The Role of Physicians in Reporting and Evaluating Child Sexual Abuse Cases

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Abstract

Physicians become involved in child sexual abuse when they must report suspected abuse or when they are asked to medically evaluate a child who is an alleged victim of abuse. This article reviews recent progress in the medical profession’s attention to child sexual abuse and discusses current issues surrounding reporting and medical evaluation. The reporting requirement raises several concerns for pediatricians. Their legal responsibilities as reporters may conflict with their traditional relationship with the family as a unit and with the confidentiality of the doctor-patient relationship. Knowledge about pediatric anogenital anatomy is in a relatively early stage of development, and few pediatricians receive training adequate to enable them to determine whether medical observations are consistent with sexual abuse. Even fewer pediatricians receive training in the unique considerations and needs present when taking the medical history of a possible abuse victim or when preserving evidence for possible later use in court. The medical evidentiary evaluation of suspected sexual abuse also raises a number of concerns. There is great variability in referral patterns, which determine whether a medical examination will be requested and whether a general practice physician or a specialist will be asked to conduct the exam. Although professional medical associations have laid out broad outlines of recommended procedures for medical exams when sexual abuse is suspected, more detailed protocols are needed for addressing the many cases where findings are ambiguous or subtle. Often physicians need training in forensics and assistance in coordinating services with multiple agencies and professions. Finally, attention must be given to ensuring adequate cost reimbursement for medical evaluations.

Over the past 20 years, there has been extraordinary growth in the medical community’s knowledge and sensitivity in handling cases of child sexual abuse. Nevertheless, in many ways, the medical profession, like so many others, is still in the infancy of its understanding of child sexual abuse and how best to deal with it. There are many important unresolved questions about medical aspects of sexual abuse. There is confusion and inconsistent practice regarding physician involvement in reporting. There is no clear consensus about
when and how to use physicians in investigating child sexual abuse allegations or even about which physicians should be involved in these investigations. Some of these questions will not be answered by research, but rather will require discussion and consensus-building in the medical community over the next several years. The purpose of this article is to describe the current role of physicians in reporting and investigating child sexual abuse, to identify where improvement is needed, and to make recommendations responding to some of these identified needs.

This article focuses on physicians. Physicians usually become involved in child sexual abuse matters in one of two ways. First, they may be involved in reporting suspected instances of child sexual abuse. Physicians are mandated by law to report to child protective services (CPS) whenever they suspect that a child has been sexually abused. Second, they may become involved when law enforcement or CPS asks them to examine a child who has allegedly been sexually abused. The doctors typically involved in reporting and investigating child sexual abuse are pediatricians and emergency medicine physicians, and the descriptions and observations in this article relate most directly to them. Much of this article is also relevant to the many nurse practitioners and physician’s assistants who often play a major role in reporting and investigating child sexual abuse, but this article does not attempt to comprehensively describe all issues relevant to them.

Finally, it should be noted that, in practice today, there is a great diversity among physicians, even among pediatricians, in the level of contact with child sexual abuse. Some pediatricians rarely identify cases of suspected child sexual abuse and never get involved in these investigations. Others work in places where child sexual abuse is identified more frequently and do get involved in reporting. Still others have developed both interest and experience in the field of child sexual abuse and are frequently called upon to conduct medical evaluations of alleged victims of sexual abuse.

This article is organized into three sections. The first section consists of a brief history of some of the highlights of the medical profession’s attention to child sexual abuse. The second and third sections describe the physician’s role as reporter and evaluator of medical evidence, respectively, and suggest areas where practice may be improved or research is needed.

**History**

Most of the medical profession’s attention to child sexual abuse is recent. The profession began focusing on the physical abuse of children in the mid-1960s; that attention gradually expanded to include a focus on child sexual abuse.

In 1962, an article titled “The Battered Child Syndrome” was published in the *Journal of the American Medical Association*, and soon thereafter, two influential books were published: *The Maltreated Child* by Vince Fontana (1964) and *The Battered Child* edited by Ray Helfer and C. Henry Kempe (1968). These publications described for the first time detailed medical aspects of physical child abuse. Prior to this time, there were virtually no materials or training available to medical students and physicians on medically identifying battered children.

Also in the 1960s, Congress authorized grants to individual states to combat child abuse. These grants were made available only to those states with mandatory reporting laws. At least partly in response to this grant program, by 1967 all 50 states had adopted laws that required doctors, teachers, therapists, and other professionals working with children to report suspected child abuse, including sexual abuse. Medical schools began informing medical students of their duty to report suspected abuse.

