

This is a pre-copyedited version of an article accepted for publication in the *Journal of the History of Sexuality* following peer review. The definitive publisher-authenticated version is available through the University of Texas Press, in the *Journal of the History of Sexuality*, 8, 3 (January 1998): 345-388

Stephen Robertson, "Signs, Marks, and Private Parts: Doctors, Legal Discourses, and Evidence of Rape in the United States, 1823-1930"

“Now, the newspaper said that a Doctor examined you and said that he didn’t think you’d been raped.” Paul Begler, a small town attorney played by James Stewart, asked this question of Laura Manion early in Otto Preminger’s 1959 film, *Anatomy of a Murder*.¹ Laura’s husband Frederick had shot and killed the man she had said raped her; Begler’s question came during an interview to gather information for Frederick’s defense. Laura Manion answered, “I don’t care what the Doctor thought, a woman doesn’t mistake these things.” And indeed, the events of Frederick Manion’s trial revealed it was a doctor, rather than a woman, who could “mistake” the fact that she had been raped. When cross-examined by Begler, the doctor not only denied ever stating that Laura Manion had not been raped, but denied even forming an opinion on the question of whether the rape had taken place. The doctor testified he had no opinion because, “It’s impossible to tell if a mature, married woman has been raped.” Even though the tests the doctor had conducted had not shown the presence of semen on Laura Manion’s person, he had to assent to Begler’s statement that, “The fact that no evidence was present in her body does not mean that she was not raped....” In sum, Begler established that the evidence produced by the doctor’s examination did not

allow for a definitive statement about whether Laura Manion had been raped.²

The uncertain nature and limited significance of medical evidence in rape trials in the mid-twentieth century accurately captured in *Anatomy of a Murder* stands in stark contrast to the situation in the early nineteenth century. Doctors in this period commonly drew conclusions about whether a woman had been raped from the results of their examinations of her body, making statements like the one the doctor in the film disavowed and disclaimed the ability to make. The knowledge claimed by nineteenth century doctors did not stop at the determination of whether a woman had been raped. Medical writings reveal that doctors also claimed the ability to determine whether an adult woman could be raped at all. In 1823, in the first American treatise on medical jurisprudence, Theodoric Beck articulated what he identified as the general medical opinion on that issue: “I am strongly inclined to doubt the probability [that] a rape can be consummated on a grown female in good health and strength.”³ While Beck’s position is typical, his qualified language is not: most doctors were certain that a conscious, healthy adult woman could not be raped. In this paper I will explore how the certainty and authority of nineteenth century doctors regarding rape became transformed into the uncertainty portrayed in *Anatomy of a Murder*.

The evolving inability of doctors to make definitive statements about rape grew out of the interaction between the discourses of medicine and the law in the course of the nineteenth century. Prior to the nineteenth century, American doctors rarely played a role in rape trials. In the eighteenth century, the examination of the body of a woman who charged rape was the province of respectable, married women from the community. Women called in doctors only when they suspected venereal disease or when an injured woman required significant treatment, cases that involved the abnormal rather than the normal body.⁴ In the early

nineteenth century, doctors sought a more formal, prominent role in the legal system as a way to perform a civic duty and advance the authority of their profession -- and make a reputation for themselves.⁵ Doctors initially envisioned this new field of professional endeavor -- medical jurisprudence -- in terms of the knowledge, skills and tests that medicine could bring to the legal process; they took little account of legal authority and legal discourse and had limited experience of the types of cases that appeared in the legal system. It is at this moment, at a remove from legal authority and legal practice, that Beck and others in the first generation of American medical jurists made their strongest statements that doctors could determine when a woman could be raped and whether she had been raped.

As doctors became a regular presence in courtrooms in the nineteenth century, they found their role shaped by “rules established, interpreted and administered by lawyers,” judicial interpretations of legal definitions and cases that contradicted the expectations generated by their theoretical knowledge.⁶ Treatises and textbooks published in the nineteenth century chart the development of an accommodation between medical knowledge and that legal discourse; my concern here is one aspect of that accommodation, the development of a “medico-legal” understanding of rape.

Legal discourse dictated the terms of the accommodation medical jurists reached with “legal realities.” The involvement of doctors in rape cases produced judicial decisions that applied legal rules of evidence to exclude or limit the authority of doctors’ testimony. In the middle decades of the nineteenth century, appellate courts began to exclude doctor’s statements about when adult women could be raped. Judges ruled that such a determination did not require any expert knowledge of the capacities of human bodies. Nineteenth century appellate courts also denied doctors the right to draw conclusions about the causes of the

signs and marks they found on the bodies of women who made charges of rape and limited doctors to descriptions of what they found and statements of the possible causes of those conditions. In taking this position, judges argued that, since the variety of possible causes for physical conditions made medical knowledge inherently uncertain, doctors did not possess the expertise the law required before a witness could offer an opinion. Judicial decisions about the authority of medical knowledge thus limited what doctors could say in rape trials and reduced the role their direct testimony played in determining the outcome of a case.

Legal discourse also narrowed the scope of the medical knowledge. Doctors came to the legal system with an understanding of rape as a physical struggle. As medical jurists gained more experience in the legal system and became more familiar with the details of legal definitions of rape, they found that legal discourse defined rape more broadly than they did. The knowledge and expertise claimed by doctors did not extend to all aspects of the legal definition of rape, so as medical jurists broadened their understanding of rape to fit the legal definition they qualified and eventually reversed their statement that a healthy adult woman could be raped and narrowed the range of situations in which they claimed to be able to determine whether a woman had been raped.

While legal discourse had effectively shaped the expression of medical knowledge in rape cases by the late nineteenth century, the role of doctors in rape cases in New York City prosecuted between 1886 and 1921 reveals that legal discourse less effectively shaped the reception of medical evidence. Outside courtrooms, working-class families and the reformers and police who enforced the law in New York City all relied on doctors to determine whether a rape had taken place. Inside courtrooms, middle-class jurors -- and, on occasion, trial judges -- did not show the same skepticism of medical evidence expressed by

appellate court judges. The authority families, reformers and jurors granted doctors flowed from the authoritative position the medical profession had begun to attain in American society and culture by the end of the century. Jurors also displayed the understanding of rape as a physical struggle that doctors had brought to the legal system -- an understanding of rape that gave a central place to the physiological capacities and bodily signs about which doctors had become the acknowledged experts.

This analysis of the transformation in the nature and role of medical evidence in rape trials in the nineteenth and early twentieth century offers a corrective to the limited existing literature on doctors and rape and adds to our understanding of nineteenth century rape law and the way legal discourse structured testimony given as part of legal processes. In common with much historical writing, the literature on doctors and rape has treated the medical profession as authoritative, homogenous and misogynist and has failed to consider both medical writings and practice.⁷ My analysis presents a more complex view of medical knowledge that explores its uncertain and contested nature and examines how legal discourse prevented doctors from managing that uncertainty inside the courtroom in the way they did outside it. The process by which medical jurists developed a “medico-legal” understanding of rape highlights a gap between ‘popular’ middle-class understandings of rape and legal definitions and a new attention in courts to threats as a form of force, a neglected element of the legal definition. A study of medical jurists’ writing about rape and medical evidence in rape trials obviously illuminates only some of the many sets of competing understandings of rape at work in nineteenth and early twentieth century rape cases, but it also has implications for scholars seeking to analyze how other participants and observers understood rape. The legal discourse with which doctors struggled to reach an accommodation also shaped the

testimony of other witnesses -- and thus warrants more attention than it has received in the work social and cultural history that relies on legal records as sources.

This article is organized into three sections. The first explores medical jurists' statement that a healthy adult woman could not be raped. This section examines the basis of that claims, the legal decisions that foreclosed their expression in court and the aspects of the legal definition that led medical jurists to reverse their position. As courts denied doctors the role of determining when an adult woman could be raped, their role in rape cases became focused on the identification and interpretation of signs of rape left on a woman's body. The second section examines medical knowledge about the signs of rape, the uncertain nature of that knowledge and the legal decisions that invoked that uncertainty to restrict doctors' testimony. The final section looks at the medical jurisprudence of rape in practice through a case study of the role of doctors in cases in Manhattan County, New York City.

“The question is frequently raised....” ⁸

As part of “the plan pursued by all systematic writers on this subject,” chapters on rape in medical jurisprudence texts addressed a series of “medico-legal questions.”⁹ The most fundamental of these questions asked whether it was possible for a healthy, adult woman to be raped. Medical jurists could pose and answer that question because of how they understood rape. The definition of rape in place throughout the United States at the beginning of the nineteenth century derived from common law and defined rape as an act of sexual intercourse by force and against a woman's will. The understanding of rape medical jurists brought to the legal system interpreted both elements of that definition in bodily terms,

conceptualizing rape as a physical struggle in which a man used more than the degree of physical force considered an intrinsic part of sexual intercourse -- used the punches and blows that characterized an assault -- and a woman demonstrated her will, her lack of consent, by physical resistance to the limit of her capacity.¹⁰ The physiological capacities of the man and woman involved in a case provided crucial evidence of whether a rape, as medical jurists understood the offense, had taken place: the man could have committed rape only if he possessed the bodily capacity to exert force in excess of the resistance that the woman had the capacity to offer. Any act of sexual intercourse that occurred in the absence of such a disparity in physiological capacity implicitly became consensual, regardless of the amount of violence the man used.

Doctors asserted a particular knowledge of physiological capacities. Amos Dean elaborated physicians' claim to expertise in his treatise on medical jurisprudence, published in 1850:

Medical men, it is true, ought, and probably do, understand much better than others, the precise extent of organic capacity, and the amount of energy and power which are capable, in any given case, of being put forth, either by way of subduing or resisting. They cannot only judge more accurately of the constitutional capacity, but they can also, better than others, appreciate the modifying effect of age, and the influence that may be supposed to be exerted by habits, situations and circumstances. More especially where one of the parties is laboring under the effects of disease, must the medical examiner be relied upon to state what influence or effect that would likely to exert upon the promptings of desire and the exertion of physical power.¹¹

Dean's qualified tone highlights the novelty of his argument. By the early nineteenth century

doctors had established themselves as experts only concerning the diseased body, as the markedly more confident tone of Dean's assertion that doctors understood the effects of disease indicates; the healthy body remained part of 'common knowledge.' But if "others" had knowledge of the capacity of healthy human bodies, Dean pronounced that doctors had a superior knowledge -- more "precise," more "accurate," more attuned to "modifying effect[s]" and "influences."

As I noted in the introduction, Theodoric Beck answered the question of whether a healthy, adult woman could be raped with the statement, "I am strongly inclined to doubt the probability [that] a rape can be consummated on a grown female in good health and strength."¹² That answer, which Beck argued represented the general medical opinion in 1823, rested on the assessment that adult women possessed an inherent physical capacity to prevent rape; consequently a woman could only be raped if something occurred to impair that capacity. As one medical jurist quoted by Beck put it, "A woman always possesses sufficient power, by drawing back her limbs, and by the force of her hands, to prevent the insertion of the penis, whilst she can keep her resolution entire."¹³ Beck described four situations or circumstances that he judged "modified" or impaired a woman's physical capacity to resist sufficiently for her to be raped: where drugs had been administered, where many men were involved, where previous violence had disabled a woman and where an extreme disproportion in strength existed.¹⁴

When Beck revised his treatise in 1838, he accepted criticism that he had spoken "too strongly and exclusively" in his answer to the question of whether an adult woman could be raped.¹⁵ The excess of Beck's original statement derived from its grounding in an abstract view of rape that relied heavily on theoretical knowledge of the body and reflected little

experience with rape as it appeared in the legal system. Beck qualified his position not in the text, but in a footnote, a fitting place for what amounted to a muted voice in medical discourse in the first half of the nineteenth century. Francis Wharton and Moreton Stilles did argue in their influential 1855 text, “that no general rule should govern our opinion on this question, but that it ought to be decided in each case according to the correspondence of the injury received with the woman’s narrative, and her character for modesty and veracity.”¹⁶ Wharton and Stilles based their argument, as they did much of their treatment of rape, on the work of the renowned German medical jurist Johann Casper; Casper qualified his denial of the possibility that an adult woman could be raped as a result of his experience with cases where “a healthy powerful woman was certainly completely violated by a single man.”¹⁷ Most early nineteenth century treatise writers, however, chose to rely on their abstract knowledge of the capacities of bodies rather than experiences that defied these abstractions, and strongly denied the possibility that a healthy adult woman could be raped.

In the middle decades of the nineteenth century, when the first cases that involved doctors began to appear in American appellate courts, judges rejected doctors’ claims to possess expert knowledge about when a healthy adult woman could be raped. Instead judges ruled that doctors could not offer their answers to this question as part of the evidence they presented at rape trials. In a representative opinion, a Massachusetts court upheld a trial judge’s refusal to allow a doctor to give an answer to the following question: “Taking a woman of the ordinary health and strength, and a man -- the male -- of relatively the same strength, seeking to have carnal knowledge of her body, is it possible for him to do so without her consent?” The court did not consider that a doctor had any “special or peculiar knowledge on the subject to which the question relates”: “The relative strength and activity

of a man and a woman struggling with each other for the mastery is a matter of common knowledge, so far as it can be known at all, and there is no reason to suppose that physicians have had experience that would enable them to judge better than others as to the probable results of a struggle of the kind testified to.”¹⁸ As a New Jersey court noted in an earlier decision, “an athlete or a mechanic could have answered [a question of “relative strength or mechanical possibility”] as well as a physician, and every man upon the jury as well as either.”¹⁹ Courts granted doctors special knowledge and expertise only in regard to the abnormal bodies -- bodies effected by “some physical injury, deformity or incapacity” -- that they implicitly considered to be the domain of medical practice.²⁰ These rulings thus reiterated the limits on the scope of medical expertise that existed in practice before the nineteenth century.

