Drug-facilitated Sexual Assault: When should we collect and what type of patient consent is necessary?

By Linda E. Ledray, RN, SANE-A, PhD, LP, FAAN

Health care providers are always concerned about getting informed consent from their patients before providing medical care. This is for the benefit and protection of both the patient and the provider. The Indian Health Manual (IHM) defines informed consent as "the process by which a fully informed patient can participate in choices about his or her health care. The patient must be given all relevant information prior to the medical procedure. This includes information about the impact of declining a procedure, which may negatively affect the quality of care and usefulness of evidence collection. In order for the patient's consent to be valid, he or she must be considered competent to make the decision at hand and the consent must be voluntary. Informed consent includes a discussion of the following: the nature of the decision/procedure; reasonable alternatives to the proposed intervention; the relevant risks, benefits, and uncertainties related to each alternative; assessment of patients understanding; and the acceptance of the intervention by the patient". (IHM, 3-29.1E). This poses a dilemma for the health care provider when a patient comes to the medical facility reporting a suspected sexual assault or a sexual assault and they are intoxicated or have been drugged. This paper will discuss the concerns and options for the patient and provider.

For the purposes of this paper Drug-facilitated sexual assault (DFSA) refers to the use of any substance, legal or illegal, alcohol and drugs, taken by the victim willingly or without their knowledge, that makes them vulnerable to a sexual assault.

Provider Concerns and Options

While providing the best standard of care possible, there are many ethical issues which are unique to SANE practice. Since many of these issues are being faced for the first time SANE-SART programs are frequently required to develop new polices that provide guidance to the nurse when dealing with these unique challenges. The decision about when a sexual assault forensic examination should be completed in a DFSA case and who should make this decision if the patient cannot provide informed consent is multifaceted.

The first decision the SANE/SAFE must make is "when is the patient too drugged or intoxicated to give informed consent?" For the most part this becomes a judgment call for the nurse as she must decide if she believes the patient is competent to understand and give consent. Her decision and rationale for her decision should be well documented. Clearly getting truly informed consent to do an evidentiary examination from a significantly drugged or intoxicated patient is not possible. But at what point is that line crossed?

This is an area where there is disagreement between the most experienced SANE/SAFEs about what care should or should not be provided and unfortunately, neither the national protocol or the IHM specifically address the collection of additional evidence in the drugged or intoxicated patient who cannot give informed consent. The options range from doing nothing until the patient is "sober" and can give informed consent, to making a good faith effort to get consent from the

patient, or a family member, and if this is not possible to complete the evidentiary exam "in the patients best interest" and hold the evidence until they are able to make an informed decision.

The need for clear policies and procedures. First and foremost it is important that the facility has clear policies and procedures for the SANE/SAFE to direct their decisions. Whatever they decide, a written policy protects both patient and provider and is essential to ensure consistent care for all patients. The policy needs to cover all possibilities that may arise, if possible. While the SART will be instrumental in policy development, the hospital attorney should review and comment on the policy. If a circumstance arises that is not covered by policy the best advice is to always do what the provider truly believes is in the patient's best interest.

Medical facilities have clear policies about treatment of injuries for patients unable to consent and these should, of course, be followed for sexual assault patients who are also physically injured. The issue not routinely addressed is if evidence should also be collected.

SANE/SAFE Considerations

Toxicology testing. The National Protocol for Sexual Assault Forensic Examinations stresses the importance of seeking informed consent from the patient before collecting a sample for a toxicology screen in a suspected DFSA case. The patient should be made aware of the scope and purposes of the testing, as well as potential benefits and consequences (USDOJ, 2004). While they also stress that voluntary drug or alcohol use should not diminish the seriousness with which law enforcement pursues the case, this is a concern, and the patient should be told that the results could help the case, but could also be used against them if the case goes to court (USDOJ, 2004).

The national protocol does not, however, specifically recommend what the clinician should do if the patient is unable to give consent due to the drugs or alcohol.