The federal government’s involvement in child abuse expanded during the 1970s. In 1974, the National Center on Child Abuse and Neglect (NCCAN) was established by Congress to provide guidance for government and independent agencies, as well as funding for research and public awareness on child abuse and neglect.
In the mid to late 1970s, this focus on child abuse and neglect began to include specific attention to sexual abuse. In 1977, Dr. Kempe delivered the Aldrich lecture at the American Academy of Pediatrics (AAP) annual meeting in New York, emphasizing how little most pediatricians knew about sexual abuse of children, how reluctant most physicians were to consider the possibility of sexual abuse, and consequently, how seriously underreported the phenomenon was. In 1980, Helfer and Kempe included for the first time discussion of child sexual abuse in the third edition of their general work on child abuse, *The Battered Child.* Shortly thereafter, other books appeared, many devoted exclusively to sexual abuse. A notable early book was *The Handbook of Clinical Intervention in Child Sexual Abuse* (1982) by Suzanne Sgroi.

During the 1980s, there was a great increase in the number of professional publications about child sexual abuse and an explosion of coverage in the media. Notorious cases such as the McMartin Preschool case and the Jordan, Minnesota, case revealed serious evidentiary problems, which led to a demand for more scientific evidence and better interviewing protocols.

In the past 10 years, there has also been considerable activity about child sexual abuse within the medical community. In 1985, the AAP established its Committee on Child Abuse and Neglect. In 1991, the committee published its Guidelines for the Evaluation of Sexual Abuse of Children for use by primary care pediatricians. The committee will review those guidelines in 1994 to determine if they need to be updated. In addition to the AAP guidelines, the American Medical Association (AMA) published the AMA Diagnostic and Treatment Guidelines on Child Sexual Abuse (1992). The AMA guidelines are identical to AAP’s in advising how to decide whether an individual case should be reported.

Guidance for the general practitioner is found primarily in the AAP and AMA published guidelines. Specialists in child sexual abuse, however, are also finding more opportunity for peer discussion and continuing education about child abuse generally. In 1987, a number of medical professionals joined with child protective service workers, therapists, law enforcement personnel, attorneys, and others to form the American Professional Society on the Abuse of Children (APSAC). Today, approximately 10% of APSAC’s 3,600 members are medical professionals. APSAC and its state chapters provide information, referrals, education, and advocacy for professionals who respond to child maltreatment. APSAC also provides advanced training for specialists in child abuse, including special training related to child sexual abuse.

There has also been progress over the past decade in understanding pediatric anogenital anatomy and what can be deemed normal versus abnormal. Significant advances on this front were made with the publication of two anatomic atlases: *Color Atlas of Child Sexual Abuse* (1989) by Chadwick and colleagues and *Evaluation of the Sexually Abused Child* (1992) by Heger and Emans. In addition, recent efforts have been made to classify physical findings into those that are highly indicative of sexual abuse, those that are consistent with sexual abuse, those sometimes seen following sexual abuse, and those that are unlikely to be caused by abuse.

Despite this increase in attention to child sexual abuse, physician training about reporting and medically evaluating suspected abuse is inconsistent. Although medical students and pediatric residents are instructed regarding their legal duty to report suspected cases of child abuse generally, there is no national accrediting or licensing body that requires medical schools or pediatric residency programs to provide training in how to recognize child sexual abuse or how to conduct or to interpret data from a medical exam in a suspected sexual abuse case. Some medical school and pediatric residency programs cover these topics, but the degree of detail and practice provided varies widely from program to program; most cover the topic only briefly. A few institutions, such as the University of Missouri, provide a detailed, supervised course on
child sexual abuse as an elective within the pediatric residency program.\(^{17}\)

Finally, over the past two decades there has been increased interest in the medical community in working with other professions that handle child sexual abuse. In the late 1970s, the staff of the Kempe National Center on Prevention and Treatment of Child Abuse and Neglect, at the University of Colorado Health Sciences Center, began to promote the use of multidisciplinary teams, which include physicians, to investigate child abuse cases. Barton Schmitt edited *The Child Protection Team Handbook: A Multidisciplinary Approach to Managing Child Abuse and Neglect* in 1978.\(^{18}\)

The federally funded National Resource Center on Child Sexual Abuse opened its doors in 1985, with a specific mandate to promote interagency and multidisciplinary cooperation.

Another major development has been the creation of centers where suspected abuse cases that are difficult to evaluate medically may be referred to specialists. These centers are frequently established to serve a broad geographic region. Regional evaluation centers are often hospital based, although in some areas they are located on the site of a multidisciplinary child advocacy center. Regional centers may also establish consulting relationships with pediatricians within their service area who have developed this area of expertise.

This regionalization of medical expertise is often driven by funding and by the limited number of practitioners with this expertise. While there is general acceptance that a tiered regional system is most appropriate, so far only a few states—namely Florida, North Carolina, and Missouri—\(^{19,20}\) have taken action to formalize regional medical referral networks. In many other areas, such regionalization is proceeding on an ad hoc basis.

In sum, as recently as 20 years ago, there was almost no professional literature about or attention given to child sexual abuse or to the medical role in recognizing it, and there was virtually no information that would allow a doctor to interpret the often subtle findings of a pediatric gynecological exam. Considerably more information is now available. Significant progress has also been made in creating multidisciplinary centers specializing in investigation of child sexual abuse allegations. However, many gaps remain in the medical community’s response to this problem, and these are the focus of the next two sections on reporting and evaluation.