The legal system’s exclusion of doctors’ statements about when a healthy adult woman could be raped from courtrooms did not cause the authors of medical jurisprudence treatises to give up posing and answering that question. In the last quarter of the nineteenth century, after experience in the legal system and familiarity with the details of the law made clear to medical jurists that the legal definition of rape extended beyond the scenario of physical struggle on which they had relied in framing and answering the question, most treatise writers changed their answer: a healthy adult woman could be raped. Although the understanding of rape early nineteenth century medical jurists had brought to the legal system reflected the interpretation of the statute that figured most prominently in American courts, it represented only one part of the legal definition of rape. In the course of the nineteenth century doctors broadened their understanding of rape to take account of four other aspects of the legal definition: the provision that any sexual penetration, however

slight, constituted rape; the adjustment of the resistance expected of a woman according to the circumstances of the assault; the definition of threats as a form of force; and an increased age of consent.²¹ The recognition of these aspects of the legal definition of rape forced medical jurists to attach additional qualification to their denial of the possibility that a healthy adult woman could be raped.

Early nineteenth century medical jurists offered their initial answer to the question of whether a woman could be raped on the assumption that rape involved a completed act of sexual intercourse -- an act that involved emission of semen. Although the common law definitions of rape from which American courts derived their definitions appeared to require only vaginal penetration, not emission, to constitute the carnal knowledge at the heart of the offense of rape, conflicting decisions in late eighteenth century English courts made the legal definition uncertain in the early nineteenth century.²² Requiring emission conceptualized rape as a crime against male property and a potential interference with the patriarchal line of descent; requiring evidence of emission also made obtaining convictions for rape extremely difficult. Theodoric Beck and most of his early nineteenth century American colleagues in medical jurisprudence conceptualized rape differently, as an act of violence against the woman herself. That view led them to condemn the emission requirement as “objectionable” and argue that any penetration should be enough to constitute carnal knowledge.²³ Beginning in the late eighteenth century, often at the urging of doctors, courts in Pennsylvania and South Carolina and legislatures in Illinois, Indiana, Delaware and Tennessee clarified that rape did not have to involve emission. Expressing the same view of rape as an act of violence against an individual woman articulated by medical jurists, they specified instead that any penetration, however slight, constituted rape.²⁴

The clarification of the distinction between completed sexual intercourse and the carnal knowledge that constituted rape to which medical jurists had contributed led them to qualify their statements about the possibility that an adult woman could be raped. “Of the difficulty of completing the offense, in the sense which was formerly attached to the term penetration, there can be little doubt,” William Guy argued in 1845, “but as that term is now understood, the offense must be admitted to be possible, especially when there is a great disparity of strength.”²⁵ Or as J. Kost put it more simply, writing at the end of the nineteenth century, “Successful intercourse is one thing, and rape, as now defined, is another.”²⁶

Medical jurists who worked in the legal system and became familiar with the legal definition of rape found that nineteenth century courts interpreted the requirement that a woman had to resist to the utmost of her capabilities to establish her lack of consent less narrowly than they did. Beck and his contemporaries had made a woman’s resistance primarily a question of physiology, with little regard of circumstances that might diminish a woman’s ability to resist: Beck had allowed only four situations which “modified” an adult woman’s capacity to prevent a man from raping her. Many courts, in contrast, relied on circumstances rather than physiology when they interpreted a woman’s resistance and adjusted the degree of resistance required to demonstrate a lack of consent to fit the circumstances of a particular case. As a New York decision put it in 1874,

Of course, the phrase, ‘the utmost resistance,’ is a relative one; and the resistance may be more violent and prolonged by one woman than another, or in one set of attending physical circumstances than in another. In one case a woman may be surprised at the onset, and her mouth stopped so that she cannot cry out, or her arms pinioned so that she cannot use them, or her body so pressed about and upon that she cannot

struggle.²⁷

Nineteenth century courts did not interpret the resistance requirement in these terms in all cases of rape: as Susan Estrich has shown, appellate court judges employed a broad interpretation of the resistance requirement selectively, invoking it only in cases of rape involving extrinsic violence, multiple assailants, or no prior relationship, or an inappropriate relationship, between victim and defendant.²⁸ But even the selective use of this interpretation of the resistance requirement forced medical jurists further qualify their statement that a healthy adult woman could not be raped and warn doctors, as Wharton and Stilles had done, against generalizing about when an adult woman could be raped solely on the basis of theoretical knowledge of physiology.

Difficulties prosecuting cases and instances of injustices provided the ostensible explanation for why judges interpreted the resistance requirement in broad terms. Although such experiences likely played a role in shaping judicial opinion, shifts in ideas about the appropriate place and degree of male violence in sexual behavior appear to have influenced how judges viewed the resistance requirement. By the middle of the nineteenth century, medical jurists no longer mentioned the possibility, discussed by Theodoric Beck in 1823, that “violence [during a sexual act] may not have been against the will of the female.”²⁹ Instead they saw evidence of violence as clearly marking an act as rape: as Francis Ogston put it, “The marks of blows, or of struggling, or of grasping the throat, would scarcely be produced with the woman’s concurrence....”³⁰ In cases that involved extensive violence, the recognition that violence was not an element of consensual intercourse lifted some of the burden of proving the non-consensual nature of the act from a woman’s actions.

James Mohr has traced the shift in attitudes to male violence to the influence of

Enlightenment ideas: in this theory of civilization, “civilized man...‘learnt’ to single out the object of his desire...and wanted his chosen woman to desire him.” Since women wanted “to be treated with decorum and politeness,” “[t]hreat...gave way to plea, blows to language, rape to seduction.”³¹ The changing attitude toward male violence also reflected the process of class formation being undertaken by the middle-class in this period. One element of the sexuality that the middle-class created as part of this process -- as “a self-affirmation...a defense, a protection, a strengthening, and an exaltation” -- was a stress on men’s rational control of their sexual desire and sexual activity.³² Not only did that ideal of self control leave little space for violence within the realm of sexuality, it also appeared to produce a concomitant diminution in the perceived capacity of middle-class women to resist violence. Some medical jurists, for example, expected less resistance from “refined,” “carefully brought up” middle and upper class women: they argued such women were less used to “roughness” and less able to respond to it than lower class woman, who, being “more accustomed to roughness,” could “give as good as [they got] in a struggle.”³³

The interpretation of force represented the third aspect of the legal definition of rape that early nineteenth century medical jurists had failed to take into account when they stated that a healthy adult could not be raped. Where medical jurists’ understanding of rape as a physical struggle defined force narrowly as physical violence, judicial decisions also recognized taking advantage of a woman’s insanity or obtaining a woman’s consent by fraud, by giving her alcohol or by threatening her as forms of force.³⁴ It is the last of these forms of force -- the use of threats -- that had the most impact on the ability of medical jurists to claim that a healthy adult woman could not be raped. Judicial interpretations of threats as a form of force framed rape in psychological, rather than simply physiological or bodily terms. A

rape accomplished by the use of threats involved no physical struggle and could be accomplished regardless of a woman's physical capacity to prevent sexual intercourse; in the words of George Puppe, "though a man puts no hand on a woman, yet if, by the array of physical force, he so overpowers her mind that she dares not resist, he is guilty of rape."³⁵ The logic of the understanding of rape as a physical struggle on which doctors had based their claim that a woman could not be raped held that a woman's physical response flowed directly from her will: as a New York court put it, "Can the mind conceive of a woman, in possession of her faculties and powers, revoltingly unwilling that this deed should be done upon her, who would not resist so hard and so long as she was able? And if a woman, aware that it will be done unless she does resist, does not resist to the extent of her ability on the occasion, must it not be that she is not entirely reluctant?"³⁶ Only unconsciousness, according to that physiological logic, could short-circuit a woman's instinctive physical expression of her will. The legal definition of threats as a form of force interposed a woman's mental state and psychic traits between her will and her physical response and opened up a range of explanations and interpretations of a woman's behavior that medical jurists had not allowed for when they made the claim that a healthy adult woman could not be raped. Given that legal definition, medical jurists had to add a further set of circumstances to the qualifications they attached to the statement that a healthy adult woman could not be raped.

The definition of threats as a form of force did not, as many medical jurists implied, represent a change in the legal definition of rape. Common law definitions of rape interpreted threats as a form of force and that definition survived in American law. Yet there is evidence that medical jurist's portrayal of threats as a new element in the legal definition of rape reflects more than an ignorance of the law. What medical jurists identified as a

change in the law, in fact represented a change in the attention courts gave to an element of existing law. Before the last quarter of the century, the attention of American courts focused on cases that involved physical force rather than threats. Few cases in which men used threats appeared in the appellate record; the case of New York City suggests that the dearth of cases that involved threats in the appellate courts reflected their absence from lower courts. None of the cases prosecuted as rape in New York City before the Civil War identified by historians Marybeth Hamilton Arnold and Christine Stansell involved the use of threats; instead prosecutions for rape featured an emphasis on physical struggle and physical injury.³⁷ In the last quarter of the nineteenth century, when medical jurists identified an extension of the definition of force to include threats, there is an increase in the number of cases that involved threats both in the appellate record and in the New York City legal system. By the early twentieth century, most rape charges brought by adult women in Manhattan involved men who used threats and little or no physical violence.³⁸

An increased age of consent, the final aspect of the legal definition that medical jurists had to incorporate into their understanding of rape, reflected the same focus on psychology evident in the new attention to threats as a form of force, but dealt with mental capacities rather than mental states. Common law definitions of rape had included all acts of sexual intercourse with girls under the age of ten years. That definition rested on the immaturity of young girls, an immaturity that had both bodily and psychological dimensions. The age of consent, as Beck described it, recognized that “children under the age of puberty” could easily be raped because of “their want of strength” and “their ignorance of the consequences of the act.”³⁹ Early nineteenth century medical jurists took account of the common law age of consent, limiting their statement about the impossibility of rape to females who did not

‘want of strength’ -- healthy adult women. Beginning in the late 1880s, social purity reformers spearheaded a nationwide campaign that increased the age of consent from ten years to as high as eighteen years of age in some states.⁴⁰ The increased age of consent encompassed girls physically mature enough to resist, but who, according to rationale developed by proponents of the new law, lacked the psychological maturity to employ that physical capacity. In the words of Juvenile Court judge Ben Lindsay, the physical maturity of teenage girls caused them to be “physiologically awake with the desires of maturity without the intellectual restraints and sophistication of maturity. They are women with the minds of children; and for many of them, the burden and the responsibility are too much....Sex overwhelms them before their minds and their powers of restraint and judgment are mature enough to cope with it.”⁴¹ The increased age of consent thus set medical jurists’ statement that a healthy, physically mature woman could not be raped at odds with the legal definition of rape. As a result, medical jurists had to further qualify that statement with the recognition that teenage girls could be raped regardless of their physiological capacity to resist a physical assault.

The concern with psychology that underlay both the new attention to threats as form of force and the increased age of consent represented a broad cultural phenomenon at the turn of the century. The new attention to threats drew particularly on changing ideas about sexuality. The transformations collectively labeled sexual modernity by historians -- the separation of sexuality and procreation, the acknowledgment of active female sexual desire, and a new emphasis on sexual expression and satisfaction for men and women as the key to self-realization, emotional intimacy and successful marriage -- shared a new focus on the psychological states that existed in and around sexual acts.⁴² To talk about sexual behavior in

'modern' terms became "no longer a question simply of saying what was done -- the sexual act -- and how it was done; but of reconstructing, in and around the act, the thoughts that recapitulated it, the obsessions that accompanied it, the images, desires, modulations and quality of the pleasure that animated it."⁴³ The new attention to threats in rape cases mirrored this broader shift in its concern with women's psychological state rather than simply the physiological aspects of the sexual act.

The emphasis on psychology that underlay the increased age of consent came not only from sexual modernity, but also from new ideas about childhood. The rise of the child study movement in the last quarter of the nineteenth century brought to a peak attention to cognitive development as a characteristic distinguishing childhood from adulthood that had first emerged as part of the concern with biological development spurred by the Darwinian revolution. Child study pioneer G. Stanley Hall created the figure of the adolescent -- a child buffeted by the psychological storm and stress produced by the physiological transformations of puberty -- that turn of the century social reformers seized on to explain the increasingly conspicuous sexual behavior of immigrant working class girls and rationalize their treatment of those girls as children despite their physical maturity. The increased age of consent, middle-class reformers argued, protected the innocence of these girls from the threats "within and without," from predatory men and from themselves, that assailed them as a result of the failure of their parents to shelter them within the home.⁴⁴

By the last quarter of the nineteenth century, the "medico-legal" understanding that medical jurists had developed in response to their experience with the 'legal realities' of rape had added so many qualifications to their statement that a healthy adult woman could not be raped that treatise writers began to reverse their opinion. Some medical jurists, to be sure,

did continue to make heavily qualified assertions that a healthy adult woman could not be raped. Douglas Kerr, for example, held that, “For a single man to rape a woman, unless there is a very great difference in their physique, necessitates exhausting or terrifying her; the amount of resistance will vary.”⁴⁵ More typically, treatise writers conceded that the exceptions and qualifications attached to the statement that a healthy, adult woman could not be raped had become “so numerous and broad” that such a claim had become ridiculous: they had to offer a new answer to that medico-legal question.⁴⁶ As Charles Chaddock put it in 1894,

The old question whether it is possible for a single man to force a woman of good physical development, while in full possession of her sense, to submit to coitus, is quite besides the mark in cases of actual rape. Under such circumstances, though a woman might appear to be physically capable of successfully resisting the sexual approach of a man, her failure to do so would be no evidence that she had not offered all the resistance possible for her at the time.⁴⁷

By 1931, Alfred Herzog remarked in his treatise that only those who lacked “any kind of experience in medico-legal matters” could make the statement that it is “impossible” for “an adult woman, in full possession of her senses [to be] raped.”⁴⁸

The minority of medical writers who did continue to claim that a healthy adult woman could not be raped did, as Herzog imputed, lack any experience in the legal system; the persistence of the belief that a healthy adult woman could not be raped in the broader medical profession confirms that medical jurists change of opinion represented an accommodation with legal discourse rather than a shift in doctors’ understanding of rape. Charles Mapes made the most elaborate -- and widely cited -- twentieth century statement that the rape of a

healthy adult woman was impossible:

Textbooks on medical jurisprudence contain the obviously incorrect suggestion that a normal adult female while conscious may be forcibly induced to copulate against her will; whereas every physician knows that so long as consciousness and consequent physical ability to resist remain no adult female can be forcibly compelled to acquiesce, since for anatomic and physiologic reasons the male is incapable of successfully “fighting and copulating” at the same time; moreover, regardless of what may be the relative strength of the male compared to the female, so long as she remains conscious and retains the ability to preserve intimate contact of her thighs vaginal phallic intromission is a physical impossibility.⁴⁹

Mapes and the other doctors who echoed his statement approached the question of rape in purely abstract, physiological terms: the rape of an adult woman was a “physical impossibility,” precluded by her “physical ability” to keep her thighs together and the “anatomic and physiologic” obstacles that prevented a man from overcoming her resistance and completing a sexual act. His rejection of the possibility that a healthy adult woman could be raped thus rested exclusively on medical knowledge -- what “every physician knows” about anatomy and physiology. Mapes claimed no special knowledge of the legal aspects of rape and recognized no need for such knowledge: he blamed the legal training of the lawyers he assumed wrote medical jurisprudence treatises for the “obviously incorrect suggestions” in those texts.⁵⁰ His statement represented the opinion of a doctor not a medical jurist, a medical rather than a ‘medico-legal’ understanding of rape.⁵¹

Doctors could only give voice to the position taken by Mapes at a distance from the legal system. The statements in medical jurisprudence treatises more accurately reflected the

accommodation of medical knowledge to the law that had to occur in courtrooms. While the writings of Mapes and like-minded doctors suggest that physicians continued to adhere to a conceptualization of rape in physiological, bodily terms that denied the possibility that a healthy adult woman could be raped, medical jurisprudence treatises and judicial opinions make clear that in American courtrooms legal discourse silenced and marginalized those ideas. With their testimony on the possibility of rape excluded, the focus of medical jurists became the issue of whether a rape had occurred.

