Original Article

Forensic Medical Examinations: Imagining Justice

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ABSTRACT

Depending on the type of physical contact involved during a sexual assault offense, samples collected from a suspect's body may carry greater probative value than samples collected from a victim's body. However, unlike forensic medical examinations for persons identified as victims of a sexual assault, no professional consensus exists for what constitutes a high-quality forensic medical examination standard for persons identified as suspects, or the accused. The purpose of this article is to explore underlying assumptions that may contribute to disparate practices and inequalities in the provision of forensic medical examinations for persons suspected of committing a sexual offense and persons identified as victims of a sexual offense.

KEY WORDS:

Ethics; forensic medical examinations; forensic nursing; sexual assault; suspect examinations

Collecting samples from objects containing materials transferred during a sexual assault is critical to the future investigation of the case (Apostolov, Hristov, & Angelova, 2009). For over a decade, experts have highlighted that, depending on the type of contact involved in a sexual assault offense, samples collected from a suspect's body may carry greater probative value (i.e., usefulness in proving guilt or innocence in a legal case) than samples collected from a victim's body (Archambault, 2013). For example, when a victim reports digital vaginal penetration, the suspect's fingers, particularly under the fingernails and around the cuticles, may be the best source of samples with probative value.

Similarly, when collecting samples to corroborate a history of penile penetration of the oral cavity, samples collected from the suspect's penis and scrotum are better sources for cellular findings than samples collected from the victim's oral cavity (Flanagan & McAlister, 2011). Despite this, many jurisdictions do not have protocols for the forensic medical examination of suspects in a sexual assault case, commonly referred to as "suspect examinations." When they do exist, protocols often are limited or inadequate at best (Archambault, 2013; Faugno, 2014; Newton, 2013).

Standards for receiving forensic medical examinations for patients who disclose or are suspected of experiencing sexual assault or sexual abuse exist for specific populations such as *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents* (Office on Violence Against Women, U.S. Department of Justice, 2013) and *A National Protocol for Sexual Abuse Medical Forensic Examinations: Pediatric* (Office on Violence Against Women, U.S. Department of Justice, 2016). Although the word "victim" does not appear in the title, both protocols are for living victims of sexual assaults. Interestingly, similar protocols and professional standards do not exist for forensic medical examinations of the other group of persons involved in sexual assaults: specifically those persons suspected of committing assaults. In addition, there is no agreed-upon consensus for the anatomical locations of sample collection when there are known, unknown, or conflicting histories between a suspect and the victim.

Existing protocols vary widely regarding who conducts the suspect forensic medical examination, including

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evidence technicians, law enforcement officers, and forensic nurses (Archambault, 2013; Faugno, 2014; Newton, 2013). In addition, there are inconsistencies regarding the contents of suspect sample collection kits and the container used for the kit. Suspect sample collection kits range from small 6 × 9 envelopes called "penile swabbing evidence kit" or "buccal swab kit," to the same kit used for a person identified as a victim, to a comprehensive kit specifically identified as a suspect sample collection kit. The problems associated with this variability and lack of standards are highlighted by forensic nurses' postings on discussion boards and comments at local, regional, and national committee meetings and workgroups where questions are frequent. There is a dearth of research around current practice, recommended standards, or best practices in the collection of samples from suspects of sexual assault offenses. In addition, there has been little focus on how the practices around suspect examinations may create inequities in justice for suspects of sexual violence. Newton (2013) has asserted that forensic medical examinations for those suspected of sexual violence are ad hoc in nature—if and when the examinations even occur.

Law enforcement officers and forensic nurses appear to struggle with who should conduct suspect forensic examinations and what type of standard should guide the examination. Between 2014 and 2016, the lead author collected direct quotes from attendees at national forensic conference presentations and regional multidisciplinary workshops. The following statements are examples of quotes collected from law enforcement professionals and forensic nurses:

- "There's no evidence if the victim refuses the exam."
- "Suspects are not patients."
- "Our role is to collect evidence from victims."
- "We don't need consent. We have a search warrant."
- "Why would we do a suspect exam, the victim did an exam?"

These sentiments illustrate the ethical tensions and confusion navigated as both healthcare and law enforcement professionals interact with persons suspected of sexual offenses. When a forensic nurse states, "Our role is to collect evidence from victims," a preconception is highlighted. This statement brings to the surface a possible tendency to support the legal case of the victim that may be present within some individual forensic nursing practices. Collectively, these statements highlight potential professional biases among forensic nurses and law enforcement professionals that may interfere with evidence-based, ethically sound practice in the conduct of suspect examinations.