### The Physician as Reporter

All medical professionals are required under state law to report cases of suspected child abuse, including sexual abuse. The exact legal requirements vary by state.\(^{21}\) No reliable national data exist to show the percentage of reports of sexual abuse that come from physicians. However, there are some data on the referral sources of abuse reports generally. Nationally, approximately 11% of the 1,342,638 child abuse reports made in 1991 in 44 states to child protective services came from the medical profession.\(^{22}\) Similar data from California published in 1992 indicated that 12% of all reports of child abuse came from physicians. Of the reports filed in California by physicians, 24% were for suspected sexual abuse.\(^{23}\)

Not all reported incidents lead to an investigation and/or opening of a case or to substantiation of the allegation. When analysis of the 1,342,638 reports discussed above is limited to those reports that were eventually substantiated, 15% of these were sexual abuse cases.\(^{22}\) The rest involved physical abuse or neglect. (See the articles by Besharov and by Pence and Wilson in this journal issue for discussion of investigation and substantiation.) National data do not reveal what percentage of reports were substantiated from each category of reporter, but at least one state collects that information for child abuse generally (but not child sexual abuse specifically). In New York in 1992, physicians, public health officials, and hospital staffs were the source of 13% of all child abuse reports to CPS.\(^{24}\) Forty percent of reports from these professionals were found to be “indicated” (New York’s equivalent term for “substantiated”), and 60% were “unfounded.” This compares

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### Table 1

**Physicians' Guidelines for Making the Decision to Report Sexual Abuse of Children**

<table>
<thead>
<tr>
<th>Data Available</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td><strong>Physical</strong></td>
</tr>
<tr>
<td>None</td>
<td>Normal examination</td>
</tr>
<tr>
<td>Behavioral changes</td>
<td>Normal examination</td>
</tr>
<tr>
<td>None</td>
<td>Nonspecific findings</td>
</tr>
<tr>
<td>Nonspecific history by child or history by parent only</td>
<td>Nonspecific findings</td>
</tr>
<tr>
<td>None</td>
<td>Specific findings</td>
</tr>
<tr>
<td>Clear statement</td>
<td>Normal examination</td>
</tr>
<tr>
<td>Clear statement</td>
<td>Specific findings</td>
</tr>
<tr>
<td>None</td>
<td>Normal examination, nonspecific or specific findings</td>
</tr>
<tr>
<td>Behavioral changes</td>
<td>Nonspecific changes</td>
</tr>
</tbody>
</table>

*A report may or may not be indicated. The decision to report should be based on discussion with local or regional experts and/or child protective services agencies.*


A child’s physician may come to suspect child sexual abuse in a variety of ways. Inspections of the anogenital area during routine pediatric care may reveal anatomic findings that raise concern about the possibility of prior trauma. A parent may communicate to the physician concerns that the child has been sexually abused. Though not common, the child or adolescent may make an initial disclosure of sexual contact to a physician. The medical diagnosis of a sexually transmitted disease requires an evaluation for sexual abuse. Behavioral and emotional problems may raise concern on the part of the physician, although it is important to keep in mind that the psychological findings in sexually abused children are nonspecific and may be related to a myriad of other underlying causes. (See the article by Briere and Elliott in this journal issue.)

As noted above, the AAP has developed standards that address when a report to authorities is necessary, not indicated, or optional. These standards, however, have not resolved physicians’ concerns about reporting; the standards leave many areas for individual discretion. (See Table 1.) For example, when behavior that is viewed as “sexualized” has been observed in the absence of allegations or medical findings, the AAP standards are not determinative. In addition, a significant percentage of doctors admit that they do not follow state laws that require doctors to report all “suspected” cases of child abuse.
or neglect. This problem and other barriers to and deficiencies in physicians’ reporting of child sexual abuse will now be discussed.

Resolving the Conflict in Roles

In meeting their responsibilities as reporters under state and federal law, physicians face a conflict between their roles as healers and as mandated reporters. The doctor-patient relationship is privileged, meaning that communication with one’s doctor is confidential. However, by law, the mandate to report suspected child abuse supersedes normal doctor-patient confidentiality. Most pediatricians are seriously discomforted by this requirement, which may conflict with their traditional relationship with the family as a unit. This discomfort can result in a tendency not to report when they are not certain whether child sexual abuse occurred, or when they think the problem has gone away or that they could handle the problem better than it would be handled by the child protection system. As Richard Krugman noted in 1991: “Throughout the United States, many pediatricians are faced with a major dilemma: they are knowledgeable about statutes that require them to report all cases of suspected abuse and neglect and yet, in many communities, they observe that their reports are received but inadequately acted on. The child protection system in the United States is fragmented, underfunded, overworked, episodic and unable to generate any information that would let us know that children are, in fact, being protected. Some physicians have deliberately followed a pattern of civil disobedience and do not report child abuse because of their belief that above all they should ‘do no harm.’ In my view, such an approach leaves physicians, and more importantly children, at serious risk. The answer is not to capitulate and abandon a child protection system that is in crisis.”