“There is no always in medicine.”⁵²

The practice of medical jurisprudence described and prescribed in textbooks and treatises centered on examinations of women who had made charges of rape in which doctors searched women’s bodies, both the surfaces visible to anyone and the ‘private parts’ visible only to those with sufficient expertise and ethical sanction to examine them, for certain marks and physical conditions. Medical jurists considered such marks and conditions to be physical signs of rape, bodily phenomenon whose presence they interpreted as indicating that a woman had been raped.⁵³ Statutes that required that a woman’s testimony be corroborated by other evidence before a jury could convict a man of rape created a formal role for the evidence that doctors gathered in their examinations. Judicial interpretations of the rules of evidence, however, restricted the extent to which medical evidence could fulfill the corroboration requirement. Nineteenth century courts denied doctors the right to draw conclusions about the causes of the signs and marks they found on the bodies of women who made charges of rape and thus prevented them from making a definitive statement about

whether a woman had been raped. Judges argued that the uncertain nature of medical knowledge meant that a doctor's conclusions about the causes of the conditions they found constituted only an opinion not a fact. This section first explores the nature of the evidence doctors gleaned from an examination of a woman's body and then analyzes the corroboration requirement and judicial interpretations that shaped the role that evidence played in rape trials.

Medical jurisprudence texts described two orders of signs. Authors usually began with signs of virginity. They included these discussions in the belief that doctors had to be familiar with the signs of virginity in order to be able to distinguish an 'unmarked' woman's body from a body 'marked' by sexual intercourse and rape. Doctors offered a variety of bodily phenomena as signs of virginity. The presence of an intact hymen had preeminence among these signs, but at times medical jurists also advanced a narrow vagina, labia that are large, smooth and close together, an intact flourette and small, plump and elastic breasts as indicating the virginal condition of a woman. Four groups of signs made up the second order of signs, "signs of rape": marks of violence on the genitals (an inflamed vulva, a lacerated or ruptured hymen, and a vaginal discharge), marks of violence on the body such as bruises and scratches, blood and semen stains on a woman's clothing, and the presence of venereal disease. As Fred Smith put it, "When all is said and done, however, none of [these signs] go very far towards proving rape, for they may all arise also after consent is given..."⁵⁴ The inability of medical evidence to distinguish sexual intercourse and rape -- its failure, in effect, to resolve the issue of consent -- was particularly pronounced in the early nineteenth century, when medical jurists considered physical violence to be a potential component of consensual intercourse. When medical jurists shifted to a view of physical violence as incompatible with

consensual intercourse -- a transformation discussed in the previous section -- marks of violence on a woman's body did provide one sign that distinguished rape from consensual intercourse.

If the practice of medical jurisprudence had simply been about establishing and deriving certain knowledge from the presence or absence of these physical signs, then doctors could have been the "purveyors of indisputable medical truths" that some historians have argued they claimed to be.⁵⁵ As texts described the practice of medical jurisprudence, however, the path from identifying signs to achieving certain knowledge about whether a woman had been raped or had intercourse was obstructed by the variety of meanings that these physical signs could have. Uncertainty colored both the presence and absence of signs of intercourse and rape. On the one hand, medical jurists warned that the presence of signs of rape could not always be interpreted as confirming that a woman had been raped. On the other hand, medical jurists cautioned that the absence of signs of rape could not always be interpreted as ruling out the possibility that a woman had been raped.

Uncertainty is intrinsic to medical knowledge. Kathryn Montgomery Hunter has argued that medicine is a "science of individuals": "Analysis in medicine, as in meteorology, does not always produce a firm description of fact. Variations are fine, and the object of investigation changes as it is studied; prediction, however reliable in the aggregate, is notoriously uncertain at the local or individual level." As a result, medicine is an "inexact and seldom replicable science" in which radical uncertainty is a constant.⁵⁶

Medical writers did attempt to claim more certain knowledge by arguing that the presence of a number of signs justified a doctor in giving a definitive opinion about whether a woman had lost her virginity or been raped.⁵⁷ Yet doctors rarely had the opportunity to

employ that approach: only in the case of an adult virgin -- whose body was both unmarked and mature enough to be marked -- did they consider that the full range of signs of rape could be present. Doctors argued that the immaturity of a young girl meant that a rape left fewer signs on her body: her physical immaturity meant that efforts at sexual penetration strongly marked her genitals, but left her hymen uninjured; her psychological immaturity meant she did not resist and rape consequently left her body unmarked by violence.⁵⁸ Rape left even fewer signs on the body of a sexually experienced adult woman. Doctors argued that the absence of signs of virginity, “relaxed genitals, and a vagina dilated by menstruation or frequent discharges” meant that the genitals of these women would show no signs of violence even when a rape had occurred. Marks of violence on their body would be the only signs of rape a doctor could expect to find.⁵⁹

The uncertain meaning of physical signs thus remained the preoccupation of medical jurisprudence texts and treatises. The uncertainty surrounding the presence of some signs of rape resulted from the knowledge that these signs could be attributed to more than one cause. Medical jurists recognized these signs could result from two causes other than rape or sexual intercourse: physical conditions and disease; and simulation and manufacture. The first of these sources of uncertainty applied particularly to the signs of virginity.⁶⁰ The equivocal nature of the hymen attracted particular attention in texts on medical jurisprudence. While an intact hymen constituted a sign of virginity, writers also noted that a hymen could stay intact through sexual intercourse if it had an elastic nature, deep location, or large opening.⁶¹ However equivocal a sign the presence of an intact hymen, Charles Tidy and many other medical jurists argued, “The presence of an untorn hymen in a female arrived at puberty, is undoubtedly a more certain indication of virginity than its absence is to be regarded as proof

of non-virginity.”⁶² Medical jurists also advanced congenital defect, first menstruation, surgical operations, masturbation, and in some texts even riding, dancing, leaping, and falling as causes of injuries to the hymen.⁶³

A two-edged possibility of confusion with physical conditions and disease caused medical jurists to be particularly uncertain about how to interpret the presence of a vaginal discharge in a young girl as a sign of rape. While “the inflammation arising from the irritation of connection” commonly caused a discharge that could be a sign of rape, medical jurists considered that discharges just as commonly arose spontaneously, particularly in the children of the poor, as the result of “bad diet, uncleanliness, scrofuloustaint and epidemic influences.”⁶⁴ Both the discharge produced by this condition -- called infantile leucorrhoea in the nineteenth century and vaginitis in the twentieth century -- and the discharge indicating sexual intercourse also closely resembled the discharge resulting from gonorrhoea.⁶⁵ It was not that medical jurists had no basis for diagnosing the cause of a discharge. On the one hand, discharges caused by disease, according to medical jurists, had a shorter period of incubation, were less profuse and ran their course more quickly than gonorrhoea. Discharges resulting from intercourse, on the other hand, contained blood and were accompanied by the dilation and laceration of the vagina.⁶⁶ Nineteenth century writers, however, lacked confidence in these means of diagnosis: “It should be borne in mind... that we have no diagnostic marks sufficiently certain for our guidance in arriving at a decision which shall be beyond challenge on all occasions.”⁶⁷ By the twentieth century bacteriological examinations made some medical jurists more certain they could easily determine the cause of vaginal discharges.⁶⁸ But even these examinations had their limits. Chaddock noted that only in the acute stage of gonorrhoea was its presence easily identifiable in discharges.⁶⁹

The second source of uncertainty about the presence of signs of rape came from medical jurist's recognition that some signs could be present, not as the result of a rape or another physical condition, but because the woman alleging rape or a third party had manufactured or simulated them. Medical jurists applied this argument particularly to marks of violence on the body and on the genitals and to blood stains. "[I]t must be remembered," Ralph Webster warned in 1930, "that it is a very easy matter for a woman to produce artificially and intentionally such appearances of injury to substantiate her charge...."⁷⁰ Medical jurists urged doctors to study the position of bruises and scratches: "[C]ounterfeit signs of violence...are usually trivial in nature, and are situated on parts of the person easily accessible to her hands -- i.e., the limbs and genitals. Such self-inflicted injuries are more likely to be present as abrasions and scratches than as bruises."⁷¹

The absence of signs of rape left medical jurists as uncertain about whether a woman had been raped as the presence of those signs. The equivocal meaning of the absence of signs of rape derived from two sources: the recognition that signs could be absent as the result of the passage of time and, in texts published in the second half of the nineteenth century, the recognition that the signs could be absent as the result of the circumstances of the rape. In regard to the first source of uncertainty, medical jurists argued that the absence of physical signs of rape at the time a doctor conducted a medical examination did not mean that those signs had never been present. The marks sexual intercourse and violence left on the genitals and body remained only temporarily. Marks on the genitals "[i]n almost every instance...will have become obliterated by the third or fourth day, by which time the lacerations will have healed, the cicatrices disappeared, and the torn hymen be in such a state as to make it difficult to say whether it had been divided recently or at an earlier period."⁷²

Medical jurists' lamented that most examinations took place too late for these temporary signs to be evident. As Wharton and Stilles complained, this delay meant that it was

seldom possible for the medical examiner to make any useful note of "the marks of violence upon the person, the disorder of clothing" &c which are usually prescribed by authors. The dress has been smoothed or changed, the marks of injury have disappeared and all that remains is perhaps a suspicious stain upon a chemise *alleged* to have been worn at the time of the assault.⁷³

The aspects of the legal definition of rape discussed in the previous section -- the broad judicial interpretation of the resistance requirement, the definition of threats as a form of force and the increased age of consent -- provided the second source of uncertainty about the absence of signs of rape. These legal changes all defined as rape acts in circumstances that involved little or no physical struggle and consequently left few, if any, physical signs of rape on a woman's body. Given "the legal interpretation of the kind of force and amount of penetration necessary to constitute this crime," John Glaister argued, "it will be obvious that from the medico-legal point of view the physical signs of rape will vary in different cases, or may even be absent, although the crime has been committed."⁷⁴

Whether a doctor's examination of a woman found signs of rape or failed to find any signs, it produced little certain knowledge about whether a woman had been raped. If a doctor identified signs of rape, the possibility that those signs had been produced by a physical condition or disease, manufactured by the woman or a third party, or produced by consensual intercourse made their presence uncertain evidence that a woman had been raped. If the doctor failed to find signs of rape, the effects of the passage of time and the circumstances of the rape made this absence uncertain evidence that a woman had not been

raped.

Despite the uncertain nature of their knowledge about rape, medical jurists such as Ralph Webster still claimed that the evidence they gathered had an important role in the resolution of cases:

As the unsupported evidence of the prosecutrix has so often led to false accusations and even conviction of innocent parties, judges are coming more and more to require some corroboration of the evidence of assault and juries are more loath to convict in cases in which there is no further confirmation than the mere statements of the parents or friends of the alleged victim. The most important corroborative testimony is medical in character....⁷⁵

Webster's first claim is accurate: by the early twentieth century a significant minority of states required a woman's statement be corroborated by other evidence before a jury could convict a man of rape. Webster's second claim is more open to question: while corroboration requirements provided a role for medical evidence in rape trials, judicial interpretations of the rules of evidence, together with the nineteenth century changes to the law of rape, restricted the extent to which the testimony of doctors provided the corroboration required by law.