Although the *Forensic Nursing: Scope and Standards of Practice* (American Nurses Association [ANA], 2017) reminds forensic nurses of their duty to "victims, the accused, suspects, or perpetrators" with multiple references in the context of services, roles, and settings, there are disparities in forensic nursing services provided. The underlying assumptions of who receives forensic medical interventions to address healthcare disparities across subsets of the overall forensic patient population must be identifed. The purpose of this article is to explore underlying assumptions that may contribute to disparate practices and inequalities in the provision of forensic medical examinations to persons identified as suspects of committing sexual offenses and persons identified as victims of sexual offenses.

Language Matters

The language we use to describe persons who use violence and persons who experience violence deserves our ethical and professional attention. Legal and lay terms carry recognized connotations and lend themselves to accusations of provider biases when used in the clinical setting. For example, referring to a patient as "victim" may suggest that the clinician believes this person to be a victim, with or without supporting factual evidence. Rather than referring to the person as a "patient" reporting a history of violence or assault, the nurse is referring to the patient as a "victim"—a word that holds specific meaning in legal and lay settings. It may also present the nurse as committed to collecting items to support the victim's account of events as the primary focus of the clinical encounter rather than serving as an objective forensic clinician providing specialized services for patients—whether the legal system identifies the patient as a victim, a possible victim, a potential suspect, or the accused.

Although "victim" is commonly used to refer to the person reporting an assault, many terms are used to describe the person accused of committing a sexual offense including "suspect," "offender," "perpetrator," "assailant," "rapist," and "accused." These terms have very different meanings, both literally and legally, although they are inappropriately used interchangeably by forensic nurses and other professionals. Phrases such as "perpetrator or perp," "offender," or "assailant" are problematic in that these terms infer guilt and may even be used in medical documentation such as "Victim stated the assailant John Smith 'tore off my shirt and…'" rather than "Patient stated 'he tore off my shirt and…'" (patient clarified "he" as "John Smith"). In situations where the person committing the crime is not known, forensic nurses have been known to document "the perpetrator," "assailant," or even "suspect" rather than more objective language such as "an unknown man," "a woman not known to the patient," or "a group of 5 unknown persons." Although suspect, accused, perpetrator, and assailant hold different meanings in legal and lay settings, in this article, we have chosen to use the term "suspect." By using this consistent terminology, we hope to illustrate the usefulness of standardized, unbiased language.

When a licensed healthcare provider conducts a forensic medical examination involving sample collection from a person's body, it is worth questioning why the word "patient" is not used consistently, whether referencing the person who is suspected of committing an assault or the person who reports experiencing an assault. Regardless of how a person is identified by the legal system, within the healthcare system, "patients" receive clinical forensic healthcare services including forensic medical examinations and other possible health care from licensed clinicians. Forensic nurses, in addition to the other care they may provide, collect samples for forensic analyses. Findings from the physical examination and forensic analysis of samples may serve to corroborate or contradict either parties' history of events.

The recognition that language matters has resulted in a move to more neutral language in forensic healthcare services for persons identified as victims. For example, historically, the forensic medical examination kit for persons reporting a sexual assault was commonly called a "rape kit," whereas the examination was referred to as a "rape exam," "sexual assault exam," and "victim exam." Forensic nurses and other professionals have purposefully moved toward nonjudgmental language around both the examination and the kit used to complete the examination with some jurisdictions formally renaming collection kits (e.g., biological evidence kit, physical evidence recovery kit) and the examination (e.g., forensic medical examination, medical forensic examination). However, this same effort toward neutral, nonjudgmental language has lagged for those who are identified as suspects of sexual assault. In contrast to the neutral language above, the terms used to describe the forensic medical examination for persons suspected of sexual assault may include "perp exam" and "suspect exam." Yet, the purpose of the forensic medical examination is the same for persons identified as victims of sexual assault and those suspected of sexual assault: the provision of clinical forensic healthcare services, which may include collecting samples for forensic analysis that may or may not hold probative value once analyzed.

Informed and Unbiased Sample Collection

According to Dr. Edmond Locard (1877–1966), "It is impossible for a criminal to act, especially considering the intensity of a crime, without leaving traces of this presence" (Morrish, 1940). Today, this concept is commonly known as the exchange principle. Anytime a person makes contact with another person, place, or thing, there is an exchange of physical materials. Transfer of these biological and nonbiological materials is not unidirectional. Items are transferred from perpetrator to scene, scene to the perpetrator, victim to the scene, scene to the victim, perpetrator to victim, and victim to perpetrator.

