takes on “significant medical pertinence.”⁸³ The Indiana Court of Appeals in *Perry v. State* echoed this logic, holding that knowing the assailant's identity was central to treatment planning, both for physical health risks such as HIV exposure and for psychological counseling and discharge safety.⁸⁴

Oregon's Supreme Court in *State v. Moen* confirmed that the admissibility of such statements is not confined to child abuse cases,⁸⁵ and the Tenth Circuit in *United States v. Joe* extended the principle to

identification statements in child sexual abuse cases under other states' medical diagnosis hearsay exceptions).

81. See Contreras, *supra* note 80, at 536–38.

82. See *State v. Max*, 492 N.W.2d 887, 890 (Neb. Ct. App. 1992).

83. *Cassidy v. State*, 536 A.2d 666, 682 n.14 (Md. Ct. Spec. App. 1988).

84. See *Perry v. State*, 956 N.E.2d 41, 50 (Ind. Ct. App. 2011).

85. See *State v. Moen*, 786 P.2d 111, 121 (Or. 1990) (Moen had been convicted for the aggravated murder of his wife).

adult victims of domestic sexual assault.⁸⁶ There, the court emphasized that identity is “reasonably pertinent” in virtually all domestic sexual assault cases because the treating clinician must account for the emotional and psychological impact of ongoing abuse, may tailor treatment or counseling accordingly, and may need to recommend steps to protect the patient from further harm.⁸⁷ Similarly, in *Oldman v. State*, the Supreme Court of Wyoming found identity relevant to both infection control (where bite marks raised concerns about disease transmission) and patient safety during recovery.⁸⁸

Taken together, these cases illustrate a consistent theme: in sexual assault contexts, identification of the perpetrator is not a mere attribution of fault but a medically significant fact, shaping both immediate clinical care and longer-term interventions, including safety planning, counseling, and discharge recommendations. That same rationale has been applied in jurisdictions that extend medical treatment hearsay exception to encompass statements of fault by IPV victims.

3. *Intimate Partner Violence*

Courts around the country have increasingly treated an IPV survivor’s identification of an assailant as potentially “reasonably pertinent” to medical diagnosis or treatment when the identification bears on clinical decisions—not only for physical injuries but for time-sensitive public-health interventions, safety planning, and treatment of psychological trauma.⁸⁹ Several lines of authority illustrate how and why courts reach that conclusion.

Certain courts have admitted statements identifying an abuser under the medical-treatment hearsay exception where the treating clinician explained that knowing who assaulted the patient shaped diagnosis, prophylaxis, discharge planning, or mental-health care. State and lower federal courts have followed the logic from *United States v. Joe* in domestic-violence and sexual-assault contexts: Alabama’s *Moore v. City of Leeds* applied the medical-treatment exception to a domestic-violence victim’s statements;⁹⁰ New York’s *People v. Swinger* treated a triage diagnosis of “domestic violence” as relevant to both

86. See *United States v. Joe*, 8 F.3d 1488, 1494–95 (10th Cir. 1993).

87. *Id.*

88. See *Oldman v. State*, 998 P.2d 957, 962 (Wyo. 2000).

89. See generally *State v. Stahl*, 855 N.E.2d 834, 834 (Ohio 2006); see also *Curtis v. State*, 259 Md. App. 283, 283 (2023); see also *State v. Koederitz*, 166 So. 3d 981, 986 (La. 2015).

90. See *Moore v. City of Leeds*, 1 So. 3d 145, 150 (Ala. Crim. App. 2008).

physical and psychological care;⁹¹ and Washington state appellate decisions have admitted similar hospital statements where providers used the information to assess risk and safe discharge.⁹²

The Ohio Supreme Court in *State v. Stahl* likewise held that assailant identity was provided for medical diagnosis and treatment where clinicians used it to structure a safe release plan, assess disease exposure, and guide immediate care, noting that whether identity was “reasonably pertinent” must be judged from the clinician’s contemporaneous perspective rather than in hindsight.⁹³ These decisions emphasize that identity may determine clinical choices (e.g., Sexual Assault Nurse Examiner (“SANE”) protocols, prophylaxis, who must be contacted, or whether the patient can safely return home).⁹⁴

The Maryland appellate court in *Curtis v. State* affirmed admission where, within hours of the assault and in response to a medical provider’s “what happened” question, the victim described the external cause of her symptoms as an assault by her boyfriend;⁹⁵ the court found that this relational identification was reasonably pertinent to diagnosis, psychological treatment, and safety planning: “[declarant-patient’s] statement described the external cause of her symptoms (*i.e.*, the Appellant) and was reasonably pertinent to diagnosis or treatment of her injuries as a victim of intimate partner violence, with all the attendant psychological and emotional injuries which may derive therefrom.”⁹⁶

Several courts have accepted 803(4) (or state equivalents) for statements made to psychologists, social workers, or specialized nurses, reasoning that the “medical” exception reaches emotional and psychological treatment as well as physical care. Louisiana’s *State v. Koederitz* expressly extended the rationale to psychiatric counseling and social-work treatment in a domestic-violence case and found the

91. See *People v. Swinger*, 689 N.Y.S.2d 336, 340–41 (Crim. Ct. 1998). Although *Swinger* emphasized that identifying a complainant as a domestic violence victim was relevant to diagnosis and treatment, the court ultimately admitted the statements under New York’s business records exception (803(6)), not the medical treatment exception (803(4)), reasoning that the triage notes, referral forms, and domestic violence documentation were prepared in the ordinary course of the hospital’s operations. See *id.*

92. See e.g., *State v. Sims*, 890 P.2d 521 (Wash. Ct. App. 1995); *State v. Bong*, No. 33000-1-III, 2015 Wash. App. LEXIS 1289, ¶¶ 20–21 (Wash. Ct. App. 2015).

