Medical and Health Professionals

(Doctors and supporting medical staff)

Relevant Legal Provisions in the Act and Rules and related laws:

Section 27 – Medical Examination:

27. (1) The medical examination of a child in respect of whom any offence has been committed under this Act, shall, notwithstanding that a First Information Report or complaint has not been registered for the offences under this Act, be conducted in accordance with section 164A of the Code of Criminal Procedure, 1973.

(2) In case the victim is a girl child, the medical examination shall be conducted by a woman doctor.

(3) The medical examination shall be conducted in the presence of the parent of the child or any other person in whom the child reposes trust or confidence.

(4) Where, in case the parent of the child or other person referred to in sub-section (3) cannot be present, for any reason, during the medical examination of the child, the medical examination shall be conducted in the presence of a woman nominated by the head of the medical institution.

Rule 5 - Emergency medical care:

(1) Where an officer of the SJPU, or the local police receives information under section 19 of the Act that an offence under the Act has been committed, and is satisfied that the child against whom an offence has been committed is in need of urgent medical care and protection, he shall, as soon as possible, but not later than 24 hours of receiving such information, arrange to take such child to the nearest hospital or medical care facility center for emergency medical care:

Provided that where an offence has been committed under sections 3, 5, 7 or 9 of the Act, the victim shall be referred to emergency medical care.

(2) Emergency medical care shall be rendered in such a manner as to protect the privacy of the child, and in the presence of the parent or guardian or any other person in whom the child has trust and confidence.

(3) No medical practitioner, hospital or other medical facility center rendering emergency medical care to a child shall demand any legal or magisterial requisition or other documentation as a pre-requisite to rendering such care.

(4) The registered medical practitioner rendering emergency medical care shall attend to the needs of the child, including --

(i) treatment for cuts, bruises, and other injuries including genital injuries, if any;

(ii) treatment for exposure to sexually transmitted diseases (STDs) including prophylaxis for identified

STDs;

(iii) treatment for exposure to Human Immunodeficiency Virus (HIV), including prophylaxis for HIV after necessary consultation with infectious disease experts;

(iv) possible pregnancy and emergency contraceptives should be discussed with the pubertal child and her parent or any other person in whom the child has trust and confidence; and,

(v) wherever necessary, a referral or consultation for mental or psychological health or other counselling

should be made.

(5) Any forensic evidence collected in the course of rendering emergency medical care must be collected in accordance with section 27 of the Act.

Thus, doctors and support medical staff are involved both at the time of rendering emergency medical care as well as at the time of medical examination.

2. Emergency Medical care:

The child may be brought to the hospital for emergency medical care as soon as the police receive a report of the commission of an offence against the child. In such cases, the rules under the POCSO Act, 2012 prescribe that the child is to be taken to the nearest hospital or medical care facility. This may be a government facility or a private one.

This is reiterated by Section 23 of the Criminal Law Amendment Act, which inserts Section 357C into the Code of Criminal Procedure, 1973. This section provides that all hospitals are required to provide first-aid or medical treatment, free of cost, to the victims of a sexual offence.

2.1 Medical Examination:

Medical examination is to be conducted as per the provisions of Section 27 of the POCSO Act, 2012 and Section 164A of the CrPC, 1973 which states:

(1) Where, during the stage when an offence of committing rape or attempt to commit rape is under investigation, it is proposed to get the person of the woman with whom rape is alleged or attempted to have been committed or attempted, examined by a medical expert, such examination shall be conducted by a registered medical practitioner employed in a hospital run by the Government or a local authority and in the absence of a such a practitioner, by any other registered medical practitioner, with the consent of such woman or of a person competent to give such consent on her behalf and such woman shall be sent to such registered

medical practitioner within twenty-four hours from the time of receiving the information relating to the commission of such offence.

(2) The registered medical practitioner, to whom such woman is sent shall, without delay, examine her and prepare a report of her examination giving the following particulars, namely:-

(I) the name and address of the woman and of the person by whom she was brought;

(II) the age of the woman;

(III) the description of material taken from the person of the woman for DNA profiling;

(IV) marks of injury, if any, on the person of the woman;

(V) general mental condition of the woman; and

(IV) other material particulars in reasonable detail.

(3) The report shall state precisely the reasons for each conclusion arrived at.

(4) The report shall specifically record that the consent of the woman or of the person competent to give such consent on her behalf to such examination had been obtained.

(5) The exact time of commencement and completion of the examination shall also be noted in the report.

(6) The registered medical practitioner shall, without delay forward the report to the investigation officer who shall forward it to the Magistrate referred to in section 173 as part of the documents referred to in clause (a) of sub-section (5) of that section.

