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Police Surgeons and Victims of Rape:

Cultures of Harm and Care

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Abstract:

Between the late 1960s and the late 1980s, police surgeons found themselves under concerted attack for their treatment of victims of rape and sexual assault. This article explores the tensions they face between the needs of victims and their legal responsibilities. Should they prioritise care or the collection of evidence? How did they respond to criticism and why were reforms inadequate? I show how institutional structures and ideologies help explain the longevity of cultures of harm within the sub-discipline of police doctors. However, to understand the *tenacity* of these practices, we need to interrogate more fundamental processes associated with bodily interactions, emotion, and language.

At 22.05 on Saturday, 22 January 1977, 2.5 million people in the UK turned on BBC2 to watch a 90 minute, double-feature programme about rape.[1] The film consisted of two,

[1] Viewing figures are from 'BBC Says it is 4 Pts [sic] Up', *The Stage* (17 February 1977), 16.

interlaced parts: a television play entitled 'Act of Rape', which was written by Fay Weldon, and a panel discussion, chaired by Jacky Gillott, one of Britain's first female television presenters.

Weldon's play was based on actual court cases of the 1970s. In the play, a young woman (played by 21-year-old Lesley Dunlop) talks and dances with a man in a club. There are two different versions of what happened next: in one, the woman rebuffs the man's sexual advances and only submits when threatened with a butcher's knife; in the other, she is a coy but willing participant. The woman reports the rape to the police, who act insensitively. She does not want to be medically examined but is told that if she refuses the examination she 'won't have a dog's chance if it gets to court'. The police constables refuse to allow her to be examined by her own doctor and, instead, she is examined by a police surgeon in a makeshift area next to the interrogation room. She is heard protesting his rough treatment and crying out in great pain.

Much of the rest of the play consists of the jurors debating whether the woman had really been raped. The judge emphasizes the need for 'corroboration' of the complainant's story since, he reminds them, women 'do tell false tales, for reasons good, bad, or indifferent'. The jurors – who include an army Major, a chauvinistic husband, an earnest teacher, a civil servant, a bigoted older woman, a 'dumb brunette', and a feminist – eventually decide not to convict, on the grounds that they don't want to 'destroy' the man's life.

At various times during the play, the camera shifts to a panel discussion in the studio. It included three rape victims (identified only as Penny, Susan, and Hilary), MPs Robin Corbett and Ivan Lawrence, Professor Brian Simpson (who had served on the recent Heilbron Advisory Group on the Law of Rape), the distinguished judge Christmas Humphreys, Ann Fiander (a juror in a recent rape trial), Barbara Toner (who was soon to publish a book called *The Facts of Rape*), Commander Daphne Skillern from Scotland Yard, Stuart Crane (who had been acquitted of a rape charge), and police surgeon David Paul. The three rape victims testify not only to being sexually attacked, but also to unsympathetic treatment by the police, police doctors, judges, and jurors. They argued that they had been treated unjustly. All three noted that the medical examination had been particularly brutal and unnecessary. In defending the need of 'corroborative evidence' being given by a police surgeon, Judge Humphreys argued that the 'the condition of the girls' vulva may be the most powerful corroboration… showing that something much more than forceful play had taken place'. This may have been the first time that the word 'vulva' was mentioned on British television.

Both the play and the panel discussion were devastating critiques of the treatment of rape victims. Indeed, they accused jurists, police, and police doctors of championing a 'rape culture'. A review by Michael Le Moignon in *The* Stage was convinced by the critiques, but he flippantly quipped that scheduling the programmes late on a Saturday evening 'made

a change from old movies or football'.[2] This combination of alarm and nonchalance was typical of responses to sexual violence in Britain at that time.

However, the programme caused a roar of protest from one group of people. Police surgeons – also known as police doctors and, later, Forensic Medical Examiners (FMEs) – believed that they had been unjustly maligned. Both the president and secretary of the Association of Police Surgeons of Great Britain sent a letter of protest to the *British Medical Journal*. They were furious that the play 'quite deliberately and certainly successfully' gave the impression that police surgeons treated rape victims callously. They were particularly upset by the portrayal of the medical examination. The 'plaintive cries and later screams of the victim while in the surgeon's room' and the fact that 'the police officers outside could hear everything that was going on', was totally unwarranted, they fumed. The scene 'gave an impression of a complete disregard by the police surgeon of normal medical ethics and courtesy to his patient'. Like Le Moignon, they conceded that changes had to be made to the way police doctors treated rape complainants. After all, they were already aware that Toner's soon-to-be published book, *The Facts of Rape*, was going to be a particularly trenchant attack on their profession.[3] However, they claimed to have been actively lobbying

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[2] Michael Le Moignon, 'Play and Debate Both Misfired', *The Stage* (27 January 1977), 16.

[3] Barbara Toner, *The Facts of Rape* (London: Arrow Books, 1977).

for reforms themselves for the past decade. They accused Weldon and some of the panel members of promulgating an image of police surgeons that was both obsolete and unfair.[4]

The critique of police surgeons enacted in 'Act of Rape' was not unique. Between the late 1960s and the late 1980s, police surgeons found themselves under concerted attack. The last time they had been exposed to such public scrutiny was exactly a century earlier, where their role in examining women under the Contagious Diseases Acts had been exposed in shocking detail. Particularly disconcerting for police doctors in the 1970s and 1980s, however, was the fact that they were being condemned from within their own ranks, as well as by established women's organisations and recently-constituted feminist and anti-rape groups.

Second-wave feminists were concerned about the incredible power wielded by police surgeons in criminal cases involving sexual assault. Medical reports were often decisive in determining whether or not the police took the assault seriously, if legal proceedings should be instigated, and the final decision of any subsequent court appearance. The treatment of complainants by police surgeons had profound effects on victims as well, including their physical health (what was done about injuries, sexually transmitted diseases, and unwanted pregnancies), psychological well-being (feelings of guilt, anxiety, and depression), and life outcomes (the risk of sexual and social dysfunction, drug

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[4] F. A. Gabbani (President) and H. de la Haye Davies (Hon. Secretary), '[Letter to the Editor] Act of Rape', *British Medical Journal* (12 March 1977), 709.

and alcohol abuse, self-harm, and suicide). While a series of governmental committees made recommendations for improving medical services offered to victims of sexual assault, and, in some cases, imposed reforms on the conduct of police surgeons, these doctors remained resistant to change. They continued to see their job as primarily serving the needs of the police and courts, making a clear distinction between their clinical practice as GPs or hospital doctors and their role as '*police* surgeons'. This institutional culture remained, even after they changed their name from 'police surgeon' to the more neutral 'forensic medical examiner'.

This article examines the ideology and practice of police medicine in the three decades from the early 1970s, exploring the trenchant criticisms they received and analyzing their responses. It argues that their anomalous position between medicine and the law enabled them to respond to criticism by moving pragmatically backwards and forwards from one domain (such as medicine) to the other (law) when attacked. In other words, for police surgeons, there was not so much a *conflict* of roles, but rather that the two roles were in dialogic interaction. I show how institutional structures and ideologies help explain the longevity of cultures of harm within the sub-discipline of police doctors. However, to understand the *tenacity* of these practices, we need to interrogate more fundamental processes associated with bodily interactions, emotion, and language.

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In England and Wales, the title 'police surgeon' had been first formalized in 1829, with the passing of the Metropolitan Police Act. Any person with a medical degree could be appointed to the role, but the majority were GPs chosen by local Watch Committees, police commissioners or, in the case of the Metropolitan Police, the Home Office.[5] Except in the largest cities, most worked part-time, employed on a retainer basis, with fees allocated according to their level of service. They were responsible for a range of tasks, from physically assessing new police recruits to assigning cause of death. However, their three most important responsibilities were testing drivers for alcohol consumption (in general, this took up 29 per cent of their time), inspecting prisoners (21 per cent), and medically examining complainants of sexual assault (18 per cent).[6] This article is only concerned with the latter responsibility.

