

4. The Medical Forensic History

Recommendations at a glance for health care providers to facilitate gathering information from patients:

- Coordinate medical forensic history taking and investigative interviewing.
- Advocates should be able to provide support and advocacy during the history, if desired by patients.
- Consider patients' needs prior to and during information gathering.
- Obtain the medical forensic history.

Coordinate medical forensic history taking and investigative interviewing. Examiners typically ask patients to provide a medical forensic history after initial medical care for acute problems and before the examination and evidence collection. This history, obtained by asking patients detailed forensic and medical questions related to the assault, is intended to guide the exam, evidence collection, and crime lab analysis of findings. In cases where the victim reports the assault, law enforcement representatives should also collect information from patients to help in the apprehension of suspects and in case investigation.¹⁷⁰

Gathering information from patients often takes place soon after they have experienced the assault. Not only can discussing the assault cause patients to feel re-violated, but their emotional and physical condition may make communication difficult. They may also be uncomfortable discussing personal matters with involved responders. Those seeking information about the assault should work collaboratively to create an information-gathering process that is as respectful to patients as possible and minimizes repetition of questions.¹⁷¹ However, jurisdictions should consider the implications of the evolving law on hearsay exceptions when determining the level and nature of coordination. See *Appendix C* for more information on the relevant case law and how it relates to medical forensic examinations.

Promote a streamlined, victim-centered information-gathering process. Jurisdictions employ several methods, including the following:

- Communication and coordination among responding officers, examiners, investigators, and prosecutors as they go about their separate information-gathering processes.
- Examiners and investigators together ask patients basic questions in a language that she or he understands. One asks questions while the others listen. They then speak to patients separately to gather any remaining information required.
- The medical forensic history and investigative interviews are conducted simultaneously to the extent feasible. The SART/SARRT should determine the information-gathering process, reflecting the best use of resources and needs and consent of patients. The team may agree that a particular person or agency will be the primary interviewer.¹⁷²

Whatever the method selected, jurisdictions should carefully plan how they will coordinate the logistics of medical forensic history taking and investigative interviewing.

Advocates should be able to provide support and advocacy during the history if desired by patients.

The presence of an advocate may help patients feel more comfortable answering questions. Advocates may also assist patients in voicing their concerns about questions being asked and clarifying their needs during this time. Advocates should be careful not to answer questions asked of patients or otherwise influence their statements.

¹⁷⁰ The website of the Violence Against Women Online Resources offers several resources on law enforcement investigation of sexual assault crimes. See <http://www.vaw.umn.edu/categories/2.8>.

¹⁷¹ Some repetition of questions is likely to occur during the exam process.

¹⁷² Caution should be exercised if combining medical forensic history taking with investigative interviewing. At the time of such information gathering, patients may not want to speak with law enforcement or be ready to go into the extensive details needed for investigative purposes. Patients may withhold information from law enforcement representatives or not want to talk with them about certain issues (e.g., their menstrual cycle or types of penetration). They might feel more comfortable talking to examiners in private about these topics. There is also a concern about questioners asking questions outside of their realm of responsibility.

Presence of family members, friends, and other personal support persons. Prior to taking the history, patients should be informed that the presence of personal support persons (other than advocates) may influence or be perceived as influencing their statements.¹⁷³ These individuals could be subpoenaed as witnesses in their case.¹⁷⁴ If, after receiving this information, patients choose to have personal support persons present during the history, these individuals should be advised not to actively participate in the process. For example, they should not answer questions for patients, comment on patients' answers, interrupt patients, or make facial expressions in response to patients' answers.¹⁷⁵

Consider patients' needs prior to and during information gathering. Pressing issues (e.g., for treatment of serious injuries, crisis intervention and support, translation and interpretation, and childcare during the exam process) should be addressed before commencing with information gathering. Be mindful of patients' capacity to answer questions during a lengthy information-gathering process, and take breaks as needed.

