



# DOCTORS FOR SEXUAL ABUSE CARE

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## NATIONAL NEWSLETTER

EDITORS: SANDRA RHIND & CAROLINE CORKILL

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### New DSAC Manager

DSAC is delighted to announce that Hayley Samuel has been appointed as the DSAC Manager starting from February 14<sup>th</sup> 2005.

A consideration of the DSAC organisational structure by a DSAC Review Team, assisted by Sheryl Smail, in the second half of 2004, led to the establishment of a new position of DSAC Manager to replace the Project Co-ordinator role.

Hayley and Carol had a serendipitous meeting in June 2004 when Hayley had just returned from a visit to the UK. DSAC, at that point, urgently needed a temporary Project Co-ordinator and Hayley agreed to take on the role. Since June, Hayley's involvement with DSAC and many of its members and activities has developed to our mutual benefit. After a rigorous open recruitment process Hayley was appointed to the new Manager position.

Hayley came to DSAC with a background in immunology and virology having worked in clinical laboratories at Auckland Hospital and in the UK, at times dealing with the laboratory aspects of sexual assault medicine. Hayley's next position as that of Regional Administrator for Relationship Services in Nelson, involved her in another area of sexual abuse care, the psychosocial aspect. In this role she gained administrative experience in a not-for-profit agency.

The new DSAC managerial position is part-time, Hayley will also be studying towards a Graduate Diploma in Psychosocial Studies through Auckland University of Technology. The Executive and other DSAC members who have worked with Hayley for the last 8 months have had time to recognise the extraordinary qualities that she brings to the role and to be certain that we have at our head somebody who can take us into the future with confidence. Hayley brings enthusiasm, initiative, empathy, commitment and the energy we need to take DSAC forward.

**Carol Shand**  
DSAC President

### President's and Manager's Report

We hope the pleasant summer weather that has been experienced throughout most of New Zealand has enabled you all to relax, recharge and pick up your busy lives for another year. We certainly have had some time to enjoy the sunshine.

This report is being written from Pawhooa Bay Lodge, the new home of Claire and Bill Hurst. Hayley and Carol are spending the weekend with Claire. We have all three been working on some aspects of the DSAC Visiting Speaker programme for the next three years. This is a good time to acknowledge the valuable benefit of our continuing relationship with Claire. We have also walked while we talked, swum and sunned, watched the sunset and listened to the sea lapping on the shore. We have eaten and eaten.

Hayley came down to Wellington between Christmas and New Year and went through all the papers held by Carol since the setting up of DSAC in 1987. We wanted to ensure that essential papers are archived for DSAC. This also gave Hayley an opportunity to add to her background of DSAC's history and Carol a chance to start her time as President with room in her office to see where new papers are.

Hayley has already put in place many of the recommendations of the Review Committee. A more streamlined Executive and subcommittee structure has been set-up with clearer lines of communication. The new DSAC Executive members elected in November have all accepted responsibilities on the sub-committees, which each have a Chairperson who will report to the quarterly Executive meeting.

Hayley's first initiative as Manager has been to try to make contact with as many DSAC members as possible, to identify what work they are individually doing and how DSAC can assist them. To this end

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Hayley has designed a National Overview of Sexual Abuse Care Survey. All DSAC members should have by now received a copy of this survey. Contact with DSAC members has been made by email where possible and by snail mail for those members who do not have or have not provided the Office with their email addresses.

DSAC has 226 members. Each year we publish a Liaison Directory which is on-line on the DSAC website. This provides information to agencies and individuals as to how they may access medical and other services for sexual assault care. The information in the Liaison Directory has been provided by DSAC Regional Coordinators who have done a sterling job providing liaison between the DSAC National Office and DSAC members who work to provide services in their local areas. Unfortunately there are many members with whom the DSAC office has not been able to maintain contact.

The first ten replies to the survey received a \$20 book token for their rapid responses. Hayley is keen to encourage as many members as possible to respond to this survey regardless of whether they are actually working in the field or not. In some areas of the country DSAC does not have Regional Coordinators and it has been difficult to maintain liaison with local doctors. Please complete and return the survey if you have not already done so. The collated results will assist DSAC in forming a more definitive understanding of what sexual abuse care services are available across the country, and will enable us to target problem areas such as those with little or no service provision, and endeavour to rectify them. Additionally we hope to be better informed as to what support DSAC can be offering to doctors performing these examinations.

