

CHAPTER THREE

MEDICO-LEGAL SERVICES

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1. INTRODUCTION

The discussion document makes a laudable effort in ‘putting the pieces together’ in Chapter 3, “Agencies or Service Providers”. It pays special attention to the critical importance of medico-legal services and of ‘linking agencies’ in the management of rape cases. Recognising that in cases of sexual assault, medical and forensic evidence may be the only corroboration produced to support a rape victim’s complaint, the omission of medico-legal legal services within the proposed Bill is of great concern. That nothing is contained in the proposed Bill that imposes duties on the health sector to perform specific functions in relation to the management of rape complainants, only maintains the fragmentation between criminal justice and health service provision.

Research by Parenzee, Artz and Mout (2001) on the implementation of the Domestic Violence Act¹ found that one of the major omissions of the Act is:

“... its failure to place similar (or any, for that matter) obligations on health sector personnel to assist victims of domestic violence. Health services often represent the point of first and only contact for with public sector services². Abused women often interact with the health care system for routine or emergency care before turning to the criminal justice

¹ Parenzee, P., Artz, L., & Mout, K. (2001). Monitoring the Domestic Violence Act: First Report. Institute of Criminology, University of Cape Town.

² The health consequences of domestic violence range from serious physical injuries, disabilities, hypertension, anxiety, headaches, various psychosomatic disorders and death.

system ... and therefore health care workers are in a unique position to identify abuse and intervene early on” (p. 82)

The research also found that:

“ ... criminal justice services have little or no interaction with health services, which underscores the importance of inter-sectoral interventions ... “ (p.82).

The only provision dealing with medical care in the proposed Bill is s.22 (1) whereby the rape complainant “*receives the best possible medical care, treatment and counselling as may be required for such injuries*” and 22(2) where the state shall “*bear the cost of the medical care, treatment and counselling*”. While we endorse these provisions fully, we are of the opinion that the management of rape cases by medical practitioners ought to be embodied within the proposed Bill.

2. OPERATIONAL DEFINITIONS

Following is a list of operational definitions that both update the Commission on developments within the health sector, as well as define the concepts contained within this submission –

Health Professions Council of South Africa: Previously known as The South African Medical and Dental Council

An accredited health care practitioner: refers to a medical practitioner, registered nurse or a medical specialist that has proven skills and knowledge by means of formal training and experience. These practitioners need to be registered with the Health Professions Council of South Africa or with the Nursing Council of South Africa and have successfully completed a training programme or course as formulated by a national qualifications (accreditation) body.

Sexual assault care practitioner: Refers to an accredited health care practitioner who has special skills, knowledge and experience in the management of sexually assaulted patients. Until formalized, accredited courses are developed and accepted, we will refer to health care practitioners.

A health care facility is a health care facility that may be private or public and includes:

- Hospitals (tertiary, secondary or district level)
- Primary health care clinics
- Any other facility where medical care is given

A designated health care facility is a health care facility that has been designated as able to manage sexual assault complainants based on a set of defined criteria. The criteria include, but are not limited to the following:

- Must be a 24 hour facility
- Must have an accredited health care practitioner/sexual assault care practitioner attached to the facility, who is immediately available.
- Must have separate area designated for these cases, which must include an examination room and bathroom or shower facility
- Must have available, at all times, the equipment necessary to conduct the examination of the rape complainant
- Must have a supply of SAECK's (see below)
- Must have a safe or secure cupboard with an evidence register
- Must have all the required medication in pre-packaged courses for the treatment of pregnancy, STI's, HIV, pain and tranquilizers, etc. for the rape complainant
- Must have copies of the examination protocol

Sexual Assault Examination Collection Kit (SAECK): The SAECK replaces the Crime Kit No. 1 and Crime Kit No. 3 for the collection of evidence from a sexually assaulted complainant. The SAECK was designed, manufactured and supplied by the Forensic Science Laboratory (FSL) of the South African Police Service (SAPS) in mid-2001.