93. See *State v. Stahl*, 855 N.E.2d 834, 834 (Ohio 2006).

94. See *id.* at 842.

95. See generally *Curtis v. State*, 259 Md. App. 283 (2023).

96. *Id.* at 311–12.

statements both reasonably pertinent and non-testimonial.⁹⁷ Washington's *Bong* upheld admission of a victim's identification to a hospital social worker, where the social worker used the information to prevent the patient's return to an unsafe environment.⁹⁸ These courts rely on the advisory committee's note that Rule 803(4) is not limited to physicians and on the practical reality that mental-health clinicians often provide the immediate treatment and safety planning IPV victims need.

Certainly, not all jurisdictions automatically admit identity statements. A recurring theme in contrary decisions is not a categorical rejection but rather a requirement of a sufficient factual foundation showing why identity was reasonably pertinent to diagnosis or treatment in the case. Minnesota's *State v. Robinson*,⁹⁹ Iowa's *State v. Smith*,¹⁰⁰ and Nebraska's *State v. McCulloch*¹⁰¹ each concluded that the State failed to make that foundational showing on the record before the court. Importantly, those courts generally did not foreclose the possibility that identity could be admissible in future cases in which the treating clinician provides specific testimony linking the identification to treatment choices (e.g., that knowing the assailant's health status or relationship to the victim altered prophylaxis, injury-evaluation, or discharge decisions).

Across the decisions discussed above, courts evaluating identity statements under the medical-diagnosis exception have focused on similar evidentiary foundations. In the cases admitting such statements (like *Curtis*, *Stahl*, *Koederitz*, *Moore*, and *Joe*), the record typically showed that the declarant spoke to a medical or mental-health provider while seeking treatment or during emergent care; that the provider testified the information informed diagnosis, treatment, or discharge planning; and that the statement described the external cause of the patient's symptoms or guided concrete clinical decisions such as prophylaxis, injury assessment, counseling, or safety planning. By contrast, in the cases declining to admit identity statements (as in *Robinson*, *Smith*, *McCulloch*), courts emphasized the absence of testimony tying the identification to a specific medical purpose. The cases surveyed above therefore suggest that when the record demonstrates how the identity of the assailant shaped clinical decision-making, courts are

97. See *State v. Koederitz*, 166 So. 3d 981, 986 (La. 2015).

98. See *State v. Bong*, No. 33000-1-III, 2015 Wash. App. LEXIS 1289, at *11 (Wash. Ct. App. June 18, 2015).

99. See *State v. Robinson*, 718 N.W.2d 400, 407 (Minn. 2006).

100. See *State v. Smith*, 876 N.W.2d 180, 190 (Iowa 2016).

101. See *State v. McCulloch*, 742 N.W.2d 727, 733 (Neb. 2007).

far more willing to treat the statement as reasonably pertinent to diagnosis or treatment.

These developments highlight the gap between Pennsylvania precedent and a growing body of persuasive authority, suggesting that *Smith* is ripe for reconsideration through a trauma-informed lens.

D. Other Hearsay Pathways in IPV Cases

Other hearsay exceptions may also be employed to admit an IPV survivor's identification of an assailant. For example, such statements may fall within the present sense impression exception (803(1))¹⁰² if the identifying statement is made contemporaneous to the declarant's observations of the abuse; as an excited utterance (803(2))¹⁰³ where the complainant or a bystander spontaneously identifies the perpetrator while still under the stress of the abusive incident; or as evidence of the declarant's then-existing mental, emotional, or physical condition (803(3))¹⁰⁴—for instance, “he is going to kill me!”—so long as the statement reflects the declarant's present state of mind rather than memory of past events. In some cases, identity may be captured in business records (803(6)),¹⁰⁵ as in New York's *Swinger*, where hospital intake notes documented domestic violence.¹⁰⁶ Increasingly, digital evidence—such as cell phone recordings, police body-worn camera footage, or other contemporaneous captures—can also provide admissible proof of identity if properly authenticated.

In each of these settings, the Confrontation Clause remains a limiting principle: testimonial hearsay must be excluded.¹⁰⁷ But if the primary purpose of the exchange was medical treatment, emergency response, or some other non-testimonial purpose, and a recognized hearsay exception applies, admission is proper.¹⁰⁸ Against this backdrop, there is little reason for Pennsylvania to treat the medical treatment exception differently. Where a statement of identification is made to assist in the provision of diagnosis or treatment, is reasonably pertinent to that treatment, and is of the sort on which medical providers reasonably rely, it should be admissible under Pennsylvania Rule of Evidence 803(4).

