

‘Not an Exact Science’: Medical Approaches to Age and Sexual Offences in England, 1850-1914

Submitted by Victoria Louise Bates to the University of Exeter
as a thesis for the degree of Doctor of Philosophy in Medical History
in September 2012

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Abstract

This thesis examines medical approaches to sexual offences in England between 1850 and 1914, with particular attention to law-making and judicial processes. It addresses two key research questions. Firstly, what was the place of medicine in shaping the law on sexual consent and in the implementation of laws on sexual crime? Secondly, can the analytical category of age be used to understand such medical roles? In addressing the first research question, the thesis shows that relationships between medicine, the law and wider society can be understood in terms of negotiation and shared pools of knowledge rather than impact. It demonstrates that medical ideas on sexual crime and sexual consent were deemed sufficiently valuable to be drawn upon widely by different groups, but they were not imposed ‘from above’ by a coherent medical profession. Medical roles thus need to be studied and understood rather than either oversimplified as ‘dominant’ or dismissed as non-existent. In addressing the second research question, the thesis argues that age has been unduly overlooked as a category of analysis in historiography. It shows that ideas about sexual crime shifted in relation to victims of different ages and that age can productively be situated in relation to other analytical categories, particularly class and gender. By moving beyond treating ‘children’ and ‘adults’ as homogeneous categories, this study opens up new ways of understanding histories of medico-legal relations and sexual crime.

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Abbreviations

BMJ	British Medical Journal.
CCR	Crown Cases Reserved.
CDA	Contagious Diseases Act.
CLAA	Criminal Law Amendment Act.
Cox CLC	Cox Criminal Law Cases.
Cr App R	Criminal Appeal Reports.
DRO	Devon Record Office, Exeter.
GA	Gloucestershire Archives, Gloucester.
JP	Justice of the Peace.
LMA	London Metropolitan Archives, London.
LNA	Ladies' National Association for the Repeal of the Contagious Diseases Act.
MP	Member of Parliament.
MRU	Moral Reform Union.
NA	National Archives, Kew.
(N)SPCC	(National) Society for the Prevention of Cruelty to Children.
NVA	National Vigilance Association.
OAPA	Offences against the Person Act.
OED online	Oxford English Dictionary Online (http://dictionary.oed.com).
PP	Parliamentary Papers.
SLT	Scots Law Times.
SPA	Social Purity Alliance.
SRO	Somerset Record Office, Taunton.
SA	Salvation Army
SSA	Social Science Association.

Acknowledgments

I would like to thank the Arts and Humanities Research Council for providing the funding for this research for the last three years [AH/H019553/1]. My appreciation also goes to Oxford University Press for the permission to reproduce a small amount of a recent *Social History of Medicine* article in this thesis.

My gratitude must be extended to the staff of London Metropolitan Archives, Gloucestershire Record Office, Somerset Record Office and Devon Record Office for their help and patience on my many visits.

For academic support, I could not have had a better supervisor than Dr Sarah Toulalan who has provided me with careful feedback and career advice throughout my doctoral studies. My thanks also go to my second supervisor, Professor Kate Fisher, for her constructive and helpful comments on this thesis. I would like to thank both supervisors in addition to Claire Keyte and Mark Jackson for their roles in encouraging and supporting my involvement in organising seminars, workshops and conferences since I began my M.A. in Medical History in 2008. The experience has been invaluable and would not have been possible without the support of the Centre for Medical History. Finally, I am extremely grateful to Dr Jennifer Evans for being kind enough to devote her time to reading my work.

Beyond the purely academic, I would like to thank my family who have always encouraged me to pursue my interests and without whom I would not have made it this far. My particular gratitude goes to Dr Sam Goodman who has given me the most important things of all: love, support and a sense of perspective.

Introduction

In May 2000, the *Guardian* ran an article by the chief executive of the Children's Society, which stated that 'the sexual exploitation of children during Victorian times was widespread, and little has changed since then'.¹ This comparison exemplifies a growing tendency, in both popular culture and academia, to relate recent concerns about 'child sexual abuse' to the historical treatment of children. As Hugh Cunningham notes, '[m]ore, perhaps, than any branch of history, the history of childhood has been shaped by the concerns of the world in which its historians live ... seeking understanding and guidance, people turn to the past'.² Similar comments can be made about the subject of rape, as the influence of second-wave feminism has led an increasing number of scholars to 'turn to the past' since the 1970s.³ Despite the rise of scholarly interest in the social history of medicine in the same period, in the late-twentieth and early-twenty-first centuries the theme of gender has been of paramount interest to historians of sexual crime. In consequence, there have been few medical histories of the subject. Due to interest in histories of 'rape' and 'child sexual abuse', historians also have tended to create clear divisions between sexual crimes against 'children' and against 'adults'. The following thesis addresses these two issues, by providing a medico-legal history of sexual crime and by using age as an analytical category rather than making assumptions about the existence of a child/adult binary.

Summary of Arguments

This thesis examines medical approaches to sexual consent and sexual crime during the period 1850-1914, particularly through age-of-consent debates and the interpretation of sexual consent legislation in judicial contexts.⁴ It examines the place of medical voices

¹ Ian Sparks, 'Age of Innocence', *Guardian Society Supplement*, 24 May 2000 <<http://www.guardian.co.uk/society/2000/may/24/childrenservices.guardiansocietysupplement>> (accessed 20 August 2012). Also cited in Alyson Brown and David Barrett, *Knowledge of Evil: Child Prostitution and Child Sexual Abuse in Twentieth-Century England* (Uffculme: Willan, 2002), p. 14.

² Hugh Cunningham, 'Histories of Childhood', *American Historical Review* 103 (1998), 1195-208, p. 1195.

³ Jocelyn Catty, *Writing Rape, Writing Women in Early Modern England* (Basingstoke: Palgrave Macmillan, 1999), p. xii.

⁴ The thesis often refers to this period (1850-1914) as 'Victorian and Edwardian', including the four years of George V's rule under this umbrella term because of social and cultural continuities. References to

in law-making and in local criminal trials in Middlesex and south-west England. These years were particularly significant for the subject of sexual crime, as they incorporated five pieces of sexual consent and incest legislation passed between 1861 and 1908.⁵ However, it is not only the legal context which makes this period important. The Victorian and Edwardian periods discussed in the thesis have long been considered noteworthy by historians for the attention given to child protection.⁶ The late-nineteenth and early-twentieth centuries also provide an opportunity to engage with the apparent ‘professionalisation’ of medical dealings with the law and with wider society.⁷ In more specific terms, the boundaries of this time period have not been chosen arbitrarily. Stephen Garton notes that ‘British historians ... have pinpointed a crucial shift in Victorian culture around the middle of the [nineteenth] century’ in terms of a growing middle-class emphasis on moral restraint and declining birth rates.⁸ At the other end of the time period Barry M. Coldrey emphasises the significance of the First World War as a point of declining interest in child protection and ‘child abuse’, before the resurgence of such issues in the late-twentieth century.⁹ While not seeking to overstate the uniqueness of any given period, as history is always full of both continuities and discontinuities, it is fair to assert that the period under study had some distinctive characteristics.

To quote Mark Jackson’s work on eighteenth-century infanticide, this study provides ‘more than a microhistory of a singular crime’.¹⁰ The thesis can partly be viewed as a case study of dynamics between ‘high’ and ‘low’ in the construction of medical knowledge. It demonstrates some of the processes by which medical thought on the

‘Victorian and Edwardian’ ideas do not refer to any conception that society was homogeneous. However, the thesis claims that some aspects of the period can be examined as a whole because of trends in thinking about sexual maturity, sexual behaviour, sexual consent and sexual crime.

⁵ See Chapter Three for a more detailed discussion of these pieces of legislation and the ways in which medical ideas shaped their nature, both directly and indirectly.

⁶ For example Lucy Bland, *Banishing the Beast: English Feminism and Sexual Morality 1885-1914* (London: Penguin, 1995); George K. Behlmer, *Child Abuse and Moral Reform in England, 1870-1908* (Stanford: Stanford University Press, 1982); Edward J. Bristow, *Vice and Vigilance: Purity Movements in Britain since 1700* (Dublin: Gill and Macmillan, 1977); Roger Cooter (ed.), *In the Name of the Child: Health and Welfare 1880-1940* (London: Routledge, 1992); Monica Flegel, *Conceptualizing Cruelty to Children in Nineteenth-Century England* (Farnham; Burlington: Ashgate, 2009).

⁷ See the ‘Historiographical Contexts’ section of this introduction for some examples of the literature on ‘professionalisation’.

⁸ Stephen Garton, *Histories of Sexuality* (London: Equinox, 2004), p. 123.

⁹ Barry M. Coldrey, ‘The Sexual Abuse of Children: The Historical Perspective’, *Studies: An Irish Quarterly Review* 85 (1996), 370-80, p. 370.

¹⁰ Mark Jackson, *New-Born Child Murder: Women, Illegitimacy and the Courts in Eighteenth-Century England* (Manchester: Manchester University Press, 1996), p. 22.

subjects of sexual maturity and sexual crime was informed by, and in turn informed, lay and legal ideas about the same issues. It thus responds to Ludmilla Jordanova's observation in 1995 that medical historians need to pay attention to integrating 'the "top down" approach that is so often implicit in social constructionist methods with "bottom up", localist ones'.¹¹ However, terms such as high/top and low/bottom have the potential to mislead by implying that medicine was not interwoven with society at all levels.¹² This thesis is therefore better described as a case study of medicine's place in *shared* cultures rather than high/low cultures.

The primary original argument of this thesis is that medicine was characterised by negotiation with the law and wider society during the period under study. 'Negotiation' means that medicine, as a profession, carried no automatic authority in the contexts studied but that it had the potential to be influential. Medical practitioners needed to create theoretical and practical spaces for their knowledge about sexual development, consent and crime. The thesis considers how medical practitioners negotiated positions in literary markets, pressure groups, Parliament and the courts. It argues that they did so partly by providing scientific validation for wider contemporary frameworks of middle-class thought. The most successful aspects of medicine and medical thinking drew upon existing concerns rather than challenging them. Victorian and Edwardian medicine thus was not always in competition with other forces such as religion or the law, as these social and professional groups could draw upon each other in complementary ways.

Overall, the thesis supports a scholarly shift away from viewing medicine as a coherent 'dominant discourse'.¹³ It traces medical views about sexual offences across non-medical contexts and thereby demonstrates that medical ideas were deemed sufficiently valuable to be drawn upon by members of society and by the law, even in the absence of direct medical input. However, medical concepts were used selectively to validate a range of stances on the issues of sexual consent and sexual crime. Medical practitioners often had no control over how their views were taken up, interpreted and used in law-

¹¹ Ludmilla Jordanova, 'The Social Construction of Medical Knowledge', *Social History of Medicine* 8 (1995), 361-81, p. 377.

¹² The thesis uses 'medicine' to discuss a plethora of settings, from ground-level interactions between general practitioners and patients to the work of pre-eminent medical jurists.

¹³ For a thorough and convincing analysis of the shift away from viewing Foucault's notion of discourses as powerful and coherent in the social history of medicine, see Annemarie Mol, *The Body Multiple: Ontology in Medical Practice* (Durham, NC; London: Duke University Press, 2003), pp. 56-68.

making or the courts. Nevertheless, medical practitioners were not *entirely* dictated to by forces outside their control. They also drew upon social and scientific thought in selective ways to formulate their personal and professional ideas on sexual development, crime and consent. The thesis thus demonstrates that medico-legal relations were negotiated, often on the basis of shared moral concerns, rather than either profession being inherently ‘dominant’ over the other.

The second original argument of this thesis relates to the value of age as an analytical category, particularly in terms of the transition from childhood to adulthood. It demonstrates that paying attention to the subject of age reveals some often overlooked nuances in medical ideas about sexual development, crime and consent. Without making any claims that the subject of age was more important than other key analytical categories, such as class and gender, the thesis pays particular attention to it as a gap in existing scholarship. It takes steps to resolve the following issue raised by Stephen Robertson, who is unique in having closely considered the links between age and sexual crime in the American context:

[There is a] tendency of historians who study age-specific groups to give little or no attention to the meanings of age as such and to rely, instead, on unexamined concepts of the child, the adolescent, and the adult. In doing so, they fail to treat age as a category of analysis. And yet that is exactly how age needs to be regarded. Against the tendency to restrict the concern with age to the history of childhood, we have to be alert to its broader resonance. Ideas about age were not only located in the legal system ... they flowed to that site from medicine, psychology, education, and popular culture, fields that had been permeated by a consciousness of age.¹⁴

This thesis considers not only the ideas about age that flowed ‘to’ or ‘from’ medicine, but also the place of medicine within shared middle-class cultures. It situates age against other important analytical categories such as race, class and gender. The thesis thus shows that Victorian and Edwardian interpretations of sexual crime through the lens of age were never stable or consistent. Tying in with the arguments outlined above, medical notions of links between age and sex were shared and negotiated with other members of society and professional groups. By resisting a temptation to take the legal divisions between childhood and adulthood as representative of wider society, historians

¹⁴ Stephen Robertson, *Crimes against Children: Sexual Violence and Legal Culture in New York City, 1880-1960* (Chapel Hill; London: University of North Carolina Press, 2005), p. 133.

can better understand the complex frameworks of thought surrounding sex and sexual crime.

Although the thesis focuses on negotiations between medical, social and legal frameworks of thought, it does not overlook the central role of the body in shaping medical ideas about age and sex. The analysis highlights a range of different discourses within medicine and notes distinctions between medicine and the law, but does not follow Michel Foucault's argument that 'innumerable institutional devices and discursive strategies' existed around nineteenth-century sex.¹⁵ Instead the study is developed more along the lines of thought put forward by sociologists Allison James, Chris Jenks and Alan Prout in relation to the subject of childhood. They emphasise that the biological elements of a child's body remove the possibility of 'infinite ... constructions of childhood'.¹⁶ They argue that '[t]he issue becomes not whether there exists a "real" body as distinct from the social constructions of it – because this would be taken for granted – but how different claims to "speak for" this body and enrol it in the service of intentional social action are made'.¹⁷ Such comments are applicable to the 'body' at all of its ages and developmental stages. It is the contention of this thesis that medical practitioners and authors represented claims to 'speak for' the body at different ages, whether as medical witnesses or medical authors writing about sexual maturity and consent. However, the thesis deliberately makes no attempt to judge the proportionate role played by biology and society in shaping medical thought on sex and sexual crime. As Prout argues, 'the body and its representations are not mutually exclusive but mutually dependent'; any attempt to separate the two would therefore be a futile one.¹⁸

Historiographical Contexts

In 2007 a journalist described the British nation as 'utterly in thrall to paedophilia' and recent scholarship indicates that historians are no exception to this general rule.¹⁹

¹⁵ Michel Foucault, *The History of Sexuality, Vol. 1. An Introduction*, trans. Richard Hurley (New York: Pantheon, 1978), p. 29.

¹⁶ Allison James, Chris Jenks and Alan Prout, *Theorizing Childhood* (Cambridge: Polity, 1998), p. 147.

¹⁷ James, Jenks and Prout, *Theorizing Childhood*, p. 147.

¹⁸ Alan Prout, 'Childhood Bodies: Construction, Agency and Hybridity' in *The Body, Childhood and Society*, ed. Alan Prout (Basingstoke: Palgrave Macmillan, 2000), 1-18, p. 3.

¹⁹ Brendan O'Neill, 'Misery Lit... Read On', *BBC News*, 17 April 2007

<<http://news.bbc.co.uk/1/hi/magazine/6563529.stm>> (accessed 1 December 2008).

However, undue emphasis should not be placed on histories of ‘child sexual abuse’. In the last 40 years there have been a burgeoning number of histories examining all kinds of sexual crime. In line with the growing field of the social history of medicine, medical historians have also displayed an interest in forensic medicine and to a lesser extent sexual offences. This thesis makes a unique contribution to scholarship by bringing together histories of ‘child sexual abuse’, sexual crime (particularly histories of rape) and forensic medicine in a way that has not yet been attempted in the context of Victorian and Edwardian England.²⁰

According to Lloyd DeMause, writing in 1974, ‘[t]he history of childhood is a nightmare from which we have only recently begun to awaken. The further back in history one goes the lower the level of childcare, and the more likely children are to be killed, abandoned, beaten, terrorized and sexually abused’.²¹ The influence of this comment is indicated by its extensive citation by scholars which, with the exception of the work of Philippe Ariès, has few comparisons within the field of the history of childhood.²² The impact of DeMause’s work is inseparable from the context of the 1970s, when concerns about ‘child abuse’ and ‘child sexual abuse’ were beginning to escalate. Joseph E. Davis has pinpointed 1977 as the year in which sexual abuse was ‘discovered’, although he acknowledges that this anxiety represented the culmination of over a decade of growing concerns about sexual offences against children.²³ Davis’s claims are partially substantiated by the fact that the journal *Child Abuse and Neglect*

²⁰ Although the subject of sodomy has relevance to sexual crime, it has primarily been given scholarly attention as part of the history of homosexuality rather than *forced* sodomy. For example, see H. G. Cocks, ‘Safeguarding Civility: Sodomy, Class and Moral Reform in Early Nineteenth-Century England’, *Past and Present* 190 (2006), 121-46; and Ivan Crozier, “‘All the Appearances Were Perfectly Natural’: The Anus of the Sodomite in Nineteenth-Century Medical Discourse’ in *Body Parts: Critical Explorations in Corporeality*, ed. Ivan Crozier and Christopher E. Forth (Lanham, MD: Lexington, 2005), 65-84. In this section, the subject of indecent assault against males and non-consensual sodomy is broadly included under the ‘child sexual abuse’ literature.

²¹ Lloyd DeMause, ‘The Evolution of Childhood’ in *The History of Childhood*, ed. Lloyd DeMause (New York: Psychohistory Press, 1974), 1-73, p. 1. For another historian who has approached the subject of ‘child sexual abuse’ using psychohistory, see Brett Kahr, ‘The Sexual Molestation of Children: Historical Perspectives’, *Journal of Psychohistory* 19 (1991), 191-214.

²² On 12 August 2010, Google Scholar recorded a citation index of 794 articles for DeMause’s *The History of Childhood* and a further 30 for the 1976 edition. For examples of citations in books by a sociologist, anthropologist and historian respectively see Chris Jenks, *Childhood* (London: Routledge, 1996), p. 59; Heather Montgomery, *An Introduction to Childhood: Anthropological Perspectives on Children’s Lives* (Chichester; Malden, MA: Wiley-Blackwell, 2009), p. 157; and Larry Wolff, *Child Abuse in Freud’s Vienna: Postcards from the End of the World* (New York; London: New York University Press, 1995 [1988]), p. 63.

²³ Joseph E. Davis, *Accounts of Innocence: Sexual Abuse, Trauma, and the Self* (Chicago; London: University of Chicago Press, 2005), p. 57.

was first published in the same year.²⁴ Although the popularity of DeMause's style of psychohistory has declined in the last 20 years, many scholars have continued to examine the so-called 'nightmare' of childhood in history by researching child (sexual) abuse.

The nineteenth and twentieth centuries have become focal points for historians seeking to show that 'child (sexual) abuse' existed in the past. Book-length studies include Alyson Brown and David Barrett's *Knowledge of Evil: Child Prostitution and Child Sexual Abuse in Twentieth-Century England*, George K. Behlmer's *Child Abuse and Moral Reform in England, 1870-1908* and Louise Jackson's *Child Sexual Abuse in Victorian England*.²⁵ In 1992, Carol-Ann Cooper commented that 'public awareness of what we would now call child sexual abuse arose in the 1870s'.²⁶ However, unquestioning historical application of the term overlooks how 'child sexual abuse' carries specific social and cultural connotations. Ian Hacking notes that 'child abuse' has been widely accepted as a social construction since the work of Richard J. Gelles in 1975, and was soon followed by a similar concept of 'child sexual abuse'.²⁷ This understanding of the term as a social construction has generally been examined in cultural and anthropological terms, rather than historical ones. Over a decade ago, the sociologist and criminologist Carol Smart drew attention to the need to deconstruct the term 'child sexual abuse' and problematise its application to the past.²⁸ However, there are few signs that these ideas have crossed disciplinary boundaries. Ten years after Smart's articles, for example, Maria Isabel Romero Ruiz wrote a book chapter entitled 'Child Abuse and White Slavery in Nineteenth-Century Britain' in which she used the

²⁴ *Child Abuse and Neglect* 1 (1977).

²⁵ Brown and Barrett, *Knowledge of Evil*; Behlmer, *Child Abuse and Moral Reform*; Louise A. Jackson, *Child Sexual Abuse in Victorian England* (London: Routledge, 2000). See also Coldrey, 'The Sexual Abuse of Children'; Hughes Evans, 'Physician Denial and Child Sexual Abuse in America, 1870-2000' in *Children's Health Issues in Historical Perspective*, ed. Cheryl Krasnick Warsh and Veronica Strong-Boag (Waterloo, ON: Wilfred Laurier University Press, 2005), 327-54.

²⁶ Carol-Ann Hooper, 'Child Sexual Abuse and the Regulation of Women: Variations on a Theme' in *Regulating Womanhood: Historical Essays on Marriage, Motherhood and Sexuality*, ed. Carol Smart (London: Routledge, 1992), 53-77, p. 56.

²⁷ Ian Hacking, *The Social Construction of What?* (Cambridge, MA; London: Harvard University Press, 1999), p. 133.