A Note on the Changing Role of District Surgeons

Martin, L.J. (2001), in a report to the World Health Organisation³ alerts us to the following:

“The district Surgeon system in South African has been abolished in all provinces except the Western Cape. It was intended that all clinical forensic procedures would be available at all public health service locations including primary health care clinics. Although the arguments that District Surgeons were neither economically efficient nor judicially effective were mostly valid, one the rationales behind this transformation was to make the services accessible to all. It was erroneously assumed that the District Surgeon posts could be abolished and that the expertise would remain within the cadres of existing clinicians. The policy makers also mistakenly assumed that every medical practitioner performing clinical district health services would be taught by existing full-time per District Surgeons to perform sophisticated clinical forensic examinations (rape, child abuse, drunken driving). These assumptions however have not materialised and unfortunately, due to the lack of manpower and training, the necessary expertise required for examining rape survivors is not available at most primary health care clinics. With the phasing out of District Surgeons no transfer of services was implemented to ensure that the expertise remained in the health service” (p8).

3. RECOMMENDATIONS FOR TRAINING AND ACCREDITATION

We fully endorse guiding principle 2(p) of the Bill that states that “all professionals and role players involved in the management of sexual offences must be properly and continuously trained after going through a proper selection and screening process”.

We see the training and accreditation of health practitioners as an incremental process. The mid-to-long term goal of the Department of Health and associated training institutions in South Africa should be the establishment of a national system of accreditation for health care practitioners in the management of sexual offences. These practitioners will be referred to as sexual assault care practitioners. The proposed system should work towards:

- (a) formulating a curriculum on the management of sexual assault victims;
- (b) developing a training programme, in consultation with the provinces, for accredited health care practitioners;

³ Forensic Examination Model in South Africa.

- (c) ensuring that the programme meets pre-determined criteria for accreditation;
- (d) ensuring that provincial departments implement the programme;
- (e) ensuring that the training is ongoing and continuous;
- (f) and approved by the Health Professions Council of South Africa.

It is further recommended that the accreditation body consist of individuals who have been identified as experts in the management of sexual offences. The accreditation body must be affiliated with a recognized academic institution(s).

We further submit that health care practitioners who have been trained and accredited through this process, be given the designation “**Sexual Assault Care Practitioners**”.

The National Department of Health should be responsible for developing guidelines for training health care practitioners and overseeing the implementation of such guidelines. The National Department of Health should also ensure that provinces report back to parliament, within a year of promulgation of the Act, on activities relating to the development and implementation of such a system.

Until sexual assault care practitioners are accredited, it is recommended that health care practitioners are bound by an examination and treatment protocol as set out in the following section entitled “Positive Duties on Health Care Practitioners”.

4. POSITIVE DUTIES ON HEALTH CARE PRACTITIONERS

The proposed recommendations on the provision of medico-legal services set out in this submission embrace the Commission's arguments surrounding the need for a more professional, sensitive and accurate medico-legal service. It is the opinion of the authors that legal reform of medico-legal practices in rape cases should be based on the following arguments and principles presented by the Commission:

1. Medical practitioners need to be sensitised to prevent secondary victimisation of rape complainants (s.3.3.1.2).

2. Forensic medical evidence is crucial for the successful prosecution of sexual offence cases (s.3.3.2.1.).
3. Medical evidence is only of value if the examination is properly conducted and all the specimens for forensic analysis are collected. Frequently, such evidence is badly taken or incomplete (s.3.3.2.1).
4. There are often lengthy delays before a victim is examined by a medical practitioner (s.3.3.2.1).
5. ... all appropriately trained medical personnel ... [must] conduct a proper medical examination of and treat or refer the victim of sexual violence for specialised treatment or counselling, where appropriate (Recommendation s.3.3.2.4).
6. ... medical personnel [should] link up with the investigating team to share information on the crime scene, the evidence collected or to be collected from both the victim and or the alleged offender, the injuries sustained during the attack, to advise the investigating team on what other possible evidence could be collected (Recommendation s.3.3.2.4). Proper interaction between the investigating officer and the medical practitioner is crucial (s.3.3.2.6).
7. Victims are often not told what the examination will entail and the reasons for conducting certain tests (s.3.3.2.10). The victim should be given information regarding the reason for the examination and what it entails, information on possible pregnancy ... medication given and possible side effects ... HIV ... regardless of what kind of medical officer conducts the examination (recommendation s.3.3.2.11).
8. Uniform services should be provided ... and ... coupled with appropriate sanctions for non-compliance (s.3.3.2.19).

