The doctor as witness in child abuse cases

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Summary

Doctors who have to give evidence in cases of physical or sexual child abuse usually find it a stressful experience. Factors that may help to improve the doctor's ability to cope with the situation are discussed in this article.

The importance of good medical notes and a good medical examination is stressed. Hints are given on how to minimise the inevitable delays that precede a court appearance.

The hearsay rule means that the history the doctor obtains is not accepted as evidence. The medical procedure, which involves using various facts to build up a complete picture, is contrasted with the legal procedure, which involves testing each separate fact in order to create reasonable doubt that the accused may be guilty.

Some common questions put to the doctor are discussed here. They include questions as to whether causes other than abuse, such as masturbation, infection or the use of other instruments, could have damaged the hymen or vagina.

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One is inclined to think that a doctor called to give evidence in a child abuse case will not be under real stress. After all, he has examined the patient and, as a professional person, has nothing to hide. He will therefore have no interest but to tell the truth in the cause of justice. However, most doctors who go to court find it extremely stressful, and often feel unsure whether justice was served by their evidence.

In this article, various ways of preventing the doctor's discomfiture will be considered, so that when the practitioner is called on to give evidence, the situation may be handled more easily.

The medical examination

In child abuse cases, as in all potential court cases, good notes are absolutely essential. Note down every detail of the examination. Rather than making notes on a sheet of paper or in the case notes, use a prepared case history sheet that will serve as a reminder of which questions are relevant. One such sheet is used by the Child Abuse Clinic of the Transvaal Memorial Institute for Child Health and Development (obtainable from the author). A diagram with captions is usually helpful. Photographs should be taken if possible. When the doctor is subpoenaed, the case notes are also subpoenaed. Take these notes in duplicate, in order to keep one copy for the practice or hospital records.

The investigation of a case of physical or sexual child abuse has been described in several papers.[1-2] Reece and Grodin[3] wrote a comprehensive article dealing with non-accidental injury. The practitioner is referred to these articles for details of medical examination and manage ment.

An important omission from examinations is tha doctors often do not examine the vagina and anus i normal prepubertal children. This is as true for gener practitioners as for gynaecologists and paediatrician Furthermore, the doctor does not want to disturb th child or cause vaginal or hymenal injury during th examination. For these reasons, the doctor is likely n to examine this area well enough. Many doctors ther fore do not really have a good idea what the anatomy those areas looks like; they extrapolate from what the know about adolescents and adults. It is important have a concept of what the hymen in young childre looks like, i.e. what is abnormal and what is norma The same is true of the size of the vaginal orifice whic has to be measured, not in finger-breadths, but in mi limetres. It is best to use a short piece of measuring tap mounted on the end of a spatula, so that the end of th spatula can be approximated to the vagina or to the anu in order to make measurements.

The clinical examination of the child for sexual abus is not included in this article; the following reference may be consulted.[4-9] Cowell's[4] article is especially helpfu in providing a good approach to the examination of th genitalia and in establishing what is normal. Winship *et al.*[6] describe the whole process of dealing with the sexu ally abused child, including aspects such as the histor and management. The strength of Finkel's[7] article i that it establishes how quickly healing of the genitali takes place and how the appearance of healing or heale injuries changes. The anal appearance of normal an abused children is described in two articles.[8,9]

Before the court case

What follows applies to criminal cases; the doctor wi not usually be required to appear in a children's cou inquiry held in terms of the Child Care Act No. 74 o 1983. When subpoenaed, be as co-operative as possibl both with the police and the prosecutor. It is useful t understand the process that the courts follow. When it i decided to bring an accused to court, the police office who was in charge of the investigation will be delegate to subpoena the doctor. On this subpoena will appea the time and date of the court case, but not necessaril those of the doctor's specific court appearance. Th name given there is the name of the accused, not th name of the patient examined. It is therefore essential t find out the name of the child examined. Other usefu information includes the name of the police officer deal ing with the case; the name of the prosecuting attorne dealing with the case; and the contact telephone num bers of these people.