Police surgeons had a long history of uneasy relations with women's organizations. As mentioned, feminist agitation against police surgeons was a notable feature of opposition in the 1860s and 1870s to the Contagious Diseases Acts. Under these Acts, women living in certain ports and army towns could be arrested on suspicion of being prostitutes and then subjected to compulsory medical checks for venereal diseases. Feminist and other reformist groups opposed the law on the grounds that it entrenched a

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[5] A. J. Laidlow and K. W. Cross, 'Forensic Medicine. An Analysis of 10,000 Cases', *Journal of the College of General Practitioners*, 18 (1964), 334-35; Kathleen Kelly, Graham Moon, Stephen P. Savage, and Yvonne Bradshaw, 'Ethics and the Police Surgeon: Compromise or Conflict?', *Social Science and Medicine*, 42.11 (1996), 1570.

[6] Laidlow and Cross, 'Forensic Medicine', 336-37.

double standard of sexual morality (men were not subject to such examinations), violated the rights of women, and was degrading. Indeed, the police surgeons who carried out the physical examinations were accused of symbolically raping the women brought before them. These doctors were asked to reflect on the effect of the 'violent thrust' of the speculum into the bodies of the female suspects. They were accused of being 'violators' who 'forcibly' dragged young women 'from their mother's homes', in order to be 'split open by the State… Their sobs are nothing, and his steel goes in'. The women abused in such a way felt 'hatred of the legal violator more than of the steel'.[7] The Acts were finally repealed in 1886, but left a legacy of suspicion amongst women's groups that flared up periodically in the following decades.[8]

In the 1970s and 1980s, tensions between police surgeons and feminist activists also coalesced around anxieties about sexual violence. Indeed, the uproar in 1977 over Weldon's play was not an isolated incident. On 18 January 1982, a 13-part 'fly on the wall' documentary called 'Police' broadcast a scene called 'A Compliant of Rape'. In it, a cameraman and sound recorder filmed an interview with a woman who claimed that she had been raped by three men. Directed by Roger Graef and Charles Stewart, it showed an extremely aggressive interrogation conducted by members of the Thames Valley police force. At one point, the police threatened the complainant, warning her that if she pursued her accusation she would be subjected to 'the doctors – the grabbing of all your clothes –

[7] James John Garth Wilkinson, *Forcible Introspection of Women for the Army and Navy by the Oligarchy Considered Physically* (London: F. Pitman, 1870), 4, 8, and 10.

[8] It was particularly evident during the two world wars, for example.

going to see a doctor – all the smears – all the probing about…. – it's pretty awful'.[9] Like 'Act of Rape', this documentary caused further disquiet, with police surgeons coming into the line of fire along with their police colleagues.

The public humiliation of police surgeons in these two television programmes in 1977 and 1982 was particularly passionate because they were broadcast at a time of heightened awareness of sexual abuse more generally. For example, two years before 'Act of Rape' was broadcast, the judge who participated in the panel discussion on that programme had passed a six-month suspended jail sentence on a man convicted of raping two women at knife-point. Shortly afterwards, he sentenced a man to eighteen months in prison for fraud involving £2,000.[10] In the same year as 'Act of Rape', a Guardsman named Tom Holdsworth viciously raped and mutilated a 17-year-old women (the doctor described her injuries as consistent with recent childbirth), but the judge simply berated him for allowing 'his enthusiasm for sex to overcome his normal behaviour'. He was also given a six-month suspended sentence.[11] In 1982, only a few days before the broadcast of 'A Complaint of Rape', a 17-year-old woman who was violently raped after she hitchhiked home was said by the judge to be 'guilty of a great deal of contributory negligence'. Her assailant was only

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[9] 'A Complaint of Rape': an episode in Roger Graef's and Charles Stewart's documentary, *Police* (1985).

[10] Christmas Humphreys, *Both Sides of the Circle: The Autobiography of Christmas Humphreys* (London: Allen and Unwin, 1978), 241

[11] Cited in Polly Pattullo, *Judging Women. A Study of Attitudes that Rule our Legal System* (London: NCCL Rights for Women Unit, 1983), 19.

fined.[12] The same year, a judge in the Cambridge Crown Court acquitted a man of rape, explaining that 'women who say no do not always mean no…. If she doesn't want it she only has to keep her legs shut'.[13] These were just four instances where feminists were stirred to action because of injustice towards rape victims.

Given their anomalous position between medicine and law, police surgeons were particularly vulnerable to attack. On the one hand, they were physicians with a duty of care for people who sought their help. Yet, on the other hand, they were called to assist the *police* in their enquiries. It is important to note that it was not until 1989 that the Metropolitan Police *Force* changed its name to the Metropolitan Police *Service*, following the presentation of a report entitled 'A Force for Change: Report on the Corporate Identity of the Metropolitan Police'. Significantly, the chief trigger for this change in nomenclature was the civil disturbances on Brixton in the early 1980s, which led to demands for more community liaison,[14] but agitation over the treatment of rape victims also played a role.

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[12] 'Hitch Hiker Girl Blamed by Rape Case Judge', *The Times* (6 January 1982), 1. Also see 'Father of Raped Girl Attacks "Unjust" Sentence', *The Times* (7 January 1982), 1 and 'Lock Up Your Daughters', *The Times* (7 January 1982), 7.

[13] Judge David Wild, cited in Pattullo, *Judging Women*, 20-1.

[14] Jennifer Brown, Cary Cooper, and Bruce Kirkcaldy, 'Stressor Exposure and Methods of Coping Among Senior Police Managers at a Time of Organisational and Management Changes', *International Journal of Police Science and Management*, 2 (1999-2000), 221.

Increasingly, feminist voices could be heard accusing police surgeons of being in league with the police, promoting a 'rape culture', and discouraging victims of rape from reporting their ordeal. They collected evidence showing that an exceptionally high proportion of victims did not report their attack to the police or other authority. According to a Scottish Office Society Research Study in 1983, only 27 per cent of women contacting the Rape Counselling and Research Project (Britain's first rape crisis centre) reported their attack to the police.[15] Two years later, a questionnaire sent out by the Medical Women's Federation found that 68 per cent of women who claimed that had been assaulted had not reported it.[16] Although there were many reasons for women's reluctance, it was widely accepted that the prospect of a humiliating and sometimes painful medical examination was a 'further deterrent'.[17] Indeed, there is even some evidence that rapists played on these fears. The Cambridge rapist, Peter Cook, reportedly told one victim that 'If you go to the police they will look in your knickers and look up inside you'.[18]

Anti-rape activists published lengthy accounts of unsympathetic, and even brutal, medical responses when a woman sought help after a sexual assault. Some of this was

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[15] Susan Edwards, review of Gerry Chambers and Ann Millar's *Investigating Sexual Assault (A Scottish Office Society Research Study)* (1983), in *Journal of Law and Society*, 11.2 (summer 1984), 259.

[16] 'Are Doctors Trained to Deal with Rape?', *British Medical Journal*, 291 (7 December 1985), 1655.

[17] Toner, *The Facts of Rape*, 175 (1977 ed.: 134).

[18] Toner, *The Facts of Rape*, revised, 175 (1977 ed.: 134).

anecdotal. For example, in 1985, *The Police Surgeon* reported that when one police surgeon was summoned to examine a victim, he appeared in his dinner jacket and spat out, 'You know you've spoilt my evening'. The victim bravely retorted, 'I haven't had such a good time myself'.[19] Feminists published lengthy accounts of insensitivity. Barbara Tome, for example, wrote a book called *The Facts of Rape* (the first edition came out the same year as 'Act of Rape' and a second, revised edition at the time of 'A Complaint of Rape'), in which she accused police surgeons of attempted to 'break down a suspect allegation', allowing 'their prejudices to get the better of them'. The culture of police doctoring had 'cultivated cynicism and sourness' where it should have cultivated an environment that would cause 'minimal distress' for victims.[20] Rape Crisis Centres castigated police doctors for acting as 'amateur detectives and moralists' who interrogated women about their sexual history and felt it 'incumbent on themselves to give a personal opinion on whether or not this woman has actually been raped'.[21]

These anecdotal criticisms were bolstered by evidence from more systematic surveys. One of the most influential was Gerry Chambers and Ann Millar's study of 1983, in which 42 per cent of rape complainants made negative comments about their experience of

[19] N. Davis, 'The Re-Education of Police Personnel in the Investigation of Sexual Offences', *The Police Surgeon. Journal of the Association of Police Surgeons of Great Britain* (November 1985), 11.