102. See FED. R. EVID. 803(1); see also PA. R. EVID. 803(1).

103. See FED. R. EVID. 803(2); see also PA. R. EVID. 803(2).

104. See FED. R. EVID. 803(3); see also PA. R. EVID. 803(3).

105. See FED. R. EVID. 803(6); see also PA. R. EVID. 803(6).

106. See *Swinger*, 689 N.Y.S.2d at 338.

107. See *Crawford v. Washington*, 541 U.S. 36, 42 (2004).

108. See *id.* at 51, 74.

II. ANALYSIS: WHY PERPETRATOR IDENTIFICATION SHOULD BE ADMISSIBLE IN IPV CASES

A. Medical Relevance of Perpetrator ID

The American Psychological Association defines trauma as “any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person’s attitudes, behavior, and other aspects of functioning.”¹⁰⁹ Trauma may be caused by human behavior, nature, or serious physical injury.¹¹⁰ “Psychological trauma in the context of intimate partner violence (IPV) is a subtype of psychological trauma where unique concerns and considerations due to the influencing factors of the IPV (e.g., manipulation, isolation, lack of social support) are present.”¹¹¹

Trauma is often divided into two types.¹¹² Type I trauma refers to a single, overwhelming event that leaves a lasting impact, such as a serious car accident, an unusual natural disaster, or witnessing one act of violence.¹¹³ Type II trauma involves ongoing or repeated experiences that become more complex precisely because of their repetitive nature.¹¹⁴ This repeated exposure can intensify psychological harm. While an act of IPV may occur only once—falling under the framework of Type I trauma, which involves a single, highly distressing event—it is more often characterized by repetition, coercion, and escalation, aligning it with Type II trauma, which involves ongoing or cumulative experiences. Either way, IPV produces not only somatic injuries but also significant physiological manifestations of trauma responses that require medical intervention.

Survivors frequently exhibit trauma-induced sympathetic hyperactivation, which alters the amygdala, hippocampus, and prefrontal cortex.¹¹⁵ Because the hippocampus regulates learning and memory, prolonged cortisol release from chronic IPV can impair cognition and

109. *Trauma*, APA DICTIONARY OF PSYCH. (2018) (cited by Kathryn S. Gerber et al., *Psychological Trauma in the Context of Intimate Partner Violence: A Concept Analysis*, 42 ISSUES MENT. HEALTH NURSING 1, 1 (2021)).

110. *See id.*

111. Kathryn Gerber et al., *Psych. Trauma in the Context of Intimate Partner Violence: A Concept Analysis*, 42 ISSUES MENT. HEALTH NURSING 1104, 1104 (2021).

112. *See id.* at 1105.

113. *See id.*

114. *See id.* (citing Sam Wilkinson et al., *Predictive Processing and the Varieties of Psych. Trauma*, 8 FRONTIERS IN PSYCH. 2 (2017)).

115. *See id.* at 1109.

cause memory deficits.¹¹⁶ Repetitive trauma may also result in micro-tears in brain tissue and axonal injury, while sustained traumatic brain injury (“TBI”)—prevalent in IPV contexts—further damages neuronal functioning.¹¹⁷ The physiological effects of IPV extend to the immune system as well. Research has linked IPV exposure to accelerated declines in CD4+ and CD8+ cell counts in individuals with HIV, as well as elevated inflammatory biomarkers such as cortisol, TNF- α , and C-reactive protein.¹¹⁸ These findings underscore IPV trauma as a chronic stressor with systemic health impacts.

These physiological and psychological realities show why perpetrator identification is medically relevant in the IPV context. Knowledge that a patient’s injuries or symptoms stem from intimate partner abuse allows clinicians to understand better the patient’s presentation — whether anger, despair, hopelessness, or dissociation.¹¹⁹ It explains why a patient may struggle with memory, sleep disturbances, or a distorted sense of time and loss, and it highlights the heightened risk of suicidality that accompanies such trauma.¹²⁰ In short, identifying IPV as the source of injury equips providers to form a holistic understanding of the patient and to tailor diagnosis and treatment to the full spectrum of their needs, including psychosocial interventions and long-term support, rather than treating symptoms in isolation.

B. Ethical & Public Health Imperatives

The imperative to recognize IPV in clinical settings is not solely a matter of legal doctrine or survivor advocacy. It is grounded in the ethical commitments of the medical profession itself. From its founding in 1847, the American Medical Association (“AMA”) has

116. See Gerber, *supra* note 111, at 1109 (citing Ilona S. Yim & Yasmin B. Kofman, *The Psych. of Stress and Intimate Partner Violence*, 105 PSYCHONEUROENDOCRINOLOGY 21 (2019)).

117. See *id.* at 1109–10 (citing Eve Valera & Aaron Kucyi, *Brain Injury in Women Experiencing Intimate Partner Violence: Neural Mechanistic Evidence of an “Invisible” Trauma*, 11 BRAIN IMAGING & BEHAV. 1664 (2017)).

118. See *id.* at 1110. (citing Rachel Jewkes et al., *Impact of Exposure to Intimate Partner Violence on CD4+ and CD8+ T Cell Decay in HIV Infected Women: Longitudinal Study*, 10 PLOS ONE 1 (2015); Emma Robertson Blackmore et al., *Lifetime Exposure to Intimate Partner Violence and Proinflammatory Cytokine Levels Across the Perinatal Period*, 25 J. WOMEN’S HEALTH 1009, 1013 (2016); Rafael Fernandez-Botran et al., *Correlations Among Inflammatory Markers in Plasma, Saliva and Oral Mucosal Transudate in Post-menopausal Women with Past Intimate Partner Violence*, 25 BRAIN BEHAV. IMMUN. 314 (2011)).