By law, the mandate to report suspected child abuse supersedes normal doctor-patient confidentiality.

Although some reasons for not reporting may by understandable, state law currently does not allow discretionary reporting; all suspected cases of child sexual abuse must be reported. Failure to report is subject to legal penalties, though prosecutions for this offense have been rare.

Comparable surveys of mental health professionals demonstrate that they, too, often do not follow the mandate to report. A significant number of those mental health professionals who chose discretionary reporting also expressed the belief that their clients were more likely to be helped by the services they were already receiving from the professional than by any services CPS was likely to be able to offer and that filing a report would jeopardize the existing therapeutic relationship.

The only survey of physicians on reporting patterns for child sexual abuse specifically was published in 1978. A
questionnaire was mailed to 300 randomly selected pediatricians and general practitioners listed in the Seattle telephone directory. Thirty-two percent of those who received the questionnaire responded. Fifty-three percent of the 96 doctors responding to the survey reported seeing at least one identifiable sexually abused child annually. Those physicians reported that 93% of the sexually abused children they saw suffered physical or emotional trauma ranging from “possibly serious” to “very serious.” Even so, only 42% of the respondents indicated that they would report all cases of child sexual abuse that came to their attention. The study’s authors noted that two-thirds of the physicians believed either that reporting would be harmful to the family or that the problem should be handled privately. The other third was dissatisfied with the manner in which state social service agencies handled such cases.

Physicians need opportunities to discuss their concerns about reporting. Such discussion should be part of the medical school curriculum, should be repeated in pediatric residencies, and should be part of continuing education for practicing pediatricians. State legislatures should make efforts to determine whether mandated reporters are obeying the law and to identify barriers to their doing so. If significant numbers of professionals choose to ignore a law that was established to protect patients, an effort must be made to understand and rectify the problem. Remedies might include better coordination and information sharing among physicians, child protective services, and police. Doctors who specialize in child sexual abuse evaluations are most likely to develop these multidisciplinary channels of communication. Children would be better protected if primary care pediatricians also developed these multidisciplinary, multiagency relationships and had an opportunity to discuss openly their concerns about reporting and child welfare and law enforcement responses to child sexual abuse.

**Identifying Abnormal Pediatric Anogenital Anatomy in the Primary Care Setting**

Reporting is also hindered by most pediatricians’ lack of knowledge about and inability to identify abnormalities in pediatric anogenital anatomy that might be indicative of child sexual abuse. Some training on normal and abnormal anogenital structures should be a priority for pediatric training. Such training should be more extensive for those who are or will be involved in medical evaluations of children who are alleged to have been sexually abused. All pediatricians should include anal and genital inspections in routine well-child checkups. By analogy, pediatric well-child checkups usually include a routine examination of the retina, even though pediatricians are rarely trained in ophthalmology, for the purpose of spotting gross abnormalities and referring the child to a specialist if there is reason for concern. In those instances where the routine anal and genital exam reveals some reason to suspect sexual abuse, reporting to child protective services is required in all 50 states.

It has also been suggested that all children seen in emergency rooms should be given a brief examination to screen for sexual abuse. In one study, the records of 26,000 children seen in the emergency department of a teaching hospital over an 18-month period were analyzed. Three hundred of those patients were identified by medical staff as victims of sexual abuse. Of those 300 cases, 243 were initially identified by parents or by social service or law enforcement workers as possible sexual abuse victims. The remaining 57 patients presented with complaints not specific to sexual abuse, such as abdominal pain, vaginal discharge, rectal bleeding, or constipation. In the authors’ view, the finding of 2 cases per 1,000 exams does not justify routinely conducting a somewhat invasive and unexpected anogenital exam in an emergency room setting.

**Taking Medical Histories from Children and Their Families**

The statements made by a child and her parents are often crucial to the physician’s decision making about whether to make a report. In fact, the history is frequently
more compelling than the physical evidence. Physicians need some training and guidance in how to interpret the behavior of children and the statements of children and their parents. For example, disclosures of child sexual abuse may be spontaneous or accidental, and it is not unusual for the child to react to the physician’s questions with tentative, partial allegations, contradictory statements, or immediate retraction. Adolescent victims may be angry not only toward the perpetrator, but toward adults whom the adolescent feels should have been more protecting, even if they were unaware of the abuse. This anger can be difficult or impossible to distinguish from the angry adolescent who makes a false allegation of abuse. When medical findings do not clearly show abuse and the child’s or parent’s statements are difficult to interpret, the patient should be referred to a specialist for further evaluation.