[20] Toner, *The Facts of Rape*, 179 (1977 ed.: 137).

[21] London Rape Crisis Centre, *Sexual Violence. The Reality for Women* (London: The Women's Press, 1984), 46.

police surgeons and an additional 18 per cent gave mixed positive and negative views. Only one third responded with neutral comments such as 'was alright' or 'wasn't too bothered by it'.[22] Typical complaints included the painful nature of the examination, the amount of time victims had to wait prior being seen, inappropriate examination facilities, the unavailability of a female doctor, and the lack of privacy, including male CID officers sitting behind a screen during the examination (as was depicted in the Weldon's television play). Women described how their clothes were taken away, but they were not given alternative garments. Police surgeons were described as 'insensitive', 'unsympathetic', and 'abrupt'. Victims were upset that the collection of samples and the tests took precedence over the treatment of their injuries. They resented being questioned about whether they had resisted sufficiently. One complainant was even asked if she enjoyed it. 'It was as if I was on the slab in the morgue', said another.[23]

Because Chambers and Millar were feminists, some police surgeons simply dismissed their survey as biased. The same could not be said in 1991 when, prompted by the BBC programme 'Inside Story', the Metropolitan Police carried out their own survey. One third of all reported rapes in England and Wales took place in the Metropolitan Police district and the Metropolitan police had recently introduced training in the medical examination of rape victims. Nevertheless, the survey concluded that 'many of the police surgeons who examine rape victims, though professionally competent, are unsympathetic'. Forty per cent of

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[22] Gerry Chambers and Ann Millar, *Investigating Sexual Assault. A Scottish Office Social Research Study* (Edinburgh: Her Majesty's Stationary Office, 1983), 99.

[23] Chambers and Millar, *Investigating Sexual Assault*, 100-1.

women who had reported their rape to the Met complained that the doctors who examined them had been 'unsympathetic'. Perhaps more surprising, of the 160 female police constables who worked with police surgeons in rape examinations suites in south-east London, 70 per cent *agreed* with rape victims that, though professionally competent, the surgeons lacked sympathy. The report noted that the police in London were unable to offer a choice between male and female examiners. This was worrying since they found that there was 'a correlation between the perceived lack of sympathy and the unavailability of female doctors'.[24] This complaint about the lack of choice in the sex of the police surgeon carrying out the medical examination reoccurred time and again throughout the century.[25]

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[24] Caroline White, 'Police Surgeons are "Unsympathetic" to Rape Victims', *British Medical Journal*, 303 (20 July 1991), 149.

[25] May Duddle, 'The Need for Sexual Assault Centres in the United Kingdom', *British Medical Journal*, 290 (9 March 1985), 771. This was a long-standing debate: see 'Women Police Surgeons (23) 1942-1943', Wellcome Library, Archives and Manuscripts, SA/MWF/D/18; Medical Women's Federation, 'Notes Re. Question of Designated Police Surgeons', c.1959-60, in 'Women Police Surgeons 1959-1968', in Wellcome Library, Archives, and Manuscripts, SA/MWF/H.64; J. C. Priestley, *Report of the Departmental Committee on Sexual Offences Against Young Persons*, CMD. 2561 (London: HMSO, 1925), 31-2; Dr. N. W. Sargent, '[Letter to the Editor] Women Police Surgeons', *British Medical Journal*, 2.5111 (20 December 1958), 1538; Nesta H. Wells, '[Letter to the Editor] Women Police Surgeons', *British Medical Journal* (17 January 1959), 175; J.H. Kahn, '[Letter to the Editor] Women Police Surgeons', *British Medical Journal* (17 January 1959), 175; Nesta H. Wells, 'Medical Women and the Police Force', *The Medical Press and Circular* (22 October 1961), 1632-633; Thelma M.

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What explanations were given at the time for this lack of sensitivity to rape victims? Some critics pointed to the gender of the examiners. In this period, the job of police surgeon was a highly masculine one. In 1985, the Medical Women's Federation found that the ratio of female to male police surgeon was a dismal 1 to 7.5.[26]

The post also attracted a certain *type* of doctor, specifically those willing to accept low pay and poor working conditions. The time-consuming examinations often took place late at night (most assaults occurred between midnight and 8 am).[27] If the case went to trial, it could drag on for weeks, months, even years, requiring physicians to spend valuable time

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Wagstaff, 'New Initiative by the Metropolitan Police in the Investigation of Rape', *Medicine and Law*, 8 (1989), 496.

[26] 'Are Doctors Trained to Deal with Rape?', *British Medical Journal*, 2291 (7 December 1985), 1655.

[27] Chambers and Millar, *Investigating Sexual Assault*, 98; Diana Patricia Yancey Martin Di Nitto, Diane Blum Norton, and M. Sharon Maxwell, 'After Rape: Who Should Examine the Rape Survivor?', *The American Journal of Nursing*, 86.5 (May 1986), 538-40; Dr. Hugh de la Haye Davies (Secretary of the Association of Police Surgeons), in White, 'Police Surgeons are "Unsympathetic" to Rape Victims', 149.

in court, where defence attorneys routinely questioned their authority.[28] The job attracted physicians with army or naval service, as well as those willing to have regular contact with people often considered to be the 'dregs of society': criminals, drunks, prostitutes, 'degenerates', and other 'unsavoury' characters. Nevertheless, of all their roles, police surgeons found examining victims of sexual assault most repugnant. Rape complainants often arrived in a disarranged state. They were typically distraught, stained with blood and semen, and barely able to make consistent statements. After conducting the medical examination, police surgeons rarely saw victims again: they almost never became part of their regular medical practice. They were not the 'patients' that most doctors in private practice were accustomed to dealing with.

Rather than being accountable to the victim and her (or his) family and friends, police surgeons were enmeshed in police culture. The extent of their identification with the police was revealed in a 1984 survey by criminologists Robley Geis, Richard Wright, and Gilbert Geis. Although the report concluded that police surgeons were 'both physicians and representatives of the police', in fact the police surgeons aligned themselves more with the law than with medicine. For instance, over half of the police surgeons surveyed believed that it was *always* their duty to 'offer an opinion to the police or prosecuting authorities, prior to the trial, about the legitimacy of the rape complaint' and another 40 per cent believed that they should *usually* or *sometimes* give an opinion. Around half believed that they should ask complainants about their previous sexual experiences, even though this had

[28] Di Nitto, Norton, and Maxwell, 'After Rape: Who Should Examine the Rape Survivor?', 538.

been deemed irrelevant by the Report of the Advisory Group on the Law of Rape (known as the Heilbron Report) of 1975. In fact, in the panel discussion during 'Act of Rape', one of the rape victims claimed that the chief role of the evidence given by the police surgeon was to provide jurors with information about the prior sexual activity of complainants without breaching the guidelines. When asked to elaborate on their duties, only 45 per cent of those surveyed by Geis, Wright, and Geis said that they should provide services for women who feared they were pregnant and only 36 per cent prescribed medicine against sexually transmitted diseases. Providing counseling was regarded as a responsibility by only 28 per cent of police doctors. Indeed, they observed that since their survey had been taken, the prioritisation of collecting evidence over treatment had in fact been institutionalized. Since the survey, the Association of Police Surgeons had explicitly told its members that they 'should *not* perform such tasks' (that is, pregnancy testing, treatment for STDs, and counseling), but were to refer complainants (never called 'patients') to other medical professionals.[29]

The law enforcement environment in which police surgeons worked was also not conducive to sympathetic therapy. Most medical examinations took place within police stations.[30] A handbook entitled *The Practical Police Surgeon* (1969), published by the Association of Police Surgeons of Great Britain, admitted that members typically examined

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[29] Robley Geis, Richard Wright, and Gilbert Geis, 'Police Surgeons and Rape: A Questionnaire Survey', *The Police Surgeon. Journal of the Association of Police Surgeons of Great Britain* (October 1984), 56-66. Emphasis in last quotation is mine.

