Sexual assault : The role of the examining doctor

A critique of the management of rape and sexual assault in women and girl children

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On September 21, 1997, an unnamed deaf-mute thirteen year old girl with the label Billa Number 3 1 was allegedly raped by an employee of the organisation managing the Observation Home for Children in Umerkhadi, Mumbai. A fact-findinga team appointed by the Forum against Child Sexual Exploitation investigated aspects of the case including the medical procedure followed immediately after the crime was discovered.

Following an order by the Superintendent of the Observation Home the honorary doctor examined the victim and recorded the clinical findings in four lines. This medical record was inconclusive simply because it was incomplete. To start with, there was no record of a history taken by the doctor nor was a call sent out for an expert interpreter considering that the girl was not only deaf-mute, she had no sign language. Other than sealing the clothes she was wearing, no forensic specimens were taken, nor were any investigations ordered. Records showed that there was no attempt to re-examine the girl for developing signs of injuries and infection after an interval of a few days. The doctor failed to offer first-contact counselling or treatment for the psycho-social trauma caused to the confused child. There is no record of whether she was offered the prophylaxis for pregnancy and STD. Lastly and most importantly, the assailant who was on the premises at the time was not examined by the doc tor.

The case of Billa number 3 1, a case of custodial sexual intercourse and clearly a cognisable criminal offence, will probably be lost for lack of methodic and lucid initial medical examination of the survivor and of the accused.

A middle-aged resident of a slum in Mumbai was gang raped and physically assaulted late one night by a group of young men. When she reported to the casualty department of the nearest municipal general hospital with physical injuries she was given a cursory examination by the resident doctor who prescribed pain killers. For lack of alertness and awareness the doctor failed even to elicit the history of sexual assault, let alone proceed with a detailed examination and collection of specimens. Although she told her story to the nurse, this was not conveyed to the doctor. As a result precious evidence was lost.

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A tribal girl in a remote village, was raped by a police constable at the police station where she had been called along with her husband for interrogation (2). The medical examination made 20 hours after the incident revealed no injury on her person, only an old tear of the hymen. Based on the medical findings, the Supreme Court held that sexual intercourse in this case did not amount to rape. Later after much public protest the case was reviewed and it was recognised that this was a case of criminal custodial sexual intercourse.

In another the case [illegible] girl from Gujarat, the medical examination was conducted and recorded in such a way that the doctors shielded the policemen and issued false certificates.

We have examined the records of a number of cases and found that beside recording obvious signs of injuries and opining on the state of the hymen and the laxity of the vaginal walls, there are no detailed notes available. Examinations are at best cursory and only a limited number of specimens are collected for forensic analysis. Doctors take on the duty of forensic examination, neglecting the psychosocial and physical impact on the woman or girl. The doctor-patient relationship is ignored and sadly, ethics are forgotten.

When forensic specialists are available the examination is likely to be more detailed and the notes comprehensive. But how many women in India who are violated in this manner have the benefit of a doctor trained in the methods of examination of sexual assault, collection of specimens, production of neatly written records and expert appearances in court? It is true that in our country specialists are available in the cities. But we have seen (ibid.) that even in a city which has a fair share of forensic scientists and gynaecologists, women may be examined by doctors with no training or apprenticeship in the methods to be followed in these difficult cases. Further, what of the hundreds of sexually assaulted women and girl children in remote rural areas who are dependent for their examination and treatment on doctors with no specialisation whatsoever? What is the level of training of fresh medical graduates?

More than merely a criminal justice issue, rape and sexual assault are now [illegible] as an issue of health

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and human rights (4). Women who have been sexually assaulted experience "the threat of physical injury and death, threats to their sexual integrity, their personal control, their worthiness as human beings and to their confidence and trust in others" (5). More often than not the first person that violated women and girls meet is the doctor; the doctor's management of the case is crucial to the way that they recover and the course that the case takes in court.

The scale of the problem

In 1995 there were 13,754 cases of rape reported from all over India. Almost one-third of this number were minor girls, 747 of them being below the age of 10 years. In the same year 28,475 cases of molestation were reported.