²⁸ Carol Smart, 'Reconsidering the Recent History of Child Sexual Abuse, 1910-1960', *Journal of Social Policy* 29 (2000), 55-71; Carol Smart, 'A History of Ambivalence and Conflict in the Discursive Construction of the "Child Victim" of Sexual Abuse', *Social and Legal Studies* 8 (1999), 391-409.

term ‘child abuse’ uncritically.²⁹ A thorough re-examination of the historical language and ideas surrounding sexual offences against children remains necessary.

The single term ‘child sexual abuse’ is not equivalent to the diverse historical terms used to describe sexual offences against children. Despite being a ‘chaotic conception’ made up of component parts, the phrase ‘child sexual abuse’ is often utilised and comprehended in unified terms.³⁰ It is conceptualised as an umbrella term, which incorporates a ‘continuum’ of acts ranging from penetrative sex to the indecent exposure of male genitals to young females.³¹ Conversely, in the late-nineteenth and early-twentieth centuries sexual offences against children were described using a range of terms. Carol Smart rightly notes that intergenerational sex in the mid-twentieth century was described as ‘unlawful carnal knowledge, incest, criminal assault, indecent assault, an outrage, an unnatural act, a slip and so on. It was not conceptualised as abuse, and hence was not referred to as such until the 1970s’.³² Most importantly, she argues that ‘we should not assume that this variety of terms simply reflected different ways of saying the same “thing”’.³³ This thesis builds on Smart’s approach and applies her comments to the late-nineteenth and early-twentieth centuries. It begins from the premise that applying the term ‘child sexual abuse’ historically is not only anachronistic but also restrictive. The use of this term misleadingly implies that some form of unified ‘Victorian and Edwardian’ concept of sexual consent and sexual offences existed. Conversely, conceptualisations of adult-child sex varied between and within professions, social groups and contexts. The best methodological approach to histories of ‘child sexual abuse’ is therefore to avoid utilising such a unifying term at all. Rather than starting with working definitions, this thesis aims to reconstruct the contemporary language and meanings of medical discourses.

²⁹ Maria Isabel Romero Ruiz, ‘Child Abuse and White Slavery in Nineteenth-Century Britain’ in *A Full-Bodied Society*, ed. Logie Barrow and François Poirier (Cambridge: Cambridge Scholars Publishing, 2010), 45-62.

³⁰ Sue Clegg, ‘Studying Child Sexual Abuse: Morality or Science?’, *Radical Philosophy* 66 (1994), 31-40, p. 38.

³¹ David Archard, *Children: Rights and Childhood*, 2nd edn (London: Routledge, 2004 [1993]), p. 205; Jennifer Dunn, ‘Review: When Ontologies Collide It’s a Slippery Slide: Differing Representations of the Social Construction of Child Sexual Abuse’, *Contemporary Sociology* 35 (2006), 355-58; Smart, ‘A History of Ambivalence and Conflict’, p. 393.

³² Smart, ‘A History of Ambivalence and Conflict’, p. 393.

³³ Smart, ‘A History of Ambivalence and Conflict’, p. 393.

Similar discursive problems can be highlighted in relation to definitions of ‘childhood’ itself in historical studies of ‘child sexual abuse’. In *Child Sexual Abuse in Victorian England*, Louise Jackson cites the sociologist Chris Jenks’s statement that ‘childhood is not a natural phenomenon ... childhood is a social construct’ and states that any ‘attempt to fix an age of childhood is of course an artificial categorisation’.³⁴ However, she goes on to state that ‘[i]n writing about “children” and searching for them in court records, I am referring to those whom the Victorians and Edwardians came to define as children as a result of the 1885 Criminal Law Amendment Act: those under the age of 16’.³⁵ This is problematic in implying that it is possible to identify a single ‘Victorian and Edwardian’ notion of when a child became an adult. Although Deborah Gorham rightly notes that ‘[i]n the nineteenth century the idea that children were beings apart from adults was expressed in a variety of new legal and social structures’, notions of ‘difference’ and ‘otherness’ also imply an unrealistic degree of clarity.³⁶ ‘Legal and social structures’ cannot be taken as representative of medical or societal thought. As sociologist André Turmel notes, childhood is not a single category formulated on the basis of law or policy:

[C]hildhood is neither an inevitable consequence of the historical accumulation of western societies’ public policies, be it in the form of infant welfare, compulsory schooling or whatever, nor a simple outcome of experts’ advice to

³⁴Jenks, *Childhood*, p. 6 cited in Jackson, *Child Sexual Abuse*, p. 11; Jackson, *Child Sexual Abuse*, p. 25.

³⁵Jackson, *Child Sexual Abuse*, p. 24. For comments on Louise Jackson’s relatively uncritical approach to age see Harry Hendrick, ‘Reviewed Work: *Child Sexual Abuse in Victorian England* by Louise A. Jackson’, *Journal of Victorian Culture* 6 (2001), 363-69.

³⁶Deborah Gorham, ‘The “Maiden Tribute of Modern Babylon” Re-examined: Child Prostitution and the Idea of Childhood in Late-Victorian England’, *Victorian Studies* 21 (1978), 353-79, p. 363. On childhood as a concept and the problems associated with clear categorisations, some of which are written by historians and many by sociologists, see Pia Haudrup Christensen, ‘Childhood and the Cultural Constitution of Vulnerable Bodies’ in *The Body, Childhood and Society*, ed. Prout, 38-59, p. 43; Lorraine Code, ‘Naming, Naturalizing, Normalizing: “The Child” as Fact and Artifact’ in *Toward a Feminist Developmental Psychology*, ed. Patricia H. Miller and Ellin Kofsky Scholnick (London; New York: Routledge, 2000), 215-37; Hillel Goelman, Sheila K. Marshall and Sally Ross (eds), *Multiple Lenses, Multiple Images: Perspectives on the Child across Time, Space, and Disciplines* (Toronto, ON: University of Toronto Press, 2004); Eric Heinze, ‘The Universal Child?’ in *Of Innocence and Autonomy: Children, Sex and Human Rights*, ed. Eric Heinze (Aldershot: Ashgate, 2000), 3-24; Ludmilla Jordanova, ‘Children in History: Concepts of Nature and Society’ in *Children, Parents and Politics*, ed. Geoffrey Scarre (Cambridge: Cambridge University Press, 1989), 3-24; Kathryn A. Kamp, ‘Dominant Discourses; Lived Experiences: Studying the Archaeology of Children and Childhood’, *Archaeological Papers of the American Anthropological Association* 15 (2005), 115-22; David F. Lancy, *The Anthropology of Childhood: Cherubs, Chattel, Changelings* (Cambridge; New York: Cambridge University Press, 2008); Nick Lee, ‘Faith in the Body? Childhood, Subjecthood and Sociological Enquiry’ in *The Body, Childhood and Society*, ed. Prout, 149-71; Matthew Waites, *The Age of Consent: Young People, Sexuality and Citizenship* (New York: Palgrave Macmillan, 2005).

parents and others. It is, rather, the product of a complex movement of cooperation, conflict and resistance between a broad range of social actors.³⁷

Recently scholars such as Alys Levene and Sally Shuttleworth have approached age more critically in their histories of childhood, by distinguishing between children of different ages.³⁸ However, few steps have been made to take similar approaches to the subjects of sexual crime and ‘child sexual abuse’. The only exception to this trend is Stephen Robertson’s work on sexual crimes against children in New York, 1880-1960, in which he uses age as a central analytical category.³⁹ This thesis makes a similar contribution to scholarship on sexual crime in the English context. It examines how medical evidence in criminal cases varied according to the age of complainants, rather than assuming that childhood was a homogeneous category as in law. In order to achieve this approach, it includes evidence in criminal cases with complainants both above and below the legal age of sexual consent. Because the term ‘child’ was used by contemporaries, it is suitable for use in this thesis as long as its culturally-specific connotations are recognised. As Davin notes, ‘ultimately childhood can only be defined in relative terms. The question “What is a child?” must be followed by further questions: in whose eyes? When? Where? What are the implications?’⁴⁰ The thesis positions these questions as central. It shows that sexual development was conceptualised as a continuum in medicine, which differed from the more clear-cut legal categories found in sexual consent legislation. It also demonstrates how expectations about age-based development varied according to other issues such as gender, class and race.

This analysis has so far paid little attention to *medical* histories of crimes against children, in part because of their limited number. The few medical historians who have paid attention to the subjects of sexual crime and consent have not covered the same time period (1850-1914) and geographical area (London and south-west England) as this thesis. Because social purity and child protection campaigners dominated high-profile debates about the age of sexual consent in the 1880s, medicine has been given a

³⁷ André Turmel, *A Historical Sociology of Childhood* (Cambridge: Cambridge University Press, 2008), p. 6.

³⁸ Alys Levene, ‘Childhood and Adolescence’ in *The Oxford Handbook of the History of Medicine*, ed. Mark Jackson (Oxford; New York: Oxford University Press, 2011), 321-37; Sally Shuttleworth, ‘Victorian Childhood’, *Journal of Victorian Culture* 9 (2004), 107-13, p. 107.

³⁹ Robertson, *Crimes against Children*.

⁴⁰ Anna Davin, ‘What is a Child?’ in *Childhood in Question: Children, Parents and the State*, ed. Anthony Fletcher and Stephen Hussey (Manchester: Manchester University Press, 1999), 15-36, p. 17.

secondary role in many historical accounts of sexual consent legislation and the prosecution of crimes against children.⁴¹ There is therefore great scope for original research on less prominent agents in law-making and judicial processes, such as medicine. Even in *In the Name of the Child*, an edited collection by the medical historian Roger Cooter, Harry Ferguson's chapter on 'child abuse' in the period 1880-1914 focuses on the infant welfare movement.⁴² There is also a relative lack of detailed book-length histories of medical roles in the context of sexual crimes against children, as most studies that address this subject are either book chapters or journal articles. For example, Louise Jackson uses many of the same court records as this thesis but only dedicates a single chapter of her book to the complex issue of medical witnesses.⁴³ Roger Davidson's study of medical roles in early-twentieth-century Scottish 'child sexual abuse' cases provides another example of an article-length study, published in the *Journal of the History of Sexuality* in 2001.⁴⁴ The only comparable book-length study was published by Lynn Sacco in 2009 and considers medical contributions to constructions of incest, with particular attention to the subject of venereal diseases.⁴⁵ This book is largely restricted to the United States and focuses on racial issues that have slightly less relevance to the English context.

Because the central focus of this thesis is 'age' rather than 'children', it also relates to wider scholarship on sexual crime and particularly to historical studies of rape. As with histories of 'child sexual abuse', second-wave feminism created a space for scholarly studies of all types of non-consensual sex and sexual crime. Histories of rape were inspired by writers such as Susan Brownmiller, whose 1977 text *Against Our Will: Men, Women and Rape* constructed the crime in terms of power rather than sex.⁴⁶ These studies have been more diverse in their approaches than histories of 'child sexual

⁴¹ For example Bristow, *Vice and Vigilance*; Gorham, 'The "Maiden Tribute of Modern Babylon"'; Raymond L. Schults, *Crusader in Babylon: W. T. Stead and the Pall Mall Gazette* (Lincoln: University of Nebraska Press, 1972); Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late Victorian London* (Chicago: University of Chicago Press, 1992). See Chapter Three for further discussion of this historiographical focus on first-wave feminist, child protection, social purity and 'white slave trade' debates.

⁴² Harry Ferguson, 'Cleveland in History: The Abused Child and Child Protection, 1880-1914' in *In the Name of the Child*, ed. Cooter, 146-73.

⁴³ Jackson, *Child Sexual Abuse*, ch. 4.

⁴⁴ Roger Davidson, "'This Pernicious Delusion': Law, Medicine, and Child Sexual Abuse in Early-Twentieth-Century Scotland', *Journal of the History of Sexuality* 10 (2001), 62-77.

⁴⁵ Lynn Sacco, *Unspeakable: Father-Daughter Incest in American History* (Baltimore: Johns Hopkins University Press, 2009).

⁴⁶ Susan Brownmiller, *Against Our Will: Men, Women and Rape* (Harmondsworth: Penguin, 1977).

abuse', ranging from histories of colonial law on sexual violence to representations of rape on the Jacobean stage.⁴⁷ A number of studies of local justice in rape cases have also been conducted, as in Carolyn Conley's work on crime in Kent.⁴⁸ The issue of age has received even less attention in these histories of rape than in histories of 'child sexual abuse'. These studies tend to treat 'rape' as a clearly delineated category involving adult women as a homogeneous age group. This thesis is similarly unable to consider distinctions between 'adult' women of different ages, because of the relatively limited number of trials which involved complainants above the age of 16. However, it seeks to destabilise the assumption that adulthood was a clear-cut category. It shows that ideas about the age at which a female developed the 'adult' capacity to understand and resist a rape often differed between and within professions. In the context of sexual offences, notions of adulthood were influenced by wide-ranging factors such as a female's bodily development and perceived character. The age at which a female was deemed to be an adult in body and mind was also influenced by their class, gender and race. The analysis brings together histories of 'child sexual abuse' and 'rape' by considering the boundaries between childhood and adulthood, as well as by bringing together the analytical categories of gender and age.

As discussed in relation to 'child sexual abuse' scholarship, histories of rape have been more commonly addressed by feminist scholars than by medical historians.⁴⁹ A gendered focus is by no means inappropriate due to the gendered subject matter, but it has often led medicine to be presented as a form of homogenised masculinity to the

⁴⁷ Karen Bamford, *Sexual Violence on the Jacobean Stage* (New York: St. Martin's Press, 2000); Elizabeth Kolsky, "'The Body Evidencing the Crime": Rape on Trial in Colonial India, 1860-1947', *Gender & History* 22 (2010), 109-30. For some further examples of the extensive literature on rape in history see Julie Gammon, "'A Denial of Innocence": Female Juvenile Victims of Rape and the English Legal System in the Eighteenth Century' in *Childhood in Question*, ed. Fletcher and Hussey, 74-95; Roy Porter, 'Rape – Does it have a Historical Meaning?' in *Rape: An Historical and Cultural Enquiry*, ed. Roy Porter and Sylvana Tomaselli (Oxford: Basil Blackwell, 1986), 216-36.

⁴⁸ Carolyn A. Conley, 'Rape and Justice in Victorian England', *Victorian Studies* 29 (1986), 519-36; Carolyn A. Conley, *The Unwritten Law: Criminal Justice in Victorian Kent* (Oxford: Oxford University Press, 1991).

⁴⁹ Harry Hendrick describes Louise Jackson's work as 'unremittingly feminist' in Hendrick, 'Reviewed Work: *Child Sexual Abuse*', p. 366. For other examples of feminist approaches to the history of rape and sexual crime, see also Anna K. Clark, 'Rape or Seduction? A Controversy over Sexual Violence in the Nineteenth Century' in *The Sexual Dynamics of History: Men's Power, Women's Resistance*, ed. The London Feminist History Group (London: Pluto Press, 1983), 13-27; Shani D'Cruze, *Crimes of Outrage: Sex, Violence and Victorian Working Women* (London: UCL Press, 1998); Shani D'Cruze and Louise A. Jackson, *Women, Crime and Justice in England since 1660* (Basingstoke; New York: Palgrave Macmillan, 2009); Lynn A. Higgins and Brenda R. Silver (eds), *Rape and Representation* (Chichester: Columbia University Press, 1991); Catherine A. MacKinnon, 'Feminism, Marxism, Method, and the State: Toward Feminist Jurisprudence', *Signs* 8 (1983), 635-58.

detriment of alternative explanatory frameworks of medical roles in sexual assault cases. Although some scholars have recently advanced beyond treating medical practitioners as ‘men’ judging ‘women’, such work has only been conducted for different regions or time periods to those under study for this thesis. Joanna Bourke has paid careful attention to ‘rape trauma syndrome’ and medical categories relating to sexual offenders in the late-twentieth century, for example.⁵⁰ Neither of these issues is relevant to the thesis which, in the light of Victorian and Edwardian medical frameworks of thought about sexual crime, focuses on the body and victimhood rather than the mind and/or sexual offenders.⁵¹ Stephen Robertson’s important article from 1998, ‘Signs, Marks, and Private Parts: Doctors, Legal Discourses, and Evidence of Rape in the United States, 1823-1930’, does not consider English contexts.⁵² Willemijn Ruberg has recently published on the subject of how medicine negotiated its place in relation to lay knowledge in Dutch rape cases, also without considering the English courts.⁵³ Many of these pieces of scholarship, although valuable, are also only article length. This thesis seeks to provide a closer history of medical roles in English legal contexts, in relation to sexual offences.

The thesis also contributes a new perspective to the history of forensic medicine by presenting a case study of sexual crime in local courts. To date much work on forensic medicine has focused on forensic pathology and insanity, although there have been some studies of medical evidence in trials for specific crimes such as infanticide.⁵⁴ Few

⁵⁰ Joanna Bourke, *Rape: A History from 1860 to the Present Day* (London: Virago, 2007); Joanna Bourke, ‘Sexual Violation and Trauma in Perspective’, *Arbor-Ciencia Pensamiento Y Cultura* 743 (2010), 407-16.

⁵¹ See Chapter Five, which shows that trauma was conceptualised as a form of nervous shock rather than a long-term psychological issue in the period. This thesis also focuses on victims rather than offenders because of the limited notion of ‘sexual psychopath’ or paedophile in the period. While sexual offenders were a great moral concern of the period they were not considered to be a medical issue, with the exception of some ‘deviant’ sexualities. On the contemporary nature and development of such categories, in addition to Joanna Bourke’s work already cited, see: Steven Angelides, ‘The Emergence of the Paedophile in the Late Twentieth Century’, *Australian Historical Studies* 37 (2005), 272-95; and Mark S. Micale and Paul Lerner, ‘Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction’ in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930*, ed. Mark S. Micale and Paul Lerner (Cambridge: Cambridge University Press, 2001), 1-30.

⁵² Stephen Robertson, ‘Signs, Marks, and Private Parts: Doctors, Legal Discourses, and Evidence of Rape in the United States, 1823-1930’, *Journal of the History of Sexuality* 8 (1998), 345-88.

⁵³ W. G. Ruberg, ‘“Mother Knows Best”: The Transmission of Knowledge of the Female Body and Venereal Diseases in Nineteenth-Century Dutch Rape Cases’ in *The Transmission of Health Practices (c. 1500 to 2000)*, ed. Martin Dinges and Robert Jütte (Stuttgart: Franz Steiner Verlag, 2001), 35-47; Willemijn Ruberg, ‘Trauma, Body and Mind: Forensic Medicine in Nineteenth Century Dutch Rape Cases’, *Journal of the History of Sexuality* (forthcoming, January 2013).

⁵⁴ On insanity see Joel Peter Eigen, *Unconscious Crime: Mental Absence and Criminal Responsibility in Victorian London* (Baltimore; London: Johns Hopkins University Press, 2003); Roger Smith, *Trial by*

historians of forensic medicine or medical ‘expertise’ in court have considered the context of non-consensual sex. Ivan Crozier and Gethin Rees are atypical not only in considering medical roles in nineteenth-century English rape cases but also in using their study to consider the issues of medico-legal relations and medical ‘expertise’. They have co-authored a journal article which examines ‘boundary work’ in the carving of medical and legal spheres of ‘expertise’ in cases of suspected sexual crime, which is of relevance to the current study.⁵⁵ However, it draws largely on medical jurisprudence literature rather than considering medicine in practice. The latter approach, as taken in this thesis, actually problematises the notion of ‘boundaries’ between medicine and the law. Trials for sexual offences allow for a new approach to medico-legal relations, as they present a context in which medicine and the law drew upon shared moral concerns rather than being in a constant state of competition for ‘truth’. The thesis also demonstrates that many of the national trends identified by scholars of ‘expert witnesses’ such as Tal Golan and Carol Jones were not necessarily applicable at a local level.⁵⁶ It thus has broad relevance to histories of forensic medicine and ‘expertise’ by showing the value of studying medico-legal relations in a range of contexts and at both local and national levels.⁵⁷

Medicine: Insanity and Responsibility in Victorian Trials (Edinburgh: Edinburgh University Press, 1981); Tony Ward, ‘Law, Common Sense and the Authority of Science: Expert Witnesses and Criminal Insanity in England, ca. 1840-1940’, *Social & Legal Studies* 6 (1997), 343-62. On pathology see Ian A. Burney, *Bodies of Evidence: Medicine and the Politics of the English Inquest, 1830-1926* (Baltimore, MD: Johns Hopkins University Press, 2000); Thomas Rogers Forbes, *Surgeons at the Bailey: English Forensic Medicine to 1878* (New Haven: Yale University Press, 1985). For other case studies of specific crimes or forensic techniques see Simon A. Cole, ‘Witnessing Identification: Latent Fingerprinting Evidence and Expert Knowledge’, *Social Studies of Science* 28 (1998), 687-712; Jackson, *New-Born Child Murder*.

⁵⁵ Ivan Crozier and Gethin Rees, ‘Making a Space for Medical Expertise: Medical Knowledge of Sexual Assault and the Construction of Boundaries between Forensic Medicine and the Law in late Nineteenth-Century England’, *Law, Culture and the Humanities* 8 (2012), 285-304.