In court the doctor will be given his evidence. (i.e the document he has written up and signed will b handed to him). However, it is advisable for him to con sult his own files or the hospital files before that time. is essential, therefore, to know the name of the patient.

Child abuse cases may be booked either for a hal day or for a one-day court appearance. Occasionall when the prosecutor is aware that it could be a length case, 2 days are booked.

When the case is called to court, the accused is aske to respond to the charges and then to plead guilty or n

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guilty. This may take half an hour or even longer. After that, it is usual to call the alleged victim. The child will then give evidence, guided by the prosecutor's questions. The accused is entitled to legal representation; if he does not have a lawyer, he conducts his own defence. This may occasionally lead to the iniquitous consequence of a possible criminal cross-examining his victim. If the child is being cross-examined by an attorney, this process may take anything from 1 hour to a whole day. If the child is not cross-examined by an attorney, but by the accused, it may take about an hour, and if there is no cross-examination at all, it may take even less time. Obviously this can be quite harrowing for the child,[10] and the legislature is considering ways in which to improve the situation.

If called as a witness, the doctor will be called third or possibly even later in the proceedings. The earliest time he will be questioned is half an hour after the start of the court case, but it is more likely that 1½ hours or longer will elapse before he is called to the stand. If the subpoena states 09h00 or 09h30, it is unlikely that the doctor will appear before 11h00 unless the case has started earlier than the time stated on the subpoena. This is why it is essential to talk to the prosecuting attorney before going to court. Most prosecutors and policemen are co-operative when it comes to adjusting times for doctors to come and give evidence. However, they do not understand how we work. We usually don't understand how their system works either, and this may be a major cause of bad feeling between doctors and legal representatives. Find out whether it is the first case for the day, whether it is the only case for the day, and whether something else is scheduled to take place before it. Ask to be called, if possible, half an hour before the medical evidence is needed. Also find out where to park, and take along some light reading material.

Doctors in full-time employment can arrange for a hospital vehicle but are not entitled to witness fees. Doctors who are not employed full-time can claim travelling expenses and witness fees; the claim forms need to be signed while at the court. Strauss points out that 'these tariffs are largely nominal and bear no relationship to the value of a doctor's services or the loss of income . . .'.[11]

In court — legal points

The hearsay rule

'Evidence is hearsay when the Court is asked to rely, not on the personal knowledge of the witness testifying, but upon the assertion of someone else.'[12] Anything that the doctor heard from another person, be it the patient, the parent of the patient, or another professional, will not be regarded by the court as admissable evidence. The court does allow the doctor to tell the court what he/she has heard, but the court will not use that as true evidence. The doctor is usually not aware of this fact. In other words, what the doctor considers a reasonable medical history is rejected by the court as hearsay evidence. The exception to the hearsay rule is in the case of first disclosure; what the child said the first time to the first person he/she told about the abuse, can be used as evidence. This person however, is very unlikely to be the doctor.

Legal terms

Doctors who deal with child abuse generally use the term 'sexual abuse' (which is not a term used in law) to include all types of such abuse ranging from fondling, watching pornographic videos and observing intercourse, to penetrative anal, vaginal or oral intercourse. Sexual abuse is sometimes sub-classified (by doctors) as penetrative or non-penetrative. However, the legal terminology is different, and the doctor going to court should be familiar with those terms, as defined below.

Rape is unlawful, intentional carnal connection with a person without their consent. A person under 12 years of age cannot give consent; such intercourse is considered statutory rape.[13] Rape (in legal terms) is penetration beyond the labia minora. Anything else falls under the classification of **indecent assault**, and often a charge of indecent assault will be accepted, when 'rape' cannot be proved. It is important to note that penetration beyond the labia can be assumed to have occurred if the hymen is damaged, since the hymen falls proximal to the labia. In other words, if the hymen is damaged it is medical proof of legal rape.

Incest is the sexual union of two persons who, being related by blood or affinity, may not marry each other.