119. See *id.* at 1105.

120. See *id.* at 1106.

positioned its Code of Medical Ethics as the cornerstone of professional responsibility, establishing the world's first national code of ethics for physicians.¹²¹ The Code—regularly updated by the Council on Ethical and Judicial Affairs (“CEJA”)—provides comprehensive guidance on how physicians must, should, or may act when confronting the challenges of medical practice.¹²² The AMA considers adherence to these standards essential to preserving patient trust and public confidence in medicine.¹²³

Although not binding law, the AMA's ethical principles define the essentials of honorable physician conduct and emphasize that physicians are expected to exercise discernment and reflection in applying them.¹²⁴ Even when guidance is not routinely relevant to a physician's practice, the Code requires awareness and responsiveness when circumstances make the guidance pertinent. Identifying and responding to IPV is precisely such a circumstance.¹²⁵

Over three decades ago, the AMA included in its stated goals to familiarize hospital staff with the magnitude of the domestic violence problem, help them identify domestic violence and its impact on a patient's health and well-being, provide them with interviewing strategies, provide them with information on referral options, and familiarize them with the legal aspects of providing medical care to domestic violence victims.¹²⁶ In its 1992 “Diagnostic and Treatment Guidelines

121. See generally *AMA Marks 175th Anniversary*, AM. MED. ASS'N (May 5, 2022), <https://www.ama-assn.org/press-center/ama-press-releases/ama-marks-175th-anniversary#:~:text=CHICAGO%20%E2%80%94%20The%20American%20Medical%20Association,the%20betterment%20of%20public%20health> (on file with Syracuse Law Review).

122. See generally *Modernization of Code of Medical Ethics: CEJA Reports*, AM. MED. ASS'N, <https://www.ama-assn.org/councils/council-ethical-judicial-affairs-ceja/modernization-code-medical-ethics-ceja-reports> (on file with Syracuse Law Review) (last visited Feb. 28, 2026).

123. See *Augmented Intelligence Development, Deployment, and Use in Health Care*, AM. MED. ASS'N (Nov. 2024), <https://www.ama-assn.org/system/files/ama-ai-principles.pdf> (on file with Syracuse Law Review).

124. See *AMA Principles of Medical Ethics*, AM. MED. ASS'N (June 2001), <https://code-medical-ethics.ama-assn.org/principles> (on file with Syracuse Law Review).

125. “The AMA has long advocated against the culture of violence in America. [For instance,] along with other members of the medical community, the AMA was a catalyst for the passage of the Violence Against Women Act in 1994.” *Preventing Violence*, AM. MED. ASS'N, <https://www.ama-assn.org/delivering-care/injury-violence-prevention/preventing-violence> (on file with Syracuse Law Review) (last visited Jan. 21, 2026).

126. See AM. MED. ASS'N, *Diagnostic and Treatment Guidelines on Domestic Violence*, 1 ARCH. FAM. MED. 39, 39 (Sep. 1992).

on Domestic Violence,” the AMA posited that “[d]omestic violence and its medical and psychiatric sequelae are sufficiently prevalent to justify *routine screening* of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings.”¹²⁷ The AMA recommended that physicians incorporate direct, specific screening questions about abuse into routine clinical practice, whether during social history, medical history, review of systems, or history of present illness.¹²⁸

Once IPV was identified, physicians were advised to treat the immediate physical injuries while also attending to the patient’s safety and psychological well-being.¹²⁹ The guidelines emphasized that disbelief, silence, or indifference from the physician could be experienced as tacit approval of the abuse, while recognition and validation were themselves therapeutic. Physicians were expected to assess whether patients needed emergency shelter, counseling, or other community-based resources, and to discuss safety planning before discharge, regardless of the severity of the presenting injury.¹³⁰

The 1992 Guidelines also stressed the importance of careful documentation. Detailed, professional medical records were considered critical not only for ongoing medical care but also for potential legal proceedings, where they could serve as more credible evidence than later patient testimony.¹³¹ Records were to include “chief complaint and description of the abusive event, using the patient’s own words whenever possible rather than the physician’s assessment.”¹³² Detailed descriptions of injuries were to include type, number, size, location, resolution, possible causes, and explanations given.¹³³

Finally, the AMA underscored that all physicians had an ethical responsibility to ask patients¹³⁴ about abuse, to diagnose IPV

127. *Id.* at 40.

128. *See id.*

129. *See id.* at 42.

130. *See id.*

131. *See* AM. MED. ASS’N, *supra* note 125, at 43.

132. *Id.*

133. *See id.*

134. *See id.* In 1992, the AMA’s diagnostic and treatment guidelines specifically instructed physicians to ask “women patients” about abuse. While that language reflected the dominant framing of IPV at the time, subsequent research and advocacy have broadened the lens. Over the past three decades, there has been increasing recognition that intimate partner violence affects individuals of all genders, sexual orientations, and identities. This expanded understanding underscores the need for inclusive screening practices and treatment protocols that address the full spectrum of survivors’ experiences.

accurately, and to respond in line with professional standards that require recognition, crisis intervention, and referral.¹³⁵

Nearly a quarter century later, at its 2016 annual meeting, the AMA House of Delegates adopted the Code of Medical Ethics Opinion 8.10 on “Preventing, Identifying and Treating Violence & Abuse.”¹³⁶ This section was part of a major update that year to existing ethical opinions and was “intended to more thoroughly address physicians’ roles in assessment, prevention, and reporting of violence or abuse. Moreover, this Opinion amendment revise[d] the scope of guidance provided to physicians to more accurately reflect current standards of practice.”¹³⁷