Traughber & Spear (1999) conducted a feasibility study to show the presence of female DNA on swabs collected after consensual, postvaginal coitus, from the penis and scrotum of a male partner. All sample collection occurred within 15 hours after coitus. Analysis revealed glycogenated epithelial cells from the female partner in 11 of 13 penile swabs and 10 of 13 scrotum swabs. Similar results were found in a study conducted by Cina, Collins, Fitts, and Pettenati (2000). Researchers collected cells from the penis of the male partner during a 1- to 24-hour interval after vaginal coitus. Polymerase chain reaction (PCR) analysis of the DNA extracted from the collected samples identified the female participant. These findings suggested that penile samples collected from sexual assault suspects could associate a male suspect with a female victim reliably within 1–24 hours after physical contact. (as cited in Archambault, 2013) reported the forensic laboratory results from the analysis of suspect kits from 77 sexual assault cases involving known suspects. Analysis revealed that the most common source of a victim's DNA during sample analysis was epithelial cells found on penile swabs collected during the suspect examination, with 44% of analyzed suspect kits identifying the assailant of an adolescent victim and 30% of kits identifying the assailant of adult victims.

In sexual offenses involving condoms, there tends to be even less emphasis on obtaining a forensic medical examination. The fact that sensitivity of current forensic science technologies for obtaining probative profiles from samples as small as a few skin cells indicates concerns about a limited amount of trace sample is an antiquated rationale for not collecting from the accused or suspects in a sexual offense case. In addition, all involved in the decision making for obtaining and providing forensic medical examinations must understand the ability to collect cellular and other materials of importance (e.g., lubricant, spermicide) even when a condom is used during the act. Although noncellular items may not result in an identity profile, these items can contribute a corroborative link between the victim and the suspect (Musah, Vuong, Henck, & Shepard, 2012).

Findings from these studies illustrate Locard's exchange principle where the transfer of epithelial cells, and the DNA they contain, allows for the identification of a sexual partner, or a sexual assailant, hours later. Forensic nurses and law enforcement professionals are likely to be focused on the reality that, if the persons involved in sexual violence do not agree to have forensic examinations conducted, future evidence will not exist. However, these studies suggest that the assumption that the victim of a sexual assault must consent immediately to an examination may be only partially accurate. The value of the forensic medical examination for the person or persons suspected of a sexual assault is of at least equal importance.

Do Equal Standards Extend to All?

There are assumptions regarding sexual offenses and forensic examinations that are interwoven and worth challenging.

These include biases around gender, whether there is a need for specialized forensic training, and the purpose of the forensic medical examination. Underlying assumptions in each of these areas hold the potential to affect equal care and standards for all persons receiving forensic medical examinations.

An overarching assumption when discussing sexual offenses is that people committing sexual offenses are men and their victims are women. Historically, the Federal Bureau of Investigation (FBI) held a gendered definition of rape involving the "carnal knowledge of a female forcibly and against her will" (FBI, 2014). It was not until 2013 that a new definition focused on forced penetration without a focus on gender (FBI, 2014). Concerns regarding a lack of awareness about the prevalence of female sexual perpetration (Sgroi & Sargent, 1993) and gendered stereotypes contributing to this lack of awareness are not new. Stemple, Flores, and Meyer (2017) analyzed data from four large-scale U.S. data sets and found the "data to contradict the common belief that female sexual perpetration is rare." Because of these findings, they also looked at the literature related to high-risk populations and called out gender stereotypes as contributing to the downplaying of female perpetration. They argue that a lack of recognition of female perpetrators among multidisciplinary professionals is partially because of female gender stereotypes and add that doing so adversely affects victims of female perpetrators.

A current study led by the lead author involves analysis of sexual assault sample collection kits obtained from several U.S. jurisdictions for persons identified as victims and persons identified as suspects. The name and contents of collection kits designated for suspects reflect the abovementioned gendered assumptions such as collection kits labeled "penile swabbing evidence kit" or "suspect kit" with a limited number of identified anatomical collection sites, including male genitalia only. These gender-biased kits do not allow for collection from female anatomy and direct the focus of sample collection on the penis rather than other sites of sample collection such as hands, fingers, or mouth. Such assumptions can have particularly detrimental effects in cases involving child victims, where fondling or oral contact with the victim's genitalia often occurs and requires collection from nongenital sites. Whether forensic nurses and law enforcement professionals hold an overarching assumption about who commits sexual offenses and the impact of such assumptions on practice and the development of specific collection kits deserves further exploration.

