
8 Documentation and reporting

SUMMARY

- All consultations with patients must be documented in the form of hand-written notes, diagrams or body charts and, if appropriate, photography. Use of standard examination forms can greatly assist the process of documentation, and ensure that important details are not omitted.
- All aspects of the consultation should be documented, including consents given; medical history; account of the abuse; outcome of the physical examination; samples taken; tests and their results; treatments and medications prescribed; and schedule of follow-up care and referrals.
- In the interests of accuracy, notes should be made during the course of the consultation, rather than after.
- Patient records are strictly confidential and should be stored securely.
- Health workers may be required to comment on their findings in a written report and/or give evidence in court. If so required, health workers must ensure that their evidence is impartial and represents a balanced interpretation of their findings.
- If not trained in medico-legal matters, health workers should confine their service to health care provision and documentation of findings, and leave the interpretation of physical and other observations to a suitably qualified expert.

8.1 Documentation

Health workers have a professional obligation to record the details of any consultation with a patient. The notes should reflect what was said (by the patient, in her own words) and what was seen and done (by the health worker).

In cases of alleged sexual abuse, the taking of accurate and complete notes during the course of an examination is critical for the following reasons:

- As medical records can be used in court as evidence, documenting the consequences of sexual violence may help the court with its decision-making as well as provide information about past and present sexual violence.
- Documenting that a patient has been a victim of sexual violence will alert other health care providers who later attend the patient to this fact and so assist them in providing appropriate and sympathetic follow-up care.
- Documentation can provide administrators and policy-makers with an estimate of the incidence and prevalence of sexual violence that can be used to guide decisions about allocating resources (see also section 8.1.3 Epidemiological surveys).

8.1.1 How and what should be documented?

Mechanisms for documenting consultations include hand-written notes, diagrams, body charts and photography. Photography should be used to supplement, not replace, the other methods of recording findings and is discussed in more detail below (see section 8.2 Photography).

Some states or local authorities provide standard forms or proformas for recording the details of medical consultations. A sample proforma has been prepared by WHO specifically for recording consultations with victims of sexual violence and is attached to these guidelines as Annex 1. This proforma can be copied and used as it stands, or can be adapted to suit local needs and circumstances.

In sexual abuse cases, documentation should include the following:

- demographic information (i.e. name, age, sex);
- consents obtained;
- history (i.e. general medical and gynaecological history);
- an account of the assault;
- results of the physical examination;
- tests and their results;
- treatment plan;
- medications given or prescribed;
- patient education;
- referrals given.

Comprehensive and accurate documentation can be assured by following the set of instructions given in Box 9. In the interests of patient safety, health workers are advised not to make a note of the names, addresses or telephone numbers of any shelter or safe houses given to the patient. It is usually sufficient to make an entry in the records to the effect that, “Patient was given referrals for emergency shelter and counselling”.

BOX 9

Documenting cases of sexual abuse: a check-list for health workers

The following check-list is intended to assist health workers develop their documentation skills:

- Document all pertinent information accurately and legibly.
- Notes and diagrams should be created during the consultation; this is likely to be far more accurate than if created from memory.
- Notes should not be altered unless this is clearly identified as a *later* addition or alteration. Deletions should be scored through once and signed, and not erased completely.
- Ensure that the notes are accurate; deficiencies may cast doubts over the quality of the assessment.
- Record verbatim any statements made by the victim regarding the assault. This is preferable to writing down your own interpretation of the statements made.
- Record the extent of the physical examination conducted and all “normal” or relevant negative findings.

8.1.2 Storage and access to records

Patient records and information are strictly confidential. All health care providers have a professional, legal and ethical duty to maintain and respect patient confidentiality and autonomy. Records and information should not be disclosed to anyone except those directly involved in the case or as required by local, state and national statutes (20).

All patient records (and any specimens) should be stored in a safe place. Biological evidence usually needs to be refrigerated or frozen; check with your laboratory regarding the specific storage requirements for biological specimens.

8.1.3 Epidemiological surveys

Medical records of cases of sexual violence are a rich source of data for surveillance purposes. Information can be used to determine (12):

- the patterns of sexual violence;
- who is most at risk for becoming a victim of sexual violence;
- locations or areas where there is a high incidence of sexual violence;
- the time of day when most of the offences take place;
- medical and staffing resources required to improve the care of, and services to, victims of sexual violence.