9. Without appropriate training, the use of registered nurses to perform clinical forensic duties may not be ethical. The same argument applies to general practitioners and other medically qualified persons who have not undergone forensic training (s.3.3.2.22).

10. All health care practitioners should receive the necessary training and ongoing support in order for them to be able to examine victims of sexual assault, provide the necessary medical treatment and give expert evidence in court (s.3.3.2.24).

The Commission must take seriously their acknowledgment that the skills of medical practitioners in examining victims of sexual assault and in collecting the necessary forensic evidence, varies considerably.

In light of the above recommendations and principles, we recommend that following provisions be embodied in the Bill:

DUTIES ON THE HEALTH CARE PRACTITIONER

1. The health care practitioner must provide the complainant with:

- (a) Information relating to the legal rights and options available to the complainant in terms of this Act;**

- (b) Information regarding the reason for the examination and what it entails;**

- (c) Information on possible pregnancy, sexual transmitted infections, PTSD and Rape Trauma Syndrome and the preventative treatment options available to the complainant;**

- (d) Information regarding HIV as a result of the sexual assault, the risks of acquiring HIV from a penetrative act of sexual assault, and the treatment options available to the complainant;**
- (e) An explanation of any medication given and possible side effects;**
- (f) An updated list of local resources that assist survivors of sexual assault as well as relevant literature on sexual assault; and**
- (g) Results or outcome of the medical examination.**

2. Prior to the examination or treatment of the sexual assault complainant, the health care practitioner must ensure that fully informed consent is given, freely and willingly, by the complainant.

3. The health care practitioner must:

- (a) Assess the complainant as soon as possible upon arrival at the designated health care facility, but no longer than two (2) hours;**
- (b) Advise the complainant that a support person may be present throughout the examination, which may include family members, friends or other support persons prescribed in this Act, but may not include the investigating officer;**
- (c) Examine the complainant in a safe and private examination room;**
- (d) Utilise a standardized management protocol for sexual assault examinations;**
- (e) Complete the sexual assault examination protocol form, in detail, as prescribed by the protocol guidelines;**
- (f) Complete the J88 if a criminal charge has been laid; and**

- (g) Give the completed J88 to the attending investigating officer and inform the attending officer of the findings of the examination.**
- 4. No victim of a sexual assault may be turned away from a designated health care facility.**
- 5. If the complainant declines to report the sexual assault to the police, or declines the forensic evidence collection aspect of the examination, this choice should be respected and without pressure from the practitioner.**
- 6. If the complainant wants to report the case to the police, the practitioner must be responsible for contacting the police in their area and to request that an investigating officer attends the health care facility.**

THE FORENSIC EXAMINATION

- 7. Where the complainant presents at the designated health care facility within five days, the health care practitioner must:**
 - (a) Take an appropriate and relevant detailed history with regard to the sexual assault to guide the examination, collection of evidence and management of the complainant;**
 - (b) Conduct a thorough total body examination and document any injuries as well as collect forensic evidence from the complainant's body;**
 - (c) Conduct a thorough examination of the complainant's genitalia, documenting any injuries and collecting forensic biological evidence;**
 - (d) Offer the complainant the various treatment options regarding pregnancy prevention, STI prevention, HIV baseline testing, and PEP;**

- (e) **Provide the complainant with the options available in terms of counseling agencies, other relevant medical specialists or any other service provider, as deemed necessary;**
- (f) **Ensure that follow-up services are provided for the complainant by the designated health care facility, as provided the national standardized protocol.**

These positive duties shall be accompanied by a set of Regulations developed in terms of this Act by the Department of Health.