⁵⁶ Tal Golan, *Laws of Men and Laws of Nature: The History of Scientific Expert Testimony in England and America* (Cambridge, MA; London: Harvard University Press, 2004); Carol Jones, *Expert Witnesses: Science, Medicine and the Practice of Law* (Oxford: Clarendon Press, 1994). See also Christopher Hamlin, ‘Scientific Method and Expert Witnessing: Victorian Perspectives on a Modern Problem’, *Social Studies of Science* 16 (1986), 485-513; Catherine Crawford, ‘A Scientific Profession: Medical Reform and Forensic Medicine in British Periodicals of the Early Nineteenth Century’ in *British Medicine in an Age of Reform*, ed. Roger French and Andrew Wear (London; New York: Routledge, 1991), 203-30; M. Anne Crowther, ‘Forensic Medicine and Medical Ethics in Nineteenth-Century Britain’ in *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Centuries*, ed. Robert Baker, vol. 2 (Dordrecht; London: Kluwer Academic Publishers, 1995), 173-90; M. Anne Crowther and Brenda White, *On Soul and Conscience: The Medical Expert and Crime: 150 Years of Forensic Medicine in Glasgow* (Aberdeen: Aberdeen University Press, 1988).

⁵⁷ ‘Expertise’ is in inverted commas throughout the thesis, not to indicate that it is a quote but rather to highlight the contested nature of such a category.

The thesis is situated at an intersection between medical, legal and social studies of sex and sexual crime. For this reason, it has been impossible to review all relevant literature or to demonstrate fully the potential contribution of this thesis to various fields of study and historiographical ‘gaps’. However, the range of scholarship that this thesis draws upon and contributes to should briefly be noted. Its primary argument about the negotiated nature of medical authority supports historiography on the contested nature of Victorian and Edwardian medical ‘professionalisation’, specialisation and ‘expertise’.⁵⁸ As noted above in the ‘summary of arguments’ it also speaks to scholarship on medical knowledge and supports recent reinterpretations of Foucauldian ideas about power and medical authority, such as Annemarie Mol’s nuanced work which emphasises the heterogeneous nature of medical knowledge.⁵⁹ In terms of more specific topics, the thesis touches upon histories of wide-ranging but relevant subjects such as sexuality, prostitution, venereal disease and sexual trauma.⁶⁰ By focusing on medical ideas about the age(s) of transition from childhood and adulthood, the study

⁵⁸ For example see John C. Burnham, ‘How the Idea of Profession Changed the Writing of Medical History’, *Medical History* suppl. no. 18 (1998), 1-195; M. J. D. Roberts, ‘The Politics of Professionalization: MPs, Medical Men, and the 1858 Medical Act’, *Medical History* 53 (2009), 37-56; George Weisz, *Divide and Conquer: A Comparative History of Medical Specialization* (Oxford: Oxford University Press, 2006).

⁵⁹ On power and medical authority see: David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press, 1983); Ludwik Fleck, *Genesis and Development of a Scientific Fact*, ed. Thaddeus J. Trenn and Robert K. Merton, trans. Frederick Bradley and Thaddeus J. Trenn (Chicago: University of Chicago Press, 1979 [1935]); Jordanova, ‘The Social Construction of Medical Knowledge’; Deborah Lupton, ‘Foucault and the Medicalisation Critique’ in *Foucault, Health and Medicine*, ed. Alan Petersen and Robin Bunton (London: Routledge, 1997), 94-112; Mol, *The Body Multiple*; Roy Porter and Lesley Hall, *The Facts of Life: The Creation of Sexual Knowledge in Britain, 1650-1950* (New Haven; London: Yale University Press, 1995).

⁶⁰ Just a few of the relevant examples are cited here because of space constraints; see the bibliography for a fuller list of relevant literature. For some of the key texts on sexuality see: Foucault, *The History of Sexuality*; Catherine Gallagher and Thomas Laqueur (eds), *The Making of the Modern Body: Sexuality and Society in the Nineteenth Century* (Berkeley; London: University of California Press, 1987); Michael Mason, *The Making of Victorian Sexuality* (Oxford; New York: Oxford University Press, 1994); Frank Mort, *Dangerous Sexualities: Medico-Moral Politics in England since 1830* (London: Routledge, 1987); Robert A. Nye (ed.), *Sexuality* (Oxford; New York: Oxford University Press, 1999); and Jeffrey Weeks, *Sex, Politics and Society: The Regulation of Sexuality since 1800* (London: Longman, 1981). On prostitution see: Vern L. Bullough and Bonnie Bullough, *Women and Prostitution: A Social History* (Buffalo, NY: Prometheus Books, 1987); Trevor Fisher, *Prostitution and the Victorians* (Stroud: Sutton, 1997); Paul McHugh, *Prostitution and Victorian Social Reform* (London: Croom Helm, 1979); and Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge: Cambridge University Press, 1980). On venereal diseases see: Peter Lewis Allen, *The Wages of Sin: Sex and Disease, Past and Present* (London; Chicago: The University of Chicago Press, 2000); Allan M. Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, expanded edn (New York: Oxford University Press, 1987 [1985]); K. J. Taylor, ‘Venereal Diseases in Nineteenth-Century Children’, *Journal of Psychohistory* 12 (1985), 431-64; and Claude Quénel, *History of Syphilis*, trans. Judith Braddock and Brian Pike (London: Polity Press in association with Basil Blackwell, 1990 [1986]). On trauma see: Bourke, ‘Sexual Violation and Trauma in Perspective’; Davis, *Accounts of Innocence*; and Micale and Lerner (eds), *Traumatic Pasts*.

contributes to medical histories of sexual maturity and sexual development. Although a small number of historical studies have examined the subject of puberty from a medical perspective, most notably Helen King's work on chlorosis, nearly all have focused on questions of gender difference and on the characteristics associated with puberty rather than taking the approach of this thesis by examining the age at which it was expected to occur.⁶¹ The thesis also connects to a number of important subject areas other than medical history. For example, Chapter Two contributes to histories of social science, statistics and normality because it discusses how the nineteenth-century statistical turn was used to define 'normal' ages of puberty.⁶² Histories of crime provide another example of the relevance of this thesis beyond medical history, as Chapter Four considers the processes by which criminal cases reached trial.⁶³ Beyond historiography, the thesis draws upon sociological and anthropological studies which provide

⁶¹ There is a more extensive field of study relating to UK and international histories of child development, adolescence, precocious puberty and 'normal' bodily changes at puberty in relation to the 'abnormal' such as hermaphroditism. However, most of these also focus on the perceived *characteristics* of bodily change and puberty rather than detailed analysis of the age at which it was expected to occur. See Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* (Cambridge, MA; London: Harvard University Press, 1998); Crista DeLuzio, *Female Adolescence in American Scientific Thought, 1830-1930* (Baltimore: Johns Hopkins University Press, 2007); Helen King, *The Disease of Virgins: Green Sickness, Chlorosis and the Problems of Puberty* (London: Routledge, 2004); R. P. Neuman, 'Masturbation, Madness, and the Modern Concepts of Childhood and Adolescence', *Journal of Social History* 8 (1975), 1-27; Robert A. Nye, 'Developmental Biology and Psychology' in *Sexuality*, ed. Nye, 253-54; M. Jeanne Peterson, 'Precocious Puberty in the Victorian Medical Gaze', *Nineteenth-Century Gender Studies* 4 (2008) <<http://www.ncgsjournal.com/issue42/peterson.htm>> (accessed 23 May 2012); Alice Schlegel, 'The Cultural Management of Adolescent Sexuality' in *Sexual Nature, Sexual Culture*, ed. Paul R. Abramson and Steven D. Pinkerton (Chicago; London: University of Chicago Press, 1995), 177-94; Sally Shuttleworth, 'Female Circulation: Medical Discourse and Popular Advertising in the Mid-Victoria Era' in *Body Politics: Women and the Discourses of Science*, ed. Mary Jacobus, Evelyn Fox Keller and Sally Shuttleworth (Oxford; New York: Routledge, 1990), 47-68.

⁶² For example see: Georges Canguilhem, *The Normal and the Pathological*, trans. Carolyn R. Fawcett (New York: Zone Books, 1989); Anna G. Creadick, *Perfectly Average: The Pursuit of Normality in Postwar America* (Amherst; Boston: University of Massachusetts Press, 2010); Waltraud Ernst (ed.), *Histories of the Normal and the Abnormal*; Lynn Fendler and Irfan Muzaffar, 'The History of the Bell Curve: Sorting and the Idea of Normal', *Educational Theory* 58 (2008), 63-82; Jane Fielding and Nigel Gilbert, *Understanding Social Statistics* (London: SAGE Publications, 2006); Ian Hacking, 'Normal People' in *Modes of Thought: Explorations in Culture and Cognition*, ed. Nancy Torrance and David R. Olson (Cambridge: Cambridge University Press, 1996), 59-71; J. M. Tanner, *A History of the Study of Human Growth* (Cambridge: Cambridge University Press, 1981); Eileen Yeo, 'Social Surveys in the Eighteenth and Nineteenth Centuries' in *The Cambridge History of Science: The Modern Social Sciences*, ed. Theodore M. Porter and Dorothy Ross (Cambridge: Cambridge University Press, 2003), 83-99.

⁶³ For some relevant histories of general crime see Victor Bailey (ed.), *Policing and Punishment in Nineteenth-Century Britain* (London: Croom Helm, 1981); Jennifer Davis, 'Prosecutions and their Context: The Use of the Criminal Law in Later Nineteenth-Century London' in *Policing and Prosecution in Britain, 1750-1850*, ed. Douglas Hay and Francis Snyder (Oxford: Clarendon Press, 1989), 397-426; Clive Emsley, *Crime and Society in England, 1750-1900*, 3rd edn (Harlow: Longman, 2005 [1987]); Peter King, *Crime, Justice, and Discretion in England 1740-1820* (Oxford: Oxford University Press, 2003); R. D. Summers, 'History of the Police Surgeon', *Practitioner* 221 (1978), 383-87; Carolyn Steedman, *Policing the Victorian Community: The Formation of English Provincial Police Forces, 1856-80* (London: Routledge & Kegan Paul, 1984); Martin J. Wiener, *Reconstructing the Criminal: Culture, Law and Policy in England, 1830-1914* (Cambridge: Cambridge University Press, 1990).

frameworks for understanding social anxieties about childhood, puberty, pollution, sexual consent and scientific 'expertise'.⁶⁴

This discussion of historiographical and scholarly contexts has sought to highlight the main ways in which the thesis is both original and important. It has emphasised that the thesis takes a new approach to the study of sexual crime by merging histories of 'child sexual abuse' and 'rape'. This methodology is novel in positioning age as a central category of analysis, rather than defining childhood or adulthood at the study's outset. The thesis also presents a uniquely detailed case study of medical roles in legal contexts relating to sexual crime. It consolidates and builds on some important existing work in this field, by considering the contested nature of medical 'expertise' in the period 1850-1914 and by closely analysing processes of negotiation and exchange between medicine, the law and wider society.

Primary Sources

This study draws upon a range of sources in order to situate medicine within wider frameworks of social and legal thought. By far the most extensively used primary sources are medical literature and court records, which complement each other by allowing the thesis to move from examining medical ideas about sexual development, consent and crime to the practical implementation of these ideas in a judicial context. They will be considered here in turn, with particular attention to their value and limitations.

The medical literature used for this thesis is selected from a cross-section of genres, in order to examine a range of medical ideas about sexual consent and their place both within and beyond the profession. The thesis compares medical literature from specialist or specific areas of medicine such as psychiatry, physiology, sexology,

⁶⁴ The sociology and anthropology texts drawn on for this thesis include Thomas Buckley and Alma Gottlieb (eds), *Blood Magic: The Anthropology of Menstruation* (Berkeley, CA; London: University of California Press, 1988); Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo* (London: Routledge and Kegan Paul, 1978); Matthew Engelke, *The Objects of Evidence: Anthropological Approaches to the Production of Knowledge* (London: Royal Anthropological Society, 2008); Thomas F. Gieryn, 'Boundary-Work and the Demarcation of Science from Non-Science: Strains and Interests in Professional Ideologies of Scientists', *American Sociological Review* 48 (1983), 781-95; Robert A. LeVine, 'Anthropology and Child Development', *New Directions for Child Development* 8 (1980), 71-86; Montgomery, *An Introduction to Childhood*; Lancy, *The Anthropology of Childhood*; Waites, *The Age of Consent*.

gynaecology and medical jurisprudence. It also examines general medical journals, particularly *The Lancet* and the *British Medical Journal (BMJ)* as the two most widely-read journals of the period.⁶⁵ This is not to say that a small selection of medical literature can reveal everything about medical ideas on a given subject, as medical writings were both varied and extensive. For example William F. Bynum identifies 100 separate publications in the context of venereal diseases alone in the eighteenth century, which were authored by a range of disparate medical and fringe practitioners and differed according to their markets.⁶⁶ It would be impossible to examine every medical text on the broad subject areas relevant to this thesis such as sexual maturity, sexual behaviour and sexual consent. The thesis therefore, for the purposes of manageability and coherence, focuses on works by qualified medical practitioners and excludes ‘the subterranean stream of popular writings ... by medical hacks and charlatans’.⁶⁷ Although the thesis includes some medical literature aimed at and read by a lay market, most writings by qualified medical practitioners were designed for their professional colleagues.⁶⁸ As M. Jeanne Peterson notes, much of this literature therefore represents a form of ‘professional discourse’.⁶⁹ However, the thesis emphasises that ‘professional discourses’ of this kind were not cut off from wider society.

The thesis also focuses on the most widely-distributed medical journals and books, particularly when discussing ‘mainstream’ medicine.⁷⁰ Many of the medical books discussed in this thesis have been chosen because they had multiple editions. George R. Drysdale’s *The Elements of Social Science* is a notable example, as it reached 35

⁶⁵ The *British Medical Journal (BMJ)* acquired its name in 1856, due to the new naming of the British Medical Association. Prior to this it had a range of names including *Provincial Medical and Surgical Journal* and *Association Medical Journal*. See Elizabeth Fee, ‘Science and the “Woman Question” 1860-1920: A Study of English Scientific Periodicals’, unpublished doctoral thesis, Princeton University (1978), pp. 188-89.

⁶⁶ W. F. Bynum, ‘Treating the Wages of Sin: Venereal Disease and Specialism in Eighteenth-Century Britain’ in *Medical Fringe and Medical Orthodoxy 1750-1850*, ed. W. F. Bynum and Roy Porter (London: Croom Helm, 1987), 5-28, p. 10

⁶⁷ F. Barry Smith, ‘Sexuality in Britain, 1800-1900: Some Suggested Revisions’ in *A Widening Sphere: Changing Roles of Victorian Women*, ed. Martha Vicinus (Indiana University Press, 1977), 182-98, p. 193.

⁶⁸ Chapter Six addresses the subject of literacy in more depth, but it is worth noting here that English society was increasingly literate in the period under study. The primarily middle-class lay readers of the most successful moralistic medical textbooks on sex, such as the works of William Acton, were certainly capable of reading and engaging with the works.

⁶⁹ Peterson, ‘Precocious Puberty’.

⁷⁰ I use ‘mainstream’ in this thesis to refer to ideas that were widely-circulated and cited regularly and positively by others in general textbooks or popular journals such as *The Lancet* and *BMJ*, as opposed to ideas circulated solely within specialist literature or occasional articles written by specialists even if they reached mainstream journals.

editions and sold 80,000 copies between publication in 1854 and 1905.⁷¹ Reaching just three editions was cited by the *BMJ* as a sign that a book had ‘met with a considerable number of readers’.⁷² Such wide medical readership had been made possible by the rise of steam-powered printing, first used by *The Times* in 1814, which meant that scientific books could be mass produced and distributed throughout London and provincial booksellers if there was suitable demand.⁷³ Although Stephen Garton rightly notes that even ‘best sellers were probably not the main way in which the bulk of the population sought and obtained information’ about sex, medical literature provides a helpful indicator of the relative popularity of different ways of thinking within and beyond scientific communities.⁷⁴

Two types of medical literature in particular, medical journals and medical jurisprudence texts, are drawn upon extensively throughout the study. When considering which medical journals succeeded in ‘having had a long a vigorous life’ during the period 1860-1920, Elizabeth Fee justifiably declares that *The Lancet* and *BMJ* were ‘clearly the front runners’.⁷⁵ Their extensive use in the following study reflects this contemporary importance. They were not intended for lay readers, but this does not undermine their significance as both creators and reflectors of medical knowledge at all levels of the profession.⁷⁶ Wide geographical distribution of these journals was possible because of ‘[t]he transport revolution and postal reform’.⁷⁷ Peter

⁷¹ Robert Jütte, *Contraception: A History*, trans. V. Russell (Cambridge: Polity Press, 2008), p. 108; Angus McLaren, *Birth Control in Nineteenth-Century England* (London: Croom Helm, 1978), p. 114 n. 4; G. R. Drysdale, *The Elements of Social Science; or Physical, Sexual and Natural Religion. An Exposition of the True Cause and Only Cure of the Three Primary Social Evils: Poverty, Prostitution, and Celibacy*, 27th edn (London: E. Truelove, 1889 [1854]).

⁷² ‘Reviews and Notices of Books: *The Functions and Disorders of the Reproductive Organs*, by William Acton, M.R.C.S’, *The Lancet*, 17 May 1862, 518, p. 518.

⁷³ James Raven, *The Business of Books: Booksellers and the English Book Trade, 1450-1850* (New Haven: Yale University Press, 2007), pp. 321-37; Aileen Fyfe, ‘Steam and the Landscape of Knowledge: W. & R. Chambers in the 1830s-1850s’ in *Geographies of the Book*, ed. Miles Ogborn and Charles W. J. Withers (Farnham, England; Burlington, VT: Ashgate, 2010), 51-78, p. 51. For an example of a nineteenth-century Devon bookseller who acquired a specific text for a local medical practitioner, albeit on the subject of typhoid fever in this case, see Ann Adams, *The Budds of North Tawton: A Nineteenth-Century Devon Medical Family* (Addlestone: Hayne Books, 2010), pp. 220-21.

⁷⁴ Garton, *Histories of Sexuality*, p. 112.

⁷⁵ Fee, ‘Science and the “Woman Question” 1860-1920’, p. 184. For basic information on *The Lancet* and *BMJ* see also William R. LeFanu, *British Periodicals of Medicine: A Chronological List 1640-1899*, revised edn (Oxford: Wellcome Unit for the History of Medicine, 1984 [1937]), pp. 11, 22.

⁷⁶ Michael Harris, ‘Social Diseases? Crime and Medicine in the Victorian Press’ in *Medical Journals and Medical Knowledge: Historical Essays*, ed. W. F. Bynum, Stephen Lock and Roy Porter (London: Routledge, 1992), 108-25, p. 123.

⁷⁷ Peter W. J. Bartrip, *Mirror of Medicine: A History of the British Medical Journal* (Oxford: British Medical Journal; Clarendon Press, 1990), p. 9.

Bartrip cites circulation figures of several thousand for *The Lancet* just two years after it was launched in 1823 and figures of 30,000 for the *BMJ* by the early-twentieth century.⁷⁸ It also should not be assumed that these journals only contained the views of elites. Rural and urban medical practitioners alike not only read but also contributed case reports or opinion pieces to the two journals. As Anne Digby notes, ‘[t]he habit of sending off a single contribution to the *BMJ* or *Lancet* appears to have become much more common during the second part of the nineteenth century’.⁷⁹ This claim is supported by the observations of contemporary authors, as indicated by James Clarke’s 1874 *Autobiographical Recollections of the Medical Profession* in which he noted that ‘these days ... every man is a lecturer or “author” and publishes his narratives in the journals or in monographs’.⁸⁰ The two journals are useful to consider together, as *The Lancet* favoured ‘rhetorical explosions’ and reformism under the editorial influence of ‘the Wakley clan’ whereas the *BMJ* tended to be more conservative and ‘respectable’ because of its links to the British Medical Association.⁸¹ However, as this thesis demonstrates, both journals also had a range of contributors and never occupied a single position on political reforms such as sexual consent legislation. They therefore provide an insight into different medical perspectives on issues such as puberty, sexual behaviour, consent and crime.

Books of medical jurisprudence, also known as forensic medicine, provide an equally important form of contemporary literature although they served a very different purpose. These books were designed to guide medico-legal testimony and covered a range of subjects including rape, sodomy and other sexual crime. *The Lancet* noted that certain members of the profession, such as house surgeons of hospitals, were particularly likely to keep up to date with medico-legal literature because they found ‘medico-legal work profitable’ and might work as lecturers on the subject.⁸² However, the texts were by no means unrepresentative of general practice. They were commonly drawn from lectures given to medical students, as courses in forensic medicine were

⁷⁸ Bartrip, *Mirror of Medicine*, pp. 11, 185.

⁷⁹ Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999), p. 216.

⁸⁰ James Fernandez Clarke, *Autobiographical Recollections of the Medical Profession* (London: J. & A. Churchill, 1874), p. 116.

⁸¹ Fee, ‘Science and the “Woman Question” 1860-1920’, pp. 183-88; ‘Our Three Thousandth Number’, *BMJ*, 29 June 1918, 729, p. 729.