At the DSAC Executive meeting in February, the Executive agreed to a proposal to change the name of Regional Coordinator to that of DSAC Regional Liaison. A discussion around this arose at the last National Regional Coordinators' meeting when one lonely rural doctor who has been doing all the work in her area for many years said she felt that she only had herself to coordinate. Where possible each region will have 2 Liaison people, one for work with adults and another for work with children. In some districts the same doctor may still be working with both age groups. In many areas doctors have found a sharing of the role of Regional Coordinator has enabled them to provide mutual support in this difficult task.

The Child Abuse Special Interest Group of the New Zealand Paediatric Society has invited the DSAC President to become an ex-officio member of this group. This is an important contact for DSAC as the paediatricians have become increasingly responsible for assessing children where sexual abuse or assault is alleged. DSAC remains the major provider of training in the medical role in assessing children who may have been abused. A close working relationship between these two groups that share common interests and goals can only help to strengthen the provision of service in this area. DSAC would like to see more paediatricians participate in the DSAC accreditation process and we will be working to promote this. Clare MacGougan has been liaising with the Royal Australasian College of Physicians to assist the uptake of paediatricians becoming DSAC Accredited. MOPS points may well be obtainable, which may act as a further incentive to undertake this process. We will keep you posted.

On occasion, the DSAC office receives items that are not really appropriate for the DSAC National Newsletter but that Regional Co-ordinators need to be kept up-to-date with e.g. Police Contracts and other interesting articles. It was suggested that Hayley collate all the information that comes in and periodically distribute this information to the Regional Co-ordinators. The results of the returned National Overview of Sexual Abuse Care Surveys to date suggest that such a bulletin may be of interest to most DSAC members. This proposal will be reviewed once more surveys are returned.

Michael Miller (GP in Whangamata) has kindly secured DSAC two workshop slots at the Rural GPs Conference on the 13<sup>th</sup> May in Auckland. Clare MacGougan and Faye Clark have agreed to co-ordinate the delivery of these two workshops.

- *Workshop 1: Recognition and Response to Partner Violence and Management of Suspected Child Abuse and Neglect.*
- *Workshop 2: General Practice Management of Sexual Assault and Abuse.*

Meanwhile, Clare Healy has been working on abstract and workshop submissions for the RNZCGP Conference on the 14 – 16 July 2005 in Christchurch as follows:

- a) Workshop 1: Recognition and Response to Partner Violence in the General Practice Setting
- b) Workshop 2: General Practice Management of Suspected Child Abuse and Neglect
- c) Abstract: Presentation of audit findings looking at implementing routine questioning about partner violence in a primary care setting
- d) Poster: Implementing the teaching sessions about Family Violence in New Zealand
- e) Consumer Information: Presentation of pamphlets in the area of domestic violence and also around sexual abuse.

Ann Pearl, Kristen Sorrenson and Hayley Samuel met with Raewyn Aston, James du Plessis and Mua Leauga from ACC on the 6<sup>th</sup> December 2004 in Auckland to discuss a number of items as co-ordinated by Kristen.

Raewyn, who has been a Team Manager in the Sensitive Claims division for sometime now, has chosen to take on a new role in the Medical Misadventures Division within ACC as of the beginning of this year. Also, Jackie Pivac, who was the ACC Manager of Sensitive Claims, has been promoted to General Manager of Specialist Rehabilitation Operations, which is a newly created 'umbrella' division including Sensitive Claims. Confirmed to replace Jackie as Manager of Sensitive Claims is Alison Maloney, who will be representing ACC along with James at the Initial Paediatric Training in Auckland in April.

**Carol Shand, DSAC President**  
**Hayley Samuel, DSAC Manager**



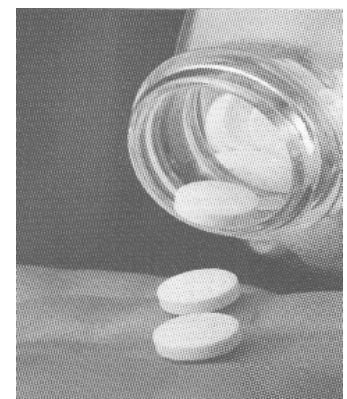
## Azithromycin

Remember that supplies of Azithromycin (Zithromax) are available for STI prophylaxis for any patient who is at risk of infection as a result of a sexual assault. The regime is absolutely simple 1G. stat. (2 x 500mg tabs)