Understanding the Legal Issues

Medical schools are generally careful to inform medical students and pediatric residents of the legal requirement to report suspected cases of abuse. As stated earlier, physicians in training should also have the opportunity to discuss difficulties and uncertainties about reporting and its aftermath, rather than face these for the first time in practice, when the decision about whether or not to report can be difficult.

All doctors also must have at least minimum knowledge of procedures for preserving evidence in a manner that will be admissible in court, as well as preserving accurate and detailed records of the patient’s oral statements. They need to understand that, although hearsay evidence is typically inadmissible in court, statements made to a doctor in the course of a medical examination are generally recognized as reliable and are an important exception to the hearsay rule. Such statements should be fully recorded by the doctor at the time they are made.

Medical Evidentiary Evaluation of Suspected Child Sexual Abuse

As discussed in the article by Finkelhor in this journal issue, there are approximately 150,000 reports of child sexual abuse substantiated annually by child protection agencies. There are no available data about the number of these cases that involved a medical examination. There is typically no formal policy or standard practice even at a local level, let alone the state or national level, to specify when medical examinations should be conducted for children alleged to be sexually abused.

In some jurisdictions, the practice is to refer every child to a doctor when sexual abuse is suspected. However, it is more likely, given the cost and sensitive nature of these medical examinations, that not all children are referred for examinations and some judgment is exercised at the local level about which children should receive examinations. In Santa Clara County, California, for example, in 1993, there were approximately 6,000 reported cases of suspected child sexual abuse. In that same year, the medical center in that county that conducts the vast majority of specialized examinations evaluated approximately 600 of these children.

One of the reasons that medical examinations are not ordered in every case is that, in most cases of child sexual abuse, even in those where there is independent confirmation (such as a confession by the perpetrator), there will be no physical findings of the sexual abuse. Normal physical exams are common, not only because many types of sexual abuse, particularly those not involving penetration, do not leave physical findings, but also because many abuse-related injuries heal quickly and completely.

But collecting and documenting physical evidence of child sexual abuse is only one of the functions of the medical examination. A medical examination can serve a number of other functions, many of which are not dependent on the presence of physical findings. Other functions include:

- **Treatment.** If needed, the doctor may treat trauma, treat the child for sexually
transmitted diseases, or provide pregnancy prophylaxis.

- **Collecting History.** A diagnosis of child sexual abuse is frequently dependent upon statements made by the child in the course of the exam and upon the physician’s observations of the child’s affect.

- **Therapeutic Function.** Children who have been sexually abused are likely to have altered feelings about their bodies. An important function of the exam is for physicians to reassure these children that their bodies are still “okay.” These children may raise serious concerns with a doctor that they might not voice with anyone else (“Will I get AIDS? Will sperm still be there when I get older and will it make me pregnant?”).

- **Aiding CPS in Making a Determination.** Child protective services must decide whether to remove a child from an unsafe environment. The doctor’s observations and conclusions on the basis of the medical exam should be considered for this decision.

- **Aiding Police and Prosecutors in Decision Making.** District attorneys must determine whether a crime has occurred and whether charges should be brought against the alleged perpetrator(s). These decisions may be influenced by the doctor’s findings and his or her description of their significance.

Given these various potentially beneficial functions, the question is whether they are sufficient to justify the costs, monetary and other, of requesting some level of medical examination for every child who is alleged to be sexually abused. If not, which children should receive examinations, and who should conduct them?

**Referring Children for Medical Examination**

The decision to have a child medically examined can be made by many different individuals in the system. The most likely sources of referrals are law enforcement and child protective services. In Santa Clara County, California, for example, of 2,614 cases seen in a child sexual abuse medical clinic between 1987 and 1993, 42% of the cases were referred by police officers, 39% were referred by child protective services, 9% were referred by juvenile probation officers, 6% were referred by doctors, and the remainder were referred by sheriff’s departments, district attorneys, and public health nurses. This regional center accepts only children whose cases are being investigated by the sociolegal system. A clinic with different criteria may have different referral sources. One clinic in Vancouver, British Columbia, reported that 51% of its referrals were from CPS, 32% were from nonoffending parents, and the remainder were referred by police or other professionals.

As noted above, very little is known in most areas about how the referral decision is made. A study currently under way in multiple centers in the western United
States is expected to shed more light on the referral process. CPS and law enforcement personnel who make decisions about whether or not to seek a medical exam in the course of a sexual abuse investigation are being interviewed about their decision-making process. Results of the study are expected in late 1994. Preliminary data indicate that the triage process needs refinement; not all children who should be referred for medical evaluations are referred, and inappropriate referrals occur. It also appears that decisions about whether to seek a medical examination are often influenced by the decision makers’ preconceptions about the usefulness of medical exams, as well as by the facts of the individual case.

There is also often no standard practice statewide or nationally as to who should conduct a medical examination when one is determined to be advisable.

There is also often no standard practice statewide or nationally as to who should conduct a medical examination when one is determined to be advisable. Such exams are conducted by the children’s primary care physicians, by medical staff in hospital emergency rooms, and by child sexual abuse experts at specialized regional centers.