But the reported cases are only the tip of the iceberg. In a country like ours where great value is placed on virginity the reporting of cases is speculated to be much lower than actual incidence. Statistics show that the conviction rates of completed trials for rape are 30.5 %. Although no study has been conducted into the conviction rates of sexual offences, a high value is placed on a thorough and lucid report of the medical examination conducted soon after the crime. Initial medical examination and collection of forensic evidence is important because of the ethereal nature of evidences. Medical evidence is the most important component of evidentiary material that is considered in a prosecution for rape (7).

Often, due to incomplete records and unnecessary comments, medical information is misused by law enforcing agencies and in the courts. This leads to secondary victimisation of the woman, compounding the psycho-social impact of the event.

The textbook attitudes

We will now proceed to highlight the attitudes and discrepancies reflected in the standard textbooks of forensic medicine (8) from which the undergraduate learns and to which the novice refers.

There is a preoccupation with virginity. One forensic textbook shows sketches of no less than 15 different types of hymen. There is no doubt that in the examination of a sexually abused girl child or a woman with no previous sexual experience, findings in relation to the hymen are important. But these are never isolated findings and they must be corroborated with other clinical findings of the genitalia. Specialists are inclined to use measuring cones or hymenoscopes to judge the size of the hymeneal opening. The result is that in every case of rape and sexual assault, a description of the hymen is recorded, even in the case of women who have borne several children. This seems to have been interpreted as the key to examination. In many instances, not much else is mentioned, as in the case of Billa number 31. Only one textbook (8) states that with regard to sexual intercourse, full penetration is not necessary and rupture of the hymen is irrelevant. Definite findings in the hymen should be recorded, such as signs of recent injury to the hymen such as bleeding, tearing and oedema.

The text usually goes on to advise the 'finger test' to distinguish between virgins and sexually habituated women. Some even urge the examiner to mention the findings in women who masturbate. "It is absolutely necessary to note the distensibility of the vaginal orifice in the number of fingers passing through the vagina without any difficulty," one author advises.

We argue that virginity or the lack of it need have no bearing on the case of a sexually assaulted woman. In fact these findings are misinterpreted in the courts and invariably used to humiliate the woman and discredit her evidence. Some textbooks warn against false allegations of sexual assault. Others assume that every charge made by a woman should be treated with suspicion. Secondary victimisation originating from such attitudes and comments is one of the reasons why women are reluctant to report cases of rape and abuse.

Another problem with the procedure lies in the matter of consent and willingness. It has been written that it is necessary to prove that the resistance offered by the woman was up to her utmost capability, and that every means such as shouting, crying, biting and beating had been tried to prevent successful completion of the act. The majority of cases of sexual abuse are perpetrated by relatives and persons known to minor girls within their homes. A study of rape cases in New Delhi in 1996 showed that 89% of the assailants were relatives, friends or neighbours (9).

In a section on medico-legal questions, one author poses the question: Can a healthy female be violated against her will? The assumption is that a working class woman will succeed in frustrating the attempts at violation while a woman belonging to middle or rich class will be rendered powerless from fright or exhaustion. No matter what socio-economic class a woman belongs to, she is not conditioned to react in an aggressive or loud manner, especially when the attack takes place inside the home by men who are powerful in the household or community. How, then, can one expect to prove, in a medico-legal record, that she did her utmost to resist an attempt at assault?

Further, there appears to be a misunderstanding with terms defined in textbooks and the same interpreted in the Courts. Penetration, it is explained, is sufficient to constitute the offence of rape. The text goes on to clarify that the slightest penetration of the penis with the vulva, such as minimal passage of the glans between the labia, is sufficient to constitute sexual intercourse. One author writes that full erection, intermission (sic) and ejaculation are not essential. However, experience in our courts shows that this definition is not accepted as evidence

of sexual intercourse. There is insistence on proof of complete penile penetration to charge for the crime of rape. Anything less is termed indecent assault.

There are records of cases where minor girls have been penetrated with fingers or objects which have resulted in severe injuries to the internal genitalia. The examination of a girl child is a delicate task, beginning with eliciting the history to the examination of the genitalia. Only one author mentions the necessity of application of local anaesthetic and the need to take a decision of examining the child under light anaesthesia.