A second important assumption is that specialized clinical training may not be necessary for sample collection from all persons involved in sexual offense cases. There are known standards and protocols indicating that persons identified as victims need specialized forensic medical interventions, whereas the same does not exist for persons identified as suspects. When sample collection does occur for the latter, it may be viewed as not needing to be done by someone with special clinical training. Law enforcement officers, evidence technicians, and forensic nurses all currently conduct examinations on those suspected of committing sexual offenses.

When nonclinical professionals such as law enforcement are assigned to complete sample collection from persons suspected of a sexual assault, there may be an assumption that examinations will not involve body cavities other than the oral cavity for buccal reference samples and the person they are collecting from will be male. Some officers may view forensic examinations as inappropriate for their role considering the intimate nature of an extensive examination. When collected by law enforcement, it has been noted that documentation surrounding the examination is less detailed and critical information may be missed (Archambault, 2013). This leaves us with the question about why there is an accepted difference in who conducts these examinations, how the examinations are completed, and if this reflects additional bias among forensic nurses and other professionals.

A third assumption is the basic purpose underlying forensic medical examinations and the collection of samples for forensic analysis. Are samples collected from the suspect and the victim primarily to establish guilt or prove innocence? For example, consider a situation where the accused and the accuser are both men, with one stating oral-penile contact was not consensual and the other stating all sexual contact was consensual. The accused reports consensual sexual contact with the accuser including oral acts and receptive anorectal acts without a condom. The accuser denies any anorectal contact occurred. If sample collection from the rectal cavity of the accused does not occur, there is no opportunity to corroborate the claim of the accused that receptive anorectal acts occurred. To not collect this evidence expresses a bias toward corroborating the accuser's history that specific nonconsensual acts occurred rather than corroborating the history of specific sexual contact of the accused.

This intersection between biases and assumptions may have a profound effect on the forensic healthcare delivered. All persons having forensic samples taken during a physical examination should be treated with human dignity. This includes having their privacy protected to the degree possible during intimate examinations, being treated nonjudgmentally, and being treated without fear of abuse. For law enforcement officers whose duty is to investigate a crime by interviewing and charging suspects, this may create role conflict when they are also responsible for collecting samples from the person they are investigating or charging with a crime. For forensic nurses, one may not initially recognize an issue exists as respect for privacy and nonjudgmental treatment are fundamental concepts in nursing care of patients. However, if only the person identified as the victim in a sexual assault is given the status of patient, then the person identified as the suspect may not be seen as deserving of the same standard of care.

Justice in Forensic Nursing Care

Ethics are at the foundation of professional nursing practice, including forensic nursing. An underlying principle of nursing is fairness, or justice, which requires forensic nurses to treat like cases alike. Forensic medical examinations for persons identified as victims (or possible victims) and persons identified as suspects (or possible suspects) vary significantly. Joanne Archambault (2013), a retired sex crimes detective, stated: "I believe that suspect exams must be conducted by examiners with specialized training and clinical experience. In most cases, this will be a health care provider, not a law enforcement officer or employee of the crime lab." Newton (2013) stated that examinations for those accused of sexual violence "should only be conducted by doctors and nurses who have received relevant, up-to-date specialist theoretical and practical training. Clear evidence shows that few other criminal offenses require as extensive an exam and collection of forensic evidence as that of a sexual assault." These experts concur that forensic medical examinations for those suspected of sexual assault deserve the same expertise as examinations for victims.

As noted, anecdotal and research evidence suggests that persons who are suspected of sexual offenses receive interventions by nonclinicians rather than forensic nursing specialists. In addition, many forensic nursing programs do not provide services to persons who are suspected of committing sexual offenses. These disparities bring forth the question of whether persons identified as victims and those identified as suspects of sexual offenses hold equal worth as patients among forensic nurses. How do forensic nurses uphold fairness for all groups of people needing a forensic medical examination? Should a legal difference in status justify providing different levels of care for the same intervention, in this case, forensic medical examinations, or even in assigning the status of "patient"? To uphold fairness, like cases should be treated alike. Given this fundamental principle, should all parties to a sexual offense, regardless of the legal labels they hold, deserve a forensic medical examination provided by a competent clinical professional?

Autonomy: "We Don't Need Consent…"

A second and equally foundational ethical principle for nursing practice is respect for autonomy. Generally speaking, respect for autonomy refers to assisting patients to make decisions for themselves that are consistent with their values and their view of themselves. For forensic medical examinations and forensic nurses, we argue that both the persons identified as suspects and those as victims should be considered patients and therefore are deserving of respect for their autonomy. However, this basic tenet of healthcare is challenged when forensic nursing practices include examinations, authorized by law enforcement officers with protocols indicating that "patient consent is not required if the suspect is in custody" or if the "patient is not in custody, documentation of voluntary consent…is the responsibility of the officer accompanying the patient" (California OCJP, 2001, p. 84).