5. MINIMUM STANDARDS OF CARE

We also refer to and endorse the following guidelines set out in the document “Standards in Clinical Forensic Medicine in South Africa” by the National Department of Health (Tromp, Martin & Muller, p.16)⁴. We have modified the guidelines for the purposes of this submission and recommend that the minimum standards of care should include the following principles:

- The physical, emotional and psychological **safety, health and well being** of a survivor of sexual assault is given precedence over all other matters. This means that the treatment of injuries or life threatening injuries takes precedence over the collection of forensic evidence and informing the survivor of legal remedies. However, it is acknowledge that the collection of biological specimens is of critical importance in cases of this nature and all attempts must be made to secure such evidence.
- Standardised evidence collection and injury documentation procedures must developed nationally and used in all sexual assault cases.
- Survivors of sexual assault must receive the same quality of assistance and treatment regardless of where the assault occurs.

⁴ Commissioned by the National Forensic Pathology Service Committee (2001)

More specifically, the Standards require that the sexual assault health care practitioner:

- Has the ability to recognize, document and appropriately interpret injuries, or the lack thereof;
- Has the ability to collect and package the appropriate forensic specimens as per the new **Sexual Assault Examination Collection Kit (SAECK)**.

It is strongly recommended that there is a process in which the continuing medical education of health care practitioners is monitored and evaluated. This can take place through case reviews, the number of contact hours/patients per year, additional courses or in-service training. Once the practitioner is accredited, it is advised that accreditation be renewed every year. The accreditation board, that we proposed earlier should be established, should be responsible for the monitoring and evaluation of accreditation.

5. ADDITIONAL COMMENTS AND RECOMMENDATIONS

s. 3.3.2.6: The J88

Although we acknowledge that the J88 may be appropriate for the purposes of prosecution (evidentiary issues), the form is totally inadequate for the medical management of a sexual offences victim. Therefore, medical management of sexual offences victims cannot be only guided by this form. We recommend that a national protocol is developed, with guidelines, preferably part of a provincial policy. The amendment of the J88, to reflect relevant health related issues, should be part of the protocol development process. We refer to “Provincial Policy on the Management of Survivors of Rape” by the Department of Health Western Cape in this regard.

s. 3.3.2.7: “The Crime Kit”

The Crime Kit mentioned in the Discussion Paper has been replaced by the new Sexual Assault Examination Collection Kit (SAECK). We recommend that the new

SAECK is accompanied by an appropriate training programme. SAPS must be responsible for developing mechanisms to ensure that all health care practitioners involved in the collection of forensic medical evidence are correctly trained in the use and application of the SAECK. Training on the use and application of the SAECK should be a part of the training and accreditation programme proposed in this submission.

We submit that where the Commission recommends:

... that the national and provincial Departments of Health and the various controlling bodies in the medical field **must** cooperate with SAPS in this program as it pertains to the medical aspects of evidence collection ...

Note on the SAECK:

The SAECK allows for the collection of evidence for up to five days after the sexual assault.

3.3.2.11: Information Provided to the Victim

We endorse this provision, but recommend that this recommendation be embodied within the Act in the manner prescribed in the section dealing with **POSITIVE DUTIES ON HEALTH CARE PRACTITIONERS** set out in this submission.

3.3.2.15-17: The Uniform National Health Guidelines

Section 3.3.2.15 –17 refers to the Uniform National Health Guidelines for dealing with Survivors of Rape and other Sexual Offences and recognises that the Guidelines have not been distributed widely, and by implication, have not been implemented adequately. We recognize that the Guidelines are an important first step in ensuring the physical and mental integrity of rape complainants, but are well aware that basic infrastructure and policy directives have not been attached to the aforementioned guidelines. The Commission must be aware that ‘guidelines’ and ‘policies’ are often unenforceable and there is limited recourse where the guidelines are not adhered to.