PHARMAC is fully subsidizing this drug through DSAC and supplies are available from:

DSAC National Office, PO Box 90723  
AUCKLAND

To order your supplies for the next 6-12 months you can either write,  
email: dsac@ihug.co.nz, or fax: 09-376 0790



## **DSAC Manual - The Medical Management of Sexual Abuse - Fifth Edition with updates dated March 2004**

Our much loved DSAC Manual will be reviewed and updated this year. The current publication was done in 2002 after much hard work and long hours by many dedicated and unpaid contributors. Times have changed and some of the content is now out of date.

The Editorial committee so far (not set in stone) will include:

Min K Lo  
Carol Shand  
Juliet Broadmore  
Jane Macdonald  
Ros Gellatly  
Rosie Williamson  
Christine Foley  
Kristen Sorrenson

Contributors to the various chapters (the people doing the work) will include:

Juliet Broadmore – Sexual Assault in NZ, Therapeutic role of the doctor  
Kim McGregor – Management of past abuse  
Paige McElhinney – Forensic Notes and ESR  
Patrick Kelly and Dawn Elder – Child Sexual Abuse  
Ann Pearl – Adolescent Sexual Abuse  
Janet Say – Sexually Transmitted Infections  
Sue Whaitiri – Nursing Role  
Phil Hamlin – Legal Section  
Peter Marshall – Police Section  
Peter Huggard – Self Care  
Kristen Sorrenson - Medical Examination, ACC  
Christine Foley – Medical Examination, Male Sexual Assault  
Ros Gellatly – Sex Offenders - Doctors as Abusers

It is envisioned that we have an updated manual by the end of the 2005 year.

Min Karen Lo  
**DSAC Manual Editor**

## **Family Violence Intervention Training**

As you will be aware, a small number of DSAC members have been delivering training sessions for GPs, Practice Nurses, Sexual Health Clinics and selected hospital staff, in identifying and dealing with Family Violence.

These sessions have been well received around the country, but there are areas where we are having difficulty organising the training.

The bureaucracy attached to arranging a fairly straightforward CME evening, particularly in an area we are not familiar with, is sometimes daunting.

I am asking if any DSAC member, who is familiar with the way CME is organised in your area, would contact the office with details. It doesn't matter how small or "unofficial" the group is, we would be happy to hear from you.

Also, the Paediatricians are presenting Child Protection Training in each region. They may contact the doctor performing child sexual abuse examinations to give the sexual abuse perspective. In my experience, this has been a 20 minute talk, and was very much appreciated by the GPs.

**Clare MacGougan**  
**DSAC Doctor & Family Violence Intervention Co-ordinator**

## **Buddying**

At the Regional Co-ordinators' meeting in October 2004, it was agreed that we should encourage Doctors working in isolation to have a 'buddy' for peer review. One of the benefits is that it will make accreditation much easier and there are several options that can be arranged.

A 'buddy' can be available by teleconference, there can be peer review locally with small groups, or if preferred doctors can travel to the nearest larger centre.

Please let the DSAC office know if you are interested in help to set this up.

## **Report from DSAC Librarian - Janice Giles**

The Journal Club material mailed in December 2004 included the first in the new format for adults. We trust you found the selection appropriate. You will soon receive the first Journal Club mailout for 2005.

Janet Say has begun the lengthy process of grading the 3000 or so research articles on file for relevance. This process will take a while and is expected to add to the usefulness of this resource in the long term.

**Janice Giles**  
**DSAC Librarian** 

## **Mars Delamere - 09 February 2005**

Ka tangi te titi, ka tangi te kaka, Ka tangi ahau, Tihei Mauri Ora.

I would like to take this opportunity to thank the members of DSAC for your on-going support and commitment to abuse care. I am moving on from Te Puaruruhau, Starship Children's Health to Wanganui where I will take up the position as Clinical Manager for Taumata Hauora Trust – A Maori Development Organisation and Primary Health Organisation. However, I am very keen to maintain my connection to DSAC. It is my hope that Taumata Hauora will be able to secure funding in order to set up a comprehensive abuse care service that will cover the Wanganui, Palmerston North area. I know that this may seem like a big dream but I believe it is more likely to materialise if one strives to maintain strong links to key organisations, such as DSAC, Te Puaruruhau, Puawaitahi and with support from whanau, hapu, iwi, the wider community, the relevant DHB's and strong willed individuals. Funding will always be an issue. However, where there is a rainbow, there is money; we just need to find it and access it. I imagine that this is going to be a huge task and journey, hopefully not as long as the Puawaitahi pre-journey. However there is a "need" and I have a "will".