(7) Nothing in this section shall be construed as rendering lawful any examination without the consent of the woman or of any person competent to give such consent on her behalf.

In the above legal provision, the term “woman” may be substituted by the term “child”, and applied in the context of the POCSO Act, 2012.

2.2 Compensation for medical expenses:

Section 33(8) provides:

“In appropriate cases, the Special Court may, in addition to the punishment, direct payment of such compensation as may be prescribed to the child for any physical or mental trauma caused to him or for immediate rehabilitation of such child.”

Rule 7 provides further details in relation to the payment of this compensation. It specifies that the Special Court may order that the compensation be paid not only at the end of the trial, but also on an interim basis, to meet the immediate needs of

the child for relief or rehabilitation at any stage after registration of the First Information Report [Rule 7(1)]. This could include any immediate medical needs that the child may have. Further, Rule 7(3) provides that the criteria to be taken into account while fixing the amount of compensation to be paid include the severity of the mental or physical harm or injury suffered by the child; the expenditure incurred or likely to be incurred on his/her medical treatment for physical and/or mental health; and any disability suffered by the child as a result of the offence.

Hence, the child may recover the expenses incurred on his/her treatment in this way.

3. Modalities of Medical Examination of Children

3.1 Role of Medical Professionals in the context of the POCSO Act, 2012

Doctors have a dual role to play in terms of the POCSO Act 2012. They are in a position to detect that a child has been or is being abused (for example, if they come across a child with an STD); they are also often the first point of reference in confirming that a child has indeed been the victim of sexual abuse.

The role of the doctor may include:

i) Having an in-depth understanding of sexual victimization

ii) Obtaining a medical history of the child's experience in a facilitating, non-judgmental and empathetic manner

iii) Meticulously documenting historical details

iv) Conducting a detailed examination to diagnose acute and chronic residual trauma and STDs, and to collect forensic evidence

v) Considering a differential diagnosis of behavioural complaints and physical signs that may mimic sexual abuse

vi) Obtaining photographic/video documentation of all diagnostic findings that appear to be residual to abuse

vii) Formulating a complete and thorough medical report with diagnosis and recommendations for treatment

viii) Testifying in court when required

There are at least three different circumstances when there is no direct allegation but when the doctor may consider the diagnosis of sexual abuse and have to ask questions of the parent and child. These include but are not limited to:

(i) when a child has a complaint that might be directly related to the possibility of sexual abuse, such as a girl with a vaginal discharge;

(ii) when a child has a complaint that is not directly related to the possibility of sexual abuse, such as abdominal pain or encopresis (soiling);

(iii) when a child has no complaint but an incidental finding, such as an enlarged hymenal ring, makes the doctor suspicious.

3.2 Mandatory Reporting: When a doctor has reason to suspect that a child has been or is being sexually abused, he/she is required to report this to the appropriate authorities (i.e. the police or the relevant person within his/her organization who will then have to report it to the police). Failure to do this would result in imprisonment of up to six months, with or without fine.

3.3 Medical or health history: The purpose of this is to find out why the child is being brought for health care at the present time and to obtain information about the child's physical or emotional symptoms. It also provides the basis for developing a medical diagnostic impression before a physical examination is conducted. The medical history may involve information about the alleged abuse, but only in so far as it relates to health problems or symptoms that have resulted there from, such as bleeding at the time of the assault, or constipation or insomnia since that time.

Where a child is brought to a doctor for a medical examination to confirm sexual abuse, the doctor must:

i) Take the written consent of the child. The three main elements of consent are information, comprehension and voluntariness. The child and his/her family should be given information about the medical examination process and what is involved therein, so that they can choose whether or not to participate. Secondly, they should be allowed enough time to understand the information and to ask questions so that they can clarify their doubts. Lastly, the child and/or his or her parent/guardian should agree to the examination voluntarily, without feeling pressurized to do so. In some situations it may be appropriate to spend time with the child/adolescent alone, without the parent/guardian present. This may make it easier for the child to ask questions and not feel coerced by a parent/guardian.

ii) Where the child is too young or otherwise incapable of giving consent, consent should be obtained from the child's parent, guardian or other person in whom the child has trust and confidence.

iii) The right to informed consent implies the right to informed refusal.

iv) To be able to give informed consent, the child and his/ her parents/guardian need to understand that health care professionals may have a legal obligation to report the case and to disclose information received during the course of the consultation to the authorities even in the absence of consent.

v) Document who was present during the conversation with the child.

vi) Document questions asked and child’s answers in the child’s own words.