⁸² H. A. Lediard, ‘Our Criminal Procedure: Scientific Imperfections and Remedy’, *The Lancet*, 18 October 1890, 812-14, p. 813.

popular in England and compulsory in Scotland.⁸³ The subject was also not simply dropped once a medical practitioner qualified. This thesis demonstrates that forensic medicine was often left to general practitioners in the period under study rather than being a specialist subject. Both rural and urban general practitioners utilised these books to guide their testimony. In the court records used for this study a London surgeon started one sentence in his pre-trial statement with ‘[i]t is stated in Books of Medical Jurisprudence that ...’ and a Gloucestershire surgeon referred to ‘the indications given in the legal books as evidence of rape’.⁸⁴ There is thus evidence that medical jurisprudence texts were widely distributed and read. Although this thesis focuses on British literature as the most representative of the profession, the widespread distribution of medical jurisprudence books was both national and international. A copy of one American jurisprudence text held by London’s Wellcome Library has a handwritten inscription of ‘Thos Stevenson M.D., 1875’ on the first page.⁸⁵ As it was initially published in 1873, this book had found its way into the hands of an eminent British toxicologist and forensic scientist very rapidly. Forensic medicine texts were also used by members of the judiciary. Medical journals repeatedly commented in their reviews that the books were in the ‘interest of the practitioner and of the lawyer’ and that ‘[I]awyers, as well as doctors, find the work of value to them’.⁸⁶ Books of medical jurisprudence were therefore drawn upon and utilised by members of a range of professions, which makes them a useful means of considering shared medico-legal pools of knowledge about rape and sexual crime.

The thesis draws upon a range of forensic medicine texts including popular works aimed at students, such as H. Aubrey Husband’s *Student’s Handbook of the Practice of*

⁸³ Crowther and White, *On Soul and Conscience*, p. 3; Forbes, *Surgeons at the Bailey*, pp. 7-15; Jennifer Ward, ‘Origins and Development of Forensic Medicine and Forensic Science in England 1823-1946’, unpublished doctoral thesis, Open University (1993), pp. 22-114; William A. Guy and David Ferrier, *Principles of Forensic Medicine*, 5th edn (London: Henry Renshaw, 1881 [1844]), pp. 1-2. For manuscript evidence of a medical student preparing for and taking examinations on forensic medicine see London, The Wellcome Library, Diary of Albert Ruskin Cook 1894-95, MSS PP/COO/G/9:Box 4, entries for 23 July 1895, 25 July 1895, 23 October 1895, 30 October 1895, 31 October 1895, 22 November 1895, 9 December 1895.

⁸⁴ London, London Metropolitan Archives (LMA), Pre-Trial Statements, James Westhall tried at the Middlesex Sessions on 29 September 1868 for carnal knowledge, MJ/SP/E/1865/003; Gloucester, Gloucestershire Archives (GA), Pre-Trial Statements, Thomas Cobb tried at the Gloucestershire Quarter Sessions on 19 October 1898 for assault with intent, Q/SD/2/1898.

⁸⁵ Francis Wharton and Moreton Stillé, *Medical Jurisprudence*, 3rd edn (Philadelphia: Kay, 1873 [1855]).

⁸⁶ ‘*Principles of Forensic Medicine* by W. A. Guy, M.B. Cantab., Professor of Forensic Medicine, King’s College. 3rd edition, enlarged. London: 1868’, *Edinburgh Medical Journal* 14 (1868-69), 157, p. 157; ‘*Medical Jurisprudence* by Alfred Swaine Taylor, M.D., F.R.S., F.R.C.P. Seventh Edition’, *BMJ*, 9 November 1861, 505, p. 505.

Medicine. When its fifth edition was published in 1889, the *Edinburgh Medical Journal* observed that ‘[t]he fact that this book has gone through so many editions must be taken as evidence of its popularity among a certain class of readers’.⁸⁷ The thesis also engages with the work of the Scottish author Francis Ogston, whose work was aimed at both Scottish and English medical markets. Ogston trained in medical jurisprudence with the famous French professor Auguste Ambroise Tardieu, who has been noted for his early recognition of the ‘reality’ and extent of sexual offences against children in the period under study.⁸⁸ Overall the thesis pays most attention to Alfred Swaine Taylor’s medical jurisprudence textbooks. Taylor was a high-profile lecturer in medical jurisprudence at Guy’s Hospital and an ‘expert’ medical witness, most famous for his work on toxicology and in poisoning trials.⁸⁹ His textbooks were by far the most widely read of the period. Their popularity is indicated by the fact that his *Manual of Medical Jurisprudence* reached 12 editions between 1844 and 1891 and his *Principles and Practice of Medical Jurisprudence* reached six editions between 1865 and 1910. The *BMJ* also reported that the first of these texts sold nearly 16,000 copies between 1844 and 1861.⁹⁰ While there is no means of assessing whether medical practitioners kept up-to-date editions of Taylor’s work, his advice on sexual crime actually changed very little over the period under study with the exception of updating the ages of sexual consent and sections on microscopy.⁹¹ Most other jurisprudence texts also drew heavily on his work, with the *Edinburgh Medical Journal* observing in 1868 that ‘the medical witness ... will be puzzled to distinguish between [Guy’s *Principles of Forensic Medicine*] and Taylor’.⁹² It can be viewed as broadly representative of the medico-legal advice that medical practitioners drew upon.

⁸⁷ ‘*The Student’s Handbook of the Practice of Medicine*. By H. Aubrey Husband, M.B., C.M., etc. Fifth Edition. Edinburgh: E. and S. Livingstone’, *Edinburgh Medical Journal* 34 (1889), 937, p. 937.

⁸⁸ London, Wellcome Library, Testimonials in Favour of Francis Ogston, Jun., M. B., Aberdeen M-C-S. Tracts 17, p. 18; Jean Labbé, ‘Ambroise Tardieu: The Man and his Work on Child Maltreatment a Century before Kempe’, *Child Abuse and Neglect* 29 (2005), 311-24.

⁸⁹ Sacco, *Unspeakable*, p. 66; Noel G. Coley, ‘Alfred Swaine Taylor, MD, FRS (1806-1880): Forensic Toxicologist’, *Medical History* 35 (1991), 409-27, p. 413.

⁹⁰ ‘*Medical Jurisprudence*. By Alfred Swaine Taylor’, p. 505.

⁹¹ For example, the section on rape in A. S. J. Taylor’s *Manual of Medical Jurisprudence* between the 1852 and 1891 editions and in his *Practice and Principles of Medical Jurisprudence* from the 1865 to 1910 editions changed only in minute degrees in terms of terminology, revised case studies and revisions of the law. The general medico-legal advice on signs to look for and how to interpret them changed very little. Sections involving microscopic analysis (such as on linen) changed dramatically, however, and were greatly extended both in words and diagrams.

⁹² ‘*Principles of Forensic Medicine* by W. A. Guy’, p. 157. On the use of Taylor by other contemporary authors see also ‘Reviews and Notices of Books’, *The Lancet*, 17 October 1885, 718, p. 718.

The second key primary source group utilised for this thesis is court records, specifically manuscript records of pre-trial proceedings. The thesis examines the same pre-trial statements from the Middlesex Sessions used in Louise Jackson's *Child Sexual Abuse in Victorian England*, due to the unparalleled extent of their survival. However, there are three main differences in this study's methodology: firstly, it examines every case in the period under study, whereas Jackson only sampled at five-yearly intervals; secondly, the thesis focuses on the pre-trial statements of medical witnesses; and thirdly, these trials are compared with a sample from the more rural Gloucestershire, Somerset and Devon Quarter Sessions. The Middlesex and south-west courts both held criminal trials with a judge and jury, with the Middlesex Sessions held eight times per year and county Quarter Sessions held four times per year. Pre-trial statements were written records of the testimony given at magistrates' courts before these trials. However, they are used primarily in this thesis as evidence of trial proceedings because they only survive for cases that were passed forward for trial rather than dismissed by magistrates or tried summarily.⁹³ Pre-trial statements can be used in this way because they are broadly indicative of the testimony that would have been given at trial. According to one contemporary text on legal practice in Quarter Sessions, written depositions from the pre-trial process 'come under the eye of the judge who ultimately tries the case, and whose only knowledge of it will, in the first instance, be derived from such depositions'.⁹⁴ Judges also usually gave copies of pre-trial statements to a jury, which meant that the testimony given at trial needed to correspond to that given in the pre-trial process to avoid negating its value on the basis of inconsistency.⁹⁵ Although medical witnesses were occasionally called at trial whose evidence had been omitted from the pre-trial statement, such cases were extremely rare.⁹⁶

⁹³ Cases that were dismissed or tried summarily do not survive for Somerset or Devon. A few survive for Gloucestershire but they are not catalogued and no information survives about the outcome of summary trials. The relevant depositions were originally kept in a systematic way in Middlesex but have since been destroyed.

⁹⁴ Thomas W. Saunders, *The Practice of Magistrates' Courts* (London: Law Times Office, 1858), p. 4.

⁹⁵ David Bentley, *English Criminal Justice in the Nineteenth Century* (London: Hambledon Press, 1998), p. 148.

⁹⁶ The only example from the cases under study was in Middlesex, when a newspaper reported that 'Robert Scott, F. R. C. S., deposed that ... he attended the police-court, and, though it was known that he was the medical man first called in, he was not examined as a witness on the second examination, but he was on the first. His evidence was not retained on the depositions'; 'Middlesex Sessions', *Morning Post*, 10 September 1856, 7, p. 7. More common was the calling of medical witnesses at trial but not at pre-trial, but this was also unusual. A comparison of Middlesex newspaper reports and pre-trial statements indicates that only three medical witnesses were called at trial who did not testify in magistrates' courts.

This thesis uses pre-trial statements to implement the approach to medico-legal history advocated by Joel Eigen, who believes that:

[W]ithout exploring the day-to-day forensic examination and cross-examination of medical claims to “expertise”, it is difficult to appreciate the significance of the courtroom’s role in shaping the dialogue between these two powerful professions and the negotiation that rendered medical testimony a legal resource.⁹⁷

Such a research methodology has its own value and limitations. Court records present a very specific form of evidence about non-consensual sex, as legal definitions of consent might not have corresponded to an individual’s perception of whether a sexual encounter was consensual.⁹⁸ Legal categories also were not stable, as definitions of consent shifted with legislative changes and with the judicial decisions that regularly reshaped the common law. Such crime categories must therefore be recognised as artificial to an extent, but this does not detract from their value as a means to consider medical roles in the courts. Historians have long noted the artificial nature of criminal trials in general, in terms of being mediated ‘scripts’ or ‘staged events’.⁹⁹ However, this thesis approaches such narratives as useful in themselves rather than as something to overcome in seeking ‘real’ medical or legal ideas about sexual crime. As the thesis focuses on negotiations between medicine and the law or wider society, the mediated nature of courtroom scripts, variable definitions of consent and the influence of ‘social myths’ on testimony can actually be viewed as useful evidence.¹⁰⁰

In addition to theoretical concerns surrounding court ‘scripts’, there are some practical issues associated with studying a source such as court depositions. Pre-trial statements often lacked details of the following aspects of a case: questions posed by counsel; the deliberations of magistrates, judges and juries; and a prisoner’s defence. However, manuscript depositions such as those used in this thesis still remain one of the best and most direct records of court proceedings. Many of the comments made by Mark Jackson

⁹⁷ Eigen, *Unconscious Crime*, p. 12.

⁹⁸ Although not a historical study, Sophie Day’s work illustrates how personal definitions of ‘rape’ can differ from legal ones; Sophie Day, ‘What Counts as Rape? Physical Assault and Broken Contracts: Contrasting Views of Rape among London Sex Workers’ in *Sex and Violence: Issues in Representation and Experience*, ed. Penelope Harvey and Peter Gow (London: Routledge, 1994), 172-89.

⁹⁹ D’Cruze and Jackson, *Women, Crime and Justice*, p. 12; Louise A. Jackson, ‘Family, Community and the Regulation of Child Sexual Abuse: London, 1870-1914’ in *Childhood in Question*, ed. Fletcher and Hussey, 133-51, p. 134; Lee, ‘Faith in the Body?’, p. 152.

¹⁰⁰ On ‘social myths’ see Catty, *Writing Rape, Writing Women*, p. xi. See also Chapters Five and Six of this thesis, in which the links between medicine and ‘rape myths’ and stereotypes of ‘real rape’ are considered.

about eighteenth-century depositions for infanticide trials are also applicable here, as he notes that they provide a means to consider medical roles as well as ‘information about initial grounds for suspicion, about motives for prosecution, about the manner in which suspects were interrogated and examined, and about the ways in which certain circumstances and signs were interpreted by different participants’.¹⁰¹ Missing details can also often be found in other sources, as Eigen rightly notes that ‘[h]appily, one can supplement the trial narrative with newspaper accounts’.¹⁰²

This thesis focuses on pre-trial statements for misdemeanours (such as attempted rape) rather than felonies (such as rape), as the cases under study were from mid-level courts which had a judge and jury but did not try felony cases. Felonies were tried at the county Assizes or the Old Bailey’s Central Criminal Court, which do not have extensive surviving records.¹⁰³ However, the difference between a ‘misdemeanour’ and a ‘felony’ was often only a matter of legal categorisation and the alleged offence did not always match the charge upon which a prisoner was tried.¹⁰⁴ The thesis therefore pays attention to a broader range of cases than is implied by the category of ‘misdemeanour’, including ones in which complainants alleged that they had been forced to engage in penetrative sex. In terms of legal charges, the thesis focuses on the following misdemeanours: attempted rape; attempted carnal knowledge of girls under the felony clause of sexual consent legislation, which was raised from 10 to 12 during the period under study; carnal knowledge or attempted carnal knowledge of girls under the misdemeanour clause of sexual consent legislation, which was raised from 12 to 16 during the period under study; indecent assault of males or females; assault with intent to commit a felony; and attempted sodomy of males under the age of 14. In this thesis the phrases ‘sexual crime’ and ‘sexual offences’ are used as umbrella terms to cover all of these types of non-consensual sex, but without claiming that they were synonymous. They all carried very different social, legal and medical meanings which are considered where relevant.

¹⁰¹ Jackson, *New-Born Child Murder*, p. 20.

¹⁰² Eigen, *Unconscious Crime*, p. 5.

¹⁰³ Assize records for the Western Circuit only survive for infanticide and murder. A very limited number of relevant Central Criminal Court cases survive, but not enough for any systematic study. They are occasionally drawn upon in this thesis, but are not a primary focus of the analysis.

¹⁰⁴ For example, the thesis later shows that cases with medical evidence of rape were commonly tried as attempted rape or indecent assault. See Chapter Five for a detailed discussion of this issue.

The categories of sexual crime outlined above have been selected for study on the basis of three criteria: they were all cases of non-consensual sex in the eyes of the law; they were crimes in which medical testimony had a potential role; and they were crimes in which a complainant's age was relevant. These parameters explain why cases of attempted sodomy are excluded unless they involved young boys, as only the latter type of crime was prosecuted as a form of assault rather than as a consensual act.¹⁰⁵ These parameters also explain why the crime of indecent exposure is excluded, as it was not constructed in terms of age and had no relevance to medical practitioners.¹⁰⁶ The crime of incest is similarly omitted from the list because after 1908 the crime generally related to sexual relations between consenting adults. The thesis pays some attention to the subject of links between age and incest in its section on legislation, but criminal cases of incest between adults and children were incorporated in the category of 'carnal knowledge' of girls under the age of consent at the Quarter Sessions. Prostitution is also not a subject of close analysis in the thesis because, with the exception of procurement charges, it was not explicitly illegal and because medical texts discussed prostitution more commonly in terms of disease, sanitation and heredity than age.¹⁰⁷ Juvenile prostitution is only considered briefly in the thesis in the context of age-of-consent legislation, when the subject was interwoven with debates about protecting and controlling the sexual behaviour of young girls. Using age-based criteria evidently limits the crimes to be considered in this thesis, but its approach is not intended to neglect other analytical categories. Instead, the emphasis on age-based crime provides

¹⁰⁵ Any forced penetrative act by an adult male on another adult male was tried as 'assault with intent to commit buggery'.

¹⁰⁶ The 'exhibitionist' became a psychiatric category in the late-nineteenth century, but in the courts studied for this thesis it was not deemed to be an issue upon which medical witnesses were consulted. As Angus McLaren notes, '[i]n Victorian England indecent exposure was treated by the courts more and more severely, the authorities regarding it as a legal rather than a medical problem. Magistrates rarely called on doctors to throw light on the mental condition of the accused'; Angus McLaren, *The Trials of Masculinity: Policing Sexual Boundaries, 1870-1930* (Chicago: University of Chicago Press, 1997), p. 194. On the late-nineteenth-century development of 'exhibitionism' as a psychiatric category see also Bourke, *Rape*, pp. 250-51.

¹⁰⁷ Prostitutes certainly came under the eye of the law in the period under study, in the form of the controversial Contagious Diseases Acts, but they were not prosecuted and nor were the men who used them. Until the 1910s, procurement charges were also exceptionally rare. Angus McLaren notes that in 1900-01 only eight cases of procurement annually were brought to trial; McLaren, *The Trials of Masculinity*, p. 18. In terms of the relevance of age, contemporary age-based anxieties about the 'white slave trade' had only a minor impact on medical discussions. These mainly took the form of references to the higher risk of juvenile prostitutes spreading diseases. See 'Select Committee on the Contagious Diseases Acts', *BMJ*, 2 July 1881, 26-27, p. 26; Drysdale, *The Elements of Social Science*, p. 241; 'Eighty-Second Annual Meeting of the British Medical Association', *BMJ*, 8 August 1914, 280-92, p. 283; D. White, 'Eugenics and Venereal Disease', *Eugenics Review* 5 (1913-1914), 264-70, p. 264; 'Protection of Minors', *The Lancet*, 1 March 1884, 401, p. 401; 'Reviews and Notices of Books: *Etudes de Physiologie Sociale: La Prostitution*', *The Lancet*, 30 December 1882, 1116-17, p. 1116.

an opportunity to situate ideas about age within other frameworks of thought about gender, class and to a lesser extent race.

Overall, for the types of sexual crime selected for this study, there were 1700 complainants in Middlesex and 928 complainants in Gloucestershire, Somerset and Devon.¹⁰⁸ Figure 0.1 depicts the breakdown of these cases across both regions and over the years under study. Supporting this chapter's earlier claim that the years 1850-1914 are particularly important for studying histories of sexual consent and crime, it demonstrates a rise in the number of criminal trials during the period. The only major decline in cases brought to trial was in Middlesex after 1890, which resulted from its reduction in size after the 1888 Local Government Act.¹⁰⁹ These statistical trends tie in with national rates in trials for sexual crime which rose from 1.5 per 10,000 in 1850 to 2 in 1880, reached a peak of 4 in 1885 and declined again to 2.5 by 1900.¹¹⁰ Without entering into complex debates about the 'dark figure' of crime, it must be noted that such statistical shifts do not represent a 'real' rise in the extent of crime but rather higher rates of reporting and prosecution.¹¹¹

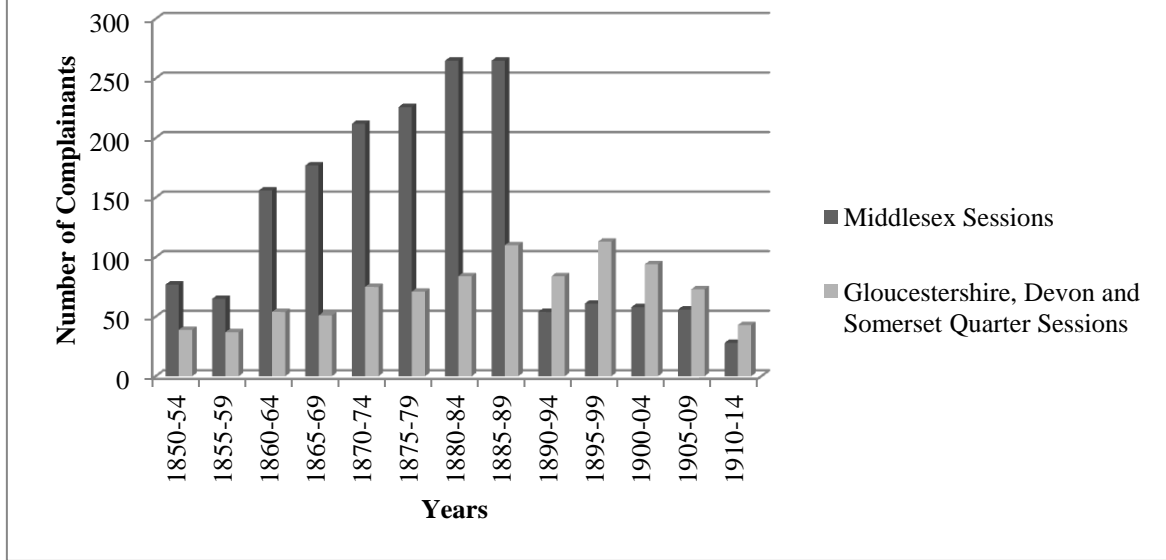
¹⁰⁸ At this point the statistics include those cases that were found a 'no bill' by a grand jury, although they are separated from 'true bills' in later analysis; see Chapter Five and Chapter Six.

¹⁰⁹ 31,484 acres of the County of Middlesex were transferred to the County of London. These were mainly heavily urbanised regions, which included 2,697,271 people; British Parliamentary Papers (BPP), Minutes of Evidence: Royal Commission on London Government, Part 1, 1922, p. 377.

