The Forensic Medical Evaluation and the Role of the Medical Practitioner in a Child Advocacy Centre

Amy Ornstein, MD, FRCPC, FAAP, Medical Director, IWK Child Protection Team, Halifax, Nova Scotia
Tanya Deurvorst Smith, RN, MN, NP-Paeds, Nurse Practitioner, The Suspected Child Abuse & Neglect (SCAN) Program, Sickkids, Toronto, Ontario

Introduction

A core component of the multidisciplinary approach to investigation of an allegation of abuse is the medical assessment. *Medical evaluation* is one of ten accreditation standards defined by the National Children's Alliance (NCA) for Child Advocacy Centres (CAC) and should be an integral component of a comprehensive "best practice" working model for CACs in Canada.

In the early planning stages of CAC development, consideration should be given as to how medical services will be delivered. Similar to the concept that there is no universally-acceptable model for CACs to meet the needs of all communities, there is no singular model for delivery of medical services. Rather, there are guiding principles and best practice guidelines for delivery of care which can be adapted to best meet the needs of the community served by the CAC.

Regardless of the service delivery model adopted, all CACs should aim to meet the standard for medical evaluation defined by the NCA (2010) which includes:

- Specialized medical evaluation and treatment services are routinely made available to all CAC clients
- The medical evaluation is coordinated with the multidisciplinary team response
- Minimal standards for providers are adhered to
- There is ongoing education in the field of child sexual abuse for practitioners
- There is peer review of photo-documented examinations

By answering frequently-asked questions, this paper will discuss the role of the medical practitioner in a CAC and outline issues to consider when developing the medical component of a CAC.

What are the goals of a medical evaluation and how can this contribute to the evaluation of an allegation of abuse?

The medical evaluation is an important part of a comprehensive response to an allegation of child abuse and serves a number of functions. All child and youth victims seen at a CAC should be offered a medical examination for allegations of physical and/or sexual abuse, neglect, and those witnessing domestic violence. The *Guidelines for Medical Care of Children who may have been Sexually Abused* [1], recommends that an examination be conducted for all children and youth where sexual abuse has been or is being considered.

Child and youth victims of maltreatment are provided with a medical examination to ensure their well being. Injuries or abnormal findings resulting from abuse can be detected to ensure appropriate treatment and follow-up. A normal examination can provide reassurance to a child /youth and their family that they are physically "normal" despite having experienced abuse. The results of an examination can provide investigators with a more clear understanding of injuries sustained by the child/youth. The medical examination can also help clarify how an injury may have been sustained and whether or not an injury is suggestive of abuse. Finally, an examination ensures investigators that an injury, which may provide evidence to support an allegation(s), has not been overlooked.

What models exist for provision of a medical evaluation within a CAC?

Various models should be considered for the provision of medical evaluation within a CAC. Many CACs in the United States are hospital-based and the medical assessment is the point of entry into the CAC. Most CACs which are not hospital-based either have medical services provided directly out of the CAC location, or have an established linkage with a designated practitioner or medical clinic that can be accessed by victims and investigators for assessment or consultation on an as-needed basis.

What types of medical services are provided in a CAC?

As CAC models vary, so do the types of medical services offered within a CAC. The types of services available will depend upon the qualifications and training of the designated medical practitioner. A medical assessment, including a comprehensive physical examination and medical history, should be offered to all children seen at a CAC, including those with allegations of physical and/or sexual abuse, neglect, and exposure to domestic violence. Additionally, intake medical assessments for child welfare agencies may be conducted. Provision of primary care for children in foster care can also be considered for delivery within a CAC depending on the medical resources available in the community.

Who should perform the medical evaluation in a CAC?

Various practitioners may be available in a community to provide medical services within a CAC, for example, paediatricians, family physicians, other physician specialists, nurse practitioners and/or sexual assault nurse examiners may all be qualified. Regardless of the practitioner's professional designation, minimal practice standards exist, including that a practitioner should have received training in child abuse medical evaluations and participates in continuing education and peer-review. Also, practitioners should be aware of and understand the nature of their medico-legal responsibility. Additionally, it is important for the practitioner to have access to other experts in the field and consultation when necessary. Within a CAC, two types of practitioners exist, each with a unique scope of practice. There are practitioners who will collect a history, perform a physical exam, and document their findings, and other practitioners, who in addition to the above duties, can provide an interpretation of their findings for medico-legal purposes.

For an allegation of physical abuse and/or neglect, when should a medical evaluation be conducted and what types of services are provided in a CAC?

For allegations of physical abuse and/or neglect, an initial verbal consultation with a medical practitioner is important to determine the medical needs of the child and how quickly an evaluation should be scheduled.

Typically, urgent cases which require rapid assessment include those in which the child has clinical symptoms suggestive of head or other major trauma, visible injuries (such as significant bruises or burns), or there is a suspicion of internal injuries. Typically, a full assessment of these types of findings will require a diagnostic work-up which may include x-rays, CT scan or MRI and blood tests. Urgent cases should not be seen in a CAC[1], because the required medical resources for timely and complete management are not routinely available. Urgent cases should be assessed in a hospital setting as soon as possible and in some instances the child or youth should be brought directly to an Emergency Department.

Less urgent physical abuse cases include those which require an evaluation of injuries but where extensive medical testing or treatment is not likely (such as documentation of bruises). In addition to documentation of injuries, a complete physical examination, including height, weight and developmental status, are performed. A practitioner may also address medical symptoms that may be a consequence of psychological trauma sustained by a child or youth related to their abuse. To enhance documentation, the practitioner may elect to photograph important clinical findings such as bruising or skin markings. Less urgent cases can be evaluated at a CAC and scheduled for an elective assessment within days or weeks of an allegation, as appropriate.