The facility should have procedures in place and examiners should be educated to accommodate patients' communication skill level and preferred mode of communicating. This is particularly important for patients with communication-related disabilities and limited English proficient patients. If interpreters are necessary, they should be present prior to questioning and there should be space for them in the exam room and other rooms where information is gathered. Patients with communication-related disabilities may wish to use wordboards, speech synthesizers, or other assistive communication devices to help them communicate. The use of cards with pictures (e.g., of medical procedures and human anatomy) may facilitate communication with patients with some types of cognitive disabilities or limited vocabularies.¹⁷⁶

It is important that examiners are aware of and responsive to verbal and nonverbal cues from patients. For example, patients may react negatively as they recall experiences during the assault or are reminded of previous violence committed upon them. (It is important to document this information.) What they may need most at this point is a break, the understanding of examiners, and opportunities to talk about what they are experiencing. Advocates can be particularly helpful to patients who are dealing with these emotions.

Use a private and quiet setting for information gathering. Ideally, there should be no interruptions and no time constraints for questioners or for use of the room where the information is being gathered. Although some facilities may lack space, an effort should be made to secure a private and quiet setting for this purpose. In many jurisdictions, history-taking takes place in the exam room prior to the exam.

Obtain the medical forensic history. The specific questions asked of patients by examiners for the medical forensic history vary from one jurisdiction to the next, as do forms used to record the history.¹⁷⁷ However, the following information should be sought routinely from patients:¹⁷⁸

1. Date and time of the sexual assault(s): It is essential to know the period of time that has elapsed between the assault and the physical examination/collection of evidence as well as documentation of

¹⁷³ Ideally, these individuals should not be present when giving patients this information or when patients make the decision whether they want the support person present.

¹⁷⁴ They should also be informed that the presence of these individuals during the medical forensic history could potentially reduce the degree of confidentiality advocates can offer patients (e.g., they may be called on to provide testimony regarding the interactions between patients and family members or friends present during this time). Also, in jurisdictions that have physician/patient privilege, but not a victim advocate privilege, the advocate could be required to testify. Victims should be informed of this before disclosing non-medically relevant information.

¹⁷⁵ Requests to have family, friends, and other personal support persons present during the medical forensic history should be allowed unless it is considered potentially harmful to the exam process by the SART/involved responders. For example, in cases involving adolescents, parents or guardians should not be allowed in the exam room if they are suspected of committing the assault or of being abusive to patients.

¹⁷⁶ Carolyn Ham, *Reducing Language Barriers to Combating Domestic Violence: The Requirements of Title VI*, Battered Women's Justice Project, October 2004, http://new.vawnet.org/summary.php?doc_id=1621&find_type=web_desc_GC.

Paragraph partially drawn from N. Baladerian, *Skills for Interviewing Adult Abuse Victims Who Have Developmental Disabilities*, p. 1.

¹⁷⁷ In some jurisdictions, examiners ask for investigative details during history taking. In others, examiners only ask for information related to treatment and collecting/interpreting physical and lab findings. One concern is that investigative details reported by examiners that differ from the law enforcement report may be used to undermine the credibility of patients. Patients should be told that if they are too uncomfortable or embarrassed to talk about something, they should say so rather than saying something that contradicts information that may be in the law enforcement report. (Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 77.) Another concern is that asking investigative questions is outside the examiner's role.

¹⁷⁸ Drawn from California's *Medical Forensic Report: Adult/Adolescent Sexual Assault Examination, Less Than 72 Hours* (OCJP 923), the *Tulsa Sexual Assault Report Form*, and the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2008, pp. 40–42.

injuries. Evidence collection may be influenced by the time interval since the assault as well as the interpretation of both the physical exam and evidence analysis.