Common law had not required corroboration of a woman's testimony that she had been raped: if a jury "cautiously scrutinized" a woman's testimony, considered "[t]he manner in which she testifies, the consistency of her testimony" and whether the surrounding circumstances supported her account, and "are satisfied of the truth of her evidence," her testimony "was alone sufficient evidence to support a conviction."⁷⁶ John Wigmore, the leading authority on American laws of evidence, did not consider a law requiring

corroboration to be necessary. He argued such a law probably had little influence upon jurors' minds and that its purpose could be attained by the judge's power to set aside verdicts where there was insufficient evidence. Despite this argument, beginning in the last quarter of the nineteenth century, a handful of states adopted such laws. Legislators argued, as medical jurists such as Webster did, that such laws protected men against false accusations. In a number of other states, judicial decisions imposed a similar corroboration requirement.⁷⁷

Judicial interpretations of these laws did not offer precise definitions of what constituted corroboration.⁷⁸ New York offers a representative example. As the New York State Law Revision Commission noted in 1937, the state's higher courts "refrained from attempting a rigid definition of what constitutes sufficient corroborating evidence."⁷⁹ The courts ruled that while the supporting evidence had to corroborate every material fact of the crime and connect the defendant to it, it did not have to be convincing or conclusive in itself to establish the commission of the crime by the defendant.⁸⁰ Corroborating evidence could be circumstantial, but the court ruled that the opportunity to commit the crime had no value as corroboration.⁸¹ Medical evidence had the potential to corroborate two of the three elements of the crime of rape: except in the case of sexually experienced women, an examination could establish whether penetration had occurred; and depending upon the circumstances of the case, an examination could provide evidence about the question of force and resistance. Doctors, in theory, could provide no evidence about the third element of the offense, the identity of the man responsible for an assault.⁸²

Judicial decisions imposed limits on doctors' ability to fulfill the potential of medical evidence to provide definitive corroboration of a woman's charge of rape. In a leading case from Wisconsin, a physician testified that his examination of the woman several days after

the alleged rape found “an aggravated inflammation of the *uterus, vagina* and other sexual organs.” The trial judge then allowed him to testify “that in his opinion such inflammation “was produced by her having connection, -- a violent not a free connection;” “that is, in substance and effect, that the inflammation was the result of the rape which had been committed upon her.” The Supreme Court ruled this testimony “clearly incompetent.” The court based this ruling on the uncertain nature of medical knowledge, noting that when cross-examined, the doctor “was constrained to admit, what any person of ordinary intelligence knows without the aid of expert testimony, that there are other causes which might have produced such inflammation.” In effect, the judges asserted that the uncertain nature of medical knowledge meant that doctors were not experts in regard to physical signs of rape. Since the law only allowed experts to offer opinions in trials, this ruling restricted doctors to testimony that described the conditions they found, stated “what effect might result from a rape” or answered questions about what might have caused the conditions they described. In excluding the opinions of doctors, higher court judges saw themselves as protecting the role of the jury: “It was for the jury to determine whether the inflammation which the witness testified to was the result of rape or some other cause.”⁸³

The very different attitude to doctors and medical knowledge outside the legal system suggests that the decision of appellate court judges to exclude the opinions of doctors derived from a concern to protect not simply the role of the jury but also the fact-finding element of the legal process. The noted legal scholar John Wigmore, for example, annotated his citation of cases that excluded the opinions of doctors in rape cases to reflect his perception that outside the legal system doctors had established their authority to draw conclusions about which of the possible causes had produced a physical condition. Wigmore described the

opinion in one case as “another of those rulings which make the medical profession jeer at the law”; he described another decision as “a piece of quibbling of the sort which accounts for the medical profession’s attitude toward the legal profession -- a sorrowful and amazed disgust.”⁸⁴ In the face of the authority granted to the opinions of doctors in the broader culture, appellate court judges could have feared that jurors would treat any conclusions offered by physicians not simply as opinions, but as facts. If juries responded to such testimony as a statement of facts, then doctors would have usurped and made redundant the fact-finding element of the trial.⁸⁵

This picture of contrasting attitudes to medical knowledge inside and outside the courtroom raises questions about how accurately judicial rulings described the role doctors played in rape cases. To what extent did doctors play a different role in rape cases outside the courtroom than they did inside it? To what extent did the legal system succeed in insulating itself from the authority granted to doctors outside courtrooms? Understanding the role doctors played in rape cases after they accommodated their claims to legal discourse thus requires an examination of practice.

“The Doctor’s story is no fiction.”⁸⁶

The case files of the Court of General Sessions and the District Attorney of Manhattan County, New York, provide a window on the role of medical evidence in practice. I examined every rape case I could identify from every fifth year beginning in 1886 and ending in 1921, a total of 610 cases. About three quarters of these case files contained only the affidavit from the Magistrates Court and the indictment from the Grand Jury. The

remaining quarter contained some additional information: briefs outlining the prosecution case, statements of witnesses, memorandums, trial transcripts and medical certificates.⁸⁷ This later group of cases provides the bulk of the evidence for my analysis of the role of doctors in rape cases. By the last quarter of the nineteenth century, doctors had established medical knowledge in an authoritative position in American society that contrasted with the limited expertise and authority that the legal system granted to medical witnesses. Outside the legal system, working-class New Yorkers and government agencies expressed their growing recognition that physicians possessed a superior understanding of the body by turning to doctors to find out the ‘truth’ about whether girls had been raped or women had had sexual intercourse. Despite the laws of evidence and judicial rulings, the increased regard for medical knowledge also seeped into courtrooms: trial judges and middle-class jurors responded to some types of medical evidence as a source of certain knowledge about a case. This section begins by describing the context for this case study of medical evidence in practice, examining New York’s rape statute, the institutions that shaped the enforcement of that statute and the nature of the cases prosecuted in Manhattan in this period. The remainder of the section then contrasts the role doctors played outside and inside the legal system.

The codification of New York State law in 1881 amended the state’s rape statute to create a broad definition of the offense that, “...expressly include[d] the various instances which have been adjudged to constitute the offense, with some others which have been held not to fall within the limited definition of the common law authorities, but to which the same penalties ought to be extended.”⁸⁸ The statute defined rape as

...an act of sexual intercourse with a female not the wife of the perpetrator, committed against her will or without her consent. A person who perpetrates such an

act,

1. When the female is under the age of ten years, or
2. When through idiocy, imbecility or any unsoundness of mind, either temporary or permanent, she is incapable of giving consent; or,
3. When her resistance is forcibly overcome; or,
4. When her resistance is prevented by fear of immediate and great bodily harm, which she has reasonable cause to believe will be inflicted upon her; or,
5. When her resistance is prevented by stupor, or weakness of mind produced by an intoxicating narcotic, or anesthetic agent administered by, or with the privity of the defendant; or,
6. When she is, at the time, unconscious of the nature of the act, and this is known to the defendant.

...Any penetration, however slight, is sufficient to complete the crime.⁸⁹

Two changes took place in New York law after 1881. First, in 1886, the Legislature extended the corroboration requirement in the state's seduction and abduction statutes to apply to rape.⁹⁰ Second, in a series of amendments between 1887 and 1895, the Legislature raised the age of consent to 18 years and divided the crime of rape into two degrees. Rape in the first degree replicated the existing definition except for the age of consent; sexual intercourse with a woman under the age of consent "under circumstances not amounting to rape in the first degree" became second degree rape and punishable with a sentence of not more than 10 years in prison rather than five to 20 years. Since the removal of any mention of age from the definition of first degree rape left no provision to punish "[t]he act of violence on a child of tender years," the amendment added intercourse with a female when "by reason of mental or physical weakness, or immaturity, or any bodily ailment, she does not offer resistance" to the acts defined as first degree rape.⁹¹ The impetus for the increased

age of consent came from the New York Committee for the Prevention of the State Regulation of Vice, a group that provided the organizational heart of the American social purity movement in the 1880s and 1890s.

The efforts of the New York Society for the Prevention of Cruelty to Children (NYSPCC) to make the increased age of consent more enforceable produced the division of the crime of rape into two degrees.⁹² The NYSPCC's legislative activity is only one aspect of the significant role the Society played in shaping the enforcement of rape laws in the years between 1880 and 1930. New York State law empowered the NYSPCC to work as a "component part of the city government," with powers of arrest and oversight of the prosecution of all cases involving children under the age of sixteen years. As part of its work the Society investigated, reported and ensured the prosecution of cases of sexual violence that involved children and adolescents.⁹³

The influence of the NYSPCC loomed large in Manhattan because, partly as a result of their efforts, second degree rape cases and first degree rape cases that involved young girls completely overshadowed rape cases that involved adult women in the case load of the New York City legal system. Second degree rape cases made up just over three quarters of the rape cases in my sample years after 1896; cases that involved girls aged under 12 years of age constituted between 25 and 30% of the remaining one quarter of cases prosecuted as first degree rape. The other significant characteristic of the case load of the Manhattan legal system is that, as I have already mentioned, physical force featured in very few rape cases. Most women over the age of 18 years who charged they had been raped testified that men threatened them, but used little or no physical violence. In the instance of the small number of adolescent girls who reported being physically assaulted, the District Attorney chose to

prosecute their cases as second degree rape rather than first degree rape. The District Attorney took this approach because it meant he did not have to prove that a defendant had coerced a girl, making it easier to win a conviction. Force did not constitute an element of the offense of second degree rape: the statute defined all acts of intercourse with underage girls as rape on the assumption that those girls lacked the capacity to consent. Force also did not constitute an element of child rape cases, since the first degree rape statute recognized that the “immaturity” of young girls prevented them from resisting. These characteristics of the rape cases prosecuted in Manhattan limited the medical evidence doctors could find. Most rape case would involve no signs or marks of violence, but only signs of penetration. That evidence limited the role of doctors to providing partial corroboration at most.

The success of doctors in establishing their authority and expertise in American society gave them a role in rape cases before they appeared in the legal system. By the late nineteenth century, the beliefs that underlay judicial restrictions on medical evidence seemed anachronistic. Earlier in the century judges had argued that an understanding of the body was part of the “common knowledge” possessed by “any person of ordinary intelligence”; the end of century brought a “growing recognition of the inadequacy of the unaided and uneducated senses in understanding the world.” Science and medicine had begun to assume the “privileged status in the hierarchy of belief” they would occupy throughout the twentieth century.⁹⁴ Medicine owed most of its new authority to successes in public health: breakthroughs in bacteriology in the 1860s and 1870s led to the identification of sources of infection and their modes of transmission, recognition of the importance of personal hygiene and, eventually, to vaccines and serums. The development of new diagnostic techniques enhanced the authority of doctors in areas more closely allied to the interpretation of

women's bodies in rape cases. Instruments such as the stethoscope, ophthalmoscope and laryngoscope made a doctor's examination more important in diagnosis than a patient's account of her symptoms and technologies such as microscopes and bacteriological and chemical tests gave a doctor access to information inaccessible to lay people. Although the scope of advanced medical knowledge remained relatively narrow, the dependence on doctors in the areas where they established strong claims to expertise became generalized into other areas where their claims remained less certain. Legal records reveal that in the period 1886 to 1921, although working-class New Yorkers on rare occasions still turned to female neighbors, relatives or midwives to interpret women's bodies and mothers continued to display confidence in their own interpretations of some physical conditions, New Yorkers invariably turned to doctors to confirm those interpretations and provide knowledge of conditions that they could not 'see with their own eyes.'

□Doctors' had their most prominent extra-legal role in cases that involved children and adolescent girls. Immigrant, working class parents seeking the truth about the physical condition or statements made by their daughters took them first to doctors to be examined. The NYSPCC also turned to doctors to determine whether girls in their care had had sexual intercourse. Both parents and the NYSPCC responded to the conclusions doctors drew from their examinations as definitive statements of fact and based their decisions about whether to turn to the legal system on those conclusions. When adult women charged they had been raped, the police also turned to doctors to provide facts on which they could base decisions about whether to proceed with a case, but the results of their examinations played a less decisive role. If the woman had been sexually active, a doctor's examination offered little help to the police in their efforts to decide if an offense had taken place. If the woman had

been a virgin, a medical examination functioned as it did in cases that involved children and provided facts about whether she had had sexual intercourse. Establishing that fact only represented one element of the offense in the case of adults, however, so doctors had less influence on decisions to charge rape in these cases than in the cases involving children.

In cases that involved girls under the age of twelve years, immigrant, working-class parents looked to doctors to interpret genital discharges and to help them understand girls' accounts of being assaulted. Unlike blood on a girl's underwear -- which parents confidently interpreted as a sign that a girl had been sexually assaulted -- the meaning of a discharge seemed less clear to working class parents.⁹⁵ The sister of a seven year old girl thought the discharge she had found resulted from "chafing," but was uncertain enough about her diagnosis to consult a neighbor, who thought the discharge resulted from an "attempt to wrong the child." The neighbor's alternative diagnosis led the woman to take her sister to a doctor. The doctor diagnosed the discharge as the product of venereal disease and, as happened in similar cases in my sample, urged the woman to report the case to the NYSPCC.⁹⁶ There is evidence that in other cases doctors betrayed the trust parents, particularly those not already suspicious that their daughters had been assaulted, put in their knowledge and ability to interpret a child's body. William Travis Gibb, a consulting physician for the NYSPCC, complained in 1894 that most doctors simply treated cases of vaginal discharges in children without inquiring about the causes, which they assumed to be vaginitis, thereby allowing indecent assaults on children to go unreported.⁹⁷

Parents also looked to doctors for help interpreting girls' accounts of being assaulted.⁹⁸ In these cases parents did not accept a girl's statement sufficiently to immediately report the assault to the legal authorities. They wanted a clearer picture of what had happened to the

child and the extent of her injuries than she could provide and appeared not to trust what she told them. The unreliability and lack of understanding commonly associated with childhood meant that bodily signs expressed more clearly and reliably what a man had done to a girl than her words. Parents turned to doctors as experts able to authoritatively read those signs and thereby tell them the ‘truth.’ In particular, they wanted doctors to tell them whether a girl’s hymen had been ruptured. The stress on the condition of the hymen implies that when a doctor found an intact hymen, a girl’s parents did not consider that the assault had harmed her sufficiently to report the case to the legal system.⁹⁹

In the case of adolescent girls, parents turned to doctors not only because their daughters could not provide clear answers about what had happened to them, but also because they would not provide any answers. Parents turned to doctors to confirm their suspicions that an adolescent girl had been sexually active, to establish whether a girl had lost her virginity or become pregnant and, if that proved to be the case, to prompt her to tell them how that had happened. In a case from 1911, for example, a woman visiting her sister’s family noticed the “condition” of her fourteen year old niece and became “suspicious.” She called the girl’s physical appearance to her brother-in-law’s attention and he took the girl to a doctor “for examination.” The doctor diagnosed her as five months pregnant; only then, in the doctor’s office, did the girl admit that her step-mother’s father had been forcing her to have intercourse with him.¹⁰⁰ In cases that did not involve pregnancy, doctors concluded that the presence of signs of penetration such as an inflamed vulva and ruptured hymen indicated that a girl had had sexual intercourse. Doctors’ willingness to draw conclusions made their examinations useful to parents seeking to prompt girls to admit and describe what had happened to them.¹⁰¹

The NYSPCC looked to doctors as a source of truth about girls and paralleled working class parents in their reliance on doctors' conclusions as a basis for decisions about whether to resort to the legal system. Several doctors -- "consulting physicians" -- conducted physical examinations of all the girls who came into the Society's care. NYSPCC doctors focused their examinations on a girl's genitals and the search for the signs of penetration that indicated that a girl had had sexual intercourse; they showed little concern with looking for signs that provided evidence of the circumstances in which the intercourse had taken place.¹⁰² NYSPCC officials, like working-class families, decided whether they should prosecute or dismiss a case based on the state of a girl's hymen. In a case in 1916, for example, a Brooklyn SPCC doctor examined a fifteen year old girl arrested for stealing from her employer and concluded that she had had intercourse. The girl admitted having intercourse on an East Side rooftop eleven months earlier; the man she identified as her partner also admitted the act. Yet when a more thorough medical examination by a NYSPCC doctor revealed that the girl had an intact hymen, the District Attorney discharged the man.¹⁰³

Outside the legal system, working-class New Yorkers, the NYSPCC and police thus all turned to doctors in search of certain knowledge about whether a girl had had sexual intercourse. Doctors generally offered conclusions based on their examinations of girls that families and the NYSPCC took as statements of fact and relied on when they made decisions about whether to bring charges of rape. The role doctors played outside the legal system therefore came close to the fact-finding role of the court that judicial rulings sought to protect: as a British medical jurist observed, "[t]he examining surgeon is practically a Court of First Instance as upon his report... the majority of these charges are not further proceeded with."¹⁰⁴

Inside the legal system, doctors testified in all rape cases except those in which a woman became pregnant -- pregnancy represented a 'self-evident' sign that penetration had taken place. In practice, the testimony of doctors always dealt with signs of penetration and occasionally with the presence of venereal disease. Except in a handful of cases, doctors did not testify about signs of violence or blood and semen stains. The lack of the former is to be expected given the nature of the cases in the legal system noted previously -- namely, the limited amount of physical violence in first degree rape cases and the District Attorney and NYSPCC's decision to prosecute almost all the cases that involved underage girls as second degree rape. The lack of blood and semen stains resulted from the frequent failure to conduct examinations immediately after an assault.¹⁰⁵ After 1886, the testimony of NYSPCC doctors complied with the restrictions the rules of evidence placed on medical evidence; other doctors, lacking experience giving testimony and unfamiliar with legal requirements, struggled to conform to these restrictions. Despite the uncertainty in which this approach shrouded medical evidence, jurors -- and even, on occasion, trial judges -- still treated evidence of penetration and the presence of venereal disease as establishing the fact of sexual intercourse and even as sufficient corroboration to justify a conviction for rape.