The AMA Code of Medical Ethics 8.10 makes clear that physicians have an affirmative duty to recognize, address, and treat the effects of interpersonal violence and abuse. This responsibility begins with clinical vigilance: physicians must learn to detect the signs of abuse and remain mindful that cultural factors may shape how patients disclose or present such experiences.¹³⁸ They are expected to maintain a working knowledge of community resources and to stay current with

135. See *id.* at 44. In *Minnesota v. Robinson*, the majority rejected Minnesota’s reliance on the 1992 AMA Guidelines discussed here, and the court referenced the Guidelines’ “specific disclaimer that they ‘are not intended to be construed or to serve as a standard of medical care.’ Apparently, they impose no obligations on health care providers in collecting information on domestic violence, in providing emotional or psychological treatment, or even in referring victims for this type of care. In short, although the Guidelines suggest domestic violence screening, they do not state that such screening is reasonably pertinent to medical diagnosis or treatment.” *Minnesota v. Robinson*, 718 N.W.2d 400, 406 (Minn. 2006). The Minnesota Supreme Court’s reasoning in *Robinson* reflects a fundamental category error. By emphasizing that the AMA Guidelines “impose no obligations” on physicians, the court conflated the Guidelines’ non-mandatory status with the evidentiary standard of whether information is “reasonably pertinent to medical diagnosis or treatment.” Those are distinct inquiries. “Reasonably pertinent” is a legal term of art used in hearsay doctrine to assess admissibility, not a measure of whether a practice is formally required by professional guidelines. The fact that the AMA disclaimed creating a binding “standard of medical care” does not diminish the medical relevance of identifying the source of trauma in IPV cases. Reasonable pertinence requires only that information be useful to diagnosis or treatment—not that it be obligatory. By collapsing pertinence into obligation, the *Robinson* Court sidestepped the weight of medical evidence and professional consensus that understanding the cause of injury, including IPV-related trauma, is clinically significant to both somatic and psychological treatment.

136. AM. MED. ASS’N COMM. ON MED. ETHICS, *Code of Medical Ethics* Op. 8.10, Preventing, Identifying & Treating Violence & Abuse (2016).

137. *Id.*

138. See *id.* at § 8.10(a)(i).

both public health prevention strategies and the legal obligations governing reporting.¹³⁹

In practice, this means physicians should consider the possibility of abuse whenever evaluating medical complaints and should incorporate routine inquiry about physical, sexual, and psychological violence into patient assessments.¹⁴⁰ Diagnosis and treatment must not be clouded by the outdated belief that abuse is rare or a “private” matter.¹⁴¹ Instead, physicians are called to treat both the immediate injuries and the longer-term physical, psychological, and social consequences of violence.¹⁴²

Equally important is the manner of communication. Physicians are expected to raise concerns with sensitivity, offer referrals to supportive services, comply with mandatory reporting laws, and protect patient autonomy to the fullest extent permitted.¹⁴³ When disclosure is not legally required, they should seek informed consent; when reporting is mandated, they should release only the minimum necessary information.¹⁴⁴ Throughout, respect for patient privacy and dignity remains paramount. These ethical directives make clear that recognizing IPV is not peripheral but central to the physician’s duty: accurate diagnosis and effective treatment demand that the physician understand not only the patient’s symptoms but their source. Accordingly, identifying the cause—and, where appropriate, the perpetrator—of IPV injuries is reasonably pertinent to medical diagnosis and treatment. Medical ethics and public health imperatives converge on the conclusion that perpetrator identification is a necessary component of sound clinical practice.

C. Doctrinal Inconsistency & Gender Bias

Despite the medical and ethical imperatives for admitting perpetrator-identifying statements in IPV cases, jurisdictions like Pennsylvania continue to resist this step. Pennsylvania’s controlling precedent, *Commonwealth v. Smith*, declined to treat an abuse victim’s identification of the perpetrator as admissible under Rule 803(4), and Pennsylvania courts have not extended the medical-treatment

139. *Id.*

140. *See* AM. MED. ASS’N COMM. ON MED. ETHICS, *supra* note 136, at § 8.10(b).

141. *See id.* at § 8.10(d).

142. *See id.* at § 8.10(e).

143. *See id.* at § 8.10(f).

144. *See* AM. MED. ASS’N COMM. ON MED. ETHICS, *supra* note 136, at § 8.10(g)(ii), (h).

exception to IPV survivors' statements identifying their abusers.¹⁴⁵ This position stands in contrast to a growing body of authority in other jurisdictions recognizing that perpetrator identity may be reasonably pertinent to medical diagnosis and treatment in abuse cases. The justifications for maintaining Pennsylvania's narrower rule are strikingly thin: both children and IPV survivors face heightened vulnerability, both require identification of the perpetrator to prevent recurrence of harm, and both rely on medical professionals not only for treatment of physical injuries but also for safety planning and psychological recovery.¹⁴⁶ If anything, survivors of domestic violence—who are often forced to interact with their abusers for months or years after initial disclosure—may have even greater medical need for the perpetrator's identification to be credited in the clinical setting.

This disparity cannot be explained by the rule's text or its underlying rationale for the exception. Nor is Pennsylvania's asymmetry doctrinally neutral; it reflects deeper gendered assumptions about whose safety, credibility, and autonomy the law prioritizes. This section examines these inconsistencies and situates them within the broader history of the legal system's minimization of women as witnesses and, more specifically, as survivors of IPV.