2. Pertinent patient medical history: The interpretation of physical findings may be affected by medical data related to menstruation, recent anal-genital injuries, surgeries, or diagnostic procedures, blood-clotting history, and other pertinent medical conditions or treatment.
3. Recent consensual sexual activity: The sensitivity of DNA analysis makes it important to gather information about recent consensual intercourse, whether it was anal, vaginal, and/or oral, and whether a condom was used. A trace amount of semen or other bodily fluid, as well as genital microtrauma, may be identified that is not associated with the crime. Once identified, it may need to be associated with a consensual partner, and then used for elimination purposes to aid in interpreting evidence.¹⁷⁹
4. Post-assault activities of patients: The quantity and quality of evidence is affected both by actions taken by patients and the passage of time. It is critical to know what, if any, activities were performed prior to the examination (e.g., have patients urinated, defecated, had consensual sexual intercourse, wiped genitals or the body, douched, removed/inserted a tampon/sanitary pad/diaphragm, used oral rinse/gargled, washed, brushed teeth, eaten or drank, smoked, used drugs, or changed clothing?).
5. Assault-related patient history: Information such as the location of nongenital injury, tenderness, pain and/or bleeding, and anal-genital injury, pain, and/or bleeding can direct evidence collection and medical care. Patients should also be questioned about strangulation since this type of injury can result in airway obstruction if swelling occurs and strangulation is a very common occurrence in sexual assault cases.
6. Suspect information (if known): Forensic scientists seek evidentiary items that may have had cross-contact or transfer among patients, suspects, and crime scenes. The gender and number of suspects may offer guidance to types and amounts of foreign materials that might be found on patients' bodies and clothing. Suspect information gathered during this history should be limited to that which will guide the exam and forensic evidence collection. Detailed questions about suspects are asked during the investigative interview.
7. Nature of the physical assault(s): Information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) and tactics employed by suspects is crucial to the detection, collection, and analysis of physical evidence. Tactics may include, but are not limited to, use of weapons (threatened and/or injuries inflicted), physical blows, grabbing, holding, pinching, biting, using physical restraints, strangulation, burns (thermal and/or chemical), threat(s) of harm, and involuntary ingestion of alcohol/drugs. Knowing whether suspects may have been injured during the assault may be useful when recovering evidence from patients (e.g., blood) or from suspects (e.g., bruising, fingernail marks, or bite marks).
8. Detection of alcohol- or drug-facilitated sexual assault: It is critical in these cases to collect information such as whether there was memory loss, lapse of consciousness, or vomiting; whether the patient was given food or drink by the suspect (if the patient knows); or whether the patient voluntarily ingested drugs or alcohol. Collecting toxicology samples within 120 hours of the suspected ingestion is recommended if there was either loss of memory or lapse of consciousness, according to jurisdictional policy.
9. Description of the sexual assault(s): An accurate but brief description is crucial to detecting, collecting, and analyzing physical evidence. The description should include any:¹⁸⁰
 - Penetration of genitalia (e.g., vulva, hymen, and/or vagina of female patient), however slight, including what was used for penetration (e.g., finger, penis, or other object);
 - Penetration of the anal opening, however slight;
 - Oral contact with genitals (of patients by suspects or of suspects by patients);
 - Other contact with genitals (of patients by suspects or of suspects by patients);
 - Oral contact with the anus (of patients by suspects or of suspects by patients);
 - Nongenital act(s) (e.g., licking, kissing, suction injury, strangulation, and biting);
 - Other act(s) including use of objects;
 - If known, whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, on clothing, on bedding, or other); and

¹⁷⁹ Patients should be aware that there might be a need at a later time to obtain an elimination sample from consensual partners. Jurisdictions may have policies in place for seeking such samples within a certain timeframe following the exam.

¹⁸⁰ Specific questions asked will depend on case facts (e.g., the gender of the patient and the gender of the suspect).

- Use of contraception or lubricants.¹⁸¹

These questions require specific and sometimes detailed answers. Some may be especially difficult for patients to answer. Examiners should explain that these questions are asked during every sexual assault medical forensic exam. They should also explain why each question is being asked.

¹⁸¹ Certain contraceptive preparations can interfere with accurate interpretation of preliminary chemical tests frequently used in the analysis of potential seminal stains. In addition, contraceptive foams, creams, or sponges can destroy sperm. Lubricants of any kind are trace evidence and may be compared with potential sources left at the crime scene or recovered from bodies of suspects. Knowing whether a condom was used also may be useful in explaining the absence of semen.