No reira, ma te Atua, koutou hei manaaki, hei tiaki mo ake tonu atu. Kia tau te rangimarie i runga i a tatou katoa.

**Mars Delamere, RCompN, MN**  
**Nurse Specialist**  
**Te Puaruruhau**

## Auckland Roster Doctors - ESR Visit - 29th November 2004

We had a very useful visit to the Auckland ESR. Enormous thanks to Paige and Gillian for giving up their time and showing us around. There was a good turnout. The main things we gleaned are summarised:

- The ESR staff are VERY DNA conscious and don gown, hat, gloves and mask religiously to enter areas where they are examining exhibits and contents of the kits. The scientists now work in isolated rooms. They swab down all surfaces etc before and after use.
- Blood specimens from kits are stored separately in the fridge. Specimens from suspects are only held for a year and are discarded if there has not been a charge laid within that time.
- The rest of the Kit items are stored in paper bags in a dry store area along with other exhibits. Moisture encourages growth of micro-organisms that destroy DNA. Wet items will be dried out first, so please indicate to police if things need to be specifically dried urgently.
- The history page of the AMP is VITAL to the ESR scientists. They rely on this as an accurate first hand account of events that will guide what and where they may look for evidence. They do get a report from the police, a green form (POL 143), but your history is more useful.
- If you have labelled a swab or specimen but then not used it PLEASE indicate on it "NOT USED", or else don't include it. Otherwise the scientists can spend hours and hours searching these swabs!!.
- Yes, please do things like fingernails scrapings etc, even if it seems that there is no history to indicate.
- Research has shown there is under-disclosure of oral sexual contact so it is best to take the swabs routinely if within the 24 hr timeframe.

- Buccal swabs are coming in as reference samples and may replace the blood specimen in the MEK. Do these after the oral swabs that you may be taking for sperm etc. Obviously we may still wish to do blood for toxicology, and health reasons, especially Hep B. We will be suggesting that the especially designed buccal swabs be included in the updated MEKs.
- If you have taken lots of extra swabs for some reason, please indicate why.
- When using the black swabs for Wet & Dry swabs please include a spare one in the kit as a reference sample and label it. "Reference swab". Cut it's tip off as well (and label NOT USED!).
- Quantity of blood for DNA analysis – we can get away with very small amounts if bleeding is difficult and certainly no longer need the 15 mls!!!!
- Including plastic speculae in the kit has yet to turn up anything that wasn't on the swabs, but if you think for some reason it may be useful please include and indicate why.
- Please don't use medical abbreviations that the ESR scientists may not know. Eg: UPSI = unprotected sexual intercourse.
- If you are asked to do a hair/nails toxicology sample (after one or more months) you will need to talk with ESR. The written guideline is in the folder at Pohutukawa, but many issues are yet to be clarified. We are working on this. In the end, the police may not be prepared to pay the potentially large costs.
- CLOTHING – If patients are adamant they do not want a particular item cut up then indicate this to ESR by adding a note in the kit. If ESR then later thought it important to cut it up they can approach the complainant separately. PLEASE only make this request if absolutely necessary as adds+++ to ESR workload.

**Kristen Sorrenson**  
**DSAC Doctor, Auckland**

## New Insights and Research Directions from the Recent Medical Literature

**Dr Janet Say, DSAC Doctor - Adult Journal Club**

It has been interesting over the years to watch the evolution and the priority given to research in the area of sexual abuse/assault. As a result of this research there is now a considerable body of work to support evidence-based practice. Much of the scientific basis for our work has come from literature out of English speaking countries, particularly from the United States. The local DSAC library has always collected as many of these publications as possible. Recently, early publications from developing countries have been included where there could be cultural issues relevant to our multi-cultural society today.