Sodomy is anal penetration of a male; according to the law, such an act perpetrated on a female is indecent assault.[13]

Legal proof

It is the duty of the State (represented by the prosecutor) to prove *beyond reasonable doubt* that the accused is guilty of the crime. The advocate for the accused will therefore try to cast doubt on every single fact that the doctor produces. In general, the facts themselves are accepted, but the interpretation of the evidence as being caused by sexual abuse, will be scrutinised. Having cast doubt on some of the doctor's statements, the defence attorney will extrapolate that the doctor's whole argument is therefore not valid. Doctors look for individual items of information which they fit together like jigsaw puzzle pieces to make a complete picture. Legal practitioners will try and take away individual pieces of this complete picture and it is important to keep drawing attention to the manner in which all the pieces fit together even though you may acknowledge that a particular piece of evidence is not conclusive (which it hardly ever is in medicine anyway).

Expert witness

This is someone, e.g. a doctor, who, because of special knowledge of a subject or on account of specific training, can be relied on to give expert testimony.[14] The doctor may also be an ordinary witness and recount the facts as he knows them, but when called on to interpret the findings and advise the court on them, he is an expert witness. Especially in the lower courts, the doctor who examined the child will usually also be used as an expert witness. (A. Skeen — personal communication).

The expert is an independent witness whose expertise is at the disposal of prosecution, defence, and also the court.[11] He must be objective in the witness box and strive to tell the 'whole scientific truth' even if he is sympathetic to one side.

If too narrow a line of questioning or cross-examination hampers the doctor's telling the whole truth, he should politely offer the magistrate other information that he considers relevant.[11] The expert witness must know the subject well. Continuing education, as well as pre-court preparation, e.g. the study of the relevant medical literature, is important.

In court — common questions to the doctor

Masturbation

A common question that may arise when dealing with girls is whether masturbation could have caused the injuries that have been found on the patient. There are different types of masturbation. Masturbation either

takes the form of clitoral or of vaginal masturbation. Clitoral masturbation generally consists of rubbing of the clitoral area, usually with the hand, or rubbing up against an object. Vaginal masturbation occurs when an object is inserted into the vagina. It is known that there are women who prefer clitoral stimulation; indeed there are some who obtain an orgasm from clitoral stimulation which they cannot obtain from vaginal intercourse.[15] It does not seem to be a frequent occurrence for girls to insert objects into their vaginas, therefore it can be assumed that in children, clitoral masturbation predominates.

It is my opinion that the form of masturbation that occurs in normal children is virtually exclusively clitoral, and that if vaginal masturbation takes place, the child has probably been taught it, either by observation, or as a result of some object being introduced into the vagina by some other person. If this argument is accepted, then the logical conclusion is that hymenal damage is still a sign of some kind of sexual abuse, either because of direct acts on the part of the perpetrator, or indirectly due to the perpetrator teaching the child (usually by example rather than instruction) to masturbate vaginally.

Infections

There are cases where cystitis or vaginal infections have led to a diagnosis of child abuse.[16] It is true that some genito-urinary infections in children arise without sexual activity having occurred, and it is also true that some of the effects of the infection such as synechiae may be observed at a subsequent physical examination for sexual abuse. In general, however, it is unlikely that the presence of infection or the reaction of the child to the infection (in other words, scratching) would cause the kind of damage to the hymen seen in cases of child abuse. Children who masturbate or scratch are more likely to do so through their clothes. This will probably minimise damage to the hymen, which is the most obvious sign of sexual abuse visible on examination.

