

Limitations of the National Protocol for Sexual Assault Medical Forensic Examinations

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The care of victims of sexual assault in the United States has seen considerable improvement during the past 20 years. According to a database maintained by the International Association of Forensic Nurses, there are at least 276 sexual assault nurse examiner (SANE) programs in the United States. The majority of SANE programs are hospital based (75%) (www.iafn.org; members only).¹ Numerous articles in medical and nursing journals and particularly in the *Journal of Emergency Nursing* have documented the science of forensic and medical care of victims of sexual assault, contributing significantly to the body of literature.

In September 2004, the first National Protocol for Sexual Assault Medical Forensic Examinations (the National Protocol) was released by the US Justice Department, Office on Violence Against Women.² This 130-page document was designed as a guide for persons caring for victims of sexual assault and is the first national protocol of its kind. Although the authors are not listed, the protocol states that it was developed with the "input of national, local, and tribal experts throughout the country, including law enforcement representatives, prosecutors, medical personnel, forensic scientists, and others."² The document states that the protocol should serve as a guideline rather than as a list of requirements and should supplement the many excellent protocols in use but not supercede these protocols. The guidelines are specific to female and male adolescents and adult populations and do not address pediatric or prepubescent examinations.

The National Protocol provides a detailed set of guidelines for criminal justice and health care practitioners in responding to the immediate needs of sexual assault victims. The major sections address overarching issues, operational challenges, and examination process.

The overall goal of most protocols related to the care of sexual assault victims seeks to ensure that the medical forensic examination is performed with expertise and sensitivity. The overall content appears congruent on many levels with evidence-based practice protocols and is consistent with current best practice, except for 2 particular issues: emergency contraception (EC) and sexually transmitted infections (STIs). In these 2 instances, the protocol lacks necessary clarity and deviates from the standard of care for female victims of sexual assault.

Emergency contraception

There are many aspects specific to the medical care of victims, and perhaps one of the most controversial is EC. In the late 1990s the Federal Food and Drug Administration approved a product for EC.³ Prior to this approval, oral contraceptives were used for the purpose of EC.⁴ Currently, 5 states require hospital emergency rooms to provide EC: California, New Mexico, New York, South Carolina, and Washington. In an effort to improve access to EC, 6 states allow pharmacists to dispense EC without a prescription with prescribed guidelines (Alaska, California, Hawaii, Maine, New York, and Washington).⁵⁻⁸

Surprisingly, less than half a page is devoted to “pregnancy risk evaluation and care” in the National Protocol (page 111), and recommendations for pregnancy prevention are limited to one sentence on pregnancy prevention: “Discuss treatment options with patients, including reproductive health services.” Although the protocol wisely advises health care personnel to discuss the possibility of pregnancy with rape victims and administer pregnancy tests if given the patient’s consent, it offers no specific suggestions, as would be expected with most sexual assault guidelines.

The risk of pregnancy associated with a sexual assault is significant. In fact, it is estimated that the pregnancy rate associated with rape in victims 12 to 45 years of age is approximately 4.7%. This information, in addition to estimates based on the US Census, suggests that there may be 32,101 annual rape-related pregnancies among American women as a result of a sexual assault,⁹ and this number is in all likelihood an underestimate.

Research began on EC in the late 1960s, and the first study was published in 1974. The emergency contraceptive regimen, also referred to as the Yuzpe Regimen, was

named after Canadian Physician Albert Yuzpe, who published the first studies on combined hormone therapy for EC. He demonstrated safe and efficient use of high-dose estrogen plus progestin.¹⁰ A number of studies have since shown that EC can reduce the risk of pregnancy when started within 120 hours of unprotected intercourse and that the sooner the regimen begins, the more effective the treatment.^{3,11-13} Most SANE protocols discuss EC and offering pregnancy prophylaxis medication.¹⁴ Omission of specific details in relation to EC in the National Protocol is unacceptable.

Even the Vatican has supported pregnancy prevention in cases of sexual assault. In the fourth edition of the Ethical and Religious Directives for Catholic Health Care Services, the Committee on Doctrine of the National Conference of Catholic Bishops approved as the national code by the full body of bishops at its June 2001 General Meeting a directive to be used in caring for victims of sexual assault. It states:

“Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum.”¹⁵

The National Protocol fails to offer a responsible, medically informed, time-sensitive option for victims of sexual assault. Specifically, pregnancy prophylaxis with the use of “Plan B”—a progesterone-only hormone—prevents a pregnancy from occurring¹⁶⁻¹⁸; it does not end a pregnancy that is already in progress and is considered a safe and easy treatment for victims of assault in preventing a pregnancy. Prior to administering the medication, a pregnancy test is conducted to ensure that no pregnancy is in

progress. Two doses of 0.75 mg of levonorgestrel are taken orally 12 hours apart.