The current trend is to have more of these examinations handled by specialists in the field. Primary care physicians are often reluctant to conduct investigative exams for many reasons. The facts of an individual case may be difficult or impossible to determine, even after a thorough history and physical examination. Where physical evidence exists, it may be subtle, and its interpretation may require technical expertise outside the doctor’s training or experience. Reimbursement rates for sexual abuse examinations, especially if the child is a Medicaid recipient, are often so low that they are unlikely to cover the doctor’s office costs. Finally, if there are physical findings or if the child makes important statements to the physician during the exam, the physician may be required to appear in court, where his credibility is likely to be questioned, his testimony will be scheduled (and possibly rescheduled numerous times) with little regard to the impact on his practice, and he is unlikely to be compensated for his time.

These concerns not only make many pediatricians reluctant to report suspected cases to CPS, but also cause some physicians to refer all cases in which there is a risk of child sexual abuse to regional medical centers, on the theory that a specialized clinic is better equipped than the private practitioner to deal with these conflicts. This may not be the best use of limited and expensive medical resources because, in many cases, the medical evidence of sexual abuse is sufficiently clear that no referral should be necessary to interpret the medical data.

Consensus needs to be reached about when medical examinations should be conducted and by whom. Prior to the development of that consensus, the authors suggest that, whenever possible, all children alleged to be sexually abused should have a medical evaluation. In cases where there is a low probability of physical findings, this referral should be to the child’s primary care practitioner, and the scope of the examination may be limited. In those cases where there is a higher probability of abnormal anogenital findings or where the primary physician deems appropriate, referrals should be made to a specialist where a more extensive examination may be conducted. Research is needed to identify those factors that indicate a higher probability of physical findings.

There are usually benefits to having a primary care physician conduct the initial exam, especially for low-risk children. In many instances, the primary care physician will be a familiar figure to the child and will also be familiar with the child’s family, living situation, and personality. This familiarity may be crucial when diagnosis is heavily influenced by the child’s or parent’s verbal statements.

On the other hand, there are many compelling reasons for evaluations to be conducted by specialists at regional centers when there is a significant likelihood of medical findings that are consistent with the allegations of sexual abuse. Comprehensive child sexual abuse evaluations require amounts of time that would be disruptive to the pace of a pediatric practice. A peaceful, private setting is very desirable. Special equipment, such as the photocolposcope, would not be available.
in the general pediatric office. The optimal materials for forensic studies and for the diagnosis of sexually transmitted diseases would likewise not be present in the typical pediatric office. In addition, the child abuse specialist has special knowledge and skills in interviewing and examining these children, and the experience and inclination to testify effectively in court. And experienced examiners are least likely to multiply the trauma that the children have experienced.

Improving Understanding of Pediatric Anogenital Anatomy

As noted earlier in this paper, the state of knowledge of normal and abnormal pediatric genital anatomy is evolving rapidly. There has not been much opportunity yet to incorporate this knowledge in pediatric training programs, especially for those who expect to specialize in investigating child sexual abuse allegations.

Considerable research remains to be done in this area. Examiners and researchers often use dissimilar terms to describe the same anatomic areas and physical findings. An APSAC task force is currently working on developing common terminology. In 1989 and 1990, John McCann and his colleagues made significant contributions to this field with the publication of cross-sectional studies of anogenital anatomy in prepubertal girls carefully screened for nonabuse and of the anal anatomy of children under two years of age who were carefully screened for nonabuse. Abbey Berenson also made significant contributions with her longitudinal cohort study of the hymen at birth and one year and of the anal anatomy of children. Expansion and confirmation of these important studies is needed to refine the landscape of normal anogenital anatomy. With the exception of a few very small studies, there have been no studies of the longitudinal process of healing following acute anogenital trauma. Understanding this process will require a logistically demanding collaboration of multiple regional centers collecting data for a number of years.

The epidemiology of sexually transmitted diseases in children also needs to be understood more clearly. It is now generally accepted that the presence of certain sexually transmitted diseases (STDs)—for example, syphilis and gonorrhea in post-neonatal children—makes the diagnosis of sexual abuse a medical certainty, but questions remain about the transmission of other STDs in children, especially genital warts. It should be a priority to develop optimal screening protocols for STDs. The American Academy of Pediatrics’ Guidelines for the Evaluation of Sexual Abuse of Children suggest STD studies when epidemiologically indicated, or when the history and/or physical findings suggest the possibility of oral, genital, or rectal contact. The Centers for Disease Control in 1989 issued recommendations for extensive culturing for STDs in suspected child sexual abuse cases, but it has been noted that these recommendations are not generally followed, largely because of the prohibitive cost. Individual pediatricians may feel that extensive cultures are invasive, expensive, and unlikely to yield positive results, at least when children are asymptomatic for STDs. Finally, more data are needed on the impact and treatment of STDs in children and on the use of matching of biotypes of STDs between victims and offenders.