Other instruments causing the damage

Analogous to the well-known trauma cases where it is asked whether a blunt injury could have created a sharp linear laceration, the advocate may suggest that some other instrument could have caused the injuries in the child. Remember that the passage of any instrument through the vaginal orifice, not just the penis, also constitutes sexual abuse. Therefore, if it is conceded that some other instrument could have been used, it must be mentioned that if the perpetrator used that instrument, that action also constitutes sexual abuse. The defending advocate will probably also try to say that the child did it, but if the child did it under the influence of the perpetrator, then that, too, constitutes sexual abuse. Unfortunately, during the court procedure, the defence attorney will not normally concede these points himself, so that it could be necessary to point them out. It is important to note that instruments do not enter the vagina of their own volition. You might be confronted with a question something like: 'Could a buckle, or a pencil or a finger, have been responsible for the injuries? The important question is really: 'Who was behind the buckle or the pencil or the finger'? In one such case, the defence led evidence that the child had a bicycle saddle which was broken and that a sharp pointed piece of the saddle was sticking up. The child used the bicycle frequently and, it was suggested, in such a way that the pointed bit of the broken saddle part penetrated her vagina. The answer to that was that the child would not have allowed this to happen. This answer had to be repeated frequently because the question was repeated often. The point is that, generally, children will not allow lifeless things to penetrate or hurt them. It is after all, the *normal* response to withdraw from painful stimuli! In reply to this argument, the defence may suggest (as they did in this case) that if the child would have avoided the bicycle saddle, she would also have avoided the perpetrator directly manipulating her vagina. This, however, is a different matter because children may allow people to cause them injury for any of various reasons: one reason is, of course, fear; another, especially in incest cases, is that the child is frequently given more attention this way than any other way. The child relishes the attention, even though he/she does not enjoy the procedure. In the third place there is often a great deal of love between the child and the perpetrator; the child being younger is not always able to resist because of the psychological as well as the physical power that the perpetrator has over him/her. This is particularly true when the child knows the perpetrator, especially when the child is dependent upon him or her. Threats, for example, of physical trauma, family breakdown and withdrawal of love are frequently used by perpetrators.

In court — other issues

Demeanour

Dress conservatively. Speak clearly and firmly. Do not look confused or uncertain. Even when voicing facts about which some uncertainty is felt, the doctor should not be uncertain about his findings, or about his opinion.

It is interesting that in a case of drunken driving, a judge (J. P. Sutton in Viljoen v. R, 1946) made the comment that he preferred the evidence of policemen to that of doctors because, unlike doctors, 'an experienced policeman has no hesitation in expressing a definite opinion.'[12] Although the author disagrees with the judge he notes that the case has been followed as an authority I think this comment reflects more upon the individual judge and policeman than on doctors in general, but it does illustrate the importance of not appearing uncertain. Be prepared to express an opinion when there is a good reason to do so.

Use non-technical language where possible; if technical phrases are necessary, be prepared to translate them into language that is understandable to lay people.

Why cases come to trial

It is not always clear to the medical and nursing personnel involved why certain cases come to trial and others do not. Only those cases where there is a chance of conviction greater than 50% are brought to trial. (M Erasmus, prosecutor — personal communication). At the risk of simplifying the situation greatly, it appears to us that those cases where the perpetrator confesses and is prepared to plead guilty, and those where there is sufficient medical evidence, are the ones that will come to court. If the medical evidence is very equivocal, the case will probably not reach the court. In terms of convictions, it is true that where the perpetrators plead guilty they will be convicted. In cases where there is no lawyer the chances are higher that the perpetrator will be convicted than if there is a defence lawyer. If the perpetrator has a lawyer, the perpetrator may well not be convicted unless the child's evidence is extremely convincing. There are cautionary rules of evidence in cases of (*i*) child witness; (*ii*) a single witness and (*iii*) a sexual offence, which all tend to devalue the child's evidence. In this case the medical evidence probably does not play as important a role as we would like to think,[17] although the defence lawyer will probably make the doctor's task a difficult one.

Doctors do not usually influence which cases come to court or not, nor do they have sufficient knowledge to

predict the outcome. Occasionally though, doctors have felt that it would be better if a case did not proceed at all, for sometimes the child is injured more by the court case than would have been the case had there not been one.

It is hoped that the points that have been made in this article will help doctors to cope better with the experience of going to court to give evidence in cases of child abuse.