The SANE/SAFE must also take into consideration the consequences of not obtaining a sample for a toxicology screen or completing a sexual exam? Evidence of drug use, voluntary or involuntary, will be lost rapidly if a sample is not collected. The two clear options are to not collect either a urine or blood sample until informed consent can be obtained, or to collect the sample and hold it, maintaining proper chain-of-custody until the patient can be fully informed about the potential benefits and consequences and decide what they want done with the sample.

Additional forensic specimen collection. The SANE/SAFE must also consider the risks and benefits to the patient both of collecting additional forensic specimens, as well as of not completing the exam as soon as possible. Fortunately, except for the speculum insertion, the remainder of the sexual assault exam procedure is relatively noninvasive and has minimal risk to the patient. The additional risk of not completing an evidentiary exam is that evidence that could identify the assailant and substantiate that a sexual assault occurred, may be lost (Ledray, 1999; Ledray, 2006; Ledray & O'Brien, 2011).

If an intoxicated patient presents to the medical facility, reporting a sexual assault and requesting a medical forensic examination, the decision is clear. The patients request should be honored and an examination, including evidence collection conducted immediately, regardless of their level of intoxication. Even a few hours delay, "until the patient is sober" could result in the loss of valuable evidence to identify a perpetrator and assist in prosecution. Not immediately collecting evidence such as urine and blood for drugs and alcohol, on a patient that appears intoxicated and suspects

they may have been sexually assaulted, could result in the loss of evidence to show that the patient was indeed drugged and raped. Not only will the patient never know what happened, but there will be no chance of justice for the victim.

The unconscious patient. The decision is more different for the unconscious patient. First the SANE/SAFE should be aware of any tribal or State laws that permit a family member to give consent for care when a patient is incapacitated. Without consent from a family member recognized by law as being able to consent, the SANE/SAFE should then determine whether evidence collection comes under any part of the laws that allow for implied consent. Implied consent is the legal concept that when a patient is unconscious they would want care sufficient to save their life or prevent permanent disability. In the case where loss of consciousness may be related to drug or alcohol intoxication, it would be reasonable for the nurse to collect a blood or urine sample to determine the presence of drugs or alcohol, because that information would guide the treatment plan of the patient. If a sample needs to be collected for the health care of the patient, it can be maintained in a fashion that would allow it to be used as evidence if the patient is later able to give consent.

The dilemma is created when there is a desire to collect evidence that goes beyond the immediate health care needs of the patient. Typically this is DNA evidence obtained during a pelvic examination. Data is clearly available that shows that delays in evidence collection will reduce the likelihood of recovery of DNA (Delfin, Madrid, Tan, & De Ungria, 2005). SANEs who want to collect evidence in this situation should have a written policy that states specific criteria for when evidence will be collected without a patient's consent, and how the evidence will be maintained until the patient can give consent. The policy should be approved by both hospital administration

and legal counsel. While decisions about evidence collection should be made with the best interest of the patient in mind, by creating a policy in advance all aspects of patient rights can be explored and acknowledged (Pierce-Weeks, & Campbell, 2008). In the state of Maine they recognized by statute, implied consent for a sexual assault exam when a patient is unconscious (Maine Revised Statutes (2005).Title 24 Chapter 21: 2986.5). By creating a statute to deal with the unconscious patient, the State of Maine has given nurses legal protection to collect evidence without obtaining the patient's informed consent.

Some facilities have chosen to require a court order prior to collecting evidence without consent. In this situation the court will determine that the patient is unable to consent and will appoint a surrogate decision maker for the patient. It will then be the duty of the surrogate decision maker to consent for evidence collection.

Summary

Because of the unique area of practice of the SANE/SAFE there are decisions that the forensic examiner must make that have not been formally addressed in the national protocol or IHM, especially in cases of DFSA in which the patient is unable to give informed consent. The best protection for the clinician and the patient is to have clear policies and procedures about what should happen under what circumstances. These must be directed by tribal, State and federal law, as well as what we believe is in the best interest of the patient.

Reference List

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