The medical evidence presented in rape cases always dealt with signs of penetration: an inflamed and excoriated vulva in the case of young girls and a ruptured hymen and dilated vagina in the case of older girls and adult women. In 1886, the first year of my sample, doctors did not always limit their testimony about penetration to descriptions of the conditions they had discovered and statements of the causes that could produce those conditions. When Cornelia Simpson, a consulting physician for the NYSPCC in several cases, found evidence of penetration, she testified that intercourse had taken place; when she

also found evidence of violence, Simpson testified that the girl had been raped.¹⁰⁶ Other doctors took different approaches to presenting their evidence. In one trial three doctors presented the results of the medical examination of the ten year old complainant in four different ways: the family doctor who conducted the initial examination certified that the girl had been raped, but testified only that an act of intercourse had taken place; a doctor called by the defense testified that the physical conditions found in the medical examination resulted from causes other than intercourse; and a police surgeon testified that the medical evidence only indicated penetration.¹⁰⁷

After 1886, doctors working for the NYSPCC consistently employed a formula in their certificates and testimony that adhered to the higher court rulings. When they presented the results of an examination of a girl's body that revealed evidence of penetration, the Society's doctors testified that they had found "signs of penetration of her genital organs by some blunt instrument."¹⁰⁸ In the words of one NYSPCC doctor, "The lay evidence must decide as to whether the blunt instrument in question was the penis of the accused."¹⁰⁹ The development of a formula that accommodated legal rules reflected the experience and specialization of NYSPCC doctors. By the 1890s the variety of doctors who conducted examinations for the NYSPCC in 1886 had dwindled to a small group of two or three who performed large numbers of examinations over the course of the subsequent decades: By 1916, William Travis Gibb, for example, had examined more than 2500 girls involved in rape cases over a 25 year period.¹¹⁰ The family doctors and emergency room doctors who testified in the minority of cases that did not involve the NYSPCC generally lacked any experience in the legal system. While these doctors generally refrained from drawing conclusions in their testimony, they did not use the formulaic language employed by

NYSPCC doctors and often struggled to clearly present the evidence they had gathered in their examinations.

The middle-class men who served on juries showed no indication that they took seriously the possibility that any ‘blunt instrument’ other than a penis produced the signs of penetration.¹¹¹ In a small number of cases defense attorneys attempted to exploit the ambiguous form of medical evidence by suggesting that masturbation had produced the signs of penetration.¹¹² Apart from those instances, defense attorneys did not contest medical evidence of penetration. Judges did ask doctors to explain to jurors the meaning of terms, such as hymen, that they used in their testimony; the concern that the medical terminology used by doctors prevented jurors from understanding the meaning of evidence of penetration that motivated judges appears, however, to be unfounded. The questions jurors asked during trials indicated a general familiarity with the terms used in testimony about penetration.¹¹³ Although no direct evidence is available on how juries responded to the testimony of doctors, in none of the cases that went to trial in my sample is the question of whether an act of intercourse had taken place an issue in the outcome. The laws of evidence notwithstanding, inside the courtroom, as outside, ordinary New Yorkers responded to a doctor’s testimony that he had found signs of penetration as a statement that a girl or woman had had sexual intercourse.

The second form of evidence doctors presented in their testimony in rape cases in Manhattan concerned the presence of venereal disease -- gonorrhea, and on rare occasions, syphilis. Almost all the cases that featured testimony about venereal disease involved prepubescent girls. By the 1880s bacteriological examinations allowed doctors to conclusively identify a discharge in a girl as the product of gonorrhea. In court, doctors

refrained from concluding, as they did outside the courtroom, that a girl had contracted this disease from an act of sexual intercourse.¹¹⁴ On occasion, defense attorneys cross-examined doctors to establish the variety of other possible ways a girl could contract gonorrhea: referring to a medical text, a defense attorney in a trial in 1891 questioned a doctor about the possibility that a girl could contract gonorrhea from sitting in a water closet or wearing the drawers of someone infected with the disease.¹¹⁵ It is the issue of whether both parties in a case had a venereal disease, rather than whether a girl had contracted the disease as the result of an act of intercourse, that shaped the role this evidence played in rape cases. In other words, venereal disease was important as evidence of the identity of the man who had intercourse with a girl, not as evidence that intercourse had taken place.

If only one party to a case suffered from a venereal disease, prosecutors and defense attorneys treated that fact as evidence that contradicted a girl's identification of her assailant. Most often this scenario occurred when a defendant claimed not to be suffering from a venereal disease found in an examination of a complainant. If a medical examination of a defendant clearly established that he was free of venereal disease, despite the variety of possible explanations for that situation, prosecutors discharged or plea-bargained the case on the presumption that jurors would infer a man's innocence from that medical evidence.¹¹⁶ Only when defense and prosecution examinations yielded ambiguous or contradictory results did cases in which an examination showed a man to be free of the venereal disease that afflicted the complainant go to trial.¹¹⁷ One second degree rape case in 1911 reversed the roles in this scenario. The defense attorney argued that the fact that his client suffered from gonorrhea while the fifteen year girl he was accused of having intercourse with did not prove his innocence: she would necessarily have contracted gonorrhea as a result of having

intercourse with him. The man only showed signs of being afflicted with gonorrhea after being given beer -- described as an ordinary procedure "to get quiescent gonorrhea to light up again." The two trials of this case involved five doctors who engaged in an extended debate about whether the fact that the defendant only showed signs of gonorrhea after drinking beer meant that he suffered from a latent form of gonorrhea that sexual intercourse would not necessarily have transmitted to the girl.¹¹⁸

If both parties to a case suffered from venereal disease, prosecutors treated this as evidence that corroborated a girl's identification of the defendant. In a handful of cases, men admitted they suffered from venereal disease or submitted to examinations that revealed their condition.¹¹⁹ More often, prosecutors relied on indirect evidence of a man's affliction. A defendant had to give permission before a doctor could examine him; in eleven of the fourteen child rape cases that relied on evidence of venereal disease to provide corroboration, the defendant did not submit to an examination. That the District Attorney and NYSPCC prosecuted these cases anyway -- especially given that in eight of the fifteen cases evidence that the girl suffered from venereal disease represented the only corroboration presented -- implied that they regarded a man's failure to show he did not have venereal disease as an admission that he did.

Although the state's higher courts rejected prosecutors' treatment of evidence of venereal disease, the outcomes of cases in Manhattan validated their assessment of the weight such evidence carried with trial judges and, especially, with jurors. In an opinion from 1913, New York's appellate court had explicitly ruled that a girl's affliction with venereal disease had no value as corroboration. If a girl suffered from gonorrhea, the court wrote, her condition constituted "some evidence of intercourse [but] not evidence of

intercourse with any particular man.” Even if the defendant also “had the disease,” that evidence did not furnish corroboration that he had intercourse with the girl. “Gonorrhoea,” the court insisted, “may be contracted without intercourse; therefore, it is of less value, if such be possible, than pregnancy as corroborative evidence.”¹²⁰ Trial judges and jurors had a completely different response to medical evidence of venereal disease. In none of the five child rape cases that relied entirely on that evidence to fulfill the corroboration requirement that went to trial, for example, did the trial judge rule that evidence of venereal disease was not corroborative in character, the position that the higher court ruling required him to take.¹²¹ Trial judges’ decision to accept evidence of venereal disease as corroborative in nature did not guarantee that juries would convict defendants on the basis of that evidence. The weight and sufficiency of that evidence were questions of fact not law and therefore up to the jury to decide. In two of the five cases that relied solely on that evidence juries convicted the defendant and in a third could not agree on a verdict, suggesting that at least some members of the jury wanted to convict the defendant solely on basis of venereal disease.¹²² The jury also convicted the defendant in two other cases that relied on a combination of evidence of venereal disease and other evidence that the appellate did not recognize as corroborative in nature.¹²³

These outcomes provide evidence that jurors frequently responded to medical evidence inside the legal system with the same deference as working class families and the NYSPCC displayed outside the legal system. They treated doctors as experts in regard to the normal, as well as the abnormal, body and took their testimony as a statement of facts. In practice, jurors thus granted doctors and medical evidence some of the authority that appellate court judges sought to deny them.

At the same time, jurors and trial judges displayed a reluctance to accept broad legal definitions of rape that relied on mental states rather than physiological capacities and bodily signs. Grand juries almost always dismissed charges of rape brought by women who had been threatened rather than physically assaulted.¹²⁴ In statutory rape cases, judges and jurors, skeptical of the statute's characterization of teenage girls as psychologically immature, stopped short of rigorous enforcement of the law. Although the proportion of defendants held for the action of the Grand Jury who were convicted is markedly higher in statutory rape cases than in rape cases that involved adult women, most of those convictions came through plea bargaining.¹²⁵ When jurors decided the outcome of cases, they convicted only 44% (33 of 75) of the defendants tried for statutory rape, a proportion well below the 61% of defendants they convicted in rape cases that involved girls under eleven years of age and the 75% of defendants they convicted in cases that involved adult women. Judges treated men convicted of statutory rape with increasing leniency, abandoning sentences of several years in duration in favor of a sentence of one year in the Penitentiary or, more often, a suspended sentence by 1921. These outcomes suggest the same gap between a popular middle-class understanding of rape as a physical struggle and the broader legal definition of rape highlighted by the experience and writings of medical jurists; middle-class jurors and even judges, in contrast to medical jurists, made little effort to accommodate their understandings of rape to the legal definition.

Resistance to broad legal definitions of rape has been an enduring part of the discourse on sexuality in the subsequent decades of the twentieth century. Even as the legal system continued to restrict the role of doctors in rape trials, critics of legal definitions of rape invoked the body and medical knowledge to support their arguments. Writing in 1951,

Morris Ploscowe, a prominent New York judge, criticized “the extensiveness of the legal concept of rape,” which he claimed “diluted” the term by including acts other than physically violent assaults by strangers. Ploscowe urged reforms that would return to “[t]he older law of rape,” a law that took “cognizance” of “medical skepticism” about the possibility that an adult woman could be raped and “demanded a very high degree of resistance on the part of the woman to a sexual assault upon her before such assault could be converted into rape.” To illustrate the medical skepticism about whether an adult woman could be raped in the circumstances that modern laws recognized as rape, Ploscowe cited the opinion Theodorick Beck offered in his 1823 treatise.¹²⁶

The persistence of these ideas about rape owed something to the lack of evidence about mental states in rape trials produced by the absence of experts to identify and interpret mental states. Located beneath the surface of the body, a woman’s psyche and mental state represented ‘private parts’ less accessible to examination than her body and genitals. The psychologists and psychiatrists who claimed to have the expertise needed to reveal mental states are not present in rape trials until the last quarter of the twentieth century. In the 1940 edition of his treatise on evidence, John Wigmore had advocated pre-trial psychiatric examinations of all women who made charges of rape to ascertain whether they suffered from “some mental or moral delusion or tendency” that would cause “distortion of the imagination” and false charges of rape.¹²⁷ No states, however, acted on these proposals.¹²⁸ When psychological experts did appear in rape trials -- in the late 1970s and 1980s, in the wake of Second Wave Feminist activism around rape -- they played a very different role than that envisioned by Wigmore. Psychologists testified about how the effects of Rape Trauma Syndrome explained behaviors, such as a woman’s failure to immediately report a rape or her

lack of emotional reaction immediately following the crime, that courts had previously regarded as undermining the credibility of a woman's testimony. This testimony provided courts and jurors with some expert knowledge about mental states, gave substance to broad definitions of rape and provided some counterbalance to the persistence of narrow understandings of sexual violence.¹²⁹

Despite the new role of psychological expertise, uncertainty about the mental states surrounding acts of sexual intercourse -- and the resistance to broad legal definitions of rape to which this uncertainty contributes -- remains a feature of contemporary understandings of rape. As legal scholar Susan Estrich has argued,

...even if most [law] students can agree these days that no means no, and that force can be established if you push a woman down, there's very little agreement about what we need to know about him or her before deciding whether she in fact said yes or no, and whether he actually pushed her down or just lay down with her. The consensus on what counts as rape is more apparent than real. ...The questions have shifted; answering them is no easier.¹³⁰

While the legal system continues to restrict the testimony of doctors, jurors still respond to the ambiguous circumstances of many rape cases by looking for reassurance in evidence derived from the body -- even if that evidence is not relevant to the issues on which a case will be decided. Tests now offer almost certain knowledge about whether the DNA in a semen or blood stain is from the accused, providing conclusive evidence of identity. In New York, District Attorneys are ordering DNA tests even when force and consent, not the offender's identity, is the issue in the case because jurors regard the failure to perform tests as a sign that there is something unreliable about prosecutors' evidence.¹³¹ The continuing

importance of bodily signs, marks and private parts in how jurors understand rape suggests that, in the face of the uncertainties produced by the ascendancy of a modern sexuality that expands the scope of the sexual and emphasizes psychology, many more Americans have clung to older certainties about sexuality that rely on the body than historians have previously recognized.¹³²

An earlier version of this paper was presented at the F. C. Wood Institute History of Medicine Seminar, College of Physicians of Philadelphia, October 15, 1995. A Littleton-Griswold Research Grant from the American Historical Association and a Research Fellowship from the F. C. Wood Institute for the History of Medicine, College of Physicians of Philadelphia, helped with the cost of the research.