[30] Chambers and Millar, *Investigating Sexual Assault*, 98.

rape victims in 'comfortless, cheerless and awe-inspiring surroundings', with 'inadequate lighting and other facilities'.[31] Throughout the 1980s, feminists and other commentators lamented the fact that medical examinations were performed by 'unskilled' male doctors in the 'rather grubby medical room of a police station next to the cells'.[32] Geis, Wright, and Geis' survey found that although 36 per cent of police doctors stated that they preferred to conduct examination in the police station, nevertheless, even they complained about 'primitive' equipment, the lack of privacy, and unhygienic conditions.[33] As an article in *The Police Surgeon* in 1985 admitted, there was something wrong with the fact that women who had been 'subjected to terrifying attacks' should then be exposed to the 'demi-monde of the police station, usually at night and in the immediate vicinity of numerous noisy, undesirable, and unsavoury characters'. That was 'not a satisfactory way' to instill 'feelings of security, support, and confidence' in victims, the author dryly concluded.[34] As one physician told a leading feminist campaigner, medical rooms in police stations were 'bleak,

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[31] Ralph D. Summers, 'Sexual Offences', in *The Practical Police Surgeon. A Handbook Published Under the Auspices of the W. G. Johnston Memorial Trust Fund by the Association of Police Surgeons of Great Britain* (London: Sweet and Maxwell, 1969), 152.

[32] See Duddle, 'The Need for Sexual Assault Centres in the United Kingdom', 771 and Raine E. I. Roberts, 'Sexual Offences – Is There Any Justice?', in W. D. S. McLay, ed., *The New Police Surgeon – Rape* (London: The W. G. Memorial Trust Fund, 1984), 60.

[33] Geis, Wright, and Geis, 'Police Surgeons and Rape: A Questionnaire Survey', 56-66.

[34] Davis, 'The Re-Education of Police Personnel in the Investigation of Sexual Offences', 11-12.

badly equipped and mainly used for the examination of prisoners and drunks': they were 'bloody awful places' for women who had recently been raped.[35] Complainants agreed.[36]

The situation was exacerbated by the fact that police surgeons invariably were not trained in forensics and medical jurisprudence. In a 1984 article in the *British Medical Journal*, Raine Roberts (an experienced police surgeon from Manchester) complained that because 'any doctor can become a police surgeon without training', cases were being 'botched… evidence has been missed, swabs wrongly taken, [and] statements inadequately written'. She lamented a situation where doctors who were 'ignorant of the law' could be heard 'giving evidence in court'.[37] Not only was there little peer review, no professional medical auditing, and dismal levels of registration for the two-week diploma in medical jurisprudence,[38] but many police doctors were also not even members of the Association of

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[35] Toner, *The Facts of Rape*, 179 (1977 ed.: 137).

[36] Chambers and Millar, *Investigating Sexual Assault,* 98.

[37] Raine Roberts, '[Letter to the Editor] Special Doctor for Rape Victims', *British Medical Journal*, 284 (3 April 1984), 1048. Also see Robin Moffat, '[Review] Carnal Knowledge. Rape on Trial. By Sue Lees and Hamish Hamilton, London', *Journal of Clinical Forensic Medicine*, 3 (1996), 152; Roberts, 'Sexual Offences – Is There Any Justice?', 63 and 67-8; Raine E. I. Roberts, 'The Trials of an Expert Witness', *Journal of the Royal Society of Medicine*, 87, (October 1994), 629.

[38] Roberts, 'The Trials of an Expert Witness', 629 and Raine Roberts, '[Letter to the Editor] 'Special Doctors for Rape Victims', *British Medical Journal*, 284 (3 April 1982), 1048.

Police Surgeons, their main professional body.[39] In 1985, only 9 per cent of police surgeons were qualified in medical jurisprudence; 20 per cent had no formal postgraduate hospital training in obstetrics or gynecology; few had attended any course on forensic instruction and medico-legal procedures.[40] Even those who *were* trained in forensic medicine described the lectures as 'dreary, pedestrian affairs, delivered from copious notes in an uninspiring monotone'.[41] Was it any wonder that an article in *The Guardian* on 28 August 1981, noted that 'When it comes to interpreting wounds, taking proper scientific evidence, and examining sexual attacks, many of the [police] surgeons are inept'?[42]

However, police surgeons and their critics could not simply blame a masculinist ethos, police culture, poor environments, and lack of training. They belonged to a profession that was acutely sensitive to issues of false accusations. Unlike all other professions, medical personnel were regularly required to have contact with the sexual organs of strangers. From their first year in medical school, they had been schooled in the risk of false accusations of sexual assault and they understood the need to always have a chaperone around while conducting intimate examinations. All would have been aware of cases where fellow-

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[39] White, 'Police Surgeons are "Unsympathetic" to Rape Victims', 149.

[40] 'Are Doctors Trained to Deal with Rape?', *British Medical Journal*, 291 (7 December 1985), 1655.

[41] A. David Matthews, *Crime Doctor. The Memoirs of a Police Surgeon* (London: John Lang, 1961), 17.

[42] Dr. Arnold Mendoza in *The Guardian* on 28 August 1981, in Edwards, review of Gerry Chambers and Ann Millar's *Investigating Sexual Assault*, 263.

practitioners had been (falsely or not) accused of sexually abusing their patients. They were particularly susceptible, therefore, to believing the most powerful of all the rape myths: 'women lie'.

As a consequence, disbelief of rape complainants was deeply entrenched. In 1977, a survey of police surgeons in England and Wales found that nearly one-third of rape complaints were believed to be false. Even female police surgeons thought that up to one-quarter of women were lying.[43] In the words of prominent police surgeon Abraham David Matthews in his 1961 memoir, women alleging rape 'need to have their status investigated with extra care'. There were

> many frustrated neurotics around who are quite capable – and indeed anxious – to cause trouble for a perfectly innocent and respectable man who has been unfortunate enough to come into contact with them.[44]

Matthew's depiction of complainants of rape as voracious in their attempts to ensnare naïve yet passive men who were simply 'unfortunate' to have sex with or otherwise 'encounter' them was not an idiosyncratic opinion of one police surgeon. It was widespread throughout the period. In their survey of police surgeons in 1984, Geis, Wright, and Geis

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[43] Geis, Wright, and Geis, 'Police Surgeons and Rape: A Questionnaire Survey', 58.

[44] Matthews, *Crime Doctor: The Memoir of a Police Surgeon*, 55.

accused police surgeons of having a 'cynical and/or 'toughened' attitude. It was exemplified by one police surgeon who described a rape complainant as 'going into the sexual episode' with her 'eyes and legs wide open'. Worryingly, these authors reflected that, since the questionnaire was skewed towards more experienced police surgeons, the results might 'reflect a stance that is *more* sympathetic to the complainant in contrast to that of the majority of police surgeons'.[45]

Indeed, heightened skepticism of rape complainants is enshrined at the very heart of both law and medicine. In common law, the 'cautionary instruction' was introduced by Lord Chief Justice Matthew Hale in the seventeenth century. It entailed the judge informing the jury that rape is a charge easily made by the accuser and yet difficult for any defendant to disprove. This was what the (fictive) judge in Weldon's play was doing when he warned that 'women lie', which is why jurors needed to ensure that there was 'corroborative' evidence.

It was also explicitly taught to physicians in textbooks of medical jurisprudence. From the first decade of the nineteenth century, when texts in medical jurisprudence started being published in large numbers, it was standard to warn police surgeons about the propensity of women to lie about rape.[46] This persisted well into the late-twentieth century.