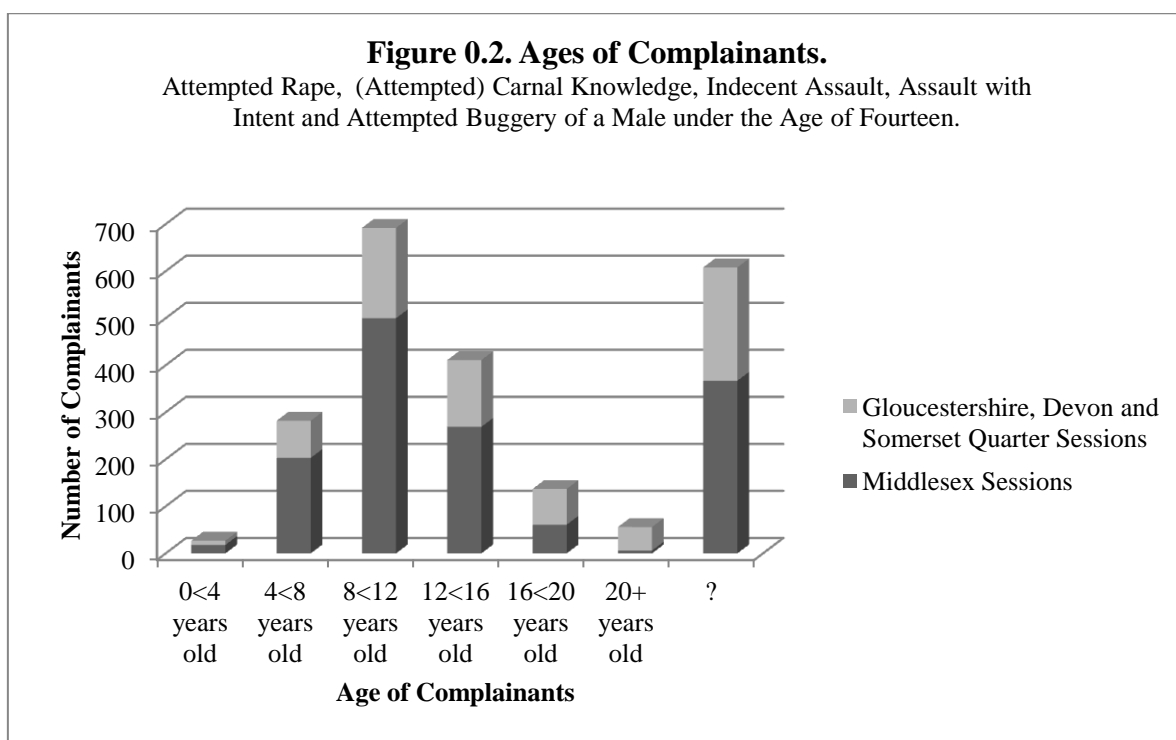
¹¹⁰ These figures incorporate all cases (tried on indictment) of: rape or unlawful carnal knowledge; attempted rape or unlawful carnal knowledge; assault with intent to rape; and indecent assault. They are taken from Figure 1.2 in Jackson, *Child Sexual Abuse*, p. 5.

¹¹¹ For further reading on the 'dark figure' of (sexual) crime and the use of this term, see Bentley, *English Criminal Justice*, p. 18; Bourke, *Rape*, pp. 15-18; D'Cruze and Jackson, *Women, Crime and Justice*, pp. 28-29; V. A. C. Gatrell, 'The Decline of Theft and Violence in Victorian and Edwardian England' in *Crime and the Law: The Social History of Crime in Western Europe since 1500*, ed. V. A. C. Gatrell, Bruce Lenman and Geoffrey Parker (London: Europa, 1980), 238-70, pp. 286-89; Porter, 'Rape', p. 221.

Figure 0.1. Pre-Trial Statements for Cases of Suspected Sexual Crime.
 Attempted Rape, (Attempted) Carnal Knowledge, Indecent Assault, Assault with Intent and Attempted Buggery of a Male under the Age of Fourteen.



Not all of these cases have surviving pre-trial statements. Overall the evidence used for this thesis is drawn from pre-trial statements for 1424 cases from Middlesex and 789 from Gloucestershire, Somerset and Devon; 429 and 179 respectively included medical testimony. 87 per cent of pre-trial statements from Middlesex and 97 per cent from Gloucestershire, Somerset and Devon involved female complainants, a statistic which partly explains why this thesis focuses on the female body and female victimhood. Figure 0.2 depicts an age breakdown of complainants from these depositions, grouped into age categories of four years. It indicates that the great majority of the evidence used in this thesis is drawn from cases with complainants aged between 12 and 16 years old, but also that there was a broad age range of alleged victims. This range makes it possible for the thesis to pay attention to the differences in medical testimony for girls at various ages along a continuum between childhood and adulthood, rather than simply examining all ‘children’ under the age of 16 as a homogeneous category.



The two regions of Middlesex and the South West (Gloucestershire, Somerset and Devon) have been selected for comparison, to avoid any temptation to treat London as representative of national trends. The counties of Gloucestershire, Somerset and Devon not only provide an opportunity for original local case studies, but were also distinct from Middlesex in many ways. One point of contextual difference related to local medical professionalisation and social position. All regions under study were characterised by a competitive market with strong ratios of medical practitioners to patients, as David McLean notes that in Devon in 1841 there was ‘a ratio of one [practitioner] per 893 of population, which was bettered only in Gloucestershire and Middlesex’.¹¹² However, these medical practitioners did not necessarily occupy the same professional and social positions. For example, Middlesex fell under the jurisdiction of the Metropolitan Police who were unique in their extensive use of police surgeons during the period under study.¹¹³ Another point of comparison relates to

¹¹² David McLean, *Public Health and Politics in the Age of Reform: Cholera, the State and the Royal Navy in Victorian Britain* (London: I. B. Tauris, 2006), p. 56. On ratios of medical practitioners to population see also Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 2002), pp. 18-24. For breakdowns of the number of medical practitioners and populations of towns with each county, see *London and Provincial Medical Directory* (London: John Churchill, 1850-69); *Medical Directory* (London: John Churchill, 1870-1914).

¹¹³ See Chapter Four for a discussion of differences between Middlesex and Gloucestershire, Somerset and Devon in the use of police surgeons.

social, employment and population patterns of the two regions. Before 1889, Middlesex 'stretched along the north bank of the river Thames from the river Colne in the West to the river Lea in the east, excluding the City of London but including within its bounds such places as Westminster, Fulham, St. Marylebone, Shoreditch and Stepney'.¹¹⁴

Louise Jackson's work provides a thorough description of this region's population, as follows:

In Middlesex the city and business districts of London provided employment in the service industries connected with commerce, while industrial development was mainly concentrated round the Thames dock ... During the course of the nineteenth century rural Middlesex was increasingly colonised by the metropolis as a suburban dormitory, but outlying areas remained rural and semi-rural in character even in 1900.¹¹⁵

Middlesex was therefore largely although not entirely urban, especially before 1889 when it included large areas of the East End of London.

Although in this thesis Middlesex has been broadly classified as 'urban' and Gloucestershire, Somerset and Devon as 'rural' or 'provincial', these are relative rather than absolute terms. The comparably rural nature of the south-west Quarter Sessions is indicated by the fact that the counties' key cities such as Exeter, Bristol and Bath were excluded.¹¹⁶ The county sessions were therefore drawn from outlying regions. This is not to say that these areas were completely cut off from the expanding urbanisation of the 1800s, as contemporaries bemoaned a declining number of the agricultural classes in all three counties.¹¹⁷ However, they still contained large agricultural regions such as the Cotswolds in Gloucestershire and Somerset's Taunton vale, 'famed for its ... fertility'.¹¹⁸ In relation to the Devon population, Joseph Melling and Bill Forsythe note that '[a]griculture remained a major employer of labour throughout the nineteenth century' and that most women were employed in domestic service despite the region's

¹¹⁴ Kenneth Goodacre and E. Doris Mercer, *Guide to the Middlesex Sessions Records 1549-1889* (Greater London Record Office: Middlesex Records, 1965), p. 3.

¹¹⁵ Jackson, *Child Sexual Abuse*, p. 24.

¹¹⁶ The cities held separate sessions, which have not been examined here in part because of the less extensive survival of their records and in part to maintain a degree of 'urban' and 'rural' comparison between Middlesex and Gloucestershire, Somerset and Devon.

¹¹⁷ The numbers of agricultural workers apparently fell by 9,475 in Devon (13 per cent), 1,166 in Gloucestershire and 2,809 in Somerset in the period 1851-1861; 'On the Decrease of the Agricultural Population of England, A. D. 1851-61, by Mr Purdy', *The Athenaeum*, 5 September 1863, 311-12, p. 311.

¹¹⁸ 'Rural Economy of the British Isles: Western Counties', *New England Farmer* 8 (1856), 276-77, p. 276.

growing commercialisation.¹¹⁹ This was also true of the other two counties. Although there was some industry in the South West, such as the woollen manufacture that took place in Gloucestershire's Wotton-under-Edge, the south-west counties were overall far less urbanised than Middlesex.¹²⁰ Comparing these two regions allows us to see how far the metropolitan area was representative of broader national trends, or in what way it was unique.

Despite selecting these regions for comparison, the thesis analyses them together at times because of the absence of clear distinctions between the witness testimony of 'urban' and 'rural' medical practitioners. This point is significant in itself, as it highlights the importance of not assuming that medical practitioners who worked in different regions came from entirely distinct backgrounds. Conversely, many provincial practitioners had originally worked elsewhere. Registered practitioners in the two regions often had similar educational backgrounds, in terms of training at the main London or Scottish institutions.¹²¹ Discursive similarities between medical witnesses in the two regions can also be linked to a use of comparable medical jurisprudence textbooks to guide their testimony, hence the fundamental inseparability of the two main primary source groups used for this thesis. When this thesis compares Middlesex and the south-west counties it focuses mainly on the local populations' differing reactions to a suspected sexual crime and uses of medical practitioners, rather than any notable distinctions in medical knowledge or its application in the courtroom.¹²²

¹¹⁹ Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity, and Society in England, 1845-1914* (London: Routledge, 2006), p. 152. On the agricultural boom in Devon in the early-nineteenth century and its position as relatively 'remote from the more rapid change brought about by the Industrial Revolution', despite some urbanisation of Devonport and Plymouth in the second half of the century, see D. Roy Tucker, *The Development of Quarter Sessions Government in Devon in the Nineteenth Century* (London: s.n., 1948), pp. 1, 24.

¹²⁰ On the agricultural and manufacturing regions of Gloucestershire in the period see *The Post Office Directory of Gloucestershire, Herefordshire, Shropshire and the City of Bristol* (London: Kelly & Co., 1863), p. 187.

¹²¹ Most practitioners were registered after it became a professional requirement in 1858, a process which often included recording their educational and professional backgrounds. The *Medical Directory* entry for one Gloucestershire medical witness serves as one such example of a provincial medical practitioner's education and previous working life in London: '* JESSOP, HENRY E., 4, Clarence-parade, Cheltenham - L.R.C.P. Edin. 1867, M.R.C.S. Eng. 1862; (*Char. Cross*); Fell. Anthropol. Soc. Lond.; Med. Ref. Royal and Scott. Union Assur. Socs.; formerly House Surg. Char. Cross Hosp'; *Medical Directory* (1871), p. 436.

¹²² Most of this comparison takes place in Chapter Four. Chapters Five and Six examine the nature of medical testimony in court and medico-legal relations, but often groups the two regions because of the absence of any notable differences between them.

The thesis utilises a wide range of additional sources to fill some of the gaps left by medical literature and court records. These alternative forms of evidence also help to contextualise the main medical sources within wider societal frameworks of thought about age, class, gender and sex. The sections on age-of-consent legislation draw on parliamentary papers such as committee reports and draft legislation. They also utilise parliamentary debates and miscellaneous papers of pressure groups as part of evaluating the processes by which legislative change was decided. Where relevant the thesis uses case law reports and appeal records to examine medical roles in shaping, or failing to shape, the common law on sexual crime. The chapters on criminal trials draw heavily upon contemporary national and local newspapers, both to fill the gaps left by pre-trial statements and to consider the representation of trials for sexual offences and medical witnesses. They also utilise the contemporary *Medical Directory* to research the background and professional status of registered medical witnesses. Although often criticised as a source because of the incomplete nature of its records, the *Medical Directory* is a useful part of locating the medical testimony under study within a wider context of medical knowledge, specialism and ‘expertise’.¹²³

Although the primary sources drawn upon for this thesis are varied, this brief analysis has provided a justification for the two key source groups used for the study. Medical literature and court records both provide valuable insights into the negotiated nature of medico-legal relations during the period under study. Both major source groups also enable a consideration of medical ideas about sexual consent and sexual crime at all levels of the profession, rather than just representing high-profile medical thinkers. They both demonstrate not only the nature of medical knowledge or thinking at a particular point in time, but also the processes by which knowledge was created, reinforced or challenged. Many potential problems associated with using medical literature and court records can either be reinterpreted as strengths, as with the issue of court ‘scripts’, or can be mitigated by using the two source groups in combination with each other and with other kinds of source material.

¹²³ On the limitations of medical directories and medical registers as a source see Digby, *The Evolution of British General Practice*, pp. 5-15.

Thesis Structure

The six chapters of this thesis demonstrate its two main arguments: firstly, medicine's negotiated position in a range of social and professional spheres relating to sexual crime and, secondly, the importance of age as an analytical category. The thesis is broadly divided into two sections. The first three chapters relate to the subjects of 'capacity and consent' and consider medical ideas about sexual development, behaviour and the legal age of sexual consent. The final three chapters discuss 'crime and the courts' and focus on medical roles in the judicial process, with particular attention to sexual offences in Middlesex and south-west England.

Chapter One engages with the broad contextual issues required to position the rest of the thesis. It considers how medical literature on sexual maturity and behaviour drew upon and reinforced wider contemporary frameworks of thought about age, class, gender and race. Although the chapter does not explicitly address the subject of sexual crime, it highlights relevant aspects of wider medical and societal thought. It demonstrates that medical ideas about age-based development were most successful, both in terms of distribution and positive citations by others, when they resonated with middle-class concerns and specific movements such as social purity and eugenics. It also highlights the importance of female puberty as a life stage, which leads into the second chapter's analysis of when this life stage was expected to occur. Chapter Two demonstrates the difficulties that medical authors found when attempting to pinpoint a 'normal' age for puberty, because of the ways in which the transition from childhood to adulthood was perceived both as a continuum and as a variable process. It then considers the problems faced when medical writers sought to relate such ideas to more rigid sexual consent legislation. The chapter shows that some medical authors and practitioners resolved this situation by selecting the 'normal' age of puberty that supported their own positions on age-of-consent legislation. In Chapter Three, the final chapter of the 'capacity and consent' section, the thesis questions whether medical practitioners had any practical role in shaping the law on sexual consent. It demonstrates that medical roles have often been overlooked by scholars in favour of a focus on feminist, social purity and child protection movements. However, medical practitioners often had direct connections with many of these groups. Such connections provided a means of communication between medical ideas and the parliamentary sphere. The chapter shows that medical ideas were also drawn upon by others to guide sexual

consent legislation, for example through case law and in parliamentary debates, but often selectively and with medical practitioners unable to control the application of their ideas. Overall, the first half of the thesis delineates some practical and theoretical negotiations between medicine, the law and members of the general public.

The second half of the thesis turns to the courts of Middlesex and south-west England, in order to consider how medical ideas about sexual consent operated in practice. Chapter Four examines how and why medical practitioners were initially consulted in cases of suspected sexual crime before cases reached trial. It shows that relationships between medicine, the police and members of the general public were rarely formalised in either location. Medical practitioners who testified in court tended to be general practitioners rather than designated 'experts'. They negotiated a range of diverse and potentially informal roles in pre-trial processes, which were subject to the discretion of the police and members of the general public. Chapter Five builds on these conclusions about the importance of discretion in Victorian and Edwardian criminal proceedings. It shows that medical evidence and medical witnesses' roles in the courtroom were heavily shaped by magistrates' discretion and by adversarial processes. It also indicates that medicine and the law could be complementary, rather than in conflict, as they often worked together to reinforce middle-class moral concerns and 'rape myths'. The final chapter examines trial outcomes and reaches a number of conclusions that relate back to those drawn in Chapter One. It argues that medical roles in shaping trial outcomes must be understood less in terms of impact and more in terms of shared frameworks of thought about age, gender, class and sex. Together, these three chapters on judicial processes demonstrate that many of the ideas identified in medical literature in the first half of the thesis also applied in the courts.

Part 1: Capacity and Consent

‘The Breakers that Separate Childhood from Youth’: Stages of Sexual Development¹

In the mid-nineteenth century the *Oxford English Dictionary* defined a child as ‘a young person of either sex below the age of puberty’, a definition which placed sexual maturity at the boundary between childhood and adulthood.² To an extent this definition still prevails, as Stephen Angelides notes that ‘sexuality’ continues to mark a ‘dividing line between childhood and adulthood’.³ However, in Victorian and Edwardian England sexual maturity was still conceptualised as a physiological developmental stage rather than as ‘sexuality’ in the current-day sense of a sexual identity.⁴ This chapter considers late-Victorian and Edwardian ideas about such sexual development, and the lack thereof, at different life stages. It demonstrates that medical ideas about sexual maturity and behaviour which had ‘social currency’, in terms of drawing on and reinforcing existing middle-class interests, were the most likely to be propagated within and beyond medical literature. The chapter also highlights the particular ‘social currency’ of medical literature on female puberty and precocity, which provides a basis for the next chapter’s closer analysis of the ages at which these were expected to occur.

Sexual maturity was the most significant marker of adulthood used in the context of sexual crime, as it had not only legal and medical but broad social significance.⁵

¹ G. Stanley Hall, *Adolescence: Its Psychology and its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education*, vol. 2 (London; New York: Appleton, 1904), p. 95.

² *Oxford English Dictionary* cited in Julie Gammon, ‘“A Denial of Innocence”: Female Juvenile Victims of Rape and the English Legal System in the Eighteenth Century’ in *Childhood in Question: Children, Parents and the State*, ed. Anthony Fletcher and Stephen Hussey (Manchester: Manchester University Press, 1999), 74-95, p. 35 n. 32.

³ Steven Angelides, ‘Feminism, Child Sexual Abuse, and the Erasure of Child Sexuality’, *GLQ: A Journal of Lesbian and Gay Studies* 10 (2004), 141-77, p. 158.

⁴ Barry Reay and Kim Phillips note that ‘the word “sexuality” and our sense of it date from ... 1879 according to the *Oxford English Dictionary*’, thus was only just becoming established during the period under study. They also note its links to sexology, which was not the most dominant medical sub-discipline of the time; Kim M. Phillips and Barry Reay, *Sex before Sexuality: A Premodern History* (Cambridge: Polity Press, 2011), p. 7.

⁵ The broad social significance of puberty as a marker of adulthood is indicated by references to its transformative nature in contemporary literature, as in Edmund Gosse’s *Father and Son* in which the narrator states that ‘[m]y father ... wished to secure me finally, exhaustively, before the age of puberty could dawn, before my soul was fettered with the love of carnal things’; Edmund Gosse, *Father and Son: A Study of Two Temperaments* (London: Folio Society, 1972 [1907]), p. 123.

Although there were other important *general* markers of childhood in the Victorian and Edwardian periods, including ages of education and marriage, sexual maturity was deemed to be a particularly important *specific* marker for sexual consent legislation.⁶ Despite the apparent simplicity of focusing on a single marker of the transition from childhood to adulthood, however, sexual markers were multifaceted in themselves. This chapter pays attention to medical ideas surrounding a number of physiological, psychological and behavioural facets of sexual development. According to Victorian and Edwardian medical writers, sexual maturity at puberty involved the development and emergence of three main features: physical maturity, such as the ability to reproduce; the ability to experience sexual sensations and pleasure; and sexual curiosity or the ability to understand sex. These corresponded to the body, nerves and mind respectively. Broadly defined, sexual maturity was also marked by a girl or boy engaging in sexual activity with a person of the opposite sex.⁷ As this chapter demonstrates, however, the life stage at which sexual activity was condoned did not correspond to the age at which it was deemed possible. Partly because of these multiple dimensions of puberty and sexual development, neither category was clearly defined by age. Two broadly delineated developmental stages of ‘before and towards’ and ‘at and beyond’ sexual maturity are therefore used to structure this chapter, with the specific issue of age being considered in closer detail in the next chapter.

As medical literature often focused on contemporary concerns about the sexual development of working-class children, this chapter is primarily an analysis of ideas about working-class sexual development that came from middle-class authors.⁸ This class-based analysis of sexual maturity has value for the current study because of the

⁶ For example the school-leaving age was established at 10 in 1880 and raised to 11 in 1893, by which time the age of sexual consent was 16 for girls. The age of marriage remained at 12 for females and 14 for males throughout the years under study. For detailed discussions of the various shifts in nineteenth-century child labour legislation and school-leaving ages see William Blackstone, *Commentaries on the Laws of England in Four Books with an Analysis of the Work* (Philadelphia: J. B. Lippincott & Co., 1867), pp. 348-49; and Eric Hopkins, *Childhood Transformed: Working-Class Children in Nineteenth-Century England* (Manchester: Manchester University Press, 1994).

⁷ Most literature on expected, healthy and ideal sexual development focused on heterosexual relationships, as same-sex relationships were increasingly marked as pathological and criminalised in the period under study. See Angus McLaren, *The Trials of Masculinity: Policing Sexual Boundaries, 1870-1930* (Chicago: University of Chicago Press, 1997), p. 30.