1. Credibility Discounting in Practice

Deborah Epstein and Lisa Goodman masterfully analyzed “the ways in which women's credibility is discounted in a range of legal and social services settings.”¹⁴⁷ These scholars describe the phenomenon of “credibility discounting”¹⁴⁸ as the pervasive pattern in which survivors' testimony is met with doubt, dismissal, or disbelief precisely because they are women reporting male violence. They note that even when legal rules ostensibly protect survivors, “women telling stories of abuse by their male partners are simply not believed,” creating what they call a “legal twilight zone” where the protective promise of law collapses under systemic skepticism.¹⁴⁹ This discounting occurs

145. See *Commonwealth v. Smith*, 681 A.2d 1288, 1292–93 (Pa. 1996).

146. See *Commonwealth v. Smith*, 681 A.2d 1288, 1293–94 (Pa. 1996) (Castille, J., dissenting).

147. Deborah Epstein & Lisa A. Goodman, *Doubting Domestic Violence Survivors' Credibility and Dismissing Their Experiences*, 167 U. PA. L. REV. 399, 399 (2019).

148. *Id.* at 402. The term “credibility discount” was originally coined by Deborah Tuerkheimer, *Incredible Women: Sexual Violence and the Credibility Discount*, 166 U. PA. L. REV. 1, 3 (2017).

149. *Id.* at 403.

in both overt and subtle ways. Judges may deem survivors' accounts implausible when they do not conform to preconceived scripts of what "real" abuse looks like—scripts that emphasize physical injury over psychological coercion, or continuous violence over episodic outbursts.¹⁵⁰ Survivors whose testimony does not track these expectations are not credited as truthful, even when their narratives are consistent with well-documented patterns of trauma.¹⁵¹

This problem is compounded by what Lynn Hecht Schafran has called women's lack of "collective, contextual, and consequential credibility."¹⁵² Women as a group continue to be treated as less reliable narrators ("collective credibility"); judges often lack the contextual knowledge to assess survivors' accounts on their own terms ("contextual credibility"); and even when abuse is acknowledged, women's injuries are minimized as inconsequential compared to other harms ("consequential credibility").¹⁵³ Taken together, these credibility gaps mean that when adult women testify about intimate partner violence, their accounts are often devalued—not because of evidentiary principles, but because of deeply entrenched gendered assumptions about truthfulness, motive, and harm.

The doctrinal carveout for children in many jurisdictions underscores this inconsistency. Courts justify admitting children's identification of abusers by appealing to necessity and the recognition that young victims may otherwise lack avenues to protect themselves. The same logic applies to IPV survivors, who often remain in dangerous proximity to their abusers and whose safety depends on medical and legal actors believing their accounts. That courts extend the benefit of the exception to children but not to women reflects what scholars and task force reports have repeatedly documented: a judicial system shaped by misogyny, in which harms primarily suffered by women are trivialized, disbelieved, or deprioritized.¹⁵⁴

150. *See id.* at 417.

151. *See id.* at 419. *See also* CHARLOTTE TRIGGS, *False Allegations of Sexual Violence: The Reality*, WOMEN AND THE CRIMINAL JUSTICE SYSTEM 46 (Emma Milne et al., eds., 2018).

152. Lynn Hecht Schafran, *Credibility in the Courts: Why Is There a Gender Gap*, 34 JUDGES' J. 5, 5 (1995).

153. *Id.* at 5–6.

154. *See, e.g.*, Molly Dragiewicz, *Gender Bias in the Courts: Implications for Battered Mothers and Their Children*, 5 FAM. & INTIMATE PARTNER VIOLENCE Q. 13, 23–24 (2012); Karen Czapanskiy, *Domestic Violence, the Family, and the Lawyering Process: Lessons from Studies on Gender Bias in the Courts*, 27 FAM. L.Q. 247, 249, 254, 263 (1993) ("Studies of gender bias in the courts document how courts too often disbelieve credible evidence of domestic violence and discount its

2. *Historic Gender Bias in Assessing Credibility*

This pattern has deep historical roots. For centuries, rape law was premised on the assumption that women were prone to fabrication; John Henry Wigmore notoriously insisted that female accusers should be presumed suspect:

Modern psychiatrists have amply studied the behaviour of errant young girls and women coming before the courts in all sorts of cases. Their psychic complexes are multifarious, distorted partly by inherent defects, partly by diseased derangements or abnormal instincts, partly by bad social environment, partly by temporary physiological or emotional conditions. One form taken by their complexes is that of contriving false charges of sexual offenses by men.¹⁵⁵

Almost a century later, several key American states catalyzed a nationwide movement for anti-domestic violence legislation.¹⁵⁶ These pioneering state legislative efforts culminated in the Violence Against Women Act (“VAWA”) of 1994, the first comprehensive federal legislative package designed to end violence against women.¹⁵⁷ The reforms of the 1990s, accelerated by federal funding and mandates from VAWA, sought to transform the legal response to domestic violence from a “private matter” to a criminal justice issue.¹⁵⁸

Although Wigmorean rhetoric has long since been discredited by the past three decades of IPV awareness and advocacy (or has it?), its underlying suspicion continues to reverberate in modern evidentiary

seriousness.... Studies repeatedly demonstrate that, in any given setting, women are accorded less credibility than are men...The problem seems particularly acute when the issue is a woman’s accusation that a man has been violent toward her.”).