Persons identified as suspects may experience coercion secondary to a search warrant or court order. The examination setting may be a uniquely coercive situation such as a police station with several uniformed law enforcement officers or plain-clothed detectives present during the examination. Additional intimidation for suspects involves being detained, cuffed, or otherwise restrained. Suspects should also be informed, just as forensic nurses inform a patient identified as a victim, that they may pause or stop an examination at any time or decline any part of an examination (Faugno, 2014). Although not related to a sexual offense investigation, a recent case in Utah involving an emergency department nurse brought to the national consciousness the issue of the enduring right to autonomy for patients who are suspected of crimes or present during a crime (Wang & Hawkins, 2017). These patients may experience a loss of autonomy when objectification occurs, and they are treated more like a crime scene than as persons who may or may not have been present during a crime.

Respect for autonomy also is challenged when search warrants and court orders are issued to collect forensic samples. Although these mechanisms do not automatically exclude a clinician's ability to obtain consent, they may hinder this process and raise questions about legal intimidation or coercive settings. Search warrants and court orders have been construed, falsely, to remove the need for respecting the autonomy of patients in the context of forensic medical examinations. A search warrant is issued to protect a person's Fourth Amendment rights: "The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized" (U.S. Constitution, Amendment IV). According to Archambault (2013), most suspects will consent to a forensic medical examination when given the opportunity to make an informed choice. As with other expressions of patient autonomy, this consent should be documented in writing.

Conclusion

Although not an exhaustive discussion of the practices around forensic medical examinations, this article begins a much needed conversation in the forensic nursing community about potentially unjust practices and inequities in the provision of forensic nursing services to persons identified as suspects in sexual assaults. Collectively and individually, we should question practices that encourage or support disparate standards of care across patient populations. Equity in the provision of forensic medical examinations supports

the recognition that all persons receiving forensic medical examinations are patients first and foremost, whereas the labels of victim or suspect, accused or accuser, may unintentionally hinder good practice.

According to the Code of Ethics for Nurses (ANA, 2015) and the *Forensic Nursing Scope and Standard of Practice* (ANA, 2017), when providing nursing care, the recipient of that care is a patient. It is essential to integrate this tenet throughout forensic nursing practice, including while providing unbiased forensic medical examinations for persons suspected of committing a sexual offense. Rather than presenting as a philosophical debate or hypothetical discussion, the need to address disparate practices across forensic medical examinations, to clarify the purpose of forensic medical examinations, and to determine who should conduct such examinations is urgent. With more exposure to training related to suspect examinations, the trend for more requests for suspect examinations is expected to continue (DeVore & Sachs, 2011).

Forensic nurses are well positioned to make immediate and important changes to support best practice and eliminate unintentional biases. Examples include (a) engaging actively in writing institutional policies and procedures to ensure that unbiased terminology is used, (b) providing clear feedback to equipment suppliers on appropriate labeling of forensic medical examination kits, and (c) offering educational opportunities around best practices in documentation for forensic and nonforensic nursing colleagues (e.g., emergency department nurses). Perhaps most importantly, forensic nurses can offer their nursing colleagues a model for how to conduct themselves with ethical comportment in emotionally challenging situations (Day & Benner, 2002). Forensic nurses have the opportunity to consider difficult cases collaboratively as colleagues within their specialty organizations or within published scholarly literature. The resulting reflection and social norming then can be offered to nonforensic nursing and nonnursing colleagues who may be encountering situations for the first time.

Nurses are challenged to respect the dignity, autonomy, and privacy of patients regardless of patient demographic, personal, or socioeconomic characteristics. This challenge may be unrealized for persons suspected of a sexual offense who need forensic nursing care. Forensic nurses have a responsibility to question why standards exist for forensic medical examinations provided to persons identified as victims yet not for another group of persons receiving the same forensic medical intervention. To address clinical forensic healthcare disparities, forensic nurses must identify and call attention to inequities in forensic healthcare services. Language matters; the labels used to describe people receiving forensic nursing care, forensic medical examinations, and forensic medical examination kits should be objective and void of inherent bias. To avoid magnifying injustice, forensic nurses have an increased obligation to confront false assumptions and myths, address their own biases, adopt nonjudgmental language, and research and utilize best practices within their specialty area. To do less would be to acknowledge injustice and accept it.

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