⁸ These ideas would likely have differed from working-class parents’ own conceptions of their children’s sexual development. The difference is indicated by a quote from the infamous Victorian sex diary *My Secret Life* in which the narrator comments that ‘I was about sixteen years old, tall, with slight whiskers and moustache, altogether manly and looking seventeen or eighteen, yet my mother thought me a mere child, and most innocent’; *My Secret Life: An Erotic Diary of Victorian London*, ed. James Kincaid (New York; London: New American Library, 1996 [1888]), p. 65.

similarly class-based management of sexual crime in Parliament and the courts, subjects which are addressed later in this thesis. However, as Ludmilla Jordanova notes, there is a ‘tension between understanding interests in individual and collective terms’ and it would be problematic to claim that any class interests were universal.⁹ While bearing in mind the heterogeneous nature of the ‘middle classes’, it remains possible to identify some trends in the class-based anxieties that informed the nature and reception of Victorian and Edwardian medical literature. This chapter demonstrates that medical ideas about sexual development with the clearest ‘social currency’ connected to specific high-profile interests of the period, such as child protection and heredity. ‘Social currency’ itself was also no mere coincidence but rather the product of shared middle-class concerns. Sally Shuttleworth refers to ‘social currency’ in the context of medical ideas that offered ‘scientific form and validity to the more vaguely defined social beliefs’ about Victorian moral insanity, but also rightly emphasises that the same social beliefs had ‘fuelled’ the development of medical ideas in the first place.¹⁰ Her conceptualisation of ‘social currency’ as a two-way process also applies to the contexts considered in this chapter. Many medical texts about sexual maturity were informed by broader societal concerns and, in turn, were considered valuable by other social and professional groups who drew upon medical rhetoric in their quest for validity. In the words of Annemarie Mol, ‘how do authors ever acquire authority? Answer: by being related to. It is a circle’.¹¹ The chapter also shows that there were some shared characteristics of those medical works that remained at the professional margins, were not commercially successful or were openly criticised by medical or lay communities. Again, without overstating the homogeneity of any social group, it is clear that some medical ideas had very little ‘currency’ either within or beyond the medical profession.

Innocence and Ignorance: Before and Towards Sexual Maturity

In his book on sexual crimes against New York children in the period 1880-1960, Stephen Robertson notes that medical practitioners believed that children had ‘several stages of physical and psychological development, including a series of sexualities,

⁹ Ludmilla Jordanova, ‘The Social Construction of Medical Knowledge’, *Social History of Medicine* 8 (1995), 361-81, p. 365.

¹⁰ Sally Shuttleworth, *Charlotte Brontë and Victorian Psychology* (Cambridge: Cambridge University Press, 1996), p. 51.

¹¹ Annemarie Mol, *The Body Multiple: Ontology in Medical Practice* (Durham, NC; London: Duke University Press, 2003), p. 23.

before reaching maturity'.¹² His recognition of the heterogeneous nature of childhood is relevant to the British context of around the same period, in which childhood was similarly conceptualised as a process of slow change rather than as a static life phase. However, the nature of these changes was disputed and certainly was not commonly conceptualised in terms of 'sexualities' before 1914. Despite some variations in the ways that medical ideas about sexual development at childhood were received within and beyond the profession, this section shows that overall medical authors who suggested that children had a form of innate 'sexuality' had the least positive reception. Medical writers had more professional and popular appeal when they emphasised that signs of sexual awareness, sensations or behaviour were premature rather than innate or acceptable before full sexual maturity. Childhood was a less gendered category than adolescence but this section demonstrates that, with the exception of masturbation panics, so-called 'precocious' girls were a particular focus of contemporary medical and social anxieties.

The most widely-distributed medical literature of the late-nineteenth and early-twentieth centuries emphasised that sexual sensations, awareness, or activity in the young were rare. Although the notion of a child's body as 'unripe' and unready for sex had a long history, this section will show that the idea was also shaped by peculiarly Victorian and Edwardian middle-class concerns about precocity, pollution and heredity.¹³ The body, mind and nerves were expected to mature to a degree before puberty, as childhood was not conceptualised as an entirely static developmental stage. However, their development was expected to be so limited that there would be an absence of any external manifestations of sexual maturity until puberty's onset. There was no recognition of any possibility that a 'normal' child could experience sexual pleasure before puberty, as children were deemed physically incapable not only of sexual pleasure but also of sex itself. A pre-pubescent boy was not expected to be able to sustain a full erection and a young girl's body was considered to be so enclosed that there were even doubts about 'whether a rape can be perpetrated on children of tender

¹² Stephen Robertson, *Crimes against Children: Sexual Violence and Legal Culture in New York City, 1880-1960* (Chapel Hill; London: University of North Carolina Press, 2005), p. 3.

¹³ Sarah Toulalan, "'Unripe' Bodies: Children and Sex in Early Modern England" in *Bodies, Sex and Desire from the Renaissance to the Present*, ed. Kate Fisher and Sarah Toulalan (Basingstoke: Palgrave MacMillan, 2011), 131-50, p. 132.

age by an adult man'.¹⁴ The Scottish professor Francis Ogston wrote in his 1878 book, which was a 'standard authority' on forensic medicine, that the rape of infants was physically impossible and that 'copulation' with pre-pubescent girls was only possible with great injury, because of 'the undeveloped state of the sexual organs'.¹⁵ This emphasis on bodily innocence had great resonance with contemporaries, particularly for child protection campaigners and journalists of the 1880s. Although couched in unscientific terms for the purposes of public engagement, high-profile campaigners like W. T. Stead utilised the medical notion that puberty was the primary marker of bodily maturity and that children's bodies were asexual. In his widely-read 'Maiden Tribute of Modern Babylon' articles which exposed a 'white slave trade' in young girls, Stead declared that '[f]ish out of season are not fit to be eaten. Girls who have not reached the age of puberty are not fit even to be seduced'.¹⁶ Children were expected to be innocent in mind as well as body, before they developed the capacity to understand sex. The perceived importance of maintaining a child's lack of awareness about sex, which tied in with the question of sexual maturity, is indicated by the fact that attempts by the *British Medical Journal (BMJ)* to suggest sex education for children in 1885 were resisted.¹⁷ One correspondent responded to the journal's suggestions by complaining that 'the holy name of innocence is to be dubbed by the harsh term of "ignorance"'.¹⁸ As Roy Porter and Lesley Hall have noted, advice literature was best received in the wider community when it helped parents to maintain the purity of children's bodies and minds, free from 'corruption'.¹⁹

Not all medical texts agreed on this matter. There was a division between those who focused on 'sexuality' as an innate quality and those who concentrated on sexual maturity as a development process.²⁰ Members of the growing professions of psychiatry

¹⁴ Alfred Swaine Taylor, *Medical Jurisprudence*, 4th edn (London: J. & A. Churchill, 1852 [1844]), p. 577. This statement was unchanged across editions in the period under study.

¹⁵ 'Obituary: Francis Ogston', *British Medical Journal (BMJ)*, 1 October 1887, 748, p. 748; Francis Ogston, *Lectures on Medical Jurisprudence* (London: J. & A. Churchill, 1878), p. 91.

¹⁶ W. T. Stead, 'The Maiden Tribute of Modern Babylon III: The Report of our Secret Commission', *Pall Mall Gazette*, 8 July 1885, 1-5, pp. 2-3.

¹⁷ 'Sexual Ignorance', *BMJ*, 15 August 1885, 303, p. 303; Peter W. J. Bartrip, *Mirror of Medicine: A History of the British Medical Journal* (Oxford: British Medical Journal; Clarendon Press, 1990), p. 166

¹⁸ 'Correspondence: Sexual Ignorance', *BMJ*, 13 February 1886, 331, p. 331.

¹⁹ Roy Porter and Lesley Hall, *The Facts of Life: The Creation of Sexual Knowledge in Britain, 1650-1950* (New Haven; London: Yale University Press, 1995), p. 227.

²⁰ Sally Shuttleworth, *The Mind of the Child: Child Development in Literature, Science and Medicine, 1840-1900* (Oxford: Oxford University Press, 2010), p. 190.

and psychology indicated that there was a ‘darker’ side to all childhood.²¹ In 1867 the British alienist Henry Maudsley was an early commentator on the notion that sexual sensations could exist innately in a healthy child, albeit in the form of a ‘blind impulse’ without ‘consciousness of the aim’ until puberty.²² He had great influence as a ‘pioneer’ within the nascent profession of psychiatry, but his ideas were largely contained within that specialism.²³ The principles of physiology continued to shape mainstream discussions of sexual development because of the contemporary notion that sexual maturity and behaviour had a somatic base.²⁴ The main bridge between these disciplines was gynaecology, due to the perceived links between the womb and psychiatric conditions. Julie-Marie Strange has observed that ‘[c]ollaboration between the gynaecologist and the “alienist” (or “head doctor”) was epitomised in the careers of prominent psychiatrists such as George Savage and Henry Maudsley’.²⁵ These links may explain why, in a lecture at the Royal College of Physicians in 1877, gynaecologist J. Braxton Hicks stated ‘[t]hat sexual feelings exist from the earliest infancy is well known, and, therefore, this function does not depend upon puberty, though intensified by it’.²⁶ Many years later in the early-twentieth century Braxton Hicks, in turn, was cited by the British sexologist Havelock Ellis – although he modified the quote to emphasise that it would be better to say ‘may exist’ than ‘exist’.²⁷ There was thus a small group of interconnected British medical thinkers of the period who drew upon each others’ work. They rarely went as far as Freud’s claims that sexual sensations were innate in all children, but they still deviated to an extent from general societal and

²¹ Shuttleworth, *The Mind of the Child*, pp. 190-91.

²² Henry Maudsley, *The Physiology and Pathology of the Mind* (London: Macmillan and Co., 1867), p. 284. The term ‘alienist’ is more appropriate than ‘psychiatrist’ because of its contemporary usage, but by the late-nineteenth century there were references to ‘psychiatry’ as a growing discipline. For example, in 1908 *The Lancet* referred to Maudsley as an ‘alienist physician’ but within the same article spoke of ‘the discipline of psychiatry’; ‘The Lessons of Insanity’, *The Lancet*, 27 June 1908, 1851-52, p. 1852.

²³ ‘Reviews and Notices of Books: *The Physiology and Pathology of the Mind*. By Henry Maudsley, M.D. Lond., Physician to the West London Hospital; formerly Resident Physician of the Manchester Royal Lunatic Hospital, &c. 8vo, pp. 44. London: Macmillan and Co. 1867’, *The Lancet*, 27 April 1867, 515-17, p. 515.

²⁴ Such bodily conceptions of sexual development were particularly clear in the context of children, see Laura C. Berry, *The Child, The State, and the Victorian Novel* (Charlottesville; London: University Press of Virginia, 1999), p. 159.

²⁵ Julie-Marie Strange, “‘I Believe It to Be a Case Depending on Menstruation’: Madness and Menstrual Taboo in British Medical Practice, c. 1840-1930’ in *Menstruation: A Cultural History*, ed. Andrew Shail and Gillian Howie (Basingstoke: Palgrave Macmillan, 2005), 102-16, p.106.

²⁶ J. Braxton Hicks, ‘The Croonian Lectures on the Difference between the Sexes in Regard to the Aspect and Treatment of Disease’, *BMJ*, 24 March 1877, 347-49, p. 347.

²⁷ Crista DeLuzio, *Female Adolescence in American Scientific Thought, 1830-1930* (Baltimore: Johns Hopkins University Press, 2007), p. 121; Havelock Ellis, *Studies in the Psychology of Sex*, vol. 3 (Philadelphia: F. A. Davis, 1904 [1903]), p. 1886.

medical thinking in which children had no tangible signs of sexual development until puberty.

Such British medical literature which engaged with the question of an innately ‘darker’ side of childhood reached few mainstream medical or popular markets until later in the twentieth century. Ellis’s books were widely criticised within the British medical community for circulating his ideas (mainly those on ‘sexual inversion’) in a form accessible to lay people and his publisher was prosecuted for obscenity.²⁸ Notably, this was a non-medical publisher because apparently no medical publisher saw a market for his book in England.²⁹ His sexology work gained some gradual acceptance by the early-twentieth century, but only with a clear emphasis within the profession that its subject matter was one for professional eyes only and was an unpleasant but necessary one.³⁰ In terms of a lay market, Ross McKibbin notes that Ellis’s work in journals was ‘too obscure for a popular audience’ and Ellis’s biographer Vincent Brome states that ‘[t]he sales of his books had not made his name a household word’ by 1909.³¹ Other works such as those of Maudsley and Braxton Hicks cited above were not openly rejected but neither were they advocated in journal editorials.³² Their ideas were also commonly restricted to specialist literature rather than being drawn upon in general texts, for example on puberty or forensic medicine.

Literature that challenged the dominant view of innate childhood innocence was more commonly imported from continental Europe or America. The fact that British writers were less likely to discuss ‘child sexuality’ is a noteworthy point in itself, indicating that they were writing in a very different professional and social context where such ideas were more problematic. Although some translated international works questioned innate

²⁸ Bartrip, *Mirror of Medicine*, p. 167; ‘The Question of Indecent Literature’, *The Lancet*, 19 November 1898, 1344-45, p. 1344.

²⁹ H. Havelock Ellis, ‘Correspondence: The Question of Indecent Literature’, *The Lancet*, 26 November 1898, 1431, p. 1431.

³⁰ Lesley A. Hall, “‘The English Have Hot-Water Bottles’: The Morganatic Marriage between Sexology and Medicine in Britain since William Acton’ in *Sexual Knowledge, Sexual Science: The History of Attitudes to Sexuality*, ed. Roy Porter and Mikuláš Teich (Cambridge: Cambridge University Press, 1994), 350-66, pp. 355-57.

³¹ Ross McKibbin, *Classes and Cultures: England 1918-1951* (Oxford: Oxford University Press, 1998), p. 319; Vincent Brome, *Havelock Ellis: Philosopher of Sex: A Biography* (London; Boston: Routledge and K. Paul, 1979), p. 158.

³² While *The Lancet* and *BMJ* paid attention to all of these ideas, for example by publishing reviews of the work cited here or allowing for journal articles to be published by Maudsley and Hicks, these ideas were not advocated in editorials.

childhood innocence, most were only published towards the end of the period under study. German sexologist Albert Moll, for example, referred to the need to examine sexual development in childhood in a book from 1908 entitled *The Sexual Life of the Child*. The book was translated into English in 1912, but even at this late time his ideas were not representative of general or mainstream medical thought. He acknowledged that his ideas were atypical and stated that '[i]t is generally assumed that the sexual life first awakens at the on-coming of puberty (the attainment of sexual maturity of manhood or womanhood); the on-coming of puberty is regarded as the termination of childhood'.³³ In the light of his alternative stance, it is significant that Moll's work on childhood was almost completely ignored by the prominent British medical journals.³⁴

Followers of Freud's work also believed that infantile 'sexual instinct' was innate, but Steven Marcus notes that 'of all Freud's findings those that have to do with infantile and childhood sexuality were resisted with the most persistency'.³⁵ This statement is supported by examining the responses of *The Lancet* and *BMJ* to Freud's notion of 'child sexuality' presented in his 1905 *Three Essays on the Theory of Sexuality*. While there was some growing acceptance of Freud's views by the very end of the period under study, as late as 1913 a review in the *BMJ* complained that 'some of [Freud's] conclusions appear somewhat grotesque. Freud believes and teaches that sexual sensations become obtrusive at a very early age – in very earliest infancy'.³⁶ Freud's ideas about innate infantile sexual 'instincts' had an ambivalent reception and only a slow acceptance in mainstream medicine. They evidently did not tap into or draw upon contemporary trends in thinking about childhood and class in the same way as issues such as sexual precocity discussed below. They certainly had no impact outside scientific communities before the First World War.

³³ Moll, *The Sexual Life of the Child*, p. 1. For another example of an international text by a psychologist that discussed sexual 'sensations' in children but was only published towards the end of the period under study see Hall, *Adolescence*, vol. 2, pp. 95-96.

³⁴ The term 'Albert Moll' can only be found in 14 articles from *The Lancet* between 1850 and 1914, and only in a further two outside this date range. Most of these entries related to his work on hypnotism, with only one passing reference to *The Sexual Life of the Child*.

³⁵ Nancy J. Chodorow, 'Foreword' in Sigmund Freud, *Three Essays on the Theory of Sexuality*, trans. and ed. James Strachey (New York: Basic Books, 2000 [1905]), vii-xviii, p. vii; Steven Marcus, 'Introduction' [1975] in Freud, *Three Essays on the Theory of Sexuality*, xxxi-lxiii, p. xxxi.

³⁶ 'Reviews: Psycho Analysis', *BMJ*, 5 July 1913, 23-24, p. 23. For some more positive discussions of Freud's ideas see J. A. Ormerod, 'The Lumleian Lectures on Some Modern Theories Concerning Hysteria', *The Lancet*, 9 May 1914, 1299-303, p. 1302; 'Puberty and the Neuro-Psychic System', *BMJ*, 3 June 1913, 1337, p. 1337.

To this point the chapter has shown that Lesley Hall is right in commenting that ‘medical discourses of sexuality at the turn of the nineteenth and twentieth centuries were largely associated with a handful of rather idiosyncratic individuals with very specific agendas’.³⁷ Challenges from both within and outside the medical profession were posed to even the most widely-cited contemporary medical writers when they questioned the dominant developmental paradigm, in which sexual bodies, ability to experience sexual pleasure and sexual awareness emerged together at puberty. These conclusions do not mean that medical ideas which carried the most ‘social currency’ eliminated the possibility that a child could undergo a degree of sexual development. However, in the most prevalent frameworks of medical thought early sexual development was presented as a dangerous and unusual form of precocity rather than as healthy or innate. Beyond a few specialist fields such as psychiatry and sexology, medical authors conceptualised the ‘darker’ side of childhood as ‘abnormal’ and used it to define the ‘normal’. By the late-nineteenth century there was an intensified medical and social focus on the dangers of the body, mind or sexual sensations developing ‘years before the proper time’.³⁸ This concept of precocity therefore emphasised that there was a ‘proper time’ after childhood at which sexual characteristics should develop. It was a useful means for medical writers to acknowledge the possibility that sexual characteristics could emerge in childhood, without deeming such a state of affairs ‘normal’ or acceptable.

Sexual precocity was a unique concern of the period under study, as the term had previously been used mainly in the context of plants or in relation to early intellectual development.³⁹ Both within and beyond the medical profession, medical writings on precocity had particular resonance with the Victorian and Edwardian middle classes. The term was not clearly defined, but was generally used to refer to an undesirable level of sexual development amongst young children in contrast to the ideal norm of bodily and mental innocence. As physician R. L. Langdon-Brown stated, at the Seventy-Fifth Annual Meeting of the British Medical Association in 1907:

³⁷ Lesley A. Hall, ‘The Sexual Body’ in *Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (Amsterdam: Harwood Academic, 2000), 261-75, p. 261; ‘Reviews, Sexual Psychology and Pathology’, *BMJ*, 8 February 1902, 339-40, p. 339.

³⁸ The ‘proper time’ statement was made by a physician speaking on precocious puberty at a BMA meeting; George R. Murray, ‘Address in Medicine on some Aspects of Internal Secretion in Disease’, *The Lancet*, 26 July 1913, 199-204, p. 204.

³⁹ ‘Precocity, n.’, OED Online (Oxford: Oxford University Press, 2012).

Speaking generally, one may say that the word carries a bad meaning ... The term “precocity” has been used with very different meanings, and often with no very definite meaning at all, but in a vague, loose, or popular way, and some attempt to understand these possible differences seems necessary if discussion of the subject is not to fall into confusion. By some it is defined as an earlier than average attainment of the ultimate growth of maturity; by others, again, as an unduly rapid development in relation to some assumed norm. Whichever of these be accepted, it is important to observe that we have in our mind some standard for comparison.⁴⁰

Despite such apparent difficulties in defining the term, it is reasonable to claim that ‘precocity’ was broadly used to refer to cases in which one or more of the features of sexual maturity had developed significantly in advance of the others and before puberty.⁴¹ The term was used in cases as wide-ranging as early menstruation, the possession of sexual knowledge without a sexually mature body, and the emergence of sexual sensations before their meaning could be understood. These diverse forms of precocity will be considered in turn here, but it is worth paying brief attention to a point of commonality between them. As Langdon-Brown observed in the address cited above, these disparate forms of precocity were tied together by the sense that they were compared to a ‘norm’ or a ‘standard for comparison’. Precocity defined the typical and the ideal, two aspects of ‘normality’ that were inextricably bound together.⁴² Authors of medical texts from a range of genres drew upon physiological explanations to emphasise that cases of precocity were sufficiently numerous to be concerning but were not ‘normal’. Most significantly, they emphasised that they occurred as a result of external influences rather than coming from a young girl or boy themselves.

Precocious puberty was deemed to be ‘far more common’ in female than male children, although it is possible that such claims were due to the greater social anxiety surrounding female sexual development in general.⁴³ In cases of precocious bodily development, authors often sought explanations in physiology and pathology rather than accepting that early development could be ‘normal’. When the *BMJ* published an ‘epitome of current medical literature’ in 1899, it confidently stated that ‘precocious

⁴⁰ R. L. Langdon-Down, ‘Precocious Development’, *BMJ*, 21 September 1907, 743-47, p. 744.

⁴¹ It was deemed possible, although extremely rare, for cases of precocity to include the early development of all three facets of sexual maturity together.

⁴² Ian Hacking, ‘Normal People’ in *Modes of Thought: Explorations in Culture and Cognition*, ed. Nancy Torrance and David R. Olson (Cambridge: Cambridge University Press, 1996), 59-71, p. 71.