There are many other research needs regarding physical indications of child sexual abuse. For example, little is known about the effects of sexual abuse on the physical health of children, including constipation, urinary tract disorders, somatic diseases, and chronic pain. More work also needs to be done on the cost and benefit of colposcopy in these exams.

Finally, practitioners conducting medical evaluations should receive training in how to reduce stress for the child during the exam. One study indicated that important factors in reducing stress were preparing the child in advance for the exam, giving the child greater control during the exam, and debriefing the child (and parents) after the exam.

Standardizing Procedures

The broad outlines of recommended procedures for medical exams in suspected sexual abuse cases have been laid out by

Examiners and researchers often use dissimilar terms to describe the same anatomic areas and physical findings.
The AAP\textsuperscript{9} and the AMA\textsuperscript{10} These procedures are sufficient for cases where trauma is clearly evident or where a thorough examination and history do not reveal any cause for concern. Cases handled by specialists typically involve considerably more ambiguity and call for more detailed protocols.

Practitioners conducting medical evaluations should receive training in how to reduce stress for the child during the exam.

Most of the regional centers have developed internal protocols for examining suspected abuse victims, and these protocols are generally shared with other centers. An example is the Collaboration for Research on the Sexual Abuse of Children, a consortium of regional centers in the western United States, which is sharing protocols in the course of developing a collaborative database to facilitate ad hoc secondary analysis of a wide range of variables in sexual abuse medical evaluations.\textsuperscript{35}

Improving Forensic Training

The practitioner conducting an evidentiary medical evaluation must be very familiar with a number of issues related to legal proceedings. Specialized training must be available on how to preserve physical and testimonial evidence as well as on how to offer expert testimony and be adequately prepared for cross-examination. Results of the examination could be used in any number of legal forums, including criminal proceedings against the alleged perpetrator, custody hearings in divorce court, and placement decisions for dependency court.

Preserving Evidence

Each regional center needs to have in place realistic policies and procedures for preserving evidence. Ideally, the practitioners conducting the medical exam will record all data from the examination, even information that may initially seem irrelevant, in detailed form. Some practitioners at regional centers routinely videotape every examination, especially the interview with the child. To be admissible in court, the records must satisfy two exceptions to the hearsay rule—one for the child’s statements (typically, the medical diagnosis exception) and one for the records (typically, the business records exception for records made in the “regular course of business” at the time of the examination, in accordance with routinely followed procedures). Those individuals who make and store the records must be prepared to describe “the chain of evidence,” where records are kept and who had access to them from the time they were created until they appeared in court.\textsuperscript{10} Realistic, consistently followed procedures for creating and storing medical records can greatly simplify this process.

With respect to physical evidence, a number of areas need improvement. Existing “rape kits” were generally designed for adult sexual assault victims. Some models are expensive, time-consuming, and potentially traumatizing to children. Cost-benefit analyses of the usefulness of different forensic tests could streamline interventions.\textsuperscript{45}

Testifying in Court

Testifying in court can be straightforward or difficult. In some cases, carefully prepared medical records may be used in place of testimony. In other cases, the doctor must be prepared to offer expert testimony, rendering an opinion as to whether the testimony given by a child or other party is consistent with the medical findings. In still other cases, the practitioner may give nonexpert testimony about the patient’s behavior or statements in the course of the exam. Because the patient’s statements made to a physician for purposes of diagnosis or treatment are often an exception to the hearsay rule, the medical professional who conducted the examination may be the only person who can properly bring this information before the court.\textsuperscript{34} Any practitioner who conducts an investigative examination in a possible abuse case should be aware of and prepared for these possibilities. AMA guidelines also suggest ways in which the examiner should work with attorneys before being called to testify.\textsuperscript{10}

Learning How to Conduct Interviews and Interpret Children’s Statements

Medical professionals conducting evaluations must be well prepared to conduct interviews and interpret statements made by the child. In reporting, the practitioner
must establish only that there is reason to suspect abuse. However, in the course of the medical evaluation, the practitioner may uncover information that will be essential to later legal actions and may inadvertently make mistakes that have the effect of keeping important information from being considered in court. These concerns are not unique to medical investigators: they apply equally to therapists, police investigators, and others who may question a child to establish the facts of a case.

Unfortunately, as other articles in this journal issue discuss, there are some unresolved disputes among experts in the field of child sexual abuse about proper methods for interviewing children. Investigative aids, such as anatomical dolls, may help the child communicate with the interviewer, but such aids must be used only by those well trained in their use. Drawings done by the child or diagrams to determine the child’s names for body parts are generally more helpful. Anyone who interviews a suspected abuse victim must be very careful to avoid suggesting answers to the child through leading questions. (See the article by Myers in this journal issue.) Because the special considerations associated with investigative exams and interviews are both extensive and unique, any medical professional who is likely to conduct these exams or interviews should receive specialized training.