The library is always keen to access articles on questions that could be relevant medico-legally or forensically. Recently the Journal Club mailout has included papers on genital trauma associated with forced digital penetration; sexual arousal and orgasm in subjects who experienced forced or non-consensual sexual stimulation; factors impacting on injury documentation after sexual assault; role of examiner, experience and gender, and the significance of Toluidine Blue – positive findings after speculum examination for sexual assault.

The library also monitors other important developments. There have been some interesting papers on neuro, "psycho", bio-pathology. These outline developments in studies that have monitored the hypothalamic pituitary thyroid axis. One such study looked at the possible effects of sexual abuse on age of menarche. There are studies looking at effects on menopause and others on sex hormone studies in aggressive behaviour in men and women. Another study looking at women with pre-menstrual dysphoric disorder (PMDD) who have a history of sexual assault demonstrated them to have hormone concentrations that are

different to those of women with no history of sexual assault. This may be part of a hyperarousal state which may respond to propranolol, significantly reducing PMT.

There is an increase in published studies on male sexual assault issues including a steady flow of evidence-based papers of "male on male" rape. One paper concluded that males were significantly more likely (6 times) than females to receive at least one injury to the anal area. Even so, males are 5 times more likely to have no anal injury.

"Will I be Raped?" – that question more than any other haunts men awaiting incarceration. Robertson in his paper 'Rape among incarcerated men: sex, coercion and STDs' is a frank insight into what happens "inside". In New Zealand, there has been very little said or acknowledged about the incidence of rape in prison. It is becoming an important factor in the spread of chronic STIs. This has been recognised, in the USA at least, where the Prison Rape Reduction Act (2002) has been introduced. A million dollar funded research programme led by Basil Donovan is to start soon in Australasian prisons. No rape should be tolerated, whatever the social environment or gender involved.

The Journal Club aims to keep abreast of a wide range of issues relating to our work. DSAC members who belong to the Journal Club automatically receive these references with regular mailouts and individual articles are available on request from the DSAC office.

**Dr Janet Say**  
**DSAC Doctor, Auckland**

## Liz Kelly -Plenary Speaker at the ANZSOC Conference

Professor Liz Kelly was a plenary speaker at the Australian and New Zealand Society of Criminology Conference held at Victoria University of Wellington, 9-11 February 2005. She is Professor of Sexualised Violence Studies, in the Child and Women Abuse Studies Unit, London Metropolitan University, England.

This is a summary of her discussion of attrition in rape cases and her ongoing work on the advisory group for serious sexual assault care in the UK.

There has been a new Sexual Offences Act (UK) passed which she feels has positive implications for the provision of representation for adults and children, for issues re trafficking, and for the reduction of discrimination against homosexual victims of sexual crime.

There are 25 Sexual Assault referral centres in the UK now.

Professor Kelly discussed the questions that are being addressed by an interministerial advisory group that she is part of; why there is minimal attention paid to sexual assault from a social science view point, the setting of goals by the group to try to increase reporting of these types of violence, and reducing the bias in the way the reporting is dealt with.

There has been an increase in reporting of sexual violence per year and a small increase in the numbers of prosecutions, but no change in conviction rates. She cited ratios of UK conviction rates of 1:3 in 1977, 1:19 in 2003 and 1:100 in Ireland in 2003. There has been a reduction in reporting rates in the Eastern European countries post Soviet Union collapse, possibly due to lack of security and infrastructure.

Professor Kelly discussed a study she has just completed that analyses when and why people 'drop out' within the process of the reporting investigation of a sexual assault.

The study included 6 areas in the UK, 3,500 cases, interviews with 143 staff, and interviews + questionnaires with 229 complainants. 28% did NOT report to the police. Some reasons for this were concern re legal systems, fear of disbelief, relationship to the perpetrator, and not wanting people to be aware of what had happened. Less reporting occurred if the offender was known by the victim, was a recent acquaintance, or if the woman was older in age.

The study focused on rapes that were reported. 2284 of the cases were prosecuted. A conviction rate of 8% occurred, mostly through a guilty plea. 3% of the cases were found guilty by trial.

Of the people who did not go ahead with a full enquiry (early attrition), 80% left the criminal justice system before the crown prosecutor became involved in the case.

Early attrition occurred more in cases in which someone else had reported the crime, and in drug assisted sexual assault cases where there was no forensic evidence.

In false allegations (3-8% of reported rapes), police reported an impression that the cases 'didn't fit together' or that there had been a history of unsubstantiated claims. The Police Officers who were interviewed believed the percentage of false allegations was more than quoted above - some felt up to 50%. This reflected a concerning culture of suspicion within the Police Force.