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[45] Geis, Wright, and Geis, 'Police Surgeons and Rape: A Questionnaire Survey', 56-66. Emphasis is mine.

[46] For instance, see Michael Ryan, *A Manual of Medical Jurisprudence* (London: Renshaw and Rush, 1831), 188.

For instance, in 1969 the Association of Police Surgeons of Great Britain published an instruction manual entitled *The Practical Police Surgeon*, which emphasized that complaints of rape were 'in some instances unjustly made or made for the purpose of blackmail'.[47] In the 1978 edition of the same manual, Stanley Herbert Burges (President of the Association) encouraged a 'formal but humane' approach to complainants, not only because the 'innocent victim' would 'recognize sympathy' but also because 'the perjurer, sensing expertise born of experience, may more quickly give an honest statement'. Burges explained that 'many allegations of sexual assault' were 'based upon the perjured evidence of an amoral accuser' who sought to establish 'an alibi to appease parents, husband or lover'. Revenge and fears of pregnancy or sexually transmitted infection also drove women to lie.[48] Similarly, in 1975, the editor of the *British Medical Journal* informed readers that there was 'no clear borderline between seduction and rape'. It was 'not uncommon' for women to have rape fantasies, the editor informed doctors, adding that although most women were able to 'differentiate between fact and fantasy', others were 'mentally disturbed'. Indeed, he continued, 'some women… seem to have invited their adventure' and 'when it is over they somehow feel cheated and claim they have been raped'.[49] Nine years later, Inspector Sandra Hood whose job it was to train female officers about sexual abuse, blandly informed

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[47] Summers, 'Sexual Offences', 151.

[48] Stanley Herbert Burges, 'Sexual Offences', in Burges with J. E. Hilton, eds, *The New Police Surgeon. A Practical Guide to Clinical Forensic Medicine* (London: Hutchinson Benham, 1978), 229.

[49] 'Victims of Rape', editorial, *British Medical Journal* (25 January 1975), 172.

a meeting of police surgeons that 'the female of the species can often be a devious creature'.[50]

Institutionalized distrust meant that the entirety of a complainant's life and comportment had to be meticulously scrutinized. In 1975, the Heilbron Committee on the reform of rape law had concluded that the private sexual history of the complainant was irrelevant to the facts of the case. However, throughout the 1970s and 1980s, the Association of Police Surgeons of Great Britain continued to insist that a woman's history of sexual liaisons was crucial to their assessment of her veracity. Key indicators were virginity and decorum. As one victim recalled in 1982, she was examined at the police station by 'a large bullying woman' who, after insinuating that she hadn't resisted sufficiently, exclaimed: 'Well, it's not been the first time, is it'.[51] Alcohol also undermined belief in a woman's accusation. As late as 1996, the President of the Section of Forensic Medicine at the Royal Society of Medicine even joked that the 'seductresses' in Sue Lees' book *Carnal Knowledge. Rape on Trial* must have 'had their lustful appetites enhanced by alcohol!'[52] The 'seductresses' he was referring to were victims of sexual assault.

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[50] Inspector Sandra Hood, 'The Role of the Police in the Investigation of Sexual Assault', *The Police Surgeon* (November 1984), 34.

[51] Toner, *The Facts of Rape*, 176 (1977 ed.: 135).

[52] Robin Moffat, '[Review] Carnal Knowledge. Rape on Trial. By Sue Lees and Hamish Hamilton, London', *Journal of Clinical Forensic Medicine*, 3 (1996), 152.

The crucial question facing police surgeons was: how could they know if a woman or child had 'really' been sexually assaulted or raped? 'Corroboration' was required. Without exception, police surgeons prioritized bodily injury. In the words of their textbook *The Practical Police Surgeon* (1969), the 'resistance of the female must be total and maintained to the end, or until such time as further resistance is impossible'. Any evidence that 'the female resisted at the commencement of the assault but later submitted is, of course, totally inadequate, unless she is in a state of stupor, unconscious or in fear of death'.[53]

There were three problems with such a statement. The first was that rape in England, Wales, Ireland, and Northern Ireland (although not Scotland until 2001) was legally defined as 'without the consent' of a person, not 'against the will'. A victim did not have to sustain wounds; she did not have to fight 'to the end'. She needed only to have refused to consent to sexual intercourse.

The second problem was that rape crisis centres and other groups seeking to help rape victims at the time were advising women that, in the case of sexual attack, it was better to submit ('however distasteful' this might be) rather than risk serious injury. This advice worried the President of the Association of Police Surgeons of Great Britain. 'What does this mean for the police surgeon', Burges asked in 1978? It meant that a 'rape victim may not show signs of violent struggle…. She may not defend herself vigorously, she may

[53] Summers, 'Sexual Offences', 150.

not be torn or bruised'.[54] The body may not yield up the signs that could be 'corroborated' by police surgeons.

The third problem was that the two main ways police surgeons were taught to 'corroborate' sexual abuse (first, by reading bodily signs and, second, by evaluating emotional states) were both critically undermined during the 1980s. The first of these – a belief that physicians could generalize from the assessment and measurement of physical marks – was catastrophically damaged during the Cleveland child abuse scandal of 1987, in which medical professionals aggressively and very publicly disagreed over the nature of the child's (and indeed, adult's) sexed body. The Cleveland scandal was one of the most public attacks on medical professionals, including police surgeons, in modern British history. Physician Raine Roberts, who had carried out hundreds of medical examinations on children suspected of having been sexually abused, was severely censured. During the governmental inquiry, she was accused of being partisan by supporting the parents of the allegedly abused children with reckless enthusiasm.

Roberts responded by criticizing some physicians, gynecologists, and social workers for misreading physiological signs. In particular, she argued that the chief sign of abuse being applied – reflex anal dilation or RAD – was misleading. She noted that she had observed signs of buggery in fewer than four per cent of the 879 children she had examined for suspected sexual abuse. How, then, was it so prevalent in Cleveland? Roberts admitted

[54] Burges, 'Sexual Offences', 231-32.

that 'anal dilatation is an odd and intriguing phenomenon for which there is no satisfactory explanation' and that it 'has many similarities to yawning', albeit 'at the opposite end of the alimentary tract'. To those people who believed that children learnt anal dilatation in response to penetration, she asked: why did 'people with anal fissure… not learn it'? And why was it 'so variable and is extinguished so quickly'? She warned against extrapolating from adult bodies – meaning: 'adult sodomites' – to children, speculating that anal dilatation may in fact 'occur more readily in the anus of the child than the adult', and perhaps was more affected by 'irritation of the anal area'. Her main position was that it 'does not aid the cause of the many sexually abused children' for 'doctors to make the diagnosis on emotional and unscientific grounds'. There was a need for much more research to 'understand the normal and abnormal anus of the child' but, meanwhile, 'the greatest caution must be observed in making a diagnosis of anal abuse without a clear and unprompted history from the child'.[55] Although Roberts' position was vindicated by the subsequent inquiry, her position as a representative of police surgeons had been significantly undermined.

Although the Cleveland scandal threw the scientific objectivity of medical professionals, including police surgeons, into crisis mode, doubts over their ability to accurately 'read' the complainants' bodies had been growing for many years before 1987. In 1978, for example, Rosemary Underhill and John Dewhurst published an article in *The Lancet* showing that, in an examination of 16 out of 28 women, physicians had been unable

[55] Raine Roberts, 'Sexual Abuse – the Final Word?', *Archives of Disease in Childhood*, 63 (1988), 446-47.

to tell whether or not they had recently engaged in sexual intercourse.[56] A year before the furore over Cleveland, Roberts could be heard being highly critical of medical evaluations of alleged child sexual abuse. She was worried that some physicians were making dogmatic statements about the anatomically correct size of the vaginal opening in young girls. She noted that some physicians were promulgating the view that four millimetres was the 'largest acceptable size of vaginal openings when measured with a tape or ruler' and that it was relatively easy to make this measurement. Both were factually untrue, Roberts insisted. She informed readers of the *British Medical Journal* that it was 'impossible' to measure hymens 'with any degree of accuracy'. She also reminded them that

> the hymen dilates and contracts quite appreciably and can vary in the same child from a pinhole to a centimetre depending on factors such as whether the child is relaxed or apprehensive, warm or cold, tired or bored.[57]

She conceded that it was often easy to scrutinize the sexual organs of abused children because they passively accepted whatever adults asked of them. However, she warned, this

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[56] Rosemary A. Underhill and John Dewhurst, 'The Doctor Cannot Always Tell. Medical Examination of the "Intact" Hymen', *The Lancet*, 311.8060 (18 February 1978), 375-76.

