

What can GPs do for adult patients disclosing recent sexual violence?

INTRODUCTION

Sexual violence has a life-time prevalence of 20–25% so it follows that GPs will encounter patients who have experienced sexual violence. While international best practice is for such patients to be managed at specialist Sexual Assault Referral Centres (SARCs),^{1–4} of which there are more than 30 in the UK alone, GPs have several important roles to play:

- GPs need to have a high index of suspicion for sexual violence because research has repeatedly demonstrated that most patients never disclose their experiences to doctors;
- GPs need to be able to advise patients with regard to their decision to attend a SARC or not;
- patients choosing to attend a SARC will need to be advised on what to do, and not to do, while awaiting appointments;
- regarding patients who do not want to attend a SARC, or where access to a SARC is not feasible, GPs need to respond to the health and forensic needs of patients, in so far as possible;
- GPs need to have a good understanding of safeguarding issues (children and vulnerable adults) and their responsibilities within these processes; and
- GPs are frequently involved in long-term follow-up of such patients.

ADVISING PATIENTS ON ATTENDING SARCS

Patients who have experienced sexual violence frequently feel loss of control over their lives. Restoring patient autonomy and a sense of self-determination should be the overriding approach to consultations. In our experience, an open mind and non-judgemental attitude, on the part of the doctor, facilitates disclosure. When providing advice, it is useful to use phrases such as 'let me explain the choices you

have', 'you can decide what you think is best for you', and 'you can stop this consultation at any time if you wish'.

SARCs offer a range of services to patients, including forensic medical examination (that is, attending to patients' immediate medical needs, injury documentation, and taking of forensic samples), immediate psychological support, and practical support, sometimes including support throughout the criminal justice process. Awareness of what typically happens at SARCs will help GPs to ensure that patients make informed decisions on attendance.

On arrival at SARCs, patients are given an opportunity to speak alone with trained support workers. When patients are ready, the forensic physician (FP) fully outlines the nature of the forensic medical evaluation. Patients may consent to or decline each component of the evaluation. Patients may stop the evaluation at any time if they so wish. FPs take a full medical history, including details of current and previous illness, medication, operations, obstetric and gynaecological issues, and sexual health. Alleged incidents are discussed; however, it is helpful to reassure patients that this part of the evaluation will not go into the same level of detail that the police may do. This is because FPs require only enough information to guide the forensic examination, to set the examination findings in context, to determine which forensic samples are appropriate, and to determine what medical care patients should receive.

A 'top-to-toe' general body and systems examination is performed, followed by an anogenital examination. In some cases, and only with consent, DVD recordings of anogenital examinations are made. These are stored in an anonymous and secure fashion, in accordance with best-practice guidelines.⁵ As well as documenting any injuries (very many acute rape victims have no injuries), forensic samples may be obtained during the examination. It is helpful to describe this to patients by explaining

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that swabs are very similar to cotton buds, though a little larger, and that rubbing them against the skin and mucosal surfaces can collect material of evidential value. Other forensic samples that may be obtained include tiny samples of patients' hair and cuttings from their fingernails. Blood and urine samples are normally obtained for toxicology screening, particularly where drug-facilitated sexual assault is suspected. In some cases, patients' clothing may be of potential evidential value and may be stored for forensic analysis. Which forensic samples are taken will depend on the patients' histories and timing of examinations relative to alleged incidents.

Risk assessments are undertaken, on a case by case basis, for pregnancy, suicidal ideation, safeguarding issues (child and vulnerable adult), HIV, and hepatitis B exposure, in accordance with best-practice guidance.⁴ Outcomes of these assessments inform further management, including, for example, provision of emergency contraception, initiation of anti-HIV Post-Exposure Prophylaxis following Sexual Exposure (PEPSE), safeguarding referrals, and sexually transmitted infection (STI) screening. While consent and confidentiality are centrally important, sometimes there may be overriding safeguarding issues that necessitate information sharing even when patients are not in full agreement.

Evaluations typically take 3–4 hours, throughout which time considerable emphasis is placed on patient empowerment and presentation of choices about what happens, because the SARC also aims to provide psychological support by restoring a sense of control. After examination, patients may shower and are offered fresh clothing.