For an allegation of sexual abuse, when should a medical evaluation be conducted and what types of services are provided in a CAC?

Similar to physical abuse cases, sexual abuse cases should be categorized into two groups: those requiring urgent or immediate medical care, and those that require less urgent evaluation. Urgent cases are those in which the child or youth complains of pain or ano-genital injury, the last contact with the alleged perpetrator is within the previous 24-72 hour period, the child/youth is experiencing a mental health crisis such as threat of suicide, or when HIV prophylaxis or other post-assault medical treatment may be required. Urgent referrals should be evaluated as soon as possible in an appropriate venue such as an Emergency Department or a sexual assault response center.

Less urgent cases include those in which the child/youth is not symptomatic[2], there is no history of ano-genital pain, bleeding, or discharge, the last known contact with the

[1] Except if it is a hospital-based facility that has required resources.
[2] Symptoms post-assault may include genital bleeding, difficulty with passage of urine, or unusual discharge from the genitals.

alleged perpetrator occurred over 72 hours[3] prior, and the child/youth is in a place of safety. In these situations, the medical evaluation can be delayed and ideally should be completed at the CAC, or a medical clinic linked with the CAC, after a forensic interview has been conducted.

What is the purpose of a sexual abuse medical evaluation and what is involved?

The purpose of a sexual abuse evaluation is to (1) ensure the well-being of the child/youth, (2) provide reassurance to the child/youth and their family, (3) identify and document injury and/or infections, (4) diagnose and treat medical conditions, and in some instances (5) assist the police by collecting a sexual assault evidence kit. An attempt should always be made to limit unnecessary or multiple genital exams.

The sexual abuse medical evaluation should occur in the most comfortable and comprehensive manner possible. The examination should always be in the presence of a non-offending caregiver or other support person that the child/youth identifies. Time should be taken to develop a rapport with the child/youth in a manner suited to their developmental stage. The medical examination, in general, should not be painful or traumatic.

The medical practitioner will conduct a general physical examination (i.e. head to toe assessment) including an external genital and anal examination (for both males and females). Visualization of the external female genital structures can be achieved with the application of gentle traction or separation of the labia majora. Use of a speculum is not indicated in the prepubescent population. If further tests are needed (i.e. swabs for sexually transmitted infections), every effort should be made to ensure that the child/youth does not experience pain or discomfort. Conscious sedation is rarely indicated. An examination under a general anesthetic should only be considered if there are clinical symptoms that require more extensive evaluation and the child/youth is unable to tolerate an examination otherwise.

Photo-documentation of the genital and anal examination is strongly encouraged, as it may eliminate the need for re-examination, and allows for peer review and/or secondary consultation if needed. A camera or colposocope is used to obtain photos, and consent should be obtained. Storage and access of these photos must be appropriately managed by the practitioner. After completion of the examination, the findings should be explained to the child/youth and caregiver. Written consent should be obtained from the caregivers to allow for sharing of medical evaluation findings with the investigators. A written report should be completed following the sexual abuse medical evaluation which details the findings of the general and genital examinations.

How do the results of a sexual abuse medical evaluation contribute to the investigation of an allegation of sexual abuse?

[3] If the last known contact with an alleged perpetrator occurred more than 72 hours prior, this is considered to be a *historical* case of sexual assault/abuse.

It is critical that genital examination findings are carefully interpreted and documented by practitioners. The majority of medical examinations conducted in children with suspected sexual abuse yield normal or non-specific[4] findings and do not confirm nor refute an allegation of abuse. Recent literature indicates that the majority of male and female children and adolescents who give a history of sexual abuse have no evidence of anal or genital injury on physical examination [2-7]. For example, in a large retrospective review of 2,384 children referred for a medical evaluation who disclosed sexual abuse, only 4% had an abnormal examination at the time of medical evaluation [2]. Practitioners should be familiar with research studies of abused and non-abused children and are encouraged to use an evidence-based tool to assist in their interpretation of physical and laboratory findings [1].

If a practitioner identifies findings that are abnormal and concerning for sexual contact, it is strongly recommended that the examination be reviewed by a peer with expertise in the field.

Is there any evidence that CACs have altered case outcomes in regards to access to a medical evaluation?

Walsh and colleagues conducted a study evaluating which children received a medical evaluation in a community with a CAC as compared with a non-CAC community[8]. Nearly half of all children seen in the CAC had a medical examination while only one fifth of those in the comparison non-CAC sample received an examination. In addition, children with an allegation of non-penetrating sexual abuse were four times more likely to have an examination completed in a CAC when compared with the comparison sample. Approximately half of the medical examinations were completed on the same day as the forensic interview and the majority of non-offending caregivers were satisfied with the medical evaluation overall.

Conclusion

The development of CACs in Canada is an exciting opportunity for multidisciplinary teams. The medical evaluation is an important step in the provision of comprehensive care within the CAC model. A medical evaluation benefits not only the children/youth and families served, but will also inform the multidisciplinary process that is the hallmark of a successful CAC.

How the medical evaluation will be incorporated into the workings of a CAC should be considered early in the CAC planning stages. Building relationships with potential medical practitioners and addressing the issues of how medical services will be provided are key steps in this process. Creative models of service delivery should be considered which reflect the needs and resources of each community. For new and existing practitioners in the field, medical training, continuing education, and peer review are available and provided in various provinces and settings across the country.

[4] A non-specific finding is one that may have numerous possible explanations

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