[57] Raine Roberts, '[Letter to the Editor] Sexual Abuse of Children in Leeds', *British Medical Journal*, 292 (7 June 1986), 1527. She is referring to data published by Hendrika B. Cantwell, 'Vaginal Inspection as it Relates to Child Sexual Abuse in Girls Under Thirteen', *Child Abuse and Neglect*, 7 (1983), 171-76.

should not lead examiners to find 'evidence when there is really no abnormality'.[58] Indeed, she argued on another occasion, some physicians were mistaking

> the vestibule for the hymenal orifice, confusing a cribriform hymen with 'lattice shaped adhesions' and identifying the urethral orifice as the hymenal orifice in a child with an imperforate hymen then going on to describe that orifice as showing hymenal tears.[59]

Roberts understood that there was a 'natural and understandable human tendency when one is confronted with a child or adult where there are concerns about abuse or assault, to wish to find evidence', especially when pressurized by the police or the social services. But the role of the medical examiner was to provide solid evidence and nothing more.[60] Roberts was caught in a bind, however: by seeking to delimit what police surgeons could or could not conclude from the examination of complainants' bodies, she was undermining their claim to exclusive and superior scientific authority. Furthermore, her critique of clinical assessments of the physiological body reiterated its constructed rather than intrinsic nature. Bodily signs – which had long been considered the 'gold standard' in the clinical 'corroboration' of sexual abuse – were flawed. In response to the lack of forensic consensus, medical examiners were forced to become much more circumspect when reporting findings.

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[58] Roberts, '[Letter to the Editor] Sexual Abuse of Children in Leeds', 1527.

[59] Roberts, 'The Trials of an Expert Witness', 629.

[60] Roberts, 'The Trials of an Expert Witness', 629.

No one wanted to find themselves publicly chastised, as Roberts had been by the Cleveland inquiry.

The second way police surgeons were taught to 'corroborate' sexual abuse – that is, the ability to accurately assess the veracity of a complaint through an evaluation of the complainant's *comportment* – was also undermined during the 1980s. Since the beginning of the nineteenth century, textbooks in medical jurisprudence had provided instruction on how to evaluate the 'demeanour' of a 'true' victim of sexual assault.[61] Mid- and late-twentieth century texts followed their predecessors. The Association of Police Surgeons' 1969 textbook advised members to ask: does the complainant show signs of 'mental shock or distress'?[62] The text *Rape: Police, and Forensic Practice* (1978) instructed physicians to note

> the method of undressing…. Is the woman a shy[,] retiring child, or is she a professional stripper? General appearance and demeanour of the victim should be noted including eccentricity of dress and use of cosmetics.[63]

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[61] See my *Rape: A History from the 1960s to the Present* (London: Virago, 2007).

[62] Summers, 'Sexual Offences', 154.

[63] *Rape: Police, and Forensic Practice* (London: Royal Commission on Criminal Procedure, 1978).

In an article entitled 'The Medical Investigation of Alleged Rape' (1974), three forensic physicians instructed police surgeons to ask whether 'the emotional attitude or affect of the patient' was 'appropriate or inappropriate to the history and physical findings?' They argued that the complainant's comportment was an important indicator for the physician since the victim would have already undergone 'extensive, pointed, and often embarrassing questioning before and after the medical examination'. This would have been a 'very traumatic and emotional ordeal' for the 'innocent victim'. Therefore, 'if the woman appears to be distraught, emotionally upset or frightened', this increased the likelihood that the rape actually happened. 'Conversely', they continued, 'a casual or almost nonchalant attitude after an alleged vicious and forcible attack might cause some doubt about the truth of the history'. Interestingly, the title of their article stresses their role as 'investigators', a policing rather than therapeutic concept.[64]

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Some police surgeons were unperturbed about the barrage of criticism about their role in investigating rape. They sought to defend themselves by reminding critics that most medical examinations took place late at night, when people were 'at a low ebb mentally'. In such circumstances, it was understandably 'difficult to remain solicitous of a perhaps

[64] Irving Root, Wendell Ogden, and Wayne Scott, 'The Medical Investigation of Alleged Rape', *Western Journal of Medicine*, 120 (April 1974), 331.

hysterical woman'.[65] As another physician complacently observed, 'much of what seems objectionable' in the medical examination of rape victims was 'done in an atmosphere of stress[,] often in the middle of the night'. In the 'cold light of day it may not look so good, but then is it not often so?'[66]

Still others attacked their critics, especially the feminists staff of rape crisis centres who they believed were 'interfering in what is seen as exclusively a police matter','rehearsing the victim in her story', and 'not encouraging' victims to 'report the rape episode to the authorities'. In the words of one surgeon, the centres were 'unfortunately' being used as 'a feminist political tool" aimed at promoting 'the general cause of women's lib'.[67] Personnel in Rape Crisis Centres were ridiculed for being unable to 'withstand vigorous cross-examination in the higher courts'.[68] They were derided for being run by untrained volunteers.[69] In the words of one critic in 1981, staff at rape crisis centres 'make a valuable contribution to the support of rape victims' but, due to their 'feminist bias', they

[65] J. W. Donnelly, '1983 — Computer Review of the Year ', *The Police Surgeon. Journal of the Association of Police Surgeons of Great Britain*, 26 (November 1984), 67.

[66] 'J.H.', 'Investigating Sexual Assault', *The Police Surgeon. Journal of the Association of Police Surgeons of Great Britain*, 25 (April 1984), 79.

[67] Geis, Wright, and Geis, 'Police Surgeons and Rape: A Questionnaire Survey', 56-66. Emphasis in last quotation is mine.

[68] Moffat, '[Review] Carnal Knowledge. Rape on Trial. By Sue Lees and Hamish Hamilton, London', 151.

[69] Duddle, 'The Need for Sexual Assault Centres in the United Kingdom', 772.

have 'sometimes leaned towards encouraging the women to reject all males and usually also have not cooperated well with the police'.[70] A review in *The Police Surgeon* in 1984 noted that arguments made in a report by the London Rape Crisis Centre were 'tendentious'. The reviewer claimed that the 'very emotions aroused, [and] the psychological reactions to [witnessing] trauma, may so altered perceptions that the picture painted of reality is distorted'. Therefore, he added, 'no place is left for dalliance' in interpersonal relationships. Admittedly, 'unwanted sexual attention is deprecated in any context' but, he queried, 'is flirtation never harmless?.... Are attitudes of male to female generally so horrific as they are portrayed here?' In the enlightened 1980s, the author continued, talk of class struggle had become 'outmoded': surely 'the constant harping on struggle between the sexes' should be seen as equally 'inappropriate'.[71]

A more trenchant counterattack included the claim that female physicians were *less* suited to the task of examining rape victims than their male colleagues. Practically, such commentators pointed out, the working hours were not conducive to family life and female doctors tended to be more sensitive to aggressive cross-examination in court.[72] The innate emotionalism of women also rendered them unfit for the job. This argument can be illustrated by correspondence in the *British Medical Journal* in 1991. Dr. Helen Murphy, a

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[70] Ibid.

[71] 'Feminist Views', *The Police Surgeon. Journal of the Association of Police Surgeons of Great Britain*, 28 (April 1984), 82. Review of the London Rape Crisis Centre, *Sexual Violence: The Reality for Women*.

[72] White, 'Police Surgeons are "Unsympathetic" to Rape Victims', 149.