52% of cases involved the voluntary consumption of alcohol. In 13% of the cases the assailant was not identified by the victim. Professor Kelly remarked on the need for societal challenge regarding alcohol use in women. Women should be able to drink and remain safe.

Insufficient evidence was the largest category for reasons for loss of cases at the investigative stage. The 'credibility' of the complainant, and the perception of 'unreliable witness' impacted on the progression of many complaints.

Opinion re consent continues to be a hurdle. For example how consent, which is said to have been obtained through fear of violence, is communicated/acknowledged in court.

Professor Kelly discussed the concern of there being 'little evidence of case building between Police and the Crown Prosecutor'. 'The largest group (1/3) are lost as complainants, leave through the case progression, or don't make a complaint, or don't have a forensic examination - often feeling disbelieved/discouraged by the criminal justice system'.

The complainants are more likely to not start a legal complaint at all rather than stop at the time of a forensic examination.

She reflected upon the impact of certain messages conveyed by the Police to the complainants. For example, discussion around the difficulty of appearing in court can be perceived as a message that the Police don't believe the complainant.

Feedback regarding Police involvement was positive for the initial support after reporting an assault, but less so at the stage of investigation and development, of the case.

She remarked that the court process currently reflects an inability to form a competent rape narrative which would include the context/ 'real' victim/assailant. She discussed the need to 'reconstruct notions of what constitutes rape'. Societal changes in sexual autonomy and agency have altered the view of victims as less 'helpless' and more likely to be 'blamed'.

The continuum of consenting sex—rape, needs to be reassessed with changes in investigation and prosecution of known offenders and 'consent' defences. A collaborative approach may lead to better utilisation and understanding of what evidence is and what evidence is not valuable to a case, especially as rates of reporting continue to increase where alcohol/drugs/absence of physical findings and preceding consenting behaviour are factors.

The involvement of procedural justice and the contribution of the legal system is required along with societal change on what is considered rape.

This information was well presented and received. I thought this quote was worth scribbling down.

'I develop and defend a view of the self as fundamentally relational, capable of being undone by violence, but also of being remade in connection with others'.

Susan Brison, *Aftermath*, 2002.

**Kathryn Leslie, DSAC Doctor  
Wellington**

# Criminal Law Committee

## Expert Medical Evidence in Sexual Cases *LawTalk 636, 22 November 2004*

Counsel involved in sexual cases will be aware that almost all medical evidence adduced by the Crown is provided by medical practitioners who are members of DSAC: Doctors for Sexual Abuse Care. A DSAC doctor is often the only medical professional to examine a complainant and rarely, if ever, gives evidence for the defence.

Some counsel have raised concern that this position makes it difficult for DSAC members to remain objective while conducting an examination and forming expert opinions. While a lack of neutrality affects credibility and can be addressed by cross-examination, the committee believes that medical examinations should be carried out in a neutral and objective manner by independent practitioners. Counsel with experience of these issues are urged to contact the committee secretary so that this concern can be investigated further.

**Aaron Lloyd**  
**NZLS Secretariat**

## Response

11 March 2005

The Editor  
LawTalk  
NZ Law Society

Dear Sir / Madam

A short article from the Criminal Law Committee\* in LawTalk of 22 November 2004 has been brought to the attention of the Executive of DSAC (Doctors for Sexual Abuse Care). It is over the name of Aaron Lloyd of the New Zealand Law Society Secretariat.

This article raises questions about the professionalism of doctors who are members of our organisation. We would appreciate the publication of this response in LawTalk for the benefit of the Criminal Law Committee and all your readers.

### **DSAC the Organisation**

Doctors for Sexual Abuse Care is a professional organisation of doctors from many disciplines, whose prime focus is education and support of medical practitioners. The purpose is to ensure maintenance of internationally recognised standards of best practice in the medical and forensic management of sexual assault.

DSAC brings international experts to teach here who are widely recognised as leaders in their fields of practice and has provided assistance for New Zealand doctors to study or attend conferences abroad. The association has developed an international reputation for provision of training and maintenance of standards in forensic medical examination.