155. John Henry Wigmore, *Evidence in Trials at Common Law* § 924a (James H. Chadbourn rev. ed. 1970), quoted in Elisabeth McDonald, *Gender Bias and the Law of Evidence: The Link Between Sexuality and Credibility*, 24 VICTORIA U. WELLINGTON L. REV. 175 (1994). See also Julie Taylor, *Rape and Women’s Credibility: Problems of Recantations and False Accusations Echoed in the Case of Cathleen Crowell Webb and Gary Dotson*, 10 HARV. WOMEN’S L.J. 59, 77 (1987).

156. Ironically, including Pennsylvania.

157. See *History of the Violence Against Women Act*, LEGAL MOMENTUM, <https://www.legalmomentum.org/history-vawa> (on file with Syracuse Law Review) (last visited Jan. 21, 2026).

158. See Silvana Andrea del Valle Bustos, *Biases in Domestic Violence Criminal Decision Making: Are System Actors Lenient in Domestic Violence Cases?*, Cornell L. Sch. Inter-Univ. Graduate Student Conference Papers, Paper No. 51 (2011) (quoting S. Rep. No. 102–197, at 41 (1991) (“[d]espite decades of law reform, [the criminal system encountered by women who experience crime has a] prevalence of ... prejudices on a daily basis”)).

doctrine. Pennsylvania's refusal to admit IPV survivors' perpetrator-identifying statements, even as neighboring courts routinely accept analogous statements from children, is best understood as a contemporary manifestation of this entrenched skepticism.

3. Intersectionality

Moreover, the credibility discount operates intersectionally. Women of color, immigrant women, and low-income survivors face compounded disbelief, as stereotypes about race, class, and immigration status intersect with gendered assumptions about victimhood.¹⁵⁹ Studies show that police and judges disproportionately discount the testimony of marginalized survivors, perceiving them as less trustworthy or as bearing ulterior motives.¹⁶⁰ Implicit bias further exacerbates these inequities: evaluators may interpret a survivor's fear or anger as instability rather than as a predictable symptom of trauma.¹⁶¹ The result is that the evidentiary system not only replicates misogyny but amplifies the exclusions faced by those at the margins of multiple social hierarchies.¹⁶²

Pennsylvania's refusal to extend Rule 803(4) to IPV survivors' identification of their abusers reflects more than a narrow doctrinal choice. It signals whose testimony courts deem worthy of belief and whose harms count as legally cognizable. Dismissing the medical pertinence of IPV perpetrator identification, Pennsylvania's evidentiary doctrine reproduces the very gender biases that decades of feminist advocacy have worked to dismantle. Recognizing this inconsistency is critical: so long as courts refuse to see IPV survivors as credible narrators of their own abuse (while being examined both as witnesses and as patients), the medical treatment exception will continue to function not as a neutral evidentiary rule, but as an instrument of gendered exclusion.

159. See Epstein & Goodman, *supra* note 147, at 433.

160. See, e.g., Silvana Andrea del Valle Bustos, *Biases in Domestic Violence Criminal Decision Making: Are System Actors Lenient in Domestic Violence Cases?*, Cornell L. Sch. Inter-Univ. Graduate Student Conference Papers, Paper No. 51 (2011); Ruth Leah Perrin, *Overcoming Biased Views of Gender and Victimhood in Custody Evaluations When Domestic Violence is Alleged*, 25 AM. U. J. GENDER SOC. POL'Y & L. 155 (2017).

161. See Ruth Leah Perrin, *Overcoming Biased Views of Gender and Victimhood in Custody Evaluations When Domestic Violence Is Alleged*, 25 AM. U. J. GENDER SOC. POL'Y & L. 155, 169–70 (2017).

162. See Epstein & Goodman, *supra* note 147, at 419–20 (citing Gaile Pohlhaus, *Varieties of Epistemic Injustice*, n. 80, THE ROUTLEDGE HANDBOOK).

D. The Case for Re-Evaluating Smith

Despite the doctrinal inconsistencies and gendered assumptions that underlie the exclusion of perpetrator-identification statements, the problem is not merely theoretical. It has concrete consequences for the prosecution of IPV cases. Scholars have long documented the phenomenon of “attrition” in domestic violence prosecutions—the steady decline in the number of cases as they progress from police report to final disposition.¹⁶³ Attrition rates are notoriously difficult to quantify given the variations in charging practices across and even within jurisdictions, but a consistent theme emerges: a significant share of IPV cases do not proceed because survivors decline to participate.¹⁶⁴

Studies confirm that survivors’ withdrawal is a central driver of attrition.¹⁶⁵ Other empirical work similarly demonstrates that full victim cooperation dramatically increases the likelihood of prosecution and conviction.¹⁶⁶ Survivors’ reluctance to continue is not irrational; it reflects the heavy collateral consequences of testifying against an intimate partner. These include economic dependence on the abuser, threats to housing and custody, immigration vulnerabilities, community stigma, and the very real risk of retaliation by the abuser or their family.

Given these realities, limiting the admissibility of survivors’ statements to medical professionals—when a perfectly fitting evidentiary exception exists—exacerbates the problem of attrition. Prosecutors are forced to rely disproportionately on live testimony from IPV survivors, thereby placing the full weight of criminal adjudication on survivors who may face enormous costs if they cooperate. Recognizing perpetrator-identification statements under Pennsylvania Rule

163. See generally Julien Chopin et al., *Attrition in Intimate Partner Violence Cases Through the Criminal Justice System: A Scoping Review of Patterns and Predictors*, 50 INT’L J. COMPAR. & APPLIED CRIM. JUST. 1 (2026).