London-based GP who was often summoned to examine rape victims, admitted that the job was tough. She noted that female examiners needed to have

> a supportive family life because emotionally it's very difficult. It can take me a couple of days to get over it…. You have to be kind and sympathetic, good at writing reports, and good in court: it's a tall order.[73]

It was a comment that rebounded on her and her female colleagues. In a response to her letter, Robin Moffat (President of the Section of Forensic Medicine at the Royal Society of Medicine) was caustic. He reminded doctors that the job of police surgeon was 'not for the faint hearted. It is traumatic and very demanding, requiring high skills'. What was needed was 'cool professionalism':'emotionalism' was 'misplaced and dangerous'.[74] Men only need apply.

However, the Association for Police Surgeons of Great Britain could not simply ignore these negative reports. At the very least, they recognized that they needed to reform if they were to retain their expert status as medical examiners serving *all* police needs. Working conditions were tackled and educational programmes introduced that focused on how physicians should approach rape complainants.

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[73] Dr. Helen Murphy in Ibid.

[74] Moffat, '[Letter to the Editor] Police Surgeons and Rape Victims', 713.

Police surgeons also sought to distance themselves from law enforcement agencies, renaming themselves 'Forensic Medical Examiners' (FMEs), which emphasized the medical as opposed to policing functions. In the words of Bernard Knight, writing in the *British Medical Journal*, the appellation 'police surgeon' 'strongly suggests a partisan affiliation for doctors'. Just as 'police courts' changed their name to 'magistrates' courts', so too police surgeons should be renamed. He noted that it was hardly surprising that the keenest members to change their title were based in Ulster, where physicians had strong reasons to want to distance themselves from the 'establishment'.[75]

The embrace of new technologies and techniques also emphasized the 'scientific' nature of their work, even if it led to tensions between police surgeons and scientists employed in the forensic laboratories that were being established from the 1970s.[76]

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[75] Bernard Knight, 'A Loaded Title', *British Medical Journal* (12 May 1979), 1272.

[76] 'Minutes of Chief Constable's Conference with Police Surgeons Held on Tuesday, 17 July 1979, at Police HQ, Chester', in Wellcome Library Archives and manuscripts, SA/BSM/G/1; 'Are Doctors Trained to Deal with Rape?', *British Medical Journal*, 291 (7 December 1985), 1655; I. E. Doney, 'Sexual Assault — Immediate Detection Methods — Caution Needed', *The Police Surgeon. Journal of the Association of Police Surgeons of Great Britain* (April 1985), 6-1; Frances Lewington, '[Letter to the Editor]', *The Police Surgeon. Journal of the Association of Police Surgeons of Great Britain* (April 1985), 45-6; D. J. Reade, 'Early Scientific Investigation of Sexual Assault', *The Police Surgeon. Journal of the Association of Police*

Professionalization included such things as devising and disseminating 'rape kits' in order to standardize examinations and safeguard the collection of specimens.[77] Although introduced with the aim of helping rape victims and improving detection rates of perpetrators, such reforms also increased emphasis on the mantra: 'no wound, no rape' and encouraged what was later to be dubbed the 'CSI effect'.

More positively, police surgeons increasingly (albeit reluctantly) accepted the existence of 'Rape Trauma Syndrome' (RTS). Of course, there was widespread understanding that victims (particularly children) of sexual assault suffered psychological problems in the aftermath of rape. As I argue elsewhere, in the nineteenth century, raped women were expected to claim 'insensibility' in the aftermath of an attack. Ironically, it was the 'insensible' woman who was able to speak about sexual assault and have her suffering publicly acknowledged since a woman who remained 'sensible' should have been able to resist attack.[78] In contrast to immediate 'insensibility', the *longer-term* emotional effects of rape on adult women had consistently been minimized. This changed slowly, beginning in 1970 when Sandra Sutherland and Donald J. Scherl published 'Patterns of Response Among Victims of Rape' in the *American Journal of Orthopsychiatry*. They were the first to delineate

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Surgeons of Great Britain (April 1986), 44; Dr. Hugh de la Haye Davies , cited by White, 'Police Surgeons are "Unsympathetic" to Rape Victims', 149.

[77] 'Minutes of Chief Constable's Conference with Police Surgeons Held on Tuesday, 17 July 1979, at Police HQ, Chester', in Wellcome Library Archives and manuscripts, SA/BSM/G/1.

[78] For a discussion, see my 'Sexual Violence, Bodily Pain, and Trauma: A History', *Theory, Culture and Society*, 29.3 (May 2012), 25-51.

the 'normal' and predictable psychological after-effects of rape.[79] Four years later, the *American Journal of Psychiatry* published Ann Wolbert Burgess' and Lynda Lytle Holmstrom's detailed analysis of 92 rape victims admitted to the emergency room of Boston City Hospital. Burgess and Holmstrom effectively invented a new diagnosis called RTS. They defined this syndrome as an 'acute stress reaction to a life-threatening situation'. Crucially, they regarded sufferers of RTS as 'normal'.[80]

From the early 1980s, however, British feminists, physicians, and others (including senior policemen such as Ian Blair, who subsequently went on to become the Commissioner of Police of the Metropolis, the highest ranking officer in the Metropolitan Police Service) adopted RTS, using it to criticize the fact that victims of sexual violence were not offered psychological counselling. In 1984, as a response to public outcry about the treatment of sex abuse victims (especially in the aftermath of the documentary 'A Complaint of Rape'), the Metropolitan Police commissioned a small working party chaired by Detective Chief Superintendent Thelma M. Wagstaff. One crucial result was the introduction of training on RTS within the police.[81] Despite subsequent criticism by many feminists that RTS simply

[79] Sandra Sutherland and Donald J. Scherl, 'Patterns of Response Among Victims of Rape', *American Journal of Orthopsychiatry* (1970).

[80] Ann Wolbert Burgess and Lynda Lytle Holmstrom, 'Rape Trauma Syndrome', *American Journal of Psychiatry*, 981 (1974).

[81] Thelma M. Wagstaff, 'New Initiative by the Metropolitan Police in the Investigation of Rape', *Medicine and Law*, 8 (1989), 494. Also see Davis, 'The Re-Education of Police Personnel in the Investigation of Sexual Offences', 11.

imposed a different script on victims (the ‘traumatized’ one), it had major repercussions because it provided a mechanism to explain why some victims did not comport themselves according to the ‘distress script’ understood by earlier generations of police surgeons.

In many areas there were also concerted attempts to increase the number of female medical surgeons available to examine complainants. For example, in 1983, police in Northumbria established a scheme in which GPs, paediatricians, and other medical specialists who were not formal ‘police surgeons’ were invited to examine victims of sexual assault. A room was made available in a local hospital, in order that examinations did not have to take place at the police station. Complainants were given disposable gowns and were allowed to choose whether they would be examined by a female or male doctor (most chose the former). An investigation of the scheme concluded that, ‘the most striking outcome’ was the

> large body of knowledge and skill that was developed over a short period. This shows that it is possible for doctors who are not police surgeons to learn the necessary skills for forensic examination in cases of sexual abuse if they have suitable teaching.[82]

[82] C. M. Wright, L. Duke, E. Fraser, and L. Sviland, ‘Northumbria Women’s Police Doctor Scheme: A New Approach to Examining Victims of Sexual Assault’, *British Medical Journal*, 298 (15 April 1989), 1011.

Although such experiments (as well as the Heilbron Report) reported favourably on the idea that examinations should take place in hospitals or GP's surgeries,[83] the Association of Police Surgeons were less enthusiastic. They worried that conceding that examinations should take place in hospitals or doctor's surgeries would further undercut their claim to be the experts in the examination of rape victims. The compromise was to advocate specific rape suites *within* police stations. Thus, in 1978, Stanley Herbert Burges (President of the Association of Police Surgeons of Great Britain) argued that when 'new purpose-built police station' were built, they would offer 'many advantages' to all alternatives.[84]

They were fighting a losing battle. From the 1970s, rape reformers in America and Australia had begun opening 'sexual assault centres' in general hospitals, offering physical help as well as psychological counselling to victims.[85] In November 1983, British activist Duddle visited sex assault centres in Perth, Adelaide, Melbourne, and Sydney. In these centres, which were usually linked to hospitals (especially casualty, gynaecology, and psychiatric departments), doctors were on call 24 hours a day. Duddle believed that this model would be applied in the UK. She admitted that the 'present financial situation in the NHS' meant that hospitals were unlikely to be able to 'set aside rooms exclusively for the use of such a centre'. Surely, she exclaimed, one private room could be found 'near to the

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[83] Rose Heilbron, *Report of the Advisory Group on the Law of Rape*, presented to Parliament by the Secretary of State for the Home Department (December 1975), cmd 6352, paras 193-94.