vii) Conduct the examination in a sensitive manner. It is important that the exam is never painful. The exam should be done in a manner that is least disturbing to the child.

viii) Focus on asking simply worded, open-ended, non-leading questions, such as the "what, when, where, and how" questions, which are important to the medical evaluation of suspected child sexual abuse.

ix) Reliance should be placed as far as possible on such questioning as "tell me more" followed by "and then what happened?"

x) Do not ask uncomfortable questions related to details of the abuse, but try to find out more about the medical and family history of the child

xi) Using the child's words for body parts may make the child more comfortable with difficult conversations about sexual activities.

xii) Using drawings may also help children describe where they may have been touched and with what they were touched.

xiii) Ensure that the child has adequate privacy while the examination is being conducted

xiv) Do not conduct the examination in a labour room or other place that may cause additional trauma to the child

xv) Always ensure patient privacy. Be sensitive to the child’s feelings of vulnerability and embarrassment and stop the examination if the child indicates discomfort or withdraws permission to continue.

xvi) Always prepare the child by explaining the examination and showing equipment; this has been shown to diminish fears and anxiety. Encourage the child to ask questions about the examination.

xvii)If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination. Some older children may choose a trusted adult to be present. Sexual abuse of children is usually not physically violent. In the large majority of children the physical exam is normal. A normal or non-specific exam does not rule out sexual abuse.

xviii) As a minimum, the medical history should cover any known health problems (including allergies), immunization status and medications. In terms of obtaining information about the child’s general health status, useful questions to ask would be:

a) Tell me about your general health.

b) Have you seen a nurse or doctor lately?

c) Have you been diagnosed with any illnesses?

d) Have you had any operations?

e) Do you suffer from any infectious diseases?

xix) Carefully collect and preserve forensic evidence

xx) Clothing collection is critical when evidence is collected. Clothing, especially underwear, is the most likely positive site for evidentiary DNA.

xxi) Scene investigation, including collection of linens and clothing should be done early.

Evidence from clothing and other objects is more likely to be positive than evidence from the patient's body.

xxii)Children often report weeks or months after the abuse event, and physical injuries to the genital or anal regions usually heal within a few days. This is why the medical provider should always consider differential diagnosis and alternative explanations for physical signs and symptoms.

xxiii) In the case of a child with special needs, ensure that the procedures are explained to the child in a manner which he/she understands and that he/she is asked what help he/she requires, if any (e.g., a child with physical disabilities may need help to get on and off the medical examination table or to assume positions necessary for the examination). However, do not assume that the child will need special aid. Also, ask for permission before proceeding to help the child.

xxiv) Recognize that it may be the first time the child is having an internal examination. The child may have very limited knowledge of reproductive health issues and not be able to describe what happened to them. He/she may not know how he/she feels about the incident or even identify that a crime was committed against him/her.

xxv)Wherever necessary, refer the child for counselling

xxvi) Wherever applicable, refer the child for testing for HIV and other Sexually Transmitted Diseases

3.4 If the child resists the examination

i) If a child of any age refuses the genital-anal examination, it is a clinical judgment of how to proceed. A rule of thumb is that the physical exam should not cause any trauma to the child. It may be wise to defer the examination under these circumstances.

ii) It may be possible to address some of the child's fears and anxieties (e.g. a fear of needles) or potential sources of unease (e.g. the sex of the examining health worker).Further, utmost comfort and care for the child should be provided e.g., examining very small children while on their mother's (or caregiver's) lap or lying with her on a couch.

iii) If the child still refuses, the examination may need to be deferred or even abandoned. Never force the examination, especially if there are no reported symptoms or injuries, because findings will be minimal and this coercion may represent yet another assault to the child.

iv) The child should not be held down or restrained for the examination (exception for infants or very young toddlers).

3.4.1 Techniques to help the child relax

i) Offer clear age-appropriate explanations for the reasons for each procedure, and offer the child some control over the exam process.

ii) Proceed slowly, explain each step in advance.

iii) Use curtains to protect privacy, if the child wishes.

iv) Explain to parent or support person that their job is to talk to and distract the child, and the findings of the exam will be discussed with them after the exam is completed.

v) Position the parent near the child’s head.

vi) Use distracters. For example, ask the parent to sing a song, or tell a familiar story, or read a book to the child. A nurse or other helper can do this if the parent is unable.

vii) Use TV, cell phone game, or other visual distraction.

viii) Do not forcibly restrain the child for the examination

3.5 Sedation for Medical Treatment

i) Sedation is rarely needed if the child is informed about what will happen and there is adequate parental support for the child.

ii) Consider sedation or a general anesthetic only if the child refuses the examination and conditions requiring medical attention, such as bleeding or a foreign body, are suspected.

iii) If it is known that the abuse was drug-assisted, the child needs to be told that he/she will be given a sedative or be put to sleep, that this may feel similar to what he/she has experienced in the past.

iv) Reassure the child about what will take place during the time under sedation and that he/she will be informed of the finding.

v) However, conscious sedation is an option if examination and evidence collection is required, and the child is not able to cooperate.

vi) Speculum exam on a pre-pubertal girl should be done under anesthesia, not conscious sedation.