I would like to thank Alice Kessler-Harris, Norma Basch, Gerald Grob, Jan Lambertz, Barbara Balliet, Jennifer Mnookin and the anonymous reviewers for the *Journal of the History of Sexuality* for helpful comments on various versions of this article, and Delwyn Elizabeth for comments, support and much, much more.

¹*Anatomy of a Murder* (dir. Otto Preminger, Columbia Pictures, 1959).

²Medical evidence could have played a greater role in this case. Laura Manion had been badly beaten in the course of the rape, producing bruises and marks that the doctor testified he had noticed. The doctor went on to testify that the police, however, did not ask him to “determine the reason” for these marks, a task that we will see should have been part of a standard examination of a woman who charged she had been raped.

³Theodoric Beck, *Elements of Medical Jurisprudence*, vol. 1 (Albany, 1823), p. 83.

⁴This account of the eighteenth century situation is drawn from Sharon Block, “Coerced Sex in British North America, 1700-1820” (Ph.D. diss., Princeton University, 1995), pp. 104-108,

111-112. Women's role in rape cases represented a continuation of the English practice of having an investigatory jury of women (or a midwife) examine a women's body in cases in which its condition could influence the verdict or sentence. For an account of this practice in the American colonies, see Kathleen Brown, "'Changed...into the fashion of man': The Politics of Sexual Difference in a Seventeenth-Century Anglo-American Settlement," *Journal of the History of Sexuality* 6, 2 (1995): 180-183, 186.

⁵For an account of the rise -- and fall -- of the field of medical jurisprudence in the nineteenth century United States, see James Mohr, *Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America* (New York, 1993).

⁶*Ibid*, p. 107.

⁷Historians of rape in North America make only passing references to medical testimony in particular cases or to the place of doctors and medical evidence in the legal process. For brief discussions see Block, pp. 104-108, 111-112; Kathleen Parker, "Law, Culture and Sexual Censure" (Ph.D. diss., Michigan State University, 1993), pp. 380-387; Karen Dubinsky, *Improper Advances: Rape and Heterosexual Conflict in Ontario, 1880-1929* (Chicago, 1993), pp. 27-28, Cornelia Dayton, *Women Before the Bar: Gender, Law and Society in Connecticut, 1710-1790* (Chapel Hill, 1995) and Mary Odem, *Delinquent Daughters: Protecting and Policing Adolescent Female Sexuality in the United States, 1885-1920* (Chapel Hill, 1995). Medical historians have paid similarly scant attention to the writings which lie behind this medical evidence. Based on the relatively small literature on rape in medical periodicals, Elizabeth Anne Mills, and more recently Elizabeth Lunbeck, have concluded that physicians were concerned with the dangers of false accusations rather than with women who had been raped. See Elizabeth Anne Mills, "One Hundred Years of Fear: Rape and the Medical Profession," in *Judge, Lawyer, Victim, Thief: Women, Gender Roles, and Criminal Justice*, ed. Nicole Hahn Rafter and Elizabeth Anne Stanko (Northeastern University Press, 1982) and Elizabeth Lunbeck, *The Psychiatric Persuasion:*

Knowledge, Gender and Power in Modern America (Princeton, 1994), p. 214. The bulk of medico-legal writing on rape, however, is not in periodicals, but in textbooks and treatises on medical jurisprudence. James Mohr has recently drawn on these sources in his broad study of medical jurisprudence in nineteenth century America, but he specifically discusses rape only briefly and without noting how medical evidence became transformed in this period; see Mohr, pp. 21, 31, 71-73.

⁸John Reese, *A Textbook of Medical Jurisprudence and Toxicology* (Philadelphia, 1895), p.535.

⁹Beck (1st ed., 1823), vol. 1, p. 73. A note on sources: My analysis of the writings of medical jurists is based on an examination of all the English language texts and periodical articles on medical jurisprudence published between 1823 and 1940 available in three major medical libraries: the New York Academy of Medicine; the College of Physicians of Philadelphia and the Columbia College of Physicians. These collections contained 74 different texts, many of which went through multiple revisions in the course of the nineteenth century. While this sample does not necessarily include all of the medical jurisprudence texts published in those years, it is certainly representative, including all the influential texts and many less influential works that simply summarized or repeated large parts of the work of one or more of the most influential medical jurists. To avoid burdening this article with long footnotes, I have generally cited only the more influential texts -- texts which are part of the collections of many major medical or law libraries.

¹⁰For a broad discussion of this understanding of force and consent, see Susan Estrich, *Real Rape: How the legal system victimizes women who say no* (Cambridge, Mass., 1987), pp. 29-41, 58-71. On the understanding of physical force as intrinsic to sexual intercourse, see Beck (1st ed., 1823), vol. 1, p. 79 (where he notes that violence “may not have been against the will of the female”); William Guy, *Principles of Forensic Medicine* (New York, 1845), p.76; and Amos Dean, *Principles of Medical Jurisprudence* (Albany, 1850), p. 29.

¹¹Dean, p.33.

¹²Beck (1st ed., 1823), vol. 1, p.83.

¹³Farr, quoted in *Ibid*, pp. 83-84.

¹⁴*Ibid* , p.84.

¹⁵Theodoric Beck and John Beck, *Elements of Medical Jurisprudence* 6th ed.(Philadelphia, 1838), p. 147.

¹⁶Francis Wharton and Moreton Stilles, *A Treatise on Medical Jurisprudence* (Philadelphia, 1855), p. 336. This treatise appears to have displaced Beck's work as the preeminent American text on medical jurisprudence in the second half of the nineteenth century. See Mohr, p. 38.

¹⁷Johann Casper, *A Handbook of the Practice of Forensic Medicine, Based upon Personal Experience*, vol. 3, trans. George Balfour (London, 1864), pp. 296-297, 311.

¹⁸Lawlor v. Wolff, 62 N.E. 973 (1902).

¹⁹Cook v. The State, 24 N. J. L.. 852 (1855). For other decisions on this point, see Woodin v. People, 1 Parker Cr. R 464 (1854); State v. Peterson, 111 Iowa 647 (1900); People v. Benc, 130 Cal. 159 (1900); Commonwealth v. Buckman, 82 Pa. Superior Ct. 433 (1923); and State v. Brown, 166 La. 43 (1928). A small number of decisions did take the opposite position; see People v. Clark, 33 Mich. 119 (1875).

²⁰Commonwealth v. Buckman, 82 Pa. Superior Ct. 434 (1923); State v. Perry, 41 W.Va. 641 (1896). The later case allowed that doctors had expert knowledge of the physical ability of a man with a wooden leg to have intercourse in the position alleged by the complainant.

²¹No extended historical analysis of rape law in the United States exists. My analysis draws on published Appellate Court cases; Estrich; Sue Bessmer, *The Laws of Rape* (New York, 1984); New York State Law Revision Commission, *Communication and Study Relating to Sexual Crimes* (Legislative Document 65(O), 1937); and Hubert Feild and Leigh Bienen, *Jurors and Rape* (Lexington, 1980), pp. 207-458.

²²Constance Backhouse, "Nineteenth-Century Canadian Rape Law 1800-92," in *Essays in the History of Canadian Law*, vol. 2, ed. David Flaherty (Toronto, 1981), p. 204; Anna Clark, *Women's Silence, Men's Violence: Sexual Assault in England, 1770-1845* (London, 1987) pp. 61-63.

²³Beck quotes a passage from the work of East, an English medical jurist, that illustrates medical jurists conceptualization of rape: "Considering the nature of the crime, that it is a brutal and violent attack upon the honor and chastity of the weaker sex, it seems more natural and consonant to the sentiments of laudable indignation which induced our ancient lawgivers to rank this offense among felonies, if all further inquiry were unnecessary after satisfactory proof of the violence having been perpetrated by actual penetration of the unhappy sufferers body." See Beck (1st ed., 1823), vol. 1, pp. 95-99. On the broad support for this position among American medical jurists, see Mohr, pp. 72-73.

²⁴Mohr, pp. 72-73; Beck (1st ed., 1823), vol. 1, pp. 95-99; *Pennsylvania v. Sullivan*, Add. 143 (1793); *State v. Le Blanc*, 1 Tread. Const. 354 (1813). Other state legislatures (California, New York, Minnesota, North Dakota) and courts (Alabama, Connecticut, Louisiana, Michigan, Nebraska) followed suit in the late nineteenth century. See *State v. Shields*, 45 Conn. 256 (1877); *State v. Burton*, 1 *Houst.Cr. Cas* 363 (1873); *Taylor v. State*, 111 Ind. 279 (1887); *State v. Turner*, 25 La. Ann 573 (1873); *People v. Courier*, 79 Mich. 366 (1890); *Comstock v. State*, 14 Neb. 205 (1883); and *State v. Hargrave*, 65 N.C. 466 (1871). The English Parliament replaced the emission requirement in 1828 (Clark, p. 61), the Canadian legislature in 1841 (Backhouse, p. 204).

²⁵Guy, p. 77.

²⁶J. Kost, *A Textbook on Medical Jurisprudence for Medical and Law Colleges* (Cincinnati, 1885), p. 232.

²⁷*People v. Dohring*, 57 N.Y. 383 (1874).

²⁸Estrich, pp. 29-37.

²⁹Beck (1st ed., 1823), vol. 1, p. 79. See also Guy, p. 76 and Dean, p. 29.

³⁰Francis Ogston, *Lectures on Medical Jurisprudence* (London, 1878), p. 90.

³¹Mohr, p. 72. The quotations are from the source of Mohr's argument: Sylvana Tomaselli, "Introduction," in *Rape*, ed. Sylvana Tomaselli and Roy Porter (London, 1986), p. 7.

³²Michel Foucault, *The History of Sexuality*. Volume 1: *An Introduction* (New York, 1980) pp. 122-124. A self controlled character served as a building block for economic success and middle-class identity; in the absence of self control, a man lapsed into an animal state of existence under the sway of sensual motivations. See Charles Rosenberg, "Sexuality, Class and Role in Nineteenth Century America," in *The American Man*, ed. Elizabeth Pleck and Joseph Pleck (Engelwood Cliffs, 1980); Stephen Nissenbaum, *Sex, Diet and Debility in Jacksonian America* (Westport, 1980); Karen Halttunen, *Confidence Men and Painted Women: A Study of Middle-class Culture in America, 1830-1870* (New Haven, 1982); and Steven Seidman, *Romantic Longings: Love in America, 1830-1980* (New York, 1991).

³³Douglas Kerr, *Forensic Medicine* (London, 1935), p. 164; Sydney Smith, *Forensic Medicine* (London, 1925), p. 221.

³⁴For an overview of these judicial decisions, see Bessmer, pp. 325-343.

³⁵George Puppe, *A Medico-Legal Study of Rape* (New York, 1894; reprinted 1935), p. 8. See also J. Clifton-Edgar and J. Johnson, "Rape," in *Medical Jurisprudence, Forensic Medicine and Toxicology*, ed. R. A. Witthaus and Tracy Becker (New York, 1894); William Brend, *A Handbook of Medical Jurisprudence and Toxicology* (London, 1915), p. 95; and Charles Chaddock, "Rape," in *A Textbook of Legal Medicine and Toxicology*, vol. 2, ed. Frederick Paterson and Lawrence Godkin (Philadelphia, 1904), p. 127.

A woman could be overpowered not only by threats against herself, but also by threats against her husband, children or other relatives. The threat of physical violence to a woman's child held a particular fascination for many medical jurists. See Alfred Herzog, *Medical Jurisprudence* (Indianapolis, 1931), who provided this account of the archetypal example:

A case which occurred in a foreign jurisdiction some years ago shows, however, that even personal violence offered to another than the prosecutrix ought to be sufficient under some circumstances. No personal violence was offered to the woman nor any threats of personal violence were made, but the intruder picked her baby out of the crib and threatened to dash its brains out by hitting it against the all of the room. The woman was alone with him in the house and help was not to be expected. Under these circumstances, he was convicted of rape by force (p. 839).

³⁶People v. Dohring, 57 N.Y. 384 (1874).

³⁷Marybeth Hamilton Arnold, ““The Life of a Citizen in the Hands of a Woman”: Sexual Assault in New York City, 1790 to 1820,” in *Passion and Power: Sexuality in History*, ed. Kathy Peiss and Christina Simmons (Philadelphia, 1989), pp. 35-56; Christine Stansell, *City of Women: Sex and Class in New York City, 1789-1860* (Urbana, 1987), pp. 23-27, 97, 182-183.

³⁸See my “Sexuality Through the Prism of Age: Modern Culture and Sexual Violence in New York City, 1880-1950,” (Ph.D. diss., Rutgers University, 1998), introduction.

³⁹Beck (1st ed., 1823), p. 87.

⁴⁰For analyses of the age of consent in the late nineteenth and early twentieth century, see my “Sexuality Through the Prism of Age,” chapter one; Odem, chapter one; David Pivar, *Purity Crusade: Sexual Morality and Social Control, 1868-1900* (Westport, Conn., 1973); and Jane Larson, ““Even a Worm Will Turn at Last”: Rape Reform in Late Nineteenth-Century America,” *Yale Journal of Law and the Humanities* 9, 1 (Winter 1997): 1-71.