[84] Burges, 'Sexual Offences', 234.

[85] Duddle, 'The Need for Sexual Assault Centres in the United Kingdom', 771.

casualty department or the admission unit of the gynaecology department'. The 'necessities for forensic examination and for prophylaxis against sexually transmitted disease and pregnancy' could be stored in these rooms. It could be made 'available for general use at other times'. She rather optimistically urged that 'some such improvements should be possible in most areas at least until finances improve'.[86]

Finally, attempts were made to reassure victims of sexual assault that the culture of insensitivity was broken. Thus, in 1994, the Metropolitan Police issued a pamphlet entitled 'Advice for Victims of Sexual Assault'. In it, they promised to 'be kind, sensitive and courteous…. Make you as comfortable as possible.... Whenever possible, give you the choice of being examined by a female or a male doctor'.[87]

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[86] Duddle, 'The Need for Sexual Assault Centres in the United Kingdom', 771-73. In 1985, Detective Inspector Ian Blair (later, the Chief Commissioner for the Metropolitan Police Service) also visited Rape Crisis Centres in the U.S., reporting favourably on them in his influential Investigating Rape: A New Approach for Police (London: Croom Helm, 1985).

[87] Metropolitan Police, 'Advice for Victims of Sexual Assault' (London: The Metropolitan Police, 1994), in Wellcome Library, Archives and Manuscripts WM655/1994/M59a.

In conclusion, let's return to 1977. The first rape crisis centre in Britain had only recently been established when, on the evening of 22 January 1977, 2.5 million people in the UK sat down to watch Weldon's television play and discussion panel on BBC2. The play purported to represent a range of positions within British society: the conventional and the apathetic, the chauvinistic and the politically correct, the earnest reformer and the militant 'women's libber'. The play also confronted the problem of police surgeons and their failure to sympathize with victims of sexual assault.

In this article, I have argued that there are numerous structural and ideological ways to help explain why a profession devoted to care of victims of sexual violence might end up violating the oath 'Primum non nocere' ('First do no harm'). These include the recruitment of certain types of physicians, 'contagion' within an environment populated with criminals, poor facilities for medical examinations, lack of training in both forensics and the law, and the shortage of female examiners. These explanations are important and go a long way towards explaining recurrent public criticisms of the treatment of rape victims.

Today, forty years after the broadcast, it would be inconceivable for FMEs to openly sneer at rape victims or ask them if they enjoyed being assaulted. Rape victims are unlikely to be medically examined in dingy rooms next to the cells. Rape trauma is an accepted phenomenon.

Nevertheless, problems remain – largely due to the unfounded assumption of physicians as rational, forensic experts on the body, able to draw precise inferences from its signs. Clearly, cultures of disbelief have persisted; the assumption of 'no wounds, no assault' remains strong. RTS has been used to *discredit* victim statements as well as exonerate alleged perpetrators of sexual violence.

More fundamentally, however, it is problematic to imply that there has been a progression *from* lack of sympathy *to* sympathy. After all, complaints about the medical treatment of rape victims continue to be heard. Despite numerous public and governmental inquiries, in addition to the composition of formal guidelines concerning the medical examination of rape victims, major grievances about medical examinations are routine. Indeed, the *same* criticisms arise at regular intervals and, each time they do so, very similar (and often identical) solutions are proffered and implemented – only to have the criticism rear up again on another occasion. In other words, what we are seeing is a 'cycle of harm': harm-accusation-reform, followed by a pause, before the 'harm-accusation-reform' cycle recommences. Why?

Suspicion of the motives of police surgeons is excessively simplistic. Although there are many exceptions, police surgeons are generally concerned about caring for vulnerable people. Equally, it is too cynical to dismiss the reforms as half-hearted; it is lazy to argue that the public enquiries are nothing more than public relations exercises. There is no reason to

doubt the sincerity of those attempting to reform the systems. Indeed, some reformers had been victims of abuse themselves; many are fervent feminists.

Rather, to understand cultures of harm within this medical sub-discipline (that is, police or forensic medicine) we need to pay more attention to the relationship between bodies and emotions. In the course of sexual violence, the victim's sense of selfhood is appropriated and wounded by the attacker. Given the supreme importance placed (at least in western cultures) on the sexed body, this denial of the self by another person disrupts and may even destroy the connection between the victim's sense of 'me and my body'. Her language may be eradicated altogether (rape-murder) or rendered fragmented, confused, or incoherent. Whether or not she succeeds in adhering to the appropriate script – comporting herself as 'sensible' or 'insensible' (as in the nineteenth century) or as self-possessed or hysterically-possessed (viz. the RTS or PTSD script) – her voice is deconstructed through violent, social action. This presents formidable phenomenological challenges for victims and witnesses to her suffering.[88]

Less often remarked upon is the way the bodies and emotions of rape complainants and police surgeons interact. The physiological body, from which police physicians extract

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[88] For a discussion on embodiment of mind, see Maurice Merleau-Ponty, *Phenomenology of Perception*, 1st pub 1945 (London: Routledge Classics, 2002) and George Lakoff and Mark L. Johnson, *Philosophy in the Flesh: The Embodied Mind and its Challenge to Western Thought* (New York: Basic Books, 1999).

‘signs’ of abuse, is not a natural, pre-social entity. It is historically constituted and reconstituted in relationship to other people and language. This is not to deny its material reality (specifically, fluids, tissue, fat, muscle, and bone). It is to observe, however, that the wounded body that police surgeons are required to observe and assess is nevertheless accessed through language and responded to emotionally. Bodies are neither private nor individual but are fundamentally connected to other bodies, with whom they communicate. Medical languages (‘specimens’, ‘contusions’, ‘ecchymosis’, etc.) are engaged in a dialogue with the victim’s body and collaborate in the creation of the wounded body. In other words, by witnessing and examining the appropriated and wounded body of a victim of sexual violence, the police physician also ‘hurts’. The sight of *her* body, broken and wounded, is registered by *his* body. This may help explain the greater revulsion of male police surgeons to the wounded bodies of male victims. Police surgeons are *required* to develop mechanisms to minimize these kinds of wounding – at least, if they are to continue in the job. Indeed, many do not: ‘burn out’ is common. The ‘cycle of harm’ within a sub-discipline devoted to care in fundamentally about the emotionally fraught nature of bodies in interaction.

This is why, if cultures of care are to be introduced, fostered, and sustained, more attention needs to be paid to inter-relationships between the bodies and emotions of the ‘carer’ and the ‘cared for’. Rational, pragmatic reform remains crucial: environments can be improved; education, enhanced; values and practices, modified. But what remains is still that breach of personal integrity (non-consent), social propriety (cruelty and violence), and aesthetic discord (the broken body). Earlier in this article, I quoted the President of the

Section of Forensic Medicine at the Royal Society of Medicine who believed that police surgeons needed 'cool professionalism': 'emotionalism is misplaced and dangerous', he asserted.[89] Quite the opposite. Cultures of care require not the *control* of emotions but an *incitement* of them. Indeed, this is precisely why some of the most important reformers engaged in anti-rape activism in the early years of second-wave feminism were successful in improving the lives of victims/survivors. They immersed themselves in the pain of victims, embraced that pain, and turned it into anger and political activism.

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[89] Moffat, '[Letter to the Editor] Police Surgeons and Rape Victims', 713.