3.6 The following pieces of information are essential to the medical history:

i) Last occurrence of alleged abuse (younger children may be unable to answer this precisely). When do you say this happened?

ii) First time the alleged abuse occurred. When is the first time you remember this happening?

iii) Threats that were made.

iv) Nature of the assault, e.g. anal, vaginal and/or oral penetration. What area of your body did you say was touched or hurt? (The child may not know the site of penetration but may be able to indicate by pointing. This is an indication to examine both genital and anal regions in all cases.)

v) Whether or not the child noticed any injuries or complained of pain.

vi) Vaginal or anal pain, bleeding and/or discharge following the event. Do you have any pain in your bottom or genital area? Is there any blood in your panties or in the toilet? (Use whatever term is culturally acceptable or commonly used for these parts of the anatomy.)

vii) Any difficulty or pain with voiding or defecating. Does it hurt when you go to the bathroom? (indication to examine both genital and anal regions in all cases.)

viii)Any urinary or faecal incontinence.

ix) Whether or not the child noticed any injuries or complained of pain.

x) In case of children, illustrative books, body charts or a doll can be used if available, to elicit the history of the assault. When it is difficult to elicit history from a child, please call an expert.

3.7 When performing the head-to-toe examination of children, the following points are particularly noteworthy:

i) Record the height and weight of the child (neglect may co-exist with sexual abuse).

Note any bruises, burns, scars or rashes on the skin. Carefully describe the size, location, pattern and colour of any such injuries.

ii) Check for any signs that force and/or restraints were used, particularly around the neck and in the extremities.

iii) Record the child’s sexual development stage and check the breasts for signs of injury.

iv) If the survivor is menstruating at the time of examination then a second examination is required on a later date in order to record the injuries clearly.

v) Some amount of evidence is lost because of menstruation. Hence it is important to record whether the survivor was menstruating at the time of assault/examination.

vi) The same applies to bathing, douching, defecating, urinating and use of spermicide after the assault.

3.8 Role of Medical Professionals as Expert Witnesses

Deciding cases of child sexual abuse would be much easier if it left clear-cut physical evidence. Unfortunately, child sexual abuse often leaves no such evidence. Child sexual abuse is often exceedingly difficult to prove. It usually occurs in secret, often over a prolonged period of time, and does not always leave physical marks; in addition to this, the child is usually the only eyewitness. While many children are capable witnesses, some cannot give conclusive testimony, and consequently, children's testimony is sometimes ineffective. In such cases, the testimony of an expert medical witness can be useful.

Physicians can provide opinion testimony that is based upon the child's history, statements, and medical examination, even if the physician's examination of the child reveals no concrete physical evidence supportive of the child's allegations.

i) Courts in India in their judgments described an expert as a person who has acquired special knowledge, skill or experience in any art, trade or profession. Experts have knowledge, skill, experience, or training concerning a particular subject matter that is generally beyond the knowledge of the average person. Such knowledge may have been obtained by practice, observation or careful study. The expert thus operates in a field beyond the range of common knowledge.

ii) Expert evidence is covered under Ss.45-51 of Indian Evidence Act. The subjects of expert testimony mentioned by the section are foreign law, science, art and the identity of handwriting or finger impressions.

iii) In general, whether or not the testimony of an expert will be useful in any given case is almost always left to the discretion of the trial judge before whom the testimony is proffered. However, even where the Court has some degree of knowledge or familiarity with the subject, an expert's testimony may be valuable to add insight and depth its understanding of the matter, or to educate them as to commonly held prejudices and misconceptions which might negatively impact upon an impartial and just decision.

iv) In general, the opinions of medical professionals are admissible upon questions such as insanity, the causes of diseases, the nature of the injuries, the weapons which might have been used to cause injuries or death, medicines, poisons, the conditions of gestation, etc.