⁴³ Alfred Swaine Taylor, *The Principles and Practice of Medical Jurisprudence*, ed. Thomas Stevenson, 4th edn, vol. 2 (London: J. & A. Churchill, 1894 [1865]), p. 306.

menstruation is associated with ill-health'.⁴⁴ By the very end of the period under study, the ill health that could cause precocity was starting to be understood as an 'excessive secretion of hormone'.⁴⁵ However, as the term 'hormone' was not established until 1905, Victorian and Edwardian medical practitioners generally conceptualised sexual development in gonadal rather than endocrinal terms and focused upon disorders of the ovaries.⁴⁶ Either way, the 'precocious' was positioned against the 'normal'. The only exception to this rule came in the form of concerns about environment and heredity, as girls from hotter climates or working-class 'factory girls' who worked in hot environments were expected to develop earlier and to be more sexually active.⁴⁷ In these contexts, precocity was 'normal'. In 1898, for example, *The Lancet* reported that "[t]he Englishman and the Scandinavian," says Ferrero, "are sexually less precocious and cooler-blooded than the Frenchman or the Spaniard".⁴⁸ Similar claims were widespread throughout medical literature, including that on the professional periphery such as sexologist Havelock Ellis's work. He wrote that 'physical precocity is greater in women than in men, and the lower the race, generally speaking, the earlier is the full stature attained'.⁴⁹ Ideas about the impact of heat on the body had roots in humoral medicine, although the notion of precocity and links to imperial concerns about race and national strength were peculiar to the period under study. The concept of precocity served to reinforce the undesirability of early puberty in the 'lower' races or classes. It was set up against not only a 'norm' but an 'ideal', which was supposed to represent the majority of respectable working-class European girls.

Like premature puberty, the subject of precocious knowledge drew upon and informed wider contemporary concerns about working-class living conditions and environment. Precocious sexual knowledge was slightly different from sexual curiosity or the ability

⁴⁴ 'Epitome of Current Medical Literature: Precocious Menstruation', *BMJ*, 4 February 1899, E19, p. E19.

⁴⁵ 'Address in Medicine on some Aspects of Internal Secretion in Disease', p. 204.

⁴⁶ Lynn Eaton, 'College Looks Back to Discovery of Hormones', *BMJ*, 25 June 2005, 1466, p. 1466. For a clear discussion of the ovarian origins of precocious puberty, see a case report in *The Lancet* from a Berlin correspondent who noted that 'in cases where precocious puberty was associated with menstruation a pathological condition of the ovaries was very likely to exist'; 'Precocious Menstruation', *The Lancet*, 15 February 1908, 518, p. 518.

⁴⁷ For the humoral roots of ideas about heat and sexuality and the rise of a 'moral panic' about factory girls, resulting from medical witness testimony at select committees for the Factory Acts in the 1830s, see Robert Gray, 'Medical Men, Industrial Labour and the State in Britain, 1830-50', *Social History* 16 (1991), 19-43, p. 38.

⁴⁸ 'The Effeminacy of the Latin Race', *The Lancet*, 12 February 1898, 447-48, p. 447.

⁴⁹ Havelock Ellis, *Man and Woman: A Study of Human Secondary Sexual Characters* (London: Walter Scott, 1894), p. 36.

to understand sex, as the former was apparently culturally imparted whereas the latter was a natural developmental stage. However, the two were interwoven in the concept of precocity. By being exposed to too much sexual knowledge, a child's inherent lack of interest in sex and inability to understand sex was apparently removed. Francis Ogston's 1878 *Lectures on Medical Jurisprudence* referred to a criminal case which involved an alleged sexual offence against a nine-year-old girl, who Ogston described as 'precocious' because her 'familiarity with the usual details connected with sexual intercourse showed that she was no stranger to the subject'.⁵⁰ Precocious knowledge of this kind was deemed to have been gained from overcrowded living quarters, bad influences, or even from a sexual assault. In feminist medical practitioner Elizabeth Blackwell's book on *The Moral Education of the Young in Relation to Sex*, published during her time in England, she commented on the extent of 'juvenile depravity' but emphasised that it was not innate. She wrote that mental depravity expressed 'itself in the unformed bodies of children corrupted by evil example'.⁵¹ The works of Ogston and Blackwell differed in the overall purpose of their comments, with the former book written for medical practitioners testifying in criminal cases and the latter intended for general practitioners who sought guidance in instructing parents about their young.⁵² Blackwell's work was also openly informed by her Christian beliefs, with a moral agenda. Despite these differences in their target readership, Ogston and Blackwell were both influential medical thinkers who drew upon similar contemporary moral concerns surrounding class and childhood.⁵³ Their comments fed into wider contemporary anxieties that precocious knowledge and immorality resulted from the working-class environment.

Concerns about the precocious knowledge that could corrupt innately innocent children were shared by medical practitioners, social purity campaigners and other members of

⁵⁰ Ogston, *Lectures on Medical Jurisprudence*, p. 93.

⁵¹ Elizabeth Blackwell, *The Moral Education of the Young in Relation to Sex*, 6th edn (London: Hatchards, Piccadilly, 1882 [1878]), p. 62.

⁵² On Blackwell and her work see Margaret Jackson, *The Real Facts of Life: Feminism and the Politics of Sexuality c.1850-1940* (London: Taylor & Francis, 1994), p. 67.

⁵³ Blackwell's text cited here, *The Moral Education of the Young in Relation to Sex*, reached its 6th edition in only four years. Although Ogston's work was not so widely proliferated, his ideas reached a wide audience in other ways as he was Professor of Medical Jurisprudence and Medical Logic at the University of Aberdeen from 1860 to 1883; Brenda White, 'Training Medical Policemen: Forensic Medicine and Public Health in Nineteenth-Century Scotland' in *Legal Medicine in History*, ed. Michael Clark and Catherine Crawford (Cambridge; New York: Cambridge University Press, 1994), 145-66, p. 153; 'Obituary: Francis Ogston', p. 748.

middle-class society. They were not purely scientific issues and did not always originate from within the medical profession. The ‘social currency’ of these ideas beyond the medical profession is indicated by a Middlesex court case from 1885, in which *The Times* reported that two girls aged nine and 10 showed awareness of W. T. Stead’s ‘Maiden Tribute of Modern Babylon’ articles.⁵⁴ As in the work of the medical practitioners cited above, the precocious sexual knowledge of these young girls was emphasised as being unusual and the children blameless in being ‘polluted’ with such knowledge from others around them. The judge explicitly emphasised that ‘the witnesses were not to blame for the evil knowledge which had been put in their way’.⁵⁵ Such concerns also extended beyond the specific subject of sexual morality. In 1868 *The Lancet* had reported a paper from the Annual Meeting of the British Medical Association which:

[D]iluted upon the evils of overcrowding, mixing of the sexes, the prevalence of incest, bastardy, infanticide, filthy and degrading habits, and, as a consequence rather than a cause of degraded homes, drunkenness, and generally the inevitable absence of religion and morality in any true sense.⁵⁶

The perceived influence of the working-class environment on moral development was evidently a general anxiety of the period, both within and beyond the medical profession. The subject was explicitly referenced by authors across a range of medical genres but was neither specific to medicine nor to the context of sexual morality. Such a lack of specificity, even within the medical profession, demonstrates that medical literature was part of shared middle-class cultures rather than a ‘dominant discourse’ that imparted knowledge upon its medical or lay readers.

The final form of precocity to be considered here is the emergence of a sexual instinct or ability to experience sexual pleasure in childhood, a subject best illustrated by medical literature on masturbation. There was not considered to be a ‘proper time’ for masturbation, but medical texts generally emphasised that one of its causes was a precocious sexual instinct that came significantly before the ability to understand or

⁵⁴ ‘Middlesex Sessions’, *The Times*, 27 August 1885, 10, p. 10.

⁵⁵ ‘Middlesex Sessions’, *The Times*, 27 August 1885, 10, p. 10. For a similar Middlesex case, in which a judge commented that ‘whatever foundation there was for observations upon their child’s depravity was owing to the prisoner’s wickedness’, see ‘Middlesex Sessions’, *The Times*, 23 January 1867, 9, p. 9.

⁵⁶ ‘Report of the Thirty-Sixth Annual Meeting of the British Medical Association’, *The Lancet*, 15 August 1868, 229-33, p. 233.

control it.⁵⁷ This subject has been thoroughly examined by historians, but remains important to consider here in more detail because of its links to precocity and its high-profile contemporary nature.⁵⁸ Writings on the subject of masturbation focused on its dangers in order to highlight the value of maintaining childhood innocence. Although some medical practitioners raised doubts about the harmful nature of masturbation, there was a far greater professional and popular market for works that expressed what American psychologist and educator G. Stanley Hall referred to as ‘exaggerated horror’ about its effects on bodily and mental health.⁵⁹ To cite just one example, physician George R. Drysdale’s popular work *The Elements of Social Science* emphasised that masturbation was ‘ruinous’ and that ‘there are few rocks, on which the health of more individuals is wrecked’.⁶⁰ Anxieties about masturbation also had ‘social currency’ beyond the profession, as they were central to the ‘religio-medical purity lecture’ that gained popularity around the turn of the century.⁶¹ These anxieties about masturbation were unusual in focusing primarily, although by no means entirely, on boys. As with girls, male children were not treated as a homogeneous category. The dangers were expected to be greatest in older boys who had not yet developed self-control but who might have semen to ‘waste’, as they were deemed more likely to be susceptible to diseases like spermatorrhoea.⁶² In 1890 *The Lancet* also highlighted the particular dangers to older boys when it stated that ‘[i]n boys, especially those nearing puberty, there is considerable evidence to show that masturbation may not only provoke paroxysms of palpitation, but may lead to conditions of irritable heart’.⁶³

⁵⁷ As this chapter will show, even in ‘normal’ puberty the emergence of the sexual instinct was expected to precede the ability to control it. However, in cases of precocity this disjunction between physical and mental development was deemed even greater and thus even more concerning.

⁵⁸ For some examples of the many histories of masturbation, from a selection of time periods, see Sterling Fishman, ‘The History of Childhood Sexuality’, *Journal of Contemporary History* 17 (1982), 269-83; Thomas Laqueur, *Solitary Sex: A Cultural History of Masturbation* (New York: Zone, 2003); Robert H. MacDonald, ‘The Frightful Consequences of Onanism: Notes on the History of a Delusion’, *Journal of the History of Ideas* 28 (1967), 423-31; and R. P. Neuman, ‘Masturbation, Madness, and the Modern Concepts of Childhood and Adolescence’, *Journal of Social History* 8 (1975), 1-27.

⁵⁹ ‘Clitoridectomy’, *The Lancet*, 1 December 1866, 616-17, p. 616; Hall, *Adolescence*, vol. 1, p. 432.

⁶⁰ George R. Drysdale, *The Elements of Social Science; or Physical, Sexual and Natural Religion. An Exposition of the True Cause and Only Cure of the Three Primary Social Evils: Poverty, Prostitution, and Celibacy*, 27th edn (London: E. Truelove, 1889 [1854]), p. 89.

⁶¹ Edward J. Bristow, *Vice and Vigilance: Purity Movements in Britain since 1700* (Dublin: Gill and Macmillan, 1977), p. 131.

⁶² ‘Spermatorrhoea’ referred to the involuntary loss of semen and was coined by Claude-François Lallemand in French and translated works of the early-nineteenth century, although drew on a longer history of medical discussions of ‘seminal weakness’; see Elizabeth Stephens, ‘Coining Spermatorrhoea: Medicine and Male Body Fluids, 1836-1866’, *Sexualities* 12 (2009), 467-85.

⁶³ ‘The Rapid Heart: A Clinical Study’, *The Lancet*, 10 July 1890, 1001-06, p. 1002.

The harmful nature of masturbation was clearly couched in physiological terms related to long-held ideas about the ‘wasting’ or ‘spilling’ of seed. These ideas represented the continuation of long-term medical concerns about the health risks of wasting spermatozoa and humoral theories about the importance of balancing bodily fluids.⁶⁴ Concerns about ‘wasting’ semen were also rooted in moral and religious concerns. As Robert H. MacDonald notes, in his work on the history of masturbation, ‘[i]n the Biblical phrase the seed is spilled to the ground, and its wastage offends God’.⁶⁵ However explicitly religious concerns were found more in the work of moralist writers such as Alfred S. Dyer than in scientific texts.⁶⁶ Medical literature instead focused on the health repercussions of ‘self-abuse’. Its influence therefore was not linked only to moral matters, but also to the culturally-specific relevance of ‘waste’ in the Victorian and Edwardian periods. As Sally Shuttleworth notes, ‘[i]n an industrial culture governed by moral, economic, and psychological ideologies of self-control and the efficient channelling of energy, masturbation, that wasteful and hidden practice, came to seem the ultimate sin of childhood’.⁶⁷ The ‘social currency’ of medical literature about the health effects of masturbation and its male focus can also be linked to anxieties about working-class masculinity, self-control, national efficiency, and the future of the British empire that were specific to the period under study.⁶⁸ Masturbation was not only expected to be more common amongst ‘degenerate children born of neurotic parents’, but also to cause emotional, moral and physical weakness in later life.⁶⁹ The links drawn between masturbation and loss of strength also explain why it was one of the few subject areas in which boys were given more attention than girls in literature, both within and beyond medicine. As Angus McLaren notes, ‘[y]oung women, it was assumed, simply had to be prepared for marriage whereas young men had to be trained for more important and complex roles in the worlds of labor [sic], the military, and

⁶⁴ Mark Breitenberg, *Anxious Masculinity in Early Modern England* (Cambridge: Cambridge University Press, 1996), p. 53; Michael C. Schoenfeldt, *Bodies and Selves in Early Modern England: Physiology and Inwardness in Spenser, Shakespeare, Herbert, and Milton* (Cambridge: Cambridge University Press, 1999), p. 83.

⁶⁵ MacDonald, ‘The Frightful Consequences of Onanism’, 423-31, p. 431.

⁶⁶ Alfred S. Dyer, *Facts for Men on Moral Purity and Health: Being Plain Words to Young Men upon an Avoided Subject with Safeguards against Immorality, & Facts that Men Ought to Know* (London: Dyer Brothers, 1884), p. 6.

⁶⁷ Shuttleworth, *The Mind of the Child*, p. 61.

⁶⁸ On the national efficiency movement in the late-nineteenth century, its links to conceptions of childhood and debates around the significance of the Boer War see Harry Hendrick, *Children, Childhood, and English Society, 1880-1990* (Cambridge: Cambridge University Press, 1997), pp. 47-48.

⁶⁹ Charles Gilmore Kerley, ‘Reviews and Notices of Books: Short Talks with Young Mothers’, *The Lancet*, 7 May 1904, 1286, p. 1286.

politics'.⁷⁰ However, McLaren arguably overstates the case by stating that 'late-nineteenth-century social observers of youth worried more about boys than about girls', as this chapter shows that the opposite was often true in relation to the subject of sexual behaviour.⁷¹ The degree to which contemporaries 'worried' about boys or girls differed depending on the context and subject matter.

Despite the specific nature of concerns about 'waste', literature on 'self abuse' followed a similar general pattern to other medical discussions of precocity. Authors on the subject evaded making links between precocious sexual development and any innate form of 'sexuality'. Masturbation was often described as the consequence of a child's attention being drawn to the genitals by disease or by a corrupting external influence, rather than as the result of an inborn ability to experience or comprehend sexual pleasure. Elizabeth Blackwell's *The Human Element in Sex* was representative of many mainstream medical texts when it rejected the possibility that children were responsible for the 'sensations' that led to masturbation, or that they were aware of the implications of their actions:

[I]n the little ignorant child this habit springs from a nervous sensation yielded to because, as it says, "it feels nice." The portion of the brain which takes cognizance of these sensations has been excited, and the child, in innocent absence of impure thought, yields to the mental suggestion supplied from the physical organs. This mental suggestion may be produced by the irritation of worms, by some local eruption, by the wickedness of the nurse, occasionally by malformation or unnatural development of the part themselves.⁷²

This quote provides evidence to support the work of Gail Hawkes and R. Danielle Egan, who have found that Victorian masturbation was conceptualised 'at a somatic rather than conscious level'.⁷³ The 'mental suggestion' to which Blackwell referred was less an active awareness than a decision made on the basis of bodily sensations, which developed in consequence of pathological symptoms or 'evil example'. Again, concerns about negative environmental influences rather than innate sexual urges were central to her work. Local medical practitioners drew upon similar ideas from the national context, particularly about the external stimuli that caused precocious sensations and in turn

⁷⁰ McLaren, *The Trials of Masculinity*, p. 31.

⁷¹ McLaren, *The Trials of Masculinity*, p. 31.

⁷² Elizabeth Blackwell, *The Human Element in Sex: A Medical Inquiry into the Relation of Sexual Physiology to Christian Morality* (London: J. & A. Churchill, 1894), p. 34.

⁷³ Gail Hawkes and R. Danielle Egan, 'Sex, Popular Beliefs and Culture: Discourses on the Sexual Child' in *A Cultural History of Sexuality in the Age of Empire*, ed. Chiara Beccalossi and Ivan Crozier (Oxford: Berg, 2011), 123-44, p. 126.

masturbation. In 1900 *The Lancet* reported on a lecture by O. J. Kauffmann, a physician at Queen's Hospital in Birmingham, in which he reported a case involving a 12-year-old boy whose 'masturbation ... was probably excited, like the precocious feelings, by the constant irritation to which the glans penis was subjected by the retained secretion [smegma]'.⁷⁴ The notions of childhood and innocence were so interwoven that, even though it was only conceptualised as a bodily action, masturbation was expected to remove the characteristics of boyhood. In 1860 one surgeon to the Hospital for Sick Children described a young habitual masturbator as having 'assumed the aspect of a little old man' in his report for *The Lancet*.⁷⁵ The notion of a child's sexual innocence was thus retained at the centre of discussions about its loss.

A small group of medical authors suggested that an inclination to masturbate could be innate in *some* boys. These medical practitioners were not always rejected by professional or lay communities, so long as they emphasised the undesirability and atypicality of any inborn propensity to masturbate. In 1857 William Acton's work, which was an 'outstanding' success with the lay public, stated that:

[L]ittle doubt exists in my own mind, that in some precocious children sexual ideas may become developed many years previously to the perfect evolution of the genital organs ... It has been supposed that this depends upon improper excitement of the sexual organs by nursemaids. That such may often be the case, I can quite believe; but I feel certain that very young children may inherit a disposition to affections of these organs, which causes them to rub themselves and incidentally to excite abnormal sensations and partial erections ... Early voluptuous ideas, which Lallemand calls *idées g n siques*, are also, I think, traceable to the brain; and, I believe, heritable, like many other qualities, from parents who have not held the animal passions in any sort of check.⁷⁶

In this book, Acton combined the questions of environment and heredity. His work tied in with masturbation debates but also went beyond them, as the quote above includes broader discussions about 'precocious' sexual ideas and 'abnormal sensations'. Acton did not deny the popular possibility that precocious sexual ideas could be the result of being led astray by nurses or of pathological conditions that drew attention to the

⁷⁴ O. J. Kauffmann, 'The Ingleby Lectures on the Commoner Neuroses of Childhood, their Pathology and Treatment', *The Lancet*, 14 July 1900, 75-80, p. 76.

⁷⁵ Athola W. Johnson, 'On an Injurious Habit Occasionally Met With in Infancy and Early Childhood', *The Lancet*, 7 April 1860, 344-45, p. 344.

⁷⁶ Michael Mason, *The Making of Victorian Sexuality* (Oxford; New York: Oxford University Press, 1994), p. 187; William Acton, *The Functions and Disorders of the Reproductive Organs in Youth, in Adult Age, and in Advanced Life, Considered in their Physiological, Social and Psychological Relations* (London: John Churchill, 1857), p. 55.

genitals. However, in the above quote he also promoted the idea that precocity could be the result of ‘heritable’ bodily and mental conditions. A few pages later he also made reference to the ‘natural curiosity of such peculiarly organized children’ and ‘a sexually disposed child’.⁷⁷ While such comments were not explicitly linked to heredity, in light of his earlier references to ‘inherit[ed]’ dispositions it seems that at the very least he merged questions of innate and externally influenced behaviour. These ideas tied in with some other comments made in the late-nineteenth century in Blackwell’s work and in correspondence to *The Lancet*, about the possibilities that ‘transmitted sensuality may blight the innocent offspring’ and that children could inherit a propensity towards sexual indulgence if their mother demonstrated ‘unrestraint of the sexual function during pregnancy’.⁷⁸ Differing from the psycho-analytic approach discussed above, however, Acton emphasised that the mind of such a child ‘may be regulated’ and thereby tapped into popular beliefs that even a child who had inherited a sexual disposition could and should be controlled.⁷⁹ Although Acton was by no means a representative member of the medical profession in many aspects, as discussed below in the context of adult sexual behaviour, his work on the importance of regulating precocious sexual development tied in with some of the other medical literature on environment, class, heredity and sexual development already discussed. Arguably his discussions of environmental influences on children had more contemporary importance than the sections on heredity, as they were not only more representative of wider medical literature but also had ‘social currency’ for child protection campaigns. Children could theoretically be protected from the working-class environment that caused precocity, including impure influences or dirty environments that created disease of the genitals, but not from an inborn propensity towards premature sexual development. However, ideas about precocity from environmental causes and precocity from heredity were not entirely separable. Both emphasised that sexual maturity was expected to come with puberty in a ‘normal’ development process. It was only the notion that ‘child sexuality’ could be innate in all ‘normal’ children that found few willing ears within or beyond the medical profession at this time.

⁷⁷ Acton, *Functions and Disorders*, p. 59.