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REFERENCES

1. Jacklin LB. Review of child abuse in the South African white urban society. *Leech* 1989; **58:** 4-7.
2. De Villiers FPR. Kindermishandeling *Trauma Emerg Med* 1989; **6:** 44-47.
3. Reece RM, Grodin MA. Recognition of non-accidental injury. *Pediatr Clin North Am* 1985; **32:** 41-60.
4. Cowell CA. The gynecologic examination of infants, children and young adolescents. *Pediatr Clin North Am* 1981; **28:** 247-266.
5. Herman-Giddens ME, Frothingham JE. Prepubertal female genitalia: Examination for evidence of sexual abuse. *Pediatrics* 1987; **80:** 203-208.
6. Winship WS, Key JA, Dawes ME, Jacob WAS. Examination of sexually abused children. *S Afr Med J* 1987; **71:** 437-439.
7. Finkel MA. Anogenital trauma in sexually abused children. *Pediatrics* 1989; **84:** 317-322.
8. Hobbs CJ, Wynne JM. Sexual abuse of English boys and girls: The importance of anal examination. *Child Abuse Negl* 1989; **13:** 195-210.
9. McCann J, Voris J, Simon M, Wells R. Perianal findings in prepubertal children selected for nonabuse: A descriptive study. *Child Abuse Negl* 1989; **13:** 179-193.
10. De Villiers FPR. Better deal for abused children sought. *De Rebus* 1991; **281:** 291.
11. Strauss SA. *Doctor, Patient and the Law: A selection of practical issues.* 2nd ed. Pretoria: Van Schaik, 1984.
12. Hoffman LH, ed. *The South African Law of Evidence.* 2nd ed. Durban: Butterworth, 1970.
13. Bosman F, ed. *Social Welfare Law.* 1st ed. Johannesburg: Lex Patricia, 1982: 106-109.
14. Schwär TG, Loubser JD, Olivier JA. *Die ABC van Geregtelike Geneeskunde.* Pretoria: HAUM, 1985.
15. La Ferla JJ. Inhibited sexual desire and orgasmic dysfunction in women. *Clin Obstet Gynecol* 1984; **27:** 738-749.
16. Reinhart MA, Adelman R. Urinary symptoms in child sexual abuse. *Paediatric Nephrology* 1989; **3:** 381-385.
17. De Jong AR, Rose M. Legal proof of child sexual abuse in the absence of physical evidence. *Pediatrics* 1991; **88:** 506-511.

Continuous intravenous propofol with nitrous oxide for ocular surgery

A comparison with etomidate, alfentanil, nitrous oxide and isoflurane

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Summary

Propofol, administered intravenously for induction and as a continuous maintenance anaesthetic with nitrous oxide, was compared, in a group of elderly patients scheduled for ophthalmic surgery, with an anaesthetic technique (etomidate, alfentanil, nitrous oxide and isoflurane) specifically chosen to be haemodynamically stable and evanescent in action. Both techniques resulted in similar effects on blood pressure after induction, intubation and surgical incision, but propofol did not prevent increases in heart rate as effectively at these times. Furthermore, during maintenance anaesthesia, cardiovascular stability and anaesthetic depth were more easily achieved in the group where etomidate, alfentanil and isoflurane were used. Propofol decreased intra-ocular pressure after intubation, while in both groups recovery was rapid with no significant complications. A subgroup of patients receiving α-methyldopa had significantly longer post-anaesthetic recovery times.

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General anaesthesia for ocular surgery in the elderly requires meticulous attention to anaesthetic technique; the rise in intra-ocular pressure and hypertensive response associated with laryngoscopy and intubation must be obtunded, while cardiovascular depression must be avoided. Cardiovascular stability presents a particular problem in the frequently elderly patients who are subjected to the relatively minor surgical stimuli associated with most eye operations. Thus the anaesthetic agents and adjuncts used should be chosen for their haemodynamic stability and evanescence of action.

Propofol, used alone, obtunds the hypertensive response to intubation[1] while lowering intra-ocular pressure.[2] It can be used in reduced dosages to induce anaesthesia in elderly patients without major effects on cardiovascular function.[3] When administered as a continuous infusion it allows rapid adjustment of anaesthetic depth[4] and has good recovery characteristics.[5] We wished to assess the suitability of propofol when administered for induction and as a continuous intravenous infusion with nitrous oxide for maintenance anaesthesia. We compared this technique with one chosen specifically for cardiovascular stability and evanescence of action.

Materials and methods

Forty consenting patients aged 51 - 91 years and scheduled for anterior segment surgery under general anaesthesia were studied, the University Ethics and Research Committee having given its approval. Patients with a