⁴¹Judge Ben Lindsey and Wainwright Evans, *The Revolt of Modern Youth* (Garden City, 1925), pp. 81-82.

⁴²The history of sexual modernity in the United States is only beginning to be written; much of the existing literature fails to elaborate a definition or broad framework for understanding how sexual modernity reconceptualized understandings of sexuality. See Kathy Peiss, *Cheap*

Amusements: Working Women and Leisure in Turn-of-the-Century New York (Philadelphia, 1986); Christina Simmons, "Modern Sexuality and the Myth of Victorian Repression," in *Passion and Power: Sexuality in History*, ed. Kathy Peiss and Christina Simmons (Philadelphia, 1989), pp. 157-177; Pamela Haag, "In Search of the "Real Thing": Ideologies of Love, Modern Romance, and Women's Sexual Subjectivity in the United States, 1920-1940," *Journal of the History of Sexuality* 2, 4 (1992): 547-577; Lunbeck, *The Psychiatric Persuasion*.

⁴³Foucault, pp. 63, 68-70, 117-118, 152-153, 155-156. See also Arnold Davidson, "Sex and the Emergence of Sexuality," *Critical Inquiry* 14 (Autumn 1987): 17-48 (esp. 21-23, 46-47); Laura Engelstein, *The Keys to Happiness: Sex and the Search for Modernity in Fin-de-Siècle Russia* (Ithaca, 1992); and Domna Stanton, "Introduction: The Subject of Sexuality," in *Discourses of Sexuality*, ed. Domna Stanton (Ann Arbor, 1992).

⁴⁴Robert Woods and Albert Kennedy, ed., *Young Working Girls : A Summary of Evidence from Two Thousand Social Workers* (Boston, 1913), p.1. Generally, see my "Sexuality Through the Prism of Age," chapters one and two. On the new emphasis on biological development as a characteristic of childhood, see Engelstein, pp. 75-84 and Carolyn Steedman, *Strange Dislocations: Childhood and the Idea of Human Interiority, 1780-1930* (Cambridge, Mass., 1995). On G. Stanley Hall and child study, see Dorothy Ross, *G. Stanley Hall: The Psychologist as Prophet* (Chicago, 1972) and Joseph Kett, *Rites of Passage: Adolescence in America, 1790 to the Present* (New York, 1977). On social reformers use of the figure of the adolescent created by Hall, see Woods and Kennedy and Ruth Alexander, *The Girl Problem: Female Sexual Delinquency in New York, 1900-1930* (Ithaca, 1995), chapter two.

⁴⁵Kerr, p. 164.

⁴⁶Francis Anthony, "Rape," *Boston Medical and Surgical Journal* 132, 2 (1895): 31.

⁴⁷Charles Chaddock, "Sexual Crimes," in *A System of Legal Medicine*, vol. 2, ed. Allan Hamilton and Lawrence Godkin (New York, 1894), p. 539. Some treatise writers even achieved an almost empathetic tone: Sydney Smith urged, "One has only to consider how in a sudden emergency one of us may be temporarily paralyzed to understand the effect on a woman suddenly accosted by a man whose intentions are obvious." (p. 221)

⁴⁸Herzog, p. 840. After the 1930s discussion of the question of whether a healthy adult woman could be raped drops out of medical jurisprudence textbooks. The recognition that a woman could be raped made such discussions redundant, particularly as textbooks became more narrowly focused on forensic issues and techniques.

⁴⁹Charles Mapes, "Sexual Assault," *The Urologic and Cutaneous Review* 21, 8 (1917): 433-434. Both Mills and Lunbeck give Mapes a prominent place in their analyses of medical ideas about rape.

⁵⁰Mapes (1917), pp. 430, 433; Charles Mapes, "A Practical Consideration of Sexual Assault," *Medical Age* 24 (1906): 928. Lawyers wrote only a small proportion of medical jurisprudence treatises and textbooks; doctors or doctors collaborating with lawyers produced most of these works.

⁵¹The location of the writings of these doctors provides further evidence on this point. Almost all the doctors who took this position, like Mapes, published in general medical periodicals rather than authoring specialized treatises on medical jurisprudence. After the mid-nineteenth century, the vast majority of writing on medical jurisprudence took the form of treatises and textbooks not articles in periodicals.

⁵²Transcript of Court of General Sessions Trial, Court of General Sessions Case File (hereafter CGSCF), *People v P. L.*, indicted 7 / 1891 (Municipal Archives, New York City), p. 22. Note: I have withheld or altered the names of the participants in the rape cases discussed in this paper; in my citation of the Court of General Sessions case files I have retained the defendants' actual initials as these records are grouped by month of indictment

and filed alphabetically by the defendants name and thus can only be accessed with this information.

⁵³My understanding of the concept of signs in medical discourse is indebted to Lester King, *Medical Thinking: A Historical Preface* (Princeton, 1982), chapter two.

⁵⁴Fred Smith, *Lectures on Medical Jurisprudence and Toxicology as delivered at London Hospital 1900* (2nd ed.) (London, 1908), p. 222.

⁵⁵Karen Dubinsky uses this phrase to characterize the arguments of Elizabeth Ann Mills (Dubinsky, p. 28).

⁵⁶Kathryn Montgomery Hunter, *Doctors' Stories: The Narrative Structure of Medical Knowledge* (Princeton, 1991), pp. 28-38.

⁵⁷Casper offered an oft cited formulation of this approach in regards to signs of virginity:

...where a forensic physician finds a hymen preserved, even its edges not being torn, and along with it a virgin condition of the breasts and external genitals, he is then justified in giving a positive opinion as to the existence of virginity (pp. 281-282; for an example of the citation of this passage, see Charles Tidy, *Legal Medicine* (New York, 1884), pp. 121-122).

See also Kost, who advocated looking to the presence or absence of other signs as a way of determining whether the marks of violence on a woman's body had been self-inflicted (p. 231).

⁵⁸See Alfred Taylor, *A Manual of Medical Jurisprudence*, 11th U. S.. ed. (Philadelphia, 1892), pp. 648, 656; Guy, pp. 65-66; Tidy, p. 116. Some medical jurists argued that incomplete penetration left few signs on the body of a young girl. See Clifton-Edgar and Johnson, p. 679. Medical jurists identified young girls as the most frequent victims of rape: see Wharton and Stilles, pp. 327-328; Clifton-Edgar and Johnson, pp. 705-706 and Chaddock (1894), pp. 543-544.

⁵⁹Tidy, p. 125; Clifton-Edgar and Johnson, p. 681; Sydney Smith, p. 229; Herzog, p. 829.

⁶⁰Ogston, p. 104. The development of medical science did not resolve this uncertainty: Gonzales, Vance and Halpern, writing in 1937, for example, argued that “the diagnosis of virginity is a difficult matter and in a large number of cases it is not possible to reach a definite conclusion from a physical examination of the genital organs.” See Gonzales, Vance and Halpern, *Legal Medicine and Toxicology* (New York, 1937), p. 357.

⁶¹Ogston, p. 102.

⁶²Tidy, p. 122.

⁶³See, for example, Ogston, p. 103. Some medical jurists did raise objections to the likelihood of dancing, leaping and riding rupturing a hymen. Tidy, for instance, argued that “no such case has occurred within his experience” (p. 122). Despite these arguments the hymen never entirely shed its status as an equivocal sign.

Doctors also attributed the uncertainty surrounding the hymen to its various forms, which led many physicians to make mistaken diagnoses. Sydney Smith, for example, remarked “Medical men are not often called to examine hymens unless specializing in medical jurisprudence, and are liable to give a mistaken opinion. In one case of incest we were called to examine in a Border town, the local practitioner had mistaken a fimbriated for a ruptured hymen” (p. 166).

Many of these comments in regards to the hymen also applied to the other signs of virginity. The flourette, labia and narrow vagina, in addition to being signs not peculiar to virgins, could also be lost from disease, discharges, falls, and masturbation, as well as being affected by the general state of health.

⁶⁴Tidy, p. 126; Wharton and Stilles, p. 330.

⁶⁵Since the presence of gonorrhea also constituted a sign of rape, a doctor’s misidentification of leucorrhea as gonorrhea provided unwarranted support for a charge of rape, while confusing a discharge for gonorrhea offered an accused man the opportunity to evade

prosecution by showing he did not have gonorrhoea. See Tidy, pp. 125-128; Ogston, pp. 94-97; Wharton and Stilles, pp. 329-336.

⁶⁶Ogston, p. 96; Clifton-Edgar and Johnson, p. 684; Reese, p. 534; Ralph Webster, *Legal Medicine and Toxicology* (Philadelphia, 1930), p. 265.

⁶⁷Ogston, p. 96.

⁶⁸Sydney Smith, p. 229; Herzog, p. 831.

⁶⁹Chaddock (1894), p. 536.

⁷⁰Webster, p. 265. See also Casper, p. 289; Ogston, pp. 106, 117; Tidy, p. 129; Chaddock (1894), pp. 538-540; Sydney Smith, p. 230.

⁷¹Chaddock (1904), p. 137. See also Dean, pp. 29-30, Ogston, p. 117; Tidy, p. 129; and Herzog, p. 827. For a similar argument in regards to bloodstains, see Casper, pp. 286-287.

Discussions of the possibility that signs could be the result of manufacture rather than rape involved medical jurists in discussions of false accusations. Medical jurisprudence texts and treatises, however, contain little evidence to support Mills' and Lunbeck's characterizations of doctors as preoccupied with lying women. See Mills, pp. 30, 33-37 and Lunbeck, p. 214. All medical jurists noted that women frequently made false charges of rape, but most did little more beyond offering an example and discussing the signs which women could simulate to support such accusations. Most of this discussion is concerned not with adult women charging they have been raped, but with mothers of young girls. Medical jurists argued that mothers used their daughters to bring charges for the same motives attributed to women who falsely charged rape: blackmail or revenge. Writing in medical periodicals exhibits a greater preoccupation with false accusations and a more vituperative tone. See Jerome Walker, "Reports with Comments, of Twenty-One Cases of Indecent Assault and Rape Upon Children," *Archives of Pediatrics* 3, 5 (1886): 269-86; 3, 6 (1886): 321-41; and Gurney Williams, "Rape in Children and in Young Girls," *International Clinics* vol. 2 (23rd Series) (1913): 245-67; and vol. 3 (23rd Series): 245-67. Only Taylor and Reese amongst

the textbook authors share this preoccupation and only Reese, whose work is laced with adjectives such as "vile", "disgusting" and "unprincipled" shares the tone. (Taylor, pp. 647-99, 650-653, 655; and Reese, pp. 530-1, 534) The emphasis on false accusations remains in the 1895 and subsequent editions of Reese's text, but most of the vituperative language is omitted (see Reese (1895), pp. 531, 533, 534).

⁷²Ogston, p. 105.

⁷³Wharton and Stilles, p. 326 (*italics in original*). See also Tidy, p. 137; and Clifton-Edgar and Johnson, pp. 661-662, 715-716.

⁷⁴John Glaister, *A Textbook of Medical Jurisprudence and Toxicology* (Edinburgh, 1921), p. 498. For other examples, see Tidy, p. 129; and Webster, p. 265.

⁷⁵Webster, p. 257. For other examples, see Tidy, p. 114; and Clifton-Edgar and Johnson, p. 661.

⁷⁶*Boddie v. State*, 52 Ala. 395, 398 (1875), cited in John Wigmore, *A Treatise on the System of Evidence in Trials at Common Law*, vol. 2 (Boston, 1904), pp. 2757-2758. See also Bessmer, pp. 104-105.

⁷⁷Wigmore, p. 2758. By 1904 only two states -- New York and Iowa -- had statutes that required corroboration in rape cases; those states and 22 others also had statutory corroboration requirements in cases of seduction, with most of these laws enacted in the 1890s. By 1940 Oklahoma had adopted a statute that required corroboration in rape cases (Hawaii and Washington introduced and then repealed laws in this period), seven other states had adopted statutes that required corroboration in rape cases that involved girls under the age of consent and eleven more states adopted statutes that applied to seduction. See Wigmore, pp. 2759-2760 and Wigmore (3rd ed., 1940), vol. 7, pp. 350-354. In the District of Columbia, Nebraska and Georgia judicial decisions required full corroboration in rape cases; by the mid-twentieth century, judicial decisions in ten other states required either limited corroboration or corroboration in certain circumstances. See Note, "The Rape

Corroboration Requirement: Repeal Not Reform,” *Yale Law Journal* 81 (1972): 1366-1368; and Janette Pratt, “The Demise of the Corroboration Requirement -- Its History in Georgia Rape Law,” *Emory Law Journal* 26 (Fall 1977): 805-839.

⁷⁸Wigmore, p. 2760.

⁷⁹New York State Law Revision Commission, p. 77.

⁸⁰*People v Grauer*, 12 App. Div. 468 (1896).

⁸¹*People v Plath*, 100 NY 590 (1885); New York State Law Revision Commission, p. 77; *People v Cole*, 134 App. Div. 759 (1909); *People v Brehm*, 218 App. Div. 266 (1926).

⁸²Webster and a small group of medical jurists urged doctors to extend their role in rape cases by using their examination of a woman charging rape as an opportunity to question her “as to the nature of the assault, the place, the exact time, and the woman’s story of the resistance offered by her,” because they had the opportunity to ask these questions “before the story (if it be manufactured) is fully concocted,” as Tidy put it (Webster, p. 258; Tidy, p. 115). As Kost pointed out, however, any statements that a woman made to a doctor would be hearsay and inadmissible. The results of an examination of a woman’s body represented the only evidence that a doctor could offer, or as Kost put it, “the medical jurist can only go by the signs...” (p. 232).

⁸³*Noonan vs. The State*, 55 Wis. 260 (1882). See also *People v Schultz*, 260 Ill. 40 (1913); *People v. O’Connor*, 295 Ill. 203 (1920); and *People v. Ardelean*, 368 Ill. 278 (1938).

⁸⁴Wigmore (3rd ed., 1940), pp. 122, 125.

⁸⁵Thanks to Jennifer Mnookin for help clarifying this point.