In the case of questions pertaining to age determination, positive evidence furnished by birth register, by members of the family, with regard to the age, will have preference over the opinion of the doctor: but, if the evidence is wholly

unsatisfactory, and if the ossification test in the case is complete, such a test can be accepted as a surer ground for determination of age.

v) In their testimony regarding a forensic examination, medical professionals typically describe the process of examining the victim, the physical findings that were observed, and their interpretation. It is important to remember that the medical professional cannot be asked to testify to “diagnose” sexual abuse. The doctor cannot make any definitive conclusions regarding the degree of force used by the abuser or whether the victim consented to any sexual activity. What he/she can appropriately conclude is whether there is evidence of sexual contact and/or recent trauma. He/she can state whether the medical history and examination are consistent with sexual abuse.

vi) In many child abuse cases, experts have firsthand knowledge of the child because the expert treated or examined the child. However, an expert may be called upon to render an opinion concerning a child without personally examining the child.

vii) However, it is important to remember that doctors are rarely expert in interviewing, and often assume the truth of what the patient tells them. The testimony is presented as if the doctor's opinion is based on physical findings when it is not. It is often largely or wholly based on statements made, a far different and less scientific basis than objective findings upon examination.

viii)In addition to this, opinions may be sought from mental health experts as to the psychological effects of child sexual abuse, such as PTSD and Child Sexual Abuse Accommodation Syndrome.

ix) It is for the legal representative who proposes the use of expert testimony to establish his/her credentials, preferably listing his/her formal qualifications. The adequacy of the qualification of the expert and the admissibility of his/her testimony are within the discretion of the Special Court.

x) Before giving evidence the expert will usually have prepared a report, either assessing one or more parties to the case or assessing other experts' reports. His/her report should be reliable on the basis of the following criteria:

a) It should provide a context in layman's terms from which to understand the basis of his/her opinion

b) It should be clear when the expert is stating corroborated fact and when he/she is merely repeating what he/she has been told by the alleged offender. Assertions which are based entirely on the alleged offender's perception are likely to be misleading.

c) The expert must review the information impartially rather than ignore matters which are inconvenient to his/her conclusions.

d) The report should avoid restating incidental trivia and give preference to examining and analyzing the crucial issues of the case.

e) The expert should demonstrate knowledge of the process and dynamics of child sexual abuse and help to make sense of the child's and non-abusing parent's experiences and perceptions. Victims and non-abusing partners of offenders often do not act rationally and can appear collusive with the offender, whereas their behavior results from the control the offender exercises over them. It is useful to have this explained in the expert report.

f) All professions have their exclusive language, but it is best that the expert present the issues in language that the court, advocate and parties can understand.

g) The expert must not rely solely on quoted research to support his/her arguments, and should refer to clinical experience as well.

An expert opinion must be premised on a reasonable degree of certainty. The expert cannot speculate or guess. It is clear, however, that an expert need not be absolutely certain about a subject before offering an opinion. All that is required is reasonable clinical certainty It is important to remember that while an expert's testimony may be deemed relevant, necessary, reliable, and therefore admissible under the aforementioned guidelines, it is ultimately the prerogative of the judge to determine what weight should be afforded the testimony. No matter how qualified the expert, the court is not bound by an expert's conclusions and can exercise its discretion in this regard, keeping in mind all the other evidence presented to it.

4. FAQs on Medical Examination

Doctors may be faced with some of these questions from children as well as parents and caregivers:

i) Why is the medical examination necessary?

The medical exam is a very important tool in evaluating sexual abuse. The physical examination can identify both new and old injuries, detect sexually transmitted diseases and provide evidence of sexual contact. If done in a sensitive manner, the examination can answer any questions or concerns the child may have and reassure the child about their well-being and that their body is private. The exam also has evidentiary value in a court of law.

ii) The last time my child was touched in a sexually inappropriate manner was over a year ago.

Is the medical exam still necessary?

Yes. Most children reveal their experience of abuse after a long time has passed, for example, when they are older or feel that they are no longer in danger of being abused again. Some even reveal it accidentally. In such cases, the medical examination can reassure the child about their well-being and address any worried the child may have about the injuries they suffered due to the abuse. Some children may have injuries that healed a long time ago but can be seen with the help of special equipment.

iii) Is the examination uncomfortable for the child?

No. the examination itself is rarely physically uncomfortable for the child; however, what may cause discomfort is the attitude of the person conducting the examination. For this reason, it is important that all medical health care professionals be trained in conducting medical examinations of children in a sensitive manner. The doctor is expected to explain the procedure to the child and his/ her parents and obtain their consent prior to conducting the examination, as well as answer any questions they may have.

iv) Can the parent(s) be present while the examination is being conducted?

Yes. Section 27 of the new POCSO Act, 2012 specifically requires that the examination be conducted in the presence of the child’s parents/ guardian or other person in whom

the child has trust and confidence.