164. See *id.* at 12.

165. See, e.g., David A. Ford, *Wife Battery and Criminal Justice: A Study of Victim Decision-Making*, 32 FAMILY REL. 463 (1991); David A. Ford, *Prosecution as a Victim Power Resource: A Note on Empowering Women in Violent Conjugal Relationships*, 25 L. & SOC’Y REV. 313, 313–34 (1991) (finding that roughly 70 percent of IPV complainants eventually discontinued participation, often within months of an offender’s arrest).

166. See, e.g., Julien Chopin et al., *Attrition in Intimate Partner Violence Cases Through the Criminal Justice System: A Scoping Review of Patterns and Predictors*, 50 INT’L J. COMPAR. & APPLIED CRIM. JUST. 1, 12 (2026) (citing Myrna Dawson & Ronit Dinovitzer, *Victim Cooperation and the Prosecution of Domestic Violence in a Specialized Court*, 18 JUST. Q. 593, 593–622 (2001)); Robert C. Davis et al., *Prosecuting Domestic Violence Cases with Reluctant Victims: Assessing Two Novel Approaches in Milwaukee*, NAT’L INST. JUS. (1997).

803(4) would not eliminate the obstacles survivors face, but it would provide an additional evidentiary pathway consistent with both the medical rationale of the rule and the ethical imperatives of trauma-informed care.

The combined weight of these arguments makes clear that *Commonwealth v. Smith* is not just doctrinally outdated but actively harmful. By excluding IPV perpetrator-identification statements from Rule 803(4), Pennsylvania courts perpetuate gender bias, discount survivors' credibility, and narrow the meaning of "treatment" in ways that ignore the realities of intimate partner violence. This exclusion does more than distort evidence law—it compounds survivors' risks, fuels prosecutorial attrition, and communicates that their safety is less worthy of protection. Recognizing IPV perpetrator-identification statements under Rule 803(4) is therefore not only doctrinally defensible but ethically imperative. To continue adhering to *Smith* is to endorse a jurisprudence that silences survivors; to re-evaluate it is to move toward a framework of evidentiary justice that the law has long denied.

III. TOWARD EVIDENTIARY REFORM: A PROPOSED FRAMEWORK

To reconcile *Smith*'s interpretation of Rule 803(4) with both medical practice and constitutional safeguards, Pennsylvania courts should adopt a structured test for admitting perpetrator-identification statements in IPV cases. The following factors, drawn from comparative jurisdictions and tailored to Pennsylvania precedent, would provide clarity and predictability:

1. *Declarant's Purpose*. The statement must be made for the purpose of obtaining a medical diagnosis or treatment. Courts may interpret this flexibly for children and other vulnerable declarants whose circumstances demonstrate no ulterior motive.
2. *Audience*. The statement should be made to a treating provider, nurse, SANE, or first responder acting in a medical role—not primarily to law enforcement or a forensic interviewer.
3. *Medical Pertinence*. The identity of the perpetrator must materially inform a treatment decision, such as STI prophylaxis, wound care, discharge planning, counseling referrals, lethality assessment, or psychiatric care.
4. *Documented Reliance*. There should be objective evidence that the provider relied on the statement in formulating a treatment plan, such as medical notes, testimony, or treatment records.

5. *Temporal Immediacy*. Statements made contemporaneously with the medical encounter, or in the immediate course of seeking care, are more reliable and thus more admissible.
6. *Non-Testimonial/Absence of Investigatory Motive*. Courts should consider whether the primary purpose of the exchange was clinical rather than investigatory. Statements elicited in the hospital setting for immediate treatment are often deemed non-testimonial under *Crawford*. This factor ensures alignment with Confrontation Clause jurisprudence.

Applying this checklist preserves the reliability rationale underlying Rule 803(4) while equipping trial courts with a concrete, judge-friendly tool to admit statements that clinicians themselves treat as integral to care.

This framework should not be understood as a license for admitting all accusatory hearsay under the guise of medical treatment. Where statements are elicited primarily for investigatory purposes—such as police-initiated forensic interviews or interactions where medical care is incidental—*Crawford* concerns should remain controlling. The test's guardrails are designed to safeguard the accused's constitutional rights while ensuring that truly treatment-oriented statements are not excluded.

CONCLUSION

Current Pennsylvania doctrine erases IPV survivors' voices by excluding the very statements that most directly explain their injuries and inform their care. Admitting statements that identify as IPV perpetrators for the medical treatment or diagnosis under Rule 803(4) would correct *Smith*'s doctrinal blind spot and align evidentiary practice with contemporary medical and ethical realities. The framework proposed here demonstrates that such statements can be admitted in a way that acknowledges survivors' lived experiences, reduces prosecutorial overreliance on live testimony, and still preserves the constitutional rights of the accused. Pennsylvania courts should reject the outdated reasoning of *Smith* and recognize the applicability of the medical treatment hearsay exception to statements of IPV-perpetrator identification. Doing so would not only advance the credibility of survivors and public health but also reaffirm the Pennsylvania judiciary's commitment to substantive justice. In short, what medicine already knows, the law must now allow.