⁸⁶Trial Transcript Collection (hereafter TTC), Case# 250, Roll 46 (1901) (John Jay College of Criminal Justice), p. 162. (District Attorney during summation)

⁸⁷I also found trial transcripts for 35 rape cases in this sample in the Trial Transcript collection at John Jay College of Criminal Justice. This material is drawn from the larger sample used in my “Sexuality Through the Prism of Age.”

⁸⁸New York State Law Revision Commission, p. 21

⁸⁹*Laws of New York, 1881*, vol. 3, chap. 676, pp. 66-67 (Penal Code Title X, Chapter II, sec. 278 and 280). An amendment in 1882 added the phrase “or an act of sexual intercourse with a female, not his wife” after the phrase “A person perpetrating such as act” in the preamble. See *Laws of New York, 1882*, chap. 384, p. 542.

⁹⁰*Laws of New York, 1886*, chap. 663, p. 953. For the original seduction and abduction statutes, see *Laws of New York, 1848*, chap. 105, p. 118 and chap. 111, p. 148. The Legislature had not taken the opportunity to apply the corroboration requirement to rape in the 1881 Penal Code; it is not clear why they changed their position in 1886.

⁹¹See *Laws of New York, 1887*, chap. 693, p. 900 for the law that increased the age of consent to 16 years; *Laws of New York, 1892*, chap. 325, p. 681 for law that divided the crime of rape into two degrees; and *Laws of New York, 1895*, chap. 460, p. 281, for the law that increased the age of consent to 18 years.

⁹²See Supplement to *The Philanthropist* 6, 3 (March 1891): 9-10.

⁹³*Laws of New York, 1881*, chap. 130, p. 114; *The Nineteenth Annual Report of the New York Society for the Prevention of Cruelty to Children* (New York, 1894), pp. 7-8. Despite the importance of the NYSPCC, it has not been the subject of a full length study; the law enforcement wing of the child protection movement that it led has been overshadowed in the historical literature by the more studied social work, family preservation wing represented by the Massachusetts SPCC. For discussions of the NYSPCC’s role in the prosecution of sex crime, see my “Sexuality Through the Prism of Age.” For general discussions of the Society, see Elizabeth Pleck, *Domestic Tyranny: The Making of Social Policy Against Family Violence from Colonial Times to the Present* (New York, 1987) and Lela Costin, Howard Jacob Karger and David Stoesz, *The Politics of Child Abuse in America* (New York, 1996), pp. 46-86.

⁹⁴Paul Starr, *The Social Transformation of American Medicine* (New York, 1982), pp. 4-5.

Starr is the source of the generalizations about the origins and growth of medical authority that follow; see particularly pp. 17-21, 134-144.

⁹⁵For examples of cases where parents went directly to the legal system upon finding blood on a girl's drawers, see CGSCF, *People v F. P.*, indicted 9/1886; District Attorney's Closed Case Files (hereafter DACCF) #82082, 1911 (Municipal Archives, New York City); DACCF #82728, 1911; DACCF # 109904, 1916. For a case that suggests courts expected blood should make parents suspicious, see DACCF #36934, 1901.

⁹⁶DACCF #84774, 1911. For other examples, see CGSCF, *People vs C. P.*, indicted 5/1886; DACCF #139570, 1921.

⁹⁷W.T. Gibb, "Indecent Assaults Upon Children," in *A System of Legal Medicine*, vol. 1., ed. Allan McLane Hamilton and Lawrence Godkin (New York, 1894), p. 656.

⁹⁸CGSCF, *People v. G. S.*, indicted 6 / 1891; CGSCF, *People v P. L.*, indicted 9 / 1891; DACCF #35362, 1901; DACCF #112009, 1916.

⁹⁹For an example of a case in which a family chose not to report an assault after a doctor found a girl's hymen to be intact, see TTC, Case #2232, Roll 280 (1916). In this trial the girl's father testified about a previous case in which his daughter had been involved that followed this pattern. Obviously, because such cases rarely came into the legal system, the evidence on this point is fragmentary. Gurney Williams, a Police Surgeon in Philadelphia in the early twentieth century, noted that in his experience "The vital point of interest to [parents] is the question, Has or has not the child been enterted? Is she still a virgin?" See Williams (vol.2), p. 262.

¹⁰⁰DACCF# 84789, 1911. For other examples, see DACCF# 11387, 1896; DACCF# 35751, 1901; DACCF# 34754, 1901; DACCF# 83905, 1911; DACCF# 86356, 1911; DACCF# 82337, 1911; DACCF# 109457, 1916; DACCF# 108927, 1916 and DACCF #110642, 1916.

¹⁰¹In some cases the mere threat of being taken to a doctor accomplished this; see DACCF# 8874, 1896; DACCF# 12298, 1896; and DACCF# 133874, 1921.

¹⁰²See, for example., doctors' descriptions of the purpose of their examinations in TTC, Case# 79, Roll 19 (1896) pp. 8-9 and TTC, Case# 1494, Roll 194 (1911), p. 34. The procedure that NYSPCC doctors employed in conducting their examinations also provided little opportunity for them to search her body or do anything other than examine her genitals for signs of penetration: "The girl was placed on a table by a nurse," Dr. Samuel Brown testified in a second degree rape trial. "She was covered with a sheet and her knees were flexed or put into a position so her genital organs could be examined" (TTC, Case# 1492, Roll 194 (1911), p. 158).

¹⁰³DACCF# 109774, 1916.

¹⁰⁴A. Powell, "Medical examination in cases of rape," *Indian Medical Gazette* 37 (1902): 230-231.

¹⁰⁵Girls and sometimes their mothers did testify about blood or semen stains they noticed on their clothing. But because these clothes had been washed or otherwise disposed of, doctors did not examine them and could not corroborate that testimony.

¹⁰⁶See for example her certificate in CGSCF, *People v. H. R.*, indicted 9 / 1886: "This certifies that I have examined Jenny Fletcher, 10 years of age and I find that Rape has been committed upon her. The hymen is torn on one side and whole vulva very much excoriated. Also find she is suffering from Gonorrhoea in its worst form."

¹⁰⁷Transcript of Court of General Sessions trial, CGSCF, *People vs. V. O.*, indicted 5 / 1886.

¹⁰⁸See for example, Dr. Samuel Brown's certificate in DACCF, Case# 83905, 1911.

NYSPCC doctors also routinely noted whether the penetration was recent.

¹⁰⁹Clifton-Edgar and Johnston, p. 725.

¹¹⁰Gibb was still performing medical examinations for the NYSPCC in 1936.

¹¹¹New York law exempted a wide range of professions from jury service, including teachers, journalists, firemen, engineers and national guardsmen. These exemptions left perhaps 25% of the city's population eligible to serve on a jury. The shorter service of petit juries meant that the wealthy businessmen who predominated on the Grand Jury did not occupy the same place on trial juries. Instead panels consisted of "retail cigar and newspaper dealers and small tailors from the East Side." See Eric Fishman, "New York City's Criminal Justice System, 1895-1932" (Ph.D. diss., Columbia University, 1980), pp. 336-337; and Arthur Train, *The Prisoner at the Bar: Sidelights on the Administration of Criminal Justice* (New York, 1926), p. 222. The only evidence I have on the specific composition of juries in rape trials in my sample comes from newspaper reports of one trial in 1891. The last five jurors chosen in this case were an electrical goods manufacturer, a merchant, a button manufacturer, a commercial traveler and an ostrich feather dresser. See *The Press*, 6 / 16 / 91 (District Attorney's Scrapbook, Municipal Archives).

¹¹²TTC, Case# 74, Roll 19 (1896); TTC, Case# 268, Roll 49 (1901); and TTC, Case# 2239, Roll 281 (1916).

¹¹³For examples of judges asking doctors to explain their testimony, see TTC, Case# 1494, Roll 194 (1911), p. 38; and TTC, Case# 1475, Roll 192 (1911), p. 42. For examples of jurors asking questions that indicate a familiarity with terms such as hymen, see CGSCF, *People v V.O.*, indicted 5/1886; and TTC, Case# 250, Roll 46 (1901), pp. 30-31. For an example that shows that jurors -- and journalists -- did have difficulty understanding the language used in medical evidence that extended beyond penetration, see James Goodman's discussion of the medical evidence in the Scottsboro trial (*Stories of Scottsboro* (New York, 1994), pp. 14, 128, 131, 139, 166).

¹¹⁴Doctors did sometimes draw such conclusions in documents certifying the results of their examinations: "It is hardly possible that a child of her tender years should have a gonorrhoeal

vaginitis without having had sexual intercourse” (Dr. Coakley to Eldbridge Gerry, NYSPCC, 7 / 29 / 91, in CGSCF, *People v. J. C.*, indicted 7 / 1891).

¹¹⁵Transcript of Court of General Sessions Trial, CGSCF, *People v P.L.*, indicted 7/1891, pp. 18-20. For a discussion of the other causes of signs of syphilis, see CGSCF, *People vs C.P.*, indicted 9/1886.

¹¹⁶See, for example, DACCF# 112205, 1916, in which the District Attorney decided to plea-bargain a case involving a man accused of having intercourse with several young girls rather than risk the inferences the jury would make from evidence that two of the girls showed signs of gonorrhoea while the man did not. A delay before doctors examined the girls possibly produced this situation. See also DACCF# 111344, 1916.

¹¹⁷CGSCF, *People v. C. P.*, indicted 9 / 1886; DACCF# 139570, 1921; and TTC, Case #3093, Roll 370 (1921). In the later case, the doctor employed by the defense re-examined the defendant during the trial and was forced to acknowledge he was in fact suffering from gonorrhoea.

¹¹⁸The first jury to hear this case could not reach a verdict. The jury in the second trial acquitted him. See TTC, Case #1436, Roll 186 (1911); TTC, Case #1492, Roll 194 (1911); and DACCF# 84596, 1911.

¹¹⁹CGSCF, *People v P.L.*, indicted 7/1891; DACCF# 36934, 1901; DACCF# 139570, 1921; and TTC, Case #3093, Roll 370 (1921).

¹²⁰*People v Shaw*, 158 App.Div. 146, 142 N. Y. S. 782 (1913). See also *People v Brehm*, 218 N. Y. S. 473 (1923).

¹²¹Three defendants facing only evidence of venereal disease agreed to plea bargains; see CGSCF, *People v. C. L.*, indicted 9/1891; DACCF# 81821, 1911; and DACCF# 85723, 1911. The willingness of these defendants to plead guilty could be the result of bad legal advice, but is more likely to reflect an awareness of how a jury would be inclined to interpret evidence of venereal disease.

¹²²For the convictions, see CGSCF, *People v. C. P.*, indicted 9 / 1886; and CGSCF, *People v. P. L.*, 7/1891. For the case in which the jury could not reach a verdict, see DACCF# 7796, 1896. The District Attorney discharged the defendant in this case. For acquittals, see CGSCF, *People v. J. C.*, indicted 7 / 1891; and DACCF# 7259, 1896.

¹²³DACCF# 36934, 1901; and DACCF# 82081, 1911. The additional evidence in these cases is evidence of opportunity. Juries convicted none of the defendants in the four child rape cases that relied entirely on evidence of opportunity as corroboration, making it likely that their decision to convict the defendants in these two cases reflected the weight they gave to evidence of venereal disease. Venereal disease is also the key evidence in one conviction for attempted rape; see DACCF# 35362, 1901.

¹²⁴Overall, 43% (24 of 55) rape cases that involved women aged 18 years and over were dismissed by the Grand Jury in the sample years 1906 to 1921, the years in which the records include cases dismissed by the Grand Jury. The Grand Jury dismissed 28% of second degree rape cases (103 of 370) and only one of 31 child rape cases in these years.

¹²⁵51% (188 of 370) of the defendants held for Grand Jury were convicted in cases of second degree rape in the sample years from 1906 to 1921 compared to 30% (23 of 76) of defendants in cases that involved adult women and 68% (19 of 28) in cases that involved girls under eleven years of age. In my sample years from 1906 to 1921, 88% of the convictions for second degree rape (165 of 188) are the result of plea bargains.

¹²⁶Morris Ploscowe, *Sex and the Law* (New York, 1951), pp. 165-166, 169-174. Twentieth century appellate court judges also cited early nineteenth century medical jurists in support of narrow interpretations of the definition of rape, without any acknowledgment of the shift in medical opinion in the subsequent decades. See, for example, *Brown v. State*, 127 Wis. 193, 106 N.W. 536 (1906).

¹²⁷Wigmore (3rd ed., 1940), section 924a, pp. 736-747.

¹²⁸In the middle decades of the twentieth century, psychiatric experts did play a role in the legal system's response to sexual offenders. In the context of a nationwide panic about sex crime, psychiatrists offered new interpretations of the causes of sexual violence and claimed the ability to treat offenders. In response to the panic and psychiatrists' claims, many states passed sexual psychopath statutes that provided for the psychiatric examination and indeterminate sentencing of sexual offenders. See Estelle Freedman, " "Uncontrolled Desires": The Response to the Sexual Psychopath, 1920-1960," in *Passion and Power: Sexuality in History*, ed. Kathy Peiss and Christina Simmons (Philadelphia, 1989), pp. 199-225; and George Chauncey, "The Postwar Sex Crime Panic," in *True Stories from the American Past*, ed. William Graebner (New York, 1993), pp. 160-178.

¹²⁹For the original study of Rape Trauma Syndrome, see Ann Burgess and Lynda Holmstrom, "Rape Trauma Syndrome," *American Journal of Psychiatry* 131 (1974): 981-986. On Rape Trauma Syndrome in the New York context, see Governor's Task Force on Rape and Sexual Assault, *Rape, Sexual Assault, and Child Sexual Abuse: Working Towards a More Responsive Society* (Albany, 1990), pp. 124-125 and *People v. Taylor*, 75 NY2d 277 (1990).

¹³⁰Susan Estrich, "Teaching Rape Law," *Yale Law Journal* 102, 2 (November 1992): 519-520.

¹³¹Clifford Krauss, "DNA: The Test of Choice in Rape Cases," *New York Times*, 8 / 13 / 1995, p. 33.

¹³²Jeffrey Moran has recently made a similar argument about the persistence of resistance to modern notions of sexuality in regards to sex education. See " "Modernism Gone Mad": Sex Education Comes to Chicago, 1913," *Journal of American History* 83, 2 (September 1996): 481-513.