### **DSAC Members**

Membership includes doctors with skills and experience from many disciplines including paediatrics, gynaecology, pathology, psychiatry, sexual health medicine and general practice. Membership is voluntary and open to doctors at the discretion of DSAC Executive. Membership of DSAC is not a qualification. Many members do not participate in acute sexual assault work. Those who do are encouraged to apply for DSAC Accreditation, for which there are specific requirements. These include appropriate clinical work, attendance at DSAC training, participation in peer review and the provision of references. DSAC Accreditation is used by the Accident Compensation Corporation and the NZ Police to help them identify doctors who have specialist skills in providing therapeutic and forensic medical care for sexual assault complainants.

### **DSAC Training**

DSAC as an organisation is an education provider not a clinical service provider. It is the only professional medical organisation in New Zealand which provides comprehensive training courses in forensic medical examinations for sexual assault. The training offered by DSAC is based on current international mainstream medical knowledge from the range of specialties involved in this area of medicine. This teaching emphasises the importance of thorough medical examination and assessment without prejudice. At DSAC courses experienced practitioners and forensic scientists provide teaching and doctors are encouraged to become familiar with the international literature in this field of medical practice. Training includes teaching on the role of being an "expert" witness, and emphasises the requirement to give objective, evidence-based and unbiased opinion.

### **The Medical Role**

Medical examination in the context of an alleged sexual assault has two components, therapeutic and forensic. The doctor is responsible for providing comprehensive medical care that includes assessment and management of physical injury, screening and management of sexual health issues, and assessment and management of patient safety and mental health concerns. The doctor also has a forensic role that involves performing a careful and thorough medical examination using specialised medical and forensic training.

### The “DSAC Doctor”

The expression “a DSAC doctor” is a misnomer. It has come into use as a shorthand term to describe doctors who make themselves available in their local communities to perform forensic medical examinations when there is an allegation of sexual assault. Doctors who do this work may be employed by District Health Boards or be self-employed, receiving requests for medical examinations from the NZ Police, other agencies such as the Department of Child, Youth and Family Services or from colleagues. These doctors are likely to have attended courses run by DSAC, but some may have been trained elsewhere. They may have had their training and expertise recognised by DSAC Accreditation, and may or may not be members of DSAC.

### Addressing comments made in the article

#### 1. A DSAC doctor is often the only one to examine a complainant:

For obvious reasons, it is usually inappropriate for more than one medical examination to be done on a complainant after an alleged sexual assault. In New Zealand, the doctor called upon to conduct that examination will probably have received their training from DSAC. It is merely common sense that a doctor with specific training should be the one to do the examination.

#### 2. DSAC doctors rarely, if ever, give evidence for the defence.

Forensic medical examiners are called primarily for the prosecution because they examined the complainant. They are however expert witnesses and as such will provide to the Court a professional opinion based on a careful medical examination and knowledge of the discipline in which they work.

Doctors for Sexual Abuse Care encourages its members to make themselves available to both prosecution and defence. It is always open therefore to defence counsel to approach a doctor who specialises in sexual abuse care, to provide a second opinion if requested to do so.

In response to this article we have emailed our members asking if they have acted for the defence. Thirty-nine replied of whom 54% indicated that they had given opinions for lawyers acting for a defendant. Many of these have been dealt with by discussion; some by a written opinion and a number have resulted in the doctors giving evidence to the Court.

#### 3. Membership of DSAC may make it difficult to remain objective ....

Membership of a professional organisation and participation in peer review activities does not impair neutrality and objectivity. On the

contrary, it enhances them. It would be negligent, for example, for a practising heart surgeon not to belong to an appropriate professional organisation. In this respect sexual assault medicine does not differ from any other field of medicine. Doctors who work in isolation without regular review by their peers are at risk of losing competence and balance.

Current medical practice requires that, for maintenance of clinical standards, doctors should belong to specialist professional organisation(s) and participate in continuing medical education as well as in a process of “peer review”, where clinical management is discussed and criticised by peers. In some respects, membership of DSAC may function for forensic examiners in a manner similar to that of the NZ Law Society for lawyers.

#### 4. The committee believes that medical examinations should be carried out in a neutral and independent way by independent practitioners...