Coordinating Interviews with Multidisciplinary Teams

Medical professionals involved in evaluating suspected victims of child sexual abuse need to coordinate their work with other professionals who are involved in the investigation. The medical professional should never be expected to assume sole responsibility for management of these complex cases. Often, there are many professionals involved, which can lead to multiple interviews of the child. A single interview, conducted by a single qualified person, is preferable. That interview, however, often must cover all the types of information needed by doctors, police officers, district attorneys, and mental health consultants, and the information obtained must be delivered to those people in a timely fashion. It will often be necessary to collect such diverse information in more than one interview, but strong efforts should be made to minimize the number of interviews.

In many regional centers, medical staff can coordinate their work with a multidisciplinary team composed of CPS staff, mental health professionals, police investigators, and district attorney’s investigative staff. The standard practice is to consult the team on difficult or complex cases. Some practitioners have found the multidisciplinary team too cumbersome and costly to be used in every case, and in relatively straightforward cases, their participation may be unnecessary. However, at least one study found that cases handled by teams were significantly more likely to result in identification of the perpetrator and the filing of charges.

Unfortunately, there are some unresolved disputes among experts in the field of child sexual abuse about proper methods for interviewing children.

Even when multidisciplinary centers are in place, however, achieving effective multidisciplinary collaboration and support is difficult. A 1988 survey of 29 pediatric hospitals with accredited residency training programs showed that 69% had a designated pediatric sexual assault center, 89% of which estimated that 250 or more medical evaluations for sexual abuse were conducted in their community annually. Despite the volume of cases at these centers, 43% of responding physicians indicated that multidisciplinary professional support services were occasionally, rarely, or never adequate.

In practice, multidisciplinary teams are expensive because they involve substantial time commitment from professionals in several different fields. Individual cases, even difficult ones, will not necessarily benefit from the team discussion process. And team recommendations, arrived at through considerable effort and expense, may not be acted upon by CPS or others with decision-making authority in the case. On the other hand, multiple professional perspectives can help achieve greater certainty in difficult cases. Also, professional relationships and lines of communication established between team members may help bring cases to a swifter, more appropriate conclusion.
Ensuring Adequate Cost Reimbursement

Nationally, there is wide variation in the mechanisms for reimbursement for medical services in child sexual abuse cases. Possible sources of funding for medical examinations, which vary by state, are CPS, police, special state funds (for example, crime victim funds), private insurance, and Medicaid. In most instances, the cost is borne by a public agency, either CPS or the police. Reimbursement patterns vary widely from locale to locale. Problems with reimbursement limit the number of hospitals willing to serve as regional centers. Reimbursement rates are often below the cost of the examination. Private insurance companies may refuse to reimburse for these examinations.

In Missouri, a statewide network (called SAFE or Sexual Assault Forensics Examination) of hospital clinics, emergency departments, and private practices has been established to standardize referrals, examinations, and reimbursements. Participants are required to take part in training (initial training plus eight hours of continuing education annually) and to collect data in a standardized format. In return, the two state agencies that administer the program and coordinate four payment sources guarantee uniform reimbursement rates plus payment of lab fees. Similar statewide networks in Florida and North Carolina help guarantee standardized cost reimbursement in those states. Among most states, however, reimbursement rates continue to vary widely.

In those states where adequate reimbursement rates have been guaranteed, steps have also been taken toward greater quality assurance. In Missouri and Florida, network members must receive initial training plus annual continuing education. North Carolina provides quality assurance through case review. Every report filed in North Carolina is individually reviewed by the state network’s medical director or nurse consultant and returned to the examiner with comments on completeness, additional suggested considerations, or management suggestions.

In sum, each state should review the variation and adequacy of payments for medical examinations to evaluate sexual abuse allegations. Although such a review may lead to the allocation of additional funds for these examinations, it may also provide an opportunity to strengthen assurances of quality in these examinations.

Conclusion

Great progress has been made in the medical profession’s understanding of and response to child sexual abuse. In the next few years, however, significant work needs to be done to improve referral and evaluation of these cases, as well as to increase the state of knowledge about the medical aspects of child sexual abuse.


17. Beal, Douglas W., medical director of the Child Protection and Advocacy Program, and division director of Green Meadows Pediatric Clinic, Children’s Hospital, University of Missouri. Telephone conversation with author D. Terman, October 25, 1993.


33. See note no. 5, Kempe, p. 385.
35. For additional information, write to David Kerns, M.D., director, Collaboration for Research on the Sexual Abuse of Children, Center for Child Protection, Santa Clara Valley Medical Center, 751 S. Bascom Ave., San Jose, CA 95128, or call (408) 299-6460.
37. For more information about this study, write to Danielle Galante, Collaboration for Research on the Sexual Abuse of Children, Center for Child Protection, Santa Clara Valley Medical Center, 751 S. Bascom Ave., San Jose, CA 95128, or call (408) 299-6460.