Contradictory statements regarding potency of the assailant have been noted in the text. Whereas authors of all the textbooks state that erection, penetration and ejaculation are not necessary to prove sexual intercourse, there is an emphasis on the potency of the assailant. Is the accused physically capable to perform the act? While questioning the usefulness of this test, it is pointed out that none of the textbooks guide the doctor on how to go about establishing the man's potency.

Lastly, let us consider the welfare of the patient as the over-riding consideration for the doctor. In certain circumstances, medical evidence may go against a case. In this situation it is preferable to depend on the statement of the woman and the circumstantial evidence. Nowhere is it mentioned in textbooks published in this country that the examining doctor should make an assessment of the case and advise the woman or the guardian of the girl child whether to take up and follow through with legal action.

Only a brief mention is made of the need to recognise the psycho-social impact of sexual assault and the need to treat the immediate and long term medical and psychological needs of the woman.

The role of the doctor

Considering the human rights and health aspects there is a need to clearly define the role of the doctor in a case of sexual assault. As we have pointed out earlier the doctor is the first safe contact in most cases. Experts in forensic medicine have argued that in cases of criminal offences, in examining the victim and the offender, the doctor acts on behalf of the state (10) . There is a need to emphasise here that the doctor is primarily a carer. The doctor-patient relationship, medical ethics experts point out, over-rules all else and must be maintained in the best interests of the patient.

There are three well defined roles a doctor must perform. First and most importantly, the doctor must offer medical curative treatment, primary level counselling and referral for physical and psychological sequelae of the assault. For the traumatised woman it is most important for the doctor to believe her story and to offer comfort. Second, doctors can provide important evidence of the crime and help judges understand the physical and mental condition of the woman. Last, reports produced by doctors can serve to corroborate the woman's story and enhance her credibility (11).

While a doctor has a special role in collecting forensic evidence and later being able to give that evidence in court, he/she is expected to treat the victim with kindness. Until everyone who works with victims can relate to the deep emotional pain and vulnerability and fear that results from rape, we won't have victims well cared for(12).

The patient must come first

It is true that in the preparation of medico-legal reports doctors have a public duty to perform. However, in carrying out this duty, medical ethics suggest that the mental and physical health of the patient should be the over-riding consideration. The doctor-patient relationship dominates and informs every decision the doctor takes in regard to the survivor. Forensic scientists claim that in a situation where a doctor is completing a medico-legal investigation the woman is not regarded as a patient. We differ from this view, holding that the woman remains the patient just as the doctor remains the carer. A doctor ought to act only in the patient's best interests when proceeding with the investigation. Any information such as irrelevant past sexual history or physical findings suggestive of active sexual activity should be given with the utmost caution.

Besides the more obvious sexually transmitted disease and fear of pregnancy as a result of rape, it is now well recognised that there is acute and long-term psycho-social trauma inflicted on the woman. A doctor may not abandon the patient after the medico-legal investigation without ensuring that medical care of these condition is handed over to someone competent. Long term care of the psycho-social impact of the incident must be ensured.

A doctor must act independently or in collaboration with other doctors and not be dictated to or influenced by political or administrative doctrines or pressure.

The Declaration of Geneva, amended by the World Medical Association in 1983, clearly states, "The health of my patients will be my first consideration. I will not permit considerations of religion, nationality, race, politics or social standing to intervene between my duty and my patients."

Conclusion

The examination of a survivor of sexual assault is at the best of times a difficult and thankless task for the doctor. Experience and training is often inadequate and the conditions for examination are difficult. Textbooks on forensic medicine appear to be an inadequate guide for the novice;.

In remote rural and tribal areas there may be no proper examination table, no gloves, no female attendant and no vaginal speculum let alone sterile

syringes and swabs for collecting specimens. More often than not, torches used for illumination during examination are either found without cells or there is simply no electricity. Policemen hover around the scene of examination. In many instances, particularly in gang rape, powerful members from the assailants side apply pressure on the doctor to change statements. These are difficult situations.

The problems faced by survivors, their families and supporting agencies have been identified by women's activists and advocates since the mid-1980s. A report written in 1990 by the investigating team on the rape of a woman in Mumbai (13) recommends that a manual be prepared, providing clinical guidelines for examining, history taking, diagnosing and treating women victims. This should be prepared by authorities with the help of a committee consisting of women doctors, and representatives of women's organisations which have consistently defended women's rights. Shally Prasad's study (1996) of thirty survivors of violence against women recommends that the Indian Medical Association upgrade rape protocol, implement comprehensive treatment and long-term care of survivors, implement training for students and doctors and establish a central bureau of forensic experts in public hospitals.

Most rape and sexual assault cases are examined and treated not by the experienced consultant but by doctors who have little or no teaching and must depend on archaic procedures and ideas reflected in the textbooks used in the undergraduate medical curriculum.

Apurba Nandy, in the introduction to his popular 'Principles of Forensic Medicine' writes, "It is unfortunate that, in our country medico-legal investigations are much behind the standard followed in developed countries. The educational, administrative and legal machinery's and the anomalous and pathological social psychology, all have contributed to the retarded growth of this highly sophisticated technical discipline in our country. We are contended (sic) and proud with our borrowed knowledge. We must come out of the limitations of the practical applications of our theoretical knowledge if we desire to improve the standard of service in our country."

References

1 Kulkarni S, Jesani A and D'souza L: Investigation Report: Sexual Assault of a deaf-mute juvenile in the Observation Home, Umerkhadi on September 21st, 1997. FACSE. 1997.

2 Mathura Rape case. SC 185, AIR 1979.

3 Amnesty International: Allegations of rape by police: the case of a tribal woman in Gujarat, Guntaben. Amnesty International, London (AI index 20/04/88). March 1988.

4 Koss M P, Heise LL and Russo N: The Global Health Burden of Rape. *Psychology of Women Quarterly*. 18.1994.

5 Sohlberg D: Care and rehabilitation of rape, torture and other severe traumas of war in the republic of ex-Yugoslavia. 1993.

6 The National Crime Research Bureau, Ministry of Home Affairs, India.1997.

7 The offence of rape and certain medico-legal aspects: A study by P. M. Bakshi. National Commission for Women.1994.

8 * Reddy KSN: The essentials of forensic medicine and toxicology. Sixteenth edition.1997. * Nandy A: Principles of forensic medicine. 1995. * Modi: Modi's medical jurisprudence and toxicology. 21st edition. 1988. * Knight B (editor): Simpson's forensic medicine. 11th edition. 1993.

9 Deol KS: IPS. Unpublished study. New Delhi. 1996.

10 See notes on Workshop sexual assault of women and girl children: Collection of medical and forensic evidence. CEHAT. Unpublished 1998.

11 Medical testimony in victims of torture. Physicians for Human Rights. 1991.

12 Standardising the approach to rape in the EU. *The Lancet*. 1998; 351(9096)

13 Jogeshwari rape case: A report by the investigating team. CEHAT and YUVA. Mumbai. 1990.

A 1995 survey of 743 doctors by the Indian Medical Association found...

71.1% had come across a case of torture or suspected torture in their medical practice. • Of these, only **23.8%** said the case was brought by the police. • **15.7%** were witness to the infliction of torture. • **18.2%** knew of a health professional who knowingly participated in torture. • Only **18.2%** knew where to report suspected cases of torture. • **57.5%** felt coercive techniques could be justified to elicit information from uncooperative suspects. • **58.3%** thought manhandling durng interrogation was unavoidable. • **36.7%** said solitary confinement was not torture. • **49.3%** justified forcible feeding of hunger strikers. • **54.8%** felt it was acceptable for physicians to help restrain a prisoner. • **49.7%** found nothing wrong or unethical in doctors remaining present during the process of execution by hanging. • Interestingly, only **14.5%** felt torture victims need not receive the same level of health care as everybody else. • And **90.6%** felt torture victims had the right to choose their own physicians. • **89.4%** felt physicians had an ethical duty to prevent the practice of torture. • **10.4%** felt physicians were justified to issue false medical certificates and falsify autopsy reports in certain circumstances. (pressure on the physicians?) • **4.6%** had participated in torture by administering drugs to facilitate interrogation • **6.3%** had withheld treatment • **8.2%** had given treatment without consent.