GPs should be aware that the likelihood of obtaining forensic evidence diminishes rapidly with time. Thus, early appointments at SARCs are ideal. If more than 7 days have elapsed since the alleged incident, the likelihood of obtaining DNA evidence is extremely low and forensic swabs and samples are usually not obtained. In such cases, it may still be worthwhile for patients to undergo evaluation as identification of other forms of forensic evidence, such as physical injuries and scars, may assist investigations.

PATIENTS PREFERRING NOT TO ATTEND SARCS OR FOR WHOM ATTENDANCE IS NOT FEASIBLE

GPs must consider what they can reasonably do, within the limitations of their expertise. They should always consider

risks of physical injury or illness requiring immediate treatment. Emergency medical needs always outweigh the need to collect evidence. If the patients have no major injury or illness, then forensic and health needs should be addressed in so far as possible. Documentation of the histories of alleged incidents, using the patients' own words in quotation marks, is advised. Leading questions should be avoided. GPs should attempt to determine if the assailants are known to be HIV or hepatitis B positive or from high-risk groups (for example, men who have sex with men, sub-Saharan Africans, and intravenous drug abusers).

GPs are advised to take full medical histories to identify individual health needs. All injuries should be carefully documented. It is important to be aware that very many patients reporting sexual violence will have no injuries on examination. Absence of injury does not mean that sexual violence did not occur. In general practice settings, it is not appropriate to take forensic samples without police involvement, because strict 'chain of custody' rules must be followed. The need for pregnancy testing and emergency contraception should be assessed. The need for a tetanus booster should also be considered. Initial STI screening 2–3 weeks after the alleged incident and further testing for blood-borne viruses at 3 months should be offered. The need to urgently involve an infectious disease specialist, if high risk for HIV or hepatitis B, should be considered. HIV post exposure prophylaxis must be commenced within 72 hours, but is more effective if taken sooner. Prophylaxis against hepatitis B can be commenced up to 6 weeks after exposure. Patients should be provided with contact details of counsellors or of rape crisis support organisations. Patients should be reassured of GPs willingness to see them again. It is important to consider the safety of the patients in terms of suicide risk and risk of exposure to further violence, particularly when sexual violence occurs in the context of domestic violence. It may be helpful to involve social workers.

PATIENTS WILLING TO ATTEND SARCS

Unless there is concern that urgent medical treatment is necessary, such patients should not be examined. GPs can enhance the potential for recovery of forensic evidence by advising patients not to shower or bathe, not to change clothing, not to wipe or clean the genital area, not to dispose of any tampons, pads, or underwear worn during or since the alleged incident, not to eat or drink if oral assault took place within

the preceding 24 hours, not to defecate if anal assault took place, and, if possible, not to urinate if drug-facilitated sexual assault is suspected.

FOLLOW-UP

SARCs generally aim to provide follow-up care in an integrated fashion with patients' GPs. Patients who attend SARCs of their own volition, or on referral from the police or some other source, are usually asked to provide consent to inform their GPs. As some patients wish to restrict the number of people becoming aware of such incidents, they may decline involvement of their GPs. When GPs consult with patients who have previously disclosed sexual violence, it is important to ensure that their aforementioned health needs have been adequately addressed (in particular STI screening) and that they are receiving adequate psychological support, as sexual violence is a leading cause of post-traumatic stress disorder.

SPECIAL CONSIDERATIONS

Patients can generally be advised that they can attend a SARC whether or not they choose to report the incident to police, although this varies according to local SARC policy, with not all units offering a 'non-reporter' service. If patients choose not to report to police, some SARCs have the capability to collect and store forensic samples for possible future use; however, GPs will need to familiarise themselves

with the services of their local SARC.

When counselling patients on decisions to report an incident of sexual violence or to attend a SARC, GPs should consider the impact of intoxication, psychiatric illness, cognitive impairment, or otherwise, on decision making. It is beyond the scope of this article to discuss the assessment of capacity in detail. If in doubt, GPs could take advice from a medical defence organisation, and endeavour to act in the patient's best interests.

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