⁷⁸ Blackwell, *The Human Element in Sex*, p. 32; ‘Notes, Short Comments & Answers to Correspondents’, *The Lancet*, 20 June 1885, 1155-56, p. 1155.

⁷⁹ Acton, *Functions and Disorders*, p. 59.

While young boys' masturbation was deemed concerning for national health, the precocious ability for girls to experience sexual pleasure or to be sexually active was considered to destabilise the country's moral foundations in a way that provoked even greater anxiety. As already noted, there was a general expectation that pre-pubescent girls would be 'physically unfit for sexual intercourse', in terms of suffering significant physical injury from penetration.⁸⁰ However, there was an expectation that their bodies could be 'sexualised' over time. They would apparently not only acquire precocious knowledge about sex but also become physically capable of sexual pleasure if sexual intercourse took place on a repeated basis. This notion was long-held for girls, although by the nineteenth century was no longer conceptualised in humoral terms.⁸¹ Instead, medical practitioners stated that a female child's body could become 'open' like an adult if repeatedly subjected to penetrative sex. Louise Jackson cites Lawson Tait's works on sexual crimes against children on this point, in which he:

[F]ound that the elder child had been living as "her own father's regular mistress" for over two years. He found it difficult to view her body as a child's body since it was no longer small and enclosed. Tait commented: "the child's vagina was as large and lax as that of a married woman of mature experience."⁸²

Once a girl's body was 'opened', sexual contact would no longer cause physical pain and her genital sensations could be stimulated so as to allow for pleasure. In this way, a young girl who had been repeatedly subject to sexual assaults could lose the bodily characteristics of childhood and become a form of social 'misfit'.⁸³ This is not to say that boys were completely absent from such discussions. This apparent loss of childlike characteristics has parallels with the case of the habitual masturbator who looked like a 'little old man' cited above. Ideas about 'openness' and the loss of childhood bodily characteristics were also relevant to young boys who had been the passive partner of anal sex on a regular basis.⁸⁴ However, comparable ideas were not prevalent in the context of young boys' heterosexual encounters. There was no expectation that the

⁸⁰ 'Child Marriage in India', *The Lancet*, 11 October 1890, 774, p. 774; Taylor, *Medical Jurisprudence*, 4th edn, p. 593.

⁸¹ Sarah Toulalan has shown that in the early modern period 'it was ... understood to be possible to sexualize pre-pubescent children, so that they *could* develop the capability of engaging in sexual intercourse and of taking pleasure in it, through the application of physical "remedies" or ointments, and through repeated exposure to the sexual act' and that such ideas were linked to 'contemporary humoral understandings of how the body worked'; Toulalan, 'Children and Sex', pp. 132, 141.

⁸² Louise A. Jackson, 'Child Sexual Abuse and the Law: London 1870-1914', unpublished doctoral thesis, Roehampton Institute (1997), p. 180.

⁸³ Louise A. Jackson, *Child Sexual Abuse in Victorian England* (London: Routledge, 2000), p. 6.

⁸⁴ This issue is returned to in the context of bodily indicators of sexual crime, see Chapter Five of this thesis.

sexual act would increase their bodily 'adult' indicators such as the capacity to sustain erections.

Girls were also central to anxieties about precocity because they were considered particularly dangerous for social order once 'fallen'. Contemporary links were drawn between female precocity and prostitution, whereas male precocity was linked to petty crime or disorderly 'juvenile delinquency'.⁸⁵ The former issue was considered to be a greater threat to social order and public morality, because a boy could theoretically be trained out of criminal habits whereas a 'fallen' girl or prostitute could reform but never regain her moral purity. These ideas about 'fallen' women extended to adult females but were considered to be most problematic in the context of precocious girls, as discussed here, because of their potential influence on other innocent children. As Louise Jackson argues, '[t]he key to understanding the nineteenth-century medical representations of the abused child ... must lie in the construction of the concept of pollution'.⁸⁶ In Mary Douglas's anthropological work on pollution beliefs, she noted that the rhetoric of dirt and uncleanness is based on the principle of 'matter out of place'.⁸⁷ Sexual contact with a young girl was 'out of place' both because it was extra-marital and because it predated the girl's maturity, with Acton complaining that 'systematic seducers ... pollute the mind of modest girls'.⁸⁸ Girls were depicted simultaneously as victims of pollution by men and as threats to the innocence of others. A sexual assault or other corrupting influence on a girl's body or mind had a perceived ripple effect, in which other children could also be corrupted. As a young victim of sexual assault could be sexualised over time, she could also apparently become a soliciting party herself and pose a danger to the chastity of impressionable young boys. Such a girl was thus deemed atypical and her 'pollution' originally came from without, rather than from within. As sociologist Nancy

⁸⁵ For gendered links between precocity and crime see Shani D'Cruze and Louise A. Jackson, *Women, Crime and Justice in England since 1660* (Basingstoke; New York: Palgrave Macmillan, 2009), p. 75; Monica Flegel, *Conceptualizing Cruelty to Children in Nineteenth-Century England* (Farnham; Burlington: Ashgate, 2009), p. 163; Rachel G. Fuchs, 'The State' in *A Cultural History of Childhood and Family in the Age of Empire*, ed. Colin Heywood (Oxford: Berg, 2010), 129-48, p. 146; Margaret May, 'Innocence and Experience: The Evolution of the Concept of Juvenile Delinquency in the Mid-Nineteenth Century', *Victorian Studies* 17 (1973), 7-29, p. 21; and Larry Wolff, "'The Boys are Pickpockets, and the Girl is a Prostitute": Gender and Juvenile Criminality in Early Victorian England from *Oliver Twist* to *London Labour*', *New Literary History* 27 (1996), 227-49.

⁸⁶ Jackson, 'Child Sexual Abuse and the Law', p. 190.

⁸⁷ Mary Douglas, *Purity and Danger: An Analysis of the Concepts of Pollution and Taboo* (London: Routledge and Kegan Paul, 1978), p. 40.

⁸⁸ William Acton, *Prostitution, Considered in its Moral, Social, & Sanitary Aspects, in London and Other Large Cities with Proposals for the Mitigation and Prevention of its Attendant Evils* (London: John Churchill, 1857), p. 60.

Fisher notes, ‘in order to become polluted one must first be pure; corruptibility only makes sense in relation to innocence’.⁸⁹ When viewed in this way, the victim/threat dichotomy often cited by historians was not a binary. ‘Polluted’ and ‘polluting’ children were threats *because* they were victims, not ‘as well as’ or ‘in spite of’ being victims.

Concerns about pollution were not purely medical in origin. Siân Pooley notes that the Victorian and Edwardian emphasis on ‘the innate innocence of children, who were constantly threatened by contamination from their diseased surroundings ... echoed scriptural ideas of sacred childhood virtue in a depraved world’.⁹⁰ A ‘systematic seducer’ or ‘a certain kind of conversation’ could ‘pollute’ a young girl’s mind, according to both medical and religious texts.⁹¹ Medical ideas were evidently not separable from long-held religious concerns. However, in the period under study ideas with religious or moral roots were reframed using the more scientific medico-moral language of pathology and contamination. High profile social purity, first-wave feminist and child protection groups drew heavily upon and shaped such ideas. Notions of pollution, corruption and precocity had particular resonance with social purity groups because of their emphasis on enforcing morality, but the groups worked together and with medical practitioners to promote a higher age of sexual consent.⁹² This collaboration was part of an international movement, which provided a bridge between the medical and popular spheres.⁹³ There were particularly striking similarities between social purity and medical uses of the pathological ‘abnormal’ sexual child to emphasise the inherent innocence of the majority. Gail Hawkes and R. Danielle Egan note that social purity activists created:

[A] binary that allowed the child’s sexuality to be understood as simultaneously present but normatively absent. The mobilization of the idea of the dangerously knowing child was an attempt to disentangle this ambivalent construction juxtaposing innocence with corruptibility ... By equating erroneously acquired sexual knowledge with pathological sexual practice in the present and future, the

⁸⁹ Nancy L. Fisher, ‘Purity and Pollution: Sex as a Moral Discourse’ in *Introducing the New Sexuality Studies: Original Essays and Interviews*, ed. Steven Seidman, Nancy Fischer and Chet Meeks (London: Routledge, 2007), 51-58, p. 54.

⁹⁰ Siân Pooley, ‘“All we parents want is that our children’s health and lives should be regarded”’: Child Health and Parental Concern in England, c.1860-1910’, *Social History of Medicine* 23 (2010), 528-48, p. 555.

⁹¹ Acton, *Prostitution*, p. 60; Dyer, *Facts for Men*, p. 23.

⁹² See Chapter Three of this thesis for some of the differences between strands of the ‘social-purity alliance’ and the ways in which social purity, child protection, first-wave feminist and medical groups temporarily put aside such differences in the 1880s.

⁹³ For the international nature of the movement see Hawkes and Egan, ‘Sex, Popular Beliefs and Culture’, p. 129.

discourse of purity became credible though its oppositional nature ... Social purity produced prurience in order to protect innocence.⁹⁴

There are clear points of comparison between this discursive strategy and that of medical authors, as outlined above, in terms of the positioning of precocity against an ideal 'norm' of childhood innocence. The extent of these parallels cannot be explained simply by the impact of medicine on social purity movements, or *vice versa*. Rather, they should be understood in terms of common middle-class concerns of the Victorian and Edwardian period. Contemporary anxieties simultaneously informed the content of medical literature and its reception or use by campaigners and the general public. As Jeffrey Weeks argues, the 1880s campaigns over child prostitution 'sometimes answered as much to middle-class anxieties as to gross sexual exploitation'.⁹⁵ The issue of these campaigns and the direct links between medical practitioners and campaigners is returned to in Chapter Three, but remains worthy of note here as part of the construction and reception of medical literature on childhood innocence and its 'darker' pathological side.

Despite the heterogeneity of medical opinion on childhood and sex, this analysis has identified some general patterns in ways of thinking about pre-pubertal sexual development. The most widely-circulated medical ideas supported specific middle-class concerns about the dangers of the working-class environment and heredity without destabilising the notion that a child should be sexually innocent. The greatest 'social currency' lay in medico-moral literature on female sexual precocity and pollution, partly because it highlighted dual questions about protection and control that could be drawn upon by pressure groups promoting legislative change in the 1880s. This conclusion provides some useful context for the next two chapters, which demonstrate that discussions about precocity were also drawn upon by medical practitioners and legislators in the context of debates about age-of-consent laws. The popularity of certain medical ideas both within and beyond the profession was not mere coincidence. Medical ideas about sexual development before puberty can only be understood in the light of a broader social context, which shaped both the nature of medical writings and the ways in which they were utilised and received. At least at a theoretical level, the

⁹⁴ Hawkes and Egan, 'Sex, Popular Beliefs and Culture', p. 131.

⁹⁵ Jeffrey Weeks, *Sex, Politics, and Society: The Regulation of Sexuality since 1800* (London: Longman, 1981), p. 38.

perceived value of medical thinking related more to its consolidation of existing middle-class concerns than to the impact of a scientific ‘dominant discourse’.

‘Storm and Stress’: At and Beyond Sexual Maturity

This section considers the ‘social currency’ of medical literature on sexual maturity and sexual behaviour during the puberty years and beyond. It builds on scholarship about the gap that existed between ‘biological’ and ‘social’ maturity to explain why medical literature on the dangers of puberty had particular social resonance. Like precocity, anxieties about puberty centred on the conflict between protection and control. Boys and girls at puberty were expected to develop physiologically before they developed the ‘will’ and ‘modesty’ respectively to control their new sexual bodies and urges. Medical literature drew on contemporary concerns about class and self-control when it emphasised that the working-class pubescent child occupied a dangerous space between childhood and adulthood, in a similar way to the precocious child. In the early-twentieth century, medical discussions of sexual relations after puberty also related to the subject of eugenicist concerns about reproduction. This section shows that many medical authors used physiological claims to justify moral positions on subjects such as extra-marital sex and illegitimacy. Supporting the conclusions of the first section, medical ideas were heterogeneous but those that had the most ‘currency’ within and beyond the profession were grounded in medico-moral rather than purely medical concerns. The female body at puberty was also a particular subject of concern, as it had been before puberty.

Across mainstream and specialist medical genres, authors conceptualised puberty as a ‘gradual’ process or ‘evolution’ that involved stages of physical and psychical maturation and which resulted in sexual differences being more clearly defined. A specific order of development was put forward in many texts, which began with the emergence of secondary sexual characteristics including hair growth in both sexes, breasts in girls and vocal changes in males.⁹⁶ Reproductive capacities apparently followed, which prompted sexual sensations and the capacity for pleasure. As Elizabeth

⁹⁶ The nature of these bodily changes and indicators of reproductive capacities are discussed in detail in Chapter Two.

Garrett Anderson wrote in 1874, the ‘functions of womanhood awaken instincts’.⁹⁷ For the male, physiologist William Carpenter wrote that ‘sensations ... may either originate in the sexual organs themselves, or may be excited through the organs of special sense’.⁹⁸ In turn, the development of sexual sensations and pleasure were expected to stimulate curiosity and an ability to comprehend the nature of sex. Sexual maturation was not expected to be only a linear process, as most medical authors implied that development of the three component parts of sexual maturity involved phases of both parallel and non-parallel development. However, psychological aspects of sexual maturity were always expected to have their roots in physiological changes and therefore to develop last.⁹⁹ This meant that puberty was conceptualised as a period of time when the body and mind often developed at different times and rates, rather than as a turning point at which sexual maturity was reached. Within this framework of thought, there could be a few years in which the sexual body had reached maturity without a girl or boy yet having the capacity to understand or control it. Although the contemporary notion that sex generally operated at a somatic level was retained, some authors such as Elizabeth Blackwell observed that ‘in the human race the mind tends to rule the body’.¹⁰⁰ Psychological development was deemed an important facet of sexual maturity, without which the sexual body and sensations could not fully be controlled.

In G. Stanley Hall’s oft-cited words, the ‘adolescent’ years marked a period of ‘storm and stress’ at which sexual difference emerged.¹⁰¹ This period of development was expected to be dangerous, both sexually and socially, and was a focus of contemporary anxieties. Because of the predominance of gonadal rather than hormonal models of sexual difference at this time, particular concerns were cited about the impact of the new activity of the ovaries on females.¹⁰² This gendered focus also drew upon wider thinking about women being closer to ‘nature’ than men and controlled by their ovaries

⁹⁷ Elizabeth Garrett Anderson, ‘Sex in Mind and Education: A Reply’, *Fortnightly Review* 15 (1874), 582-94, p. 589.

⁹⁸ William B. Carpenter, *Principles of Human Physiology: With their Chief Applications to Psychology, Pathology, Therapeutics, Hygiene & Forensic Medicine*, 5th edn (London: Blanchard & Lea, 1855 [1842]), p. 792; this was also cited in Acton, *Functions and Disorders*, p. 5.

⁹⁹ This point was sometimes used to promote a higher age of sexual consent. See Chapter Two of this thesis, section two.

¹⁰⁰ Blackwell, *The Human Element in Sex*, p. 7.

¹⁰¹ Hall, *Adolescence*, vol. 1, p. xiii.

¹⁰² On the notion of ‘true sex’ as determined by the gonads see Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* (Cambridge; MA; London: Harvard University Press, 1998), p. 29.

and/or womb.¹⁰³ In 1852 the pre-eminent medical jurist Alfred Swaine Taylor claimed that at puberty:

[F]emales become irritable, easily excited, and they have been known to perpetrate, without motive, crimes of great enormity, such as murder and arson ... [P]uberty in the male may be attended with similar morbid propensities, but these are not so commonly witnessed as in the female sex.¹⁰⁴

Despite his differing perspective on the subject of sexual development in infancy, Henry Maudsley echoed Taylor almost exactly when he stated in a lecture in 1870 that:

[T]he monthly activity of the ovaries which marks the advent of puberty in women has a notable effect on the mind and body; wherefore it may become an important cause of mental and physical derangement. Most women at that time are susceptible, irritable, and capricious, any cause of vexation affecting them more seriously than usual.¹⁰⁵

The 'darker' side of puberty was a concern of physiology and psychiatry alike because, unlike the 'darker' side of childhood, it was widely accepted as typical. As Helen King notes:

[M]edical writing from the middle and end of the nineteenth century shows very similar concerns about female puberty ... Analogies were drawn between animals on heat and women about to menstruate; the nervous system was considered to be under great stress, making a woman irritable, and prone to the passions of jealousy, anger and vengeance.¹⁰⁶

This life phase tapped into contemporary concerns, because it was expected to come hand in hand with disorderly behaviour. Girls were deemed to need both protection and control, an issue which also resonated with the social purity movements discussed above. However, girls at puberty apparently needed protection from themselves rather than just from external influences.

¹⁰³ For concerns about the pathological 'universal uterus' see Strange, "'I Believe It to Be a Case Depending on Menstruation'", p. 103. For the potential consequences of this proximity to nature, particularly in terms of 'hysteria' or 'nymphomania', see Bryan S. Turner, *Medical Power and Social Knowledge* (London: Sage, 1987), pp. 89-90. On the links between certain social groups and nature see Matthew Waites, *The Age of Consent: Young People, Sexuality and Citizenship* (New York: Palgrave Macmillan, 2005), p. 13; Leonore Davidoff, 'Class and Gender in Victorian England: The Diaries of Arthur J. Munby and Hannah Cullwick', *Feminist Studies* 5 (1979), 86-141, p. 90; and Ludmilla Jordanova, 'Natural Facts: A Historical Perspective on Science and Sexuality' in *Nature, Culture and Gender*, ed. Carol P. McCormack and Marilyn Strathern (Cambridge: Cambridge University Press, 1980), 42-69, p. 67.

¹⁰⁴ Taylor, *Medical Jurisprudence*, 4th edn, p. 564.

¹⁰⁵ Henry Maudsley, 'Gulstonian Lectures on the Relations between Body and Mind and between Mental and other Disorders of the Nervous System', *The Lancet*, 28 May 1870, 759-62, p. 760.

¹⁰⁶ Helen King, *The Disease of Virgins: Green Sickness, Chlorosis and the Problems of Puberty* (London; New York: Routledge, 2004), p. 92.

Anthropologists and historians have long noted the existence of a time lag between ‘biological’ and ‘social’ maturity in many western cultures.¹⁰⁷ The context of Victorian and Edwardian Britain was no exception. Medical writers distinguished between typical ages of sexual maturity at puberty and recommended ages for marriage, at which sexual activity was also expected to commence. Although this gap was sometimes deemed ‘adolescence’, it should not be understood as adolescence in the sense of a middle-class life stage between school and work.¹⁰⁸ Rather, it was conceptualised as a time when bodily urges existed without yet an appropriate outlet, in terms of marriage, or the ability to control them. The latter issue of self-control was deemed a marker of a civilised population and tied in with broad contemporary concerns about disorder, heredity and class. Such concerns became increasingly notable with the rise of a eugenics movement after the turn of the century, which found a receptive audience for medical ideas about puberty and adolescence in a range of new scientific and non-scientific professions. In 1914, a zoologist wrote in *Eugenics Review*:

[M]ankind is gifted during a considerable period of adolescence with a faculty, the use of which is necessarily restrained and forbidden until some time after the attainment of the adult state ... The period of adolescence when the sexual nature of man is developed is a period when the character is largely in process of formation and the restraining power of the reason is not at its strongest pitch.¹⁰⁹

This eugenicist also, like many medical writers, connected the subject of adolescence to concerns about the environment and living conditions of the poor. He stated that ‘the evil results of this disharmony of human nature ... may be incident everywhere, but, perhaps, nowhere more markedly than in the overcrowded dwellings of town and country’.¹¹⁰ Although contemporary concerns about self-control and self-discipline focused on working-class masculinities, this chapter will go on to show that female sexual desire was also a widespread topic of medical concern for girls over the age of puberty. Women were not deemed ‘sexless’ but were expected to display ‘modesty’ rather than ‘will’ in order to control their sexual urges. Indeed ‘servant girls’ were a particular focus of contemporary anxieties because of the apparent frequency with which they corrupted young boys in their dwellings, not necessarily with malicious

¹⁰⁷ On the so-called ‘puberty gap’ or the difference between ‘biological adolescence’ and ‘social adolescence’ see Alice Schlegel, ‘The Cultural Management of Adolescent Sexuality’ in *Sexual Nature, Sexual Culture*, ed. Paul R. Abramson and Steven D. Pinkerton (Chicago; London: University of Chicago Press, 1995), 177-94, p. 178; and King, *The Disease of Virgins*, pp. 87-88.

¹⁰⁸ John R. Gillis, *Youth and History: Tradition and Change in European Age Relations, 1770 -Present* (New York: Academic Press, 1974), p. 98; Neuman, ‘Masturbation, Madness’, pp. 6-20.

¹⁰⁹ Geoffrey Smith, ‘A Contribution to the Biology of Sex’, *Eugenics Review* 6 (1914), 18-35, p. 27.

¹¹⁰ Smith, ‘A Contribution to the Biology of Sex’, p. 27.

intent but because they were at the life stage where they had developed sexual curiosity but not yet ‘modesty’.¹¹¹

The notion of a gap between ‘biological’ and ‘social’ puberty was evident throughout medical literature, particularly in authors’ repeated distinctions between sexual maturity and readiness for sexual activity. Despite highlighting puberty as the life stage at which sexual maturity was reached, few medical practitioners stood against the prevailing moral code to claim that sexual activity was also safe at the same age for either sex. Medical emphasis on the multifaceted and lengthy nature of sexual development, as discussed above, allