EDITORIAL

Moving from evidence to care: ethical responsibility of health professionals in responding to sexual assault

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The brutal sexual assault and subsequent death, due to severe injuries, of a young health professional in Delhi have triggered off outrage and unprecedented mass protests across the country. Angry protesters have demanded the death penalty for those who committed this heinous rape and murder; there have also been demands for more severe punishment for rape, including chemical castration. The protestors, mostly young students, have called for better policing, investigation and prosecution. The state has responded with promises to make the law stringent and to make sure the offenders are not let off. The government has also set up a commission inviting civil society to suggest reforms in the rape law and the criminal justice system.

The discussions have also highlighted biases within the healthcare, police and judicial systems. Health professionals and health systems have a critical role in caring for survivors of sexual assault, as well as in documenting the assault and collecting relevant evidence. However, there are several gaps in the provision of care as well as in the medico-legal response. Often the health professional's medico-legal role is given precedence over that of care, and there have been several instances where immediate treatment was not provided for infections, pain, pregnancy prophylaxis and so on. Medico-legal practice is also plagued with insensitive and unscientific procedures. There is a need to change this and create an enabling environment for survivors where they can speak out about abuse without fear of being blamed, where they can receive empathetic support in their struggle for justice and rebuild their lives after the assault.

The problem

Sexual assault is one of the most pervasive forms of gender-based violence in India and may occur at home, in the workplace or in the community. Reliable data on its prevalence are marred by underreporting due to stigma, shame, complacency and complicity of the state, especially in state-sponsored pogroms and during armed conflict. There is a wide gap between the data from the National Crime Records Bureau (reported cases of sexual assault) and surveys conducted on prevalence of sexual violence. 24,206 cases of rape and 42,968 cases of molestation were reported, as per NCRB 2011. As per National Family Health Survey - III, 10 per cent of women surveyed reported sexual violence. But other surveys report much high rates. Kacker et al stated that 53 per cent of children surveyed reported sexual abuse. Patel et al reported it to be 30% (1,2). Civil rights groups and women's groups such as the People's Union For Civil Liberties (PUCL) and the International Initiative for Justice in Gujarat (IIJG), in particular have, over the years, extensively documented the nature and extent of sexual assault during communal and caste violence, wars and conflict situations. This has also been done by official commissions such as the National Tribunal on Kandhamal, the Nanavati Commission on the 2002 Gujarat riots, and the Srikrishna Commission probe into the Mumbai riots of 1992-93. However, official documentation of sexual crimes perpetrated during such state violence is weak. For example, an investigation conducted by the Medico Friend Circle in 2002 found that women who reached doctors or were treated in health camps did not report sexual assault at all. They would not show up in the official figures.

However, the conviction rate for charges of sexual assault is as low as 25 per cent, which offers impunity to the rapists as most go scot-free. The work done by researchers and activists suggests that this low conviction rate is due to the existing provisions in law: the restricted definition of rape that excludes non peno-vaginal penetration, the fact that the onus of proving that the act was 'against her will" or without her consent is on the victim, shoddy investigation and prosecution, and lastly the gender bias and attitudes entrenched in the police, health and judicial systems. Sexual assault is the only crime where the person who is reporting a crime has to prove that the crime occurred.

Current response to rape: causes of concern

In cases of rape, the medical evidence forms a crucial part of the investigation process. Under criminal law, the role of medical professionals in medical evidence collection and documentation is clearly mandated. But the entire procedure is fraught with lack of uniformity, with medieval biases against women, and with unscientific practices which then act as a barrier in the survivor's struggle for justice. Forensic science textbooks continue to perpetuate biases against women such as "a well built woman cannot be raped", "most cases are false", and "a working class woman cannot be raped as she can offer resistance" and so on. One forensic textbook devotes several pages to the different types of hymen. There are gaps in the theory and practice of forensic medicine,

as changes in the law have not been included. Doctors have stated that they don't have the necessary skills to conduct medico-legal examinations (3-5). The current procedure lays undue emphasis on injury documentation that looks for signs of physical resistance on the victim's body, examination of hymen, assessment of virginity, and the "two finger test" to determine the size and laxity of the vaginal opening (6, 7).

Doctors' focus is on evidence through collection of swabs to find residuals of intercourse. So they mindlessly collect vaginal, oral and anal swabs. The dynamics of sexual abuse, such as the nature of the assault (penetrative/ non penetrative, vaginal/anal/oral intercourse), activities undertaken after the incident, use of verbal threats/intimidation, do not inform this exercise. The swabs taken for evidence will test positive only if there has been forced peno-vaginal intercourse with ejaculation. If the woman has bathed, urinated, used a douche or washed herself – which is often the immediate response to overcome the humiliation – such evidence is not likely to be found. If a condom has been used or ejaculation has taken place outside the body, then body swabs may not provide evidence. There could be a delay in reporting the crime, and further delay in reaching a health facility. If these important facts are not accurately noted in the medico-legal form, negative findings may go against the survivor.