Such information will give an indication of how serious the problem of sexual violence is, pinpoint where prevention measures are most urgently needed and will allow service providers to monitor the effectiveness of health services available to victims of sexual violence. This information, however, must be interpreted with caution as it is known that sexual abuse is greatly under-reported. Women seeking help from health services may represent only the tip of the iceberg.

The information required to serve the above-mentioned functions is retrievable from the sample WHO Sexual Violence Examination Record (see Annex 1). It is critical that data used for surveillance purposes should have all patient identifiers removed; this ensures patient anonymity.

8.2 Photography

If using photography to document findings, the following points are worth bearing in mind:

- *Consider the patient.* Many subjects will be uncomfortable, unhappy, tired or embarrassed. Communicate the role of photography and obtain informed consent for the procedure.
- *Identification.* Each photograph must identify the subject, the date and the time that the photograph was taken. The photographs should be bound with a note stating how many photographs make up the set. Ideally, a new roll of film should be used for each subject; alternatively, there should be a clear indication of where a new series commences.
- *Scales.* A photograph of the **colour chart** should commence the sequence of photographs. **Scales** are vital to demonstrate the size of the injury. They

may be placed in the horizontal or vertical plane. Photographs should be taken with and without a scale.

- *Orientation.* The first photograph should be a facial shot for identification purposes; this may not be required if the photographs have been adequately identified (see above). Subsequent shots should include an overall shot of the region of interest followed by close-up shots of the specific injury or injuries.
- *Chain of custody.* This should be logged as for other forensic evidence (see section 5 Forensic specimens).
- *Security.* Photographs form part of a patient record and as such should be accorded the same degree of confidentiality. Legitimate requests for photographs include those from investigators and the court. If, however, a copy is made for teaching purposes, the consent of the subject or his/her parents/guardian should be obtained.
- *Sensitivity.* The taking of photographs (of any region of the body) is considered to be inappropriate behaviour in some cultures and specific consent for photography (and the release of photographs) may be required. Consent to photography can only be obtained once the patient has been fully informed about how, and why, the photographs will be taken. The briefing should also explain how this material may be used (e.g. released to police or courts and cited as evidence).

8.3 Providing written evidence and court attendance

It is beyond the scope of this document to deal with the specific obligations of health care practitioners in meeting the needs of the justice system. Generally speaking, however, the health worker would be expected to (92):

- be readily available;
- be familiar with the basic principles and practice of the legal system and obligations of those within the system, especially their own and those of the police, as it applies to their jurisdiction;
- make sound clinical observations (these will form the basis of reasonable assessment and measured expert opinion);
- reliably collect samples from victims of crime (the proper analysis of forensic samples will provide results which may be used as evidence in an investigation and prosecution).

Health workers may be called upon to give evidence, either in the form of a written report or as an expert witness in a court of law. When charged with this task, health care practitioners should be aware of the following pitfalls and potential problem areas:

- providing opinions which are at the edge of, or beyond, the expertise of the witness;
- providing opinions that are based on false assumptions or incomplete facts;
- providing opinions based on incomplete or inadequate scientific or medical analysis;

- providing opinions which are biased, consciously or unconsciously, in favour of one side or the other in proceedings.

Guidance on writing reports and giving evidence is provided in Table 18, in the form of a set of simple rules. Above all, health workers should aim to convey the truth of what they saw and concluded, be it in a written report or to the court, in an impartial way, and ensure that a balanced interpretation of the findings is given.

Health care workers providing medico-legal services to victims of sexual violence, in particular the more experienced practitioners, should be given training in such matters (see Annex 3). If not specifically trained in medico-legal aspects of service provision, health workers are advised to confine their service delivery to the health component and defer from offering an opinion. Under such circumstances, the court can seek the assistance of an expert to provide the necessary interpretation of the observations.

Table 18 **Providing evidence in sexual violence cases: guiding principles for health workers**

WRITING REPORTS	GIVING EVIDENCE
1. Explain what you were told and observed.	1. Be prepared.
2. Use precise terminology.	2. Listen carefully.
3. Maintain objectivity.	3. Speak clearly.
4. Stay within your field of expertise.	4. Use simple and precise language.
5. Distinguish findings and opinions.	5. Stay within your field of expertise.
6. Detail all specimens collected.	6. Separate facts and opinion.
7. Only say or write what you would be prepared to repeat under oath in court.	7. Remain impartial.