We therefore strongly encourage the Commission to impose positive legal duties on the health care sector in the provision of health related services to survivors of sexual assault.

3.3.2.18: Reporting Mechanisms

The Commission recognizes that the Guidelines are silent on report mechanisms available to victims where an examining practitioner has conducted the examination in an inappropriate manner, but does not provide recommendations relating to the establishment of complainants mechanisms. We therefore submit that the proposed Bill consider a section to deal with complainants mechanisms that are accessible to victims where state officials and other practitioners do not comply with designated duties, or act inappropriately towards victims.

In the case of a medical practitioner who fails to comply or acts inappropriately towards a complainant we recommend that:

- 1. The superintendent or doctor in charge of the medical facility ensure that adequate complaints mechanisms exist, where a medical practitioner does not comply with the duties imposed in the management of sexual assault cases, or treats the complainant in an inappropriate manner.**
- 2. Where complaints are lodged against the medical practitioner by someone other than the complainant, the superintendent or doctor in charge of the facility must ensure that the complaint is registered, the matter is investigated and dealt with in the established internal disciplinary structure.**
- 3. The complainant must be informed of the results of the investigation and disciplinary hearing.**

3.3.2.23: The Western Cape Model

Section 3.3.2.23 sets out practices and procedures developed and implemented in the Western Cape, for the management of sexual offences. Since the publication of this section, the Department of Health Western Cape has coordinated an inter-sectoral, multi-disciplinary rape reference group that has subsequently formulated policy, standardized guidelines and a sexual assault examination protocol on the management of survivors of rape (see appendix A). To facilitate implementation of the above mentioned protocol, a training sub-committee was established and a training manual was subsequently developed. The training programme has been in effect for the past year, comprising of 2-day workshops. To date, approximately 100 health care professionals have received training. Fundamental to the policy, and the implementation of the service, was the identification of designated health care facilities.

We recommend that the implementation of the National Guidelines be modeled on the Western Cape initiative. We advise that the national process pay specific attention to the protocol, the standardized guidelines as well as the policy developed by the Department of Health Western Cape rape reference group.

3.3.2.24

We refer to section the section entitled **RECOMMENDATIONS FOR TRAINING AND ACCREDITATION** of this document for the accreditation of “sexual assault health care practitioners”.

3.3.3 One-Stop Medico-Legal Centres

We endorse the recommendation of the Commission for a One-Stop Medico-Legal Centre, but advise that the Commission refer to “designated health care facilities” for the management of sexual assault cases. We also refer the Commission to the criteria for designated health care facilities set out earlier in this submission (see “operational definitions”).

3.3.5 Casualty Wards

We recommend that if the complainant is ambulatory, she/he must be referred to a designated health care facility. By “referral” the authors mean “arranging transport” for the complainant. If the complainant cannot be transferred (for example, potential life-threatening injuries) then a health care practitioner must attend the patient in the casualty ward.

3.3.6 Medical Practitioners in Private Practice

We again refer the Commission to the section on “designated health care facilities” outlined in this document. We strongly recommend that if a private medical practitioner has not been trained to undertake a forensic examination on sexual assault survivors, the practitioner refers the complainant to a designated health care facility (public or private) or to a health care practitioner qualified to do so.

3.3.7 Training of Medical Personnel

We again refer the Commission to the **Western Cape Protocol** and programme for an example of a comprehensive training programme. We concur with the Commission’s general comments made about specialized training at post-graduate level, but submit that the Commission recommend that some introduction to gender issues and gender-based violence is addressed at the under-graduate level.

3.3.7.7. + 3.2.7.8 Training of Prosecutors

We take note of the comments made by Drs Gräbe and Du Plessis of the “misconception” that medical evidence will be present in cases where penetration occurs.