As a professional organisation, we agree entirely with this statement. Our first obligation as doctors is to provide the best possible medical care for our patients, based on the best scientific knowledge available to us. This obligation is to be met regardless of the source of our remuneration or the implications for subsequent criminal proceedings. Furthermore, any doctor providing evidence in court is under a profound ethical obligation to provide neutral and objective evidence. We view this obligation with equal gravity. As an expert witness, the doctor trained by DSAC is trained to be independent of the alleged victim, the alleged assailant, the Police and legal counsel (whether for the prosecution or the defence).

We would be happy to meet with the Criminal Law Committee to ensure that the concerns raised in your article are addressed to our mutual satisfaction.

Yours sincerely,

**Dr Carol Shand MB ChB, FRNZCGP, FACHSHM.**

**DSAC President**

\* “Expert medical evidence in sexual cases” in LawTalk 636, 22 November 2004

## FORENSIC UPDATE

### Condom/Personal Lubricant Analysis

Present protocol in the medical examination is to introduce the speculum and then do the high vaginal swabs. It has been found that this could compromise the detection of lubricant components in the vagina. The best method to capture any condom or personal lubricant components is to do a “blind sweep” of the low vagina with a swab (an extra black top swab) before the speculum is introduced and the upper vaginal swabs taken.

**Paige McElhinney, ESR, Auckland**

With special thanks to

Image Centre,

34 Westmoreland Road West, Grey Lynn, Auckland

(09) 360 5700

for printing this newsletter



IMAGECENTRE

# DSAC Diary of Events 2005

DSAC is a RNZCGP CME Registered Special Interest Group

For all events Apply to: DSAC National Office PO Box 90 723, AUCKLAND,  
5/4 Warnock Street, Grey Lynn, AUCKLAND Tel: (09) 376 1422 Fax: (09) 376 0790  
email: dsac@ihug.co.nz website: www.dsac.org.nz

## Mike Lew M.Ed

Three One Day Seminars

### Working With Men: An Update

An Advanced Workshop for Experienced  
Clinicians Treating Male Adult  
Survivors of Childhood Sexual Abuse

**Auckland** - Monday, 30th May 2005  
West Lounge, Eden Park, Reimers Avenue,  
Carpark F, Gate 26, Mt Eden (Free Car Parking)

**Wellington** - Wednesday, 1st June 2005  
Mecure Hotel, 355 Willis Street  
One Day Parking Vouchers available for \$4.00 from Hotel  
reception with parking available in adjacent streets

**Christchurch** - Friday, 3rd June 2005  
Holiday Inn City Centre, Cnr Cashel & High Streets  
Public Car Park opposite Hotel entrance

## DSAC Forensic Training Weekend

Medical Management of Sexual Assault

Adult & Adolescent

Venue: WIPA, Level 7 Wang House,  
195-201 Willis Street, Wellington

Dates: 29 - 31 July 2005

## Dr Colin A Ross, M.D.

Three One Day Seminars

### Treatment of Complex Dissociative Disorders

**Auckland** - Monday, 17th October 2005  
Waipuna Hotel, 58 Waipuna Road, Mt Wellington

**Wellington** - Wednesday, 19th October 2005  
Illot Theatre, Wellington Town Hall,  
111 Wakefield Street, Wellington

**Christchurch** - Friday, 21st October 2005  
Holiday Inn City Centre, Cnr Cashel & High Streets

Colin Ross will also be giving the keynote address at the  
3rd Annual MAKING SENSE OF PSYCHOSIS Conference  
in Auckland, 18 & 19 October, hosted by the  
International Society for the Psychological Treatment of  
Schizophrenia (ISPS).

For further information contact  
Melissa at [m.taitimu@auckland.ac.nz](mailto:m.taitimu@auckland.ac.nz)  
People registering for both the DSAC Seminar and the ISPS  
Conference will receive a 10% discount on both.

## Taranaki Safer Centre

Presents

2ND National Stopping Sexual Violence Conference

### “HEALING THE HURT”

Keynote Speakers: Dr Nigel Latta, Dr Kim McGregor

12-13-14 May 2005

VENUE: Quality Hotel, Plymouth International,  
New Plymouth

## LETTERS TO THE EDITORS

Letters to the Editors can be submitted, although publication, editing and abbreviation are at the Editors' discretion. While the principle of 'right of reply' to articles and letters published in the Newsletter is accepted, this right is not automatically granted and is subject to Editorial discretion and the limitations of space - DSAC news and information have priority. All letters submitted must include appropriate contact details and email submissions are preferred so as to reduce the possibility of error in transcription.

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