Victims of sexual assault should be offered this medication within 120 hours of the assault. Plan B, when taken within 72 hours, reduces the risk of pregnancy by 89%.¹¹⁻¹³ Timing is crucial, and the medical provider who is responding should not “include a referral” but should provide the option for immediate treatment.

Sexually transmitted infections

The second issue that, in our opinion, requires revision in the National Protocol, is STI screening. Although The National Protocol supports offering preventive treatment (ie, prophylactic antibiotics) without mandatory testing, we suggest an even stronger and more direct position—that STI screening is not recommended. Whereas some health care providers might assume that a link between an assailant and a victim is possible through testing for and identifying an STI, this has not been our experience. Even if an assailant has an STI and transmits it to the victim, this generally will not help the legal case, because the assailant can quickly be treated and provide a negative STI result. Also, a positive test can and has been used against victims in court cases and may even provide a “defense” of the alleged perpetrator by implying that the victim is promiscuous. Lastly, a victim who initially tested negative for STIs would have to refrain from prophylactic treatment (and intercourse) and return to a health care provider for another screen to see if an STI developed. This, of course, has major logistical and moral implications and provides opportunity for further scrutiny in court.

It is important to know the incubation periods for STIs. Syphilis, gonorrhea, and chlamydia are 10 to 90 days, 2 to 30 days, and 7 to 14 days, respectively.^{19,20} Thus, detecting an STI within the 120 hours of the rape is almost impossible. Of note, test results may be negative even if the assailant was positive, because the victim may be incubating and incubation rates vary. Also of note is that victims are usually fearful of having contracted an STI and generally consent to prophylactic treatment against infection. Most prefer the immediate treatment rather than to wait for test results.

Anecdotally, we know that there are varied practices, ranging from routine STI testing of all assault victims to no testing, but screening patients for STIs within the context

of a sexual assault is introducing privacy information that is not necessary to provide medication to prevent STIs. In fact, it may be damaging. It is currently naive to think that Rape Shield Laws will protect certain sexual history²¹ when cases are litigated.

Summary

It is commendable to see a National Protocol for Sexual Assault Medical Forensic Examination published by the US Federal Government. Such documentation validates the concern the United States needs to have regarding care of sexual assault victims. The goal of the protocols is stated on page 3: “A timely, well-done medical forensic examination can potentially validate and address sexual assault patients concern, minimize the trauma they may experience, and promote their healing.” The protocol further states that “The examination and the related responsibilities of health personnel are the focus of this protocol (page 3).”

Although overall the document provides useful information, it is not a document that could stand alone, and the authors acknowledge that. The overt omission of clear procedures to address EC clearly does not “address the patients concerns” and does not “minimize the trauma they may experience.” Frankly, to state that “the examination and the related responsibilities of health personnel are the focus of this protocol” is a misnomer because the omission of EC is not congruent with the guidelines of the American Medical Association, the American College of Emergency Physicians, and the American College of Obstetricians and Gynecologists. Even the Vatican supports emergency interception when a woman has been raped. It appears that politics may have taken precedence over the medical and emotional needs of a female victim of sexual assault.

Some persons in the community of those caring for sexual assault victims are concerned that women’s access to EC is becoming increasingly more restricted. In another example, which occurred in May of 2004, the Food and Drug Administration denied over-the-counter status for EC, against the recommendation of its own staff and the advice of the American Medical Association and other medical authorities.^{22,23} We strongly believe that EC, specifically Plan B, should be offered to all women of child-bearing age. No victim of sexual assault should have to deal with a pregnancy in the aftermath of a rape. Informed

consent should be reviewed with all women of child-bearing age. We further encourage that STI screening not be done routinely in sexual assault cases. Many SANE programs and a few states have policies and procedures in place that address EC and STI screening.

The very limited information on pregnancy prophylaxis and the unclear information with regard to STI testing in this national protocol may prompt ED clinicians to look to other, more comprehensive, science-based protocols. The authors suggest the following: The Massachusetts Sexual Assault Protocol (statewide), available on the Web at <http://www.mass.gov/dph/fch/sane>,²⁴ and Dr Linda Ledray's *Sexual Assault Nurse Examiner—Development and Operation Guide*, which may be retrieved online at www.sane-sart.com/index.php?topic=Pubs.¹⁴

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Send descriptions of procedures in emergency care and/or quick-reference charts suitable for placing in a reference file or notebook to:

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