Observations on the virginity of the survivor and her past sexual conduct are routinely made through comments on the status of the hymen and size of the vaginal opening. This is contrary to scientific evidence that the presence of an intact hymen does not rule out sexual assault, and the fact of a torn hymen does not prove previous sexual intercourse, as the hymen may be torn due to other activities like cycling, horse-riding, masturbation, etc. In the standard medico-legal examination, the size of the vaginal opening is determined through the "two finger test" to ascertain past sexual activity and remarks are made about whether or not the survivor is "habituated" to sexual intercourse. Despite court judgments and changes in the Evidence Act stating that past sexual history has no bearing on the current episode of sexual assault, the past sexual conduct of the survivor continues to form an important part of a doctor's conclusion (8). These are still used during court trials to raise doubts about the survivor's character, and thus question the veracity of her statements.

The current rape law puts the onus on the survivor to prove that rape occurred against her will/without her consent. Her statement is not enough. In order to prove this, she is examined for bodily injuries. The assumption is that if it was against her will, she would have offered resistance and therefore signs of resistance/struggle should appear on her body in the form of injuries and that this has to be ascertained through the medical examination. However, several sexual assaults take place with the use of lubricants or threats to harm the survivor or in situations where the survivor is rendered unconscious or intoxicated. She may be too scared, numbed, to put up resistance, and in such instances there may be no injuries on the body. Mucosal injuries like those in genital areas also tend to heal fast. Only one third of survivors of sexual assault reporting to health facilities are likely to have any injuries (9). The intervention data of the Centre for Enquiry into Health and Allied Themes (CEHAT) project indicates that 60 per cent of the survivors reported no genital injury and 81 per cent had no bodily injury (7). Therefore, the woman's history as recorded by the doctor must be taken as evidence.

It has been observed during court trials that there is limited understanding of the medical evidence among public prosecutors and judges (10). Often negative medical evidence is interpreted in favour of the accused. Doctors therefore need to provide a rationale for why injuries were *not* present, whether it was delay in reporting, or the use of threats, or being rendered intoxicated and so on.

The Indian Penal Code defines rape as forced peno-vaginal sexual intercourse, thus excluding several other forms of sexual assault such as forced penetration by fingers, objects, oral, and anal sex, masturbation as well as fondling, acts of touching which are as humiliating. It is however known that large numbers of survivors report non-penile penetration. In such non penile penetration a doctor will rarely find medical evidence but if details of the sexual assault are documented meticulously in the words of the survivor, it could become an important piece of evidence (7).

In addition to the forensic role, the health profession has a duty to also provide healthcare including psychosocial care. The right to treatment must not be neglected at any cost. While this is true for survivors who report sexual assault, the health profession also has an important role in identifying abuse through screening and for this they need to be trained on the health consequences of sexual violence and be able to recognise abuse amongst patients coming to them for treatment (11).

Urgent need to move from evidence to care

Survivors also require psychosocial support and treatment, and health professionals can provide this. Sexual assault may result in pregnancy, and in sexually transmitted infections including HIV. Survivors may suffer from psychological distress, anxiety and thoughts of suicide. The role of the medical profession becomes paramount in such cases. Survivors and their families require counselling services that help them overcome the anxiety, shame and guilt that is associated with rape. They can be helped to understand rape as a severe form of physical assault, violation of bodily integrity and not loss of honour. Such interventions can reduce self-blame and enhance healing. Some services needed from health professionals are: interface with the police for filing of the complaint; responding to any other specific needs of the survivor; referring the survivor to legal counsel, and preparing her/

him to speak in court. This may ensure that the survivor does not give up the struggle, and may eventually increase reporting of sexual assault.

There is promising evidence of such awareness building from an ongoing partnership between CEHAT and the Brihan Mumbai Municipal Corporation since 2008 (11). Doctors have been trained to understand that the issue of sexual assault is not restricted to rape. Primary importance is given to the provision of comprehensive treatment for the assault, including psycho-social support and documentation. The protocols have been made gender sensitive in compliance with the World Health Organization (WHO) guidelines for medico-legal care for victims of sexual violence. The process of taking informed consent has been spelt out, and psychosocial support is being provided along with essential immediate and follow-up treatment. Over 125 survivors have been provided care through this initiative. There have been positive outcomes in the municipal health services from this intervention in terms of the following:

- Health professionals are being equipped to seek informed consent for treatment, examination, evidence collection and informing police. The survivor's right to refuse any part of the procedure is also ensured.
- Voluntary reporting has increased, evident in the fact that 50% of the survivors who come to the facility report directly to the health facility for treatment, and not as referred by the police.
- The history of the assault, including the nature of the assault, and any acts that resulted in the loss of forensic evidence, is recorded thoroughly. Aids such as dolls and body charts for eliciting history are used in the case of children. Special educators are engaged in cases of the disabled.
- Examination in these services is thorough and meticulous, and no remarks are made on the survivor's past sexual history.
- The type of evidence collected – in terms of the swabs taken – is based on the nature of the assault, which has been appreciated by the Forensic Science Laboratory as good practice.
- Doctors are able to provide a reasoned medical opinion, based on history and examination findings.
- Copies of documentation are given to all – survivor, forensic laboratory, police and hospital – which eliminates chances of tampering.

