Limitations of the National Protocol for Sexual Assault Medical Forensic Examinations

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The care of victims of sexual assault in the United States has seen considerable improvement during the past 20 years. According to a database maintained by the International Association of Forensic Nurses, there are at least 276 sexual assault nurse examiner (SANE) programs in the United States. The majority of SANE programs are hospital based (75%) (*www.iafn.org*; members only).[1] Numerous articles in medical and nursing journals and particularly in the *Journal of Emergency Nursing* have documented the science of forensic and medical care of victims of sexual assault, contributing significantly to the body of literature.

In September 2004, the first National Protocol for Sexual Assault Medical Forensic Examinations (the National Protocol) was released by the US Justice Department, Office on Violence Against Women.[2] This 130-page document was designed as a guide for persons caring for victims of sexual assault and is the first national protocol of its kind. Although the authors are not listed, the protocol states that it was developed with the "input of national, local, and tribal experts throughout the country, including law enforcement representatives, prosecutors, medical personnel, forensic scientists, and others."[2] The document states that the protocol should serve as a guideline rather than as a list of requirements and should supplement the many excellent protocols in use but not supercede these protocols. The guidelines are specific to female and male adolescents and adult populations and do not address pediatric or prepubescent examinations.

The National Protocol provides a detailed set of guidelines for criminal justice and health care practitioners in responding to the immediate needs of sexual assault victims. The major sections address overarching issues, operational challenges, and examination process.

The overall goal of most protocols related to the care of sexual assault victims seeks to ensure that the medical forensic examination is performed with expertise and sensitivity. The overall content appears congruent on many levels with evidence-based practice protocols and is consistent with current best practice, except for 2 particular issues: emergency contraception (EC) and sexually transmitted infections (STIs). In these 2 instances, the protocol lacks necessary clarity and deviates from the standard of care for female victims of sexual assault.

Emergency contraception

There are many aspects specific to the medical care of victims, and perhaps one of the most controversial is EC. In the late 1990s the Federal Food and Drug Administration approved a product for EC.[3] Prior to this approval, oral contraceptives were used for the purpose of EC.[4] Currently, 5 states require hospital emergency rooms to provide EC: California, New Mexico, New York, South Carolina, and Washington. In an effort to improve access to EC, 6 states allow pharmacists to dispense EC without a prescription with prescribed guidelines (Alaska, California, Hawaii, Maine, New York, and Washington).[5-8]

Surprisingly, less than half a page is devoted to "pregnancy risk evaluation and care" in the National Protocol (page 111), and recommendations for pregnancy prevention are limited to one sentence on pregnancy prevention: "Discuss treatment options with patients, including reproductive health services." Although the protocol wisely advises health care personnel to discuss the possibility of pregnancy with rape victims and administer pregnancy tests if given the patient's consent, it offers no specific suggestions, as would be expected with most sexual assault guidelines.

The risk of pregnancy associated with a sexual assault is significant. In fact, it is estimated that the pregnancy rate associated with rape in victims 12 to 45 years of age is approximately 4.7%. This information, in addition to estimates based on the US Census, suggests that there may be 32,101 annual rape-related pregnancies among American women as a result of a sexual assault,[9] and this number is in all likelihood an underestimate.

Research began on EC in the late 1960s, and the first study was published in 1974. The emergency contraceptive regimen, also referred to as the Yuzpe Regimen, was named after Canadian Physician Albert Yuzpe, who published the first studies on combined hormone therapy for EC. He demonstrated safe and efficient use of high-dose estrogen plus progestin.[10] A number of studies have since shown that EC can reduce the risk of pregnancy when started within 120 hours of unprotected intercourse and that the sooner the regimen begins, the more effective the treatment.[3,11-13] Most SANE protocols discuss EC and offering pregnancy prophylaxis medication.[14] Omission of specific details in relation to EC in the National Protocol is unacceptable.

Even the Vatican has supported pregnancy prevention in cases of sexual assault. In the fourth edition of the Ethical and Religious Directives for Catholic Health Care Services, the Committee on Doctrine of the National Conference of Catholic Bishops approved as the national code by the full body of bishops at its June 2001 General Meeting a directive to be used in caring for victims of sexual assault. It states:

> "Compassionate and understanding care should be given to a person who is the victim of sexual assault. Health care providers should cooperate with law enforcement officials and offer the person psychological and spiritual support as well as accurate medical information. A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medications that would prevent ovulation, sperm capacitation, or fertilization. It is not permissible, however, to initiate or to recommend treatments that have as their purpose or direct effect the removal, destruction, or interference with the implantation of a fertilized ovum."[15]

The National Protocol fails to offer a responsible, medically informed, time-sensitive option for victims of sexual assault. Specifically, pregnancy prophylaxis with the use of "Plan B"—a progesterone-only hormone—prevents a pregnancy from occurring[16-18]; it does not end a pregnancy that is already in progress and is considered a safe and easy treatment for victims of assault in preventing a pregnancy. Prior to administering the medication, a pregnancy test is conducted to ensure that no pregnancy is in