We recommend as per 3.3.7.8 that “*only selected* health care professionals ... should be trained to deal with cases of sexual abuse *as outlined above ... to establish specialized health care practitioners*”

The Commission recommends that training should extend to the performance of medico-legal examinations, the correct use of the sexual assault evidence collection kit and the significance thereof, the completion of the required forms, such as the protocol and the J88, police procedure and the legal aspects surrounding the presentation of such evidence in court. It is further recommended that police officials, legal practitioners and other role players who provide services to victims of sexual violence receive training on the medical aspects of sexual violence.

We endorse this position, but recommend that practitioners must also be exposed to appropriate social context training relating to the nature of sexual violence.

6. POSITIVE DUTIES ON GOVERNMENT DEPARTMENTS

s. 3.3.2.4

It is recommended that the relevant departments report to parliament regarding the linkage between medico-legal services, policing and prosecution structures.

7. POST EXPOSURE PROPHYLAXIS FOLLOWING A SEXUAL OFFENCE (Chapter 7)

We fully endorse the Commission’s recommendation that legislation is enacted to provide victims **the option of** rape HIV testing, the best possible medical care,

treatment and counseling. We also fully endorse the recommendation that the state should cover all costs for treatment and counseling required by the victim of rape as a result of the assault, including the provision of PEP, HIV-antibody testing and counseling.

We also agree with recommendation 7.5.2 where the Commission recommends that the provisions regarding the provision of treatment be embodied in the Sexual Offences Act.

We recommend that in section 7.5.3:

(a) where appropriate measures to protect the privacy and dignity of the complainant is set out, that the word “safety” is added to this provision.

(b) that the provision of PEP *must not* be dependent on reporting the offence to the police or following through with criminal charges.

8. RECOMMENDATIONS RELATING TO THE MEDICAL EXAMINATION (Chapter 9)

We are cautious about the option of having the investigating officer present **during the physical examination**, regardless of whether the officer is of the same sex as the victim, set out in section 9.1.6. We suggest that the investigating officer only be in present during the physical examination, if the patient **requests** the presence of the officer and where the officer is of the same sex.

We refer to the Gauteng Provincial Police and Protocol on the Treatment of Child Abuse Victims which states that a child of 16 or older, who has personally laid a charge, and where the parents or guardian are not available, should be allowed to sign the SAP 308 on his or her behalf. We recommend that the age of consent for a **medical examination**, in terms of this Act, should be 14 years, as per the Child Care Act, which sets out the age of consent for medical treatment at 14.

Based on the Commission's analysis of the state of medico-legal services and our recommendations in relation to positive duties on health care practitioners, we believe that section 9.1.15's assertion that an accredited health care practitioner is only responsible for gathering evidence to confirm a sexual offence, and is not tasked with providing medical treatment, is contrary to the principles set out in this Act, particularly in terms of the provision of medical services to rape complainants. It is also contrary to the National Guidelines for Victims of Sexual Offences. Furthermore, the Declaration of Geneva (1948), the International Code of Medical Ethics (1949) and the South African Medical Association's "Doctors and Patients Rights and Responsibilities" (2002) state that a doctor is obliged to treat his or her patient to the best of his or her ability and that the health of the patient is a doctor's first consideration.

With reference to section 9.1.21 where it states that "due to the fact that an adult victim may wish not to report the offence, he or she cannot be subject to medical sampling where he or she has indicated that they prefer not to report the incident to the police", we submit that:

Victims should be given the option of undergoing the full forensic examination, including the collection of medical evidence, and having it kept at the health care facility for a period of up 90 days to enable the victim to decide whether or not he or she would like to report the incident.

This implies that the SAECK needs to be available at health care facilities before being assigned a CAS number by the investigating officer.

In terms of recommendation 9.1.25 we advise that non-compliance and disciplinary measures only be taken in instances where the medical practitioner has been duly and reasonably informed of his or her obligations prescribed in the Act and accompanying Regulations and fails to perform in terms of the Act.