Patients receive good quality and comprehensive medical and psychological care which can cater to their diverse needs.

Courts have appreciated the documentation and it has played an important role in convictions in several cases (10).

Such initiatives need to be replicated so that ongoing support for survivors is available. The focus should be on rebuilding the lives of survivors, and should not be limited to punishment of the offender. If the state is able to create an enabling environment for healing, make investigations sensitive and prosecution quick, conviction rates are likely to increase. Such measures need to be accompanied by changes in the definition of rape.

Stumbling blocks

An effort to upscale this and change the procedures across the state is being made through an intervention petition by CEHAT, Anusandhan Trust, in a public interest litigation in Nagpur High Court (Dr Ranjana Pardhi v. Union of India, 2010) asking for a change in the protocols and procedures for examination of sexual assault in hospitals. This is in order to make such examinations gender sensitive and to establish the right to treatment for all survivors (12).

However, despite presenting scientific evidence, significant changes in law, technical opinions on the matter by the World Health Organization, expert opinions by senior forensic scientists and dialogue with health activists, lawyers and researchers, the committee appointed by the High Court to develop protocols and manuals continues to uphold the archaic biases rooted in forensic textbooks. Even after three years of rigourous engagement with the committee, its latest draft submitted to the court includes documentation of the build of the survivor, noting the presence and type of hymen and old tears to the hymen, and emphasis on the presence of injuries as signs of resistance/struggle. The perspective still focuses on the notion that the accusation may be false and does not uphold the survivor's right to healthcare. Informed consent remains a contentious issue. So deep rooted are these biases that the experts on the committee cannot appreciate the changes in law, scientific evidence and WHO guidelines which demand that the medical profession move from evidence to care in their response to sexual assault. The irony is that they still focus on injury of genitals to ascertain rape but do not acknowledge reported pain and likely infections of the genitals. To get the committee to include standard treatment guidelines into the medico-legal response was the most challenging task (12).

Way forward

The demands for severe punishment for rape must be revisited. It is the certainty of punishment and not its severity that acts as a deterrent for any crime. The proposed punishments after the current protests are the death penalty and chemical castration. While the death penalty needs to be opposed unequivocally, it is important to *also* state here that prescribing the death penalty

for rape is likely to result in increased murders of rape victims in order to destroy evidence. It will also make the investigation and prosecution more arduous and long drawn out, thus resulting in more acquittals. With regard to chemical castration which exists in several countries as punishment or treatment for sex offenders, there is no reliable evidence on its effectiveness. Second, chemical castration reinforces the myth that rape is the result of the sexual urge /desire which needs to be suppressed, when it is known to be an act of violence, an act of patriarchal power. Further, the procedure is also known to have adverse health consequences and has been noted as a cruel and inhuman punishment. Both these punishments involve doctors. They must be opposed by the medical fraternity as they amount to torture and violate the code of medical ethics.

There is a need to reflect on why justice has eluded victims of sexual assault in this country. In the current protest, we should refrain from suggesting ill-informed changes in the criminal justice policies that may serve no purpose. Instead the focus must be shifted to addressing the low conviction rates; the reasons why courts are forced to set free even the small numbers that are finally charged by the police; and the reasons why the system and society eventually collude and blame the victim for inviting this assault on herself. Beginning from such questions will make us examine the existing lacunae in police response, investigation and prosecution. Further, the bottom line in such cases is the nature of interface between the police and the health system which is crucial if survivors of sexual assault are to receive both health services and justice. Setting up services for survivors must be prioritised and the health system can play a crucial role as it has the technical expertise. Given that health professionals have a dual role –medical and forensic – in responding to survivors of sexual assault, a clear policy direction for the health system is imperative as it will lay down standard operating procedures for the care, treatment and rehabilitation of survivors of rape.

Acknowledgments: *This is based on the direct engagement with health professionals on the issue through an intervention project at CEHAT. The learning has been a collective process and I thank all my team members and consultants who have worked together on this, especially Sangeeta Rege, Sana Contractor and Jagadeesh Reddy. I thank Padmini Swaminathan, Sundari Ravindran and Amar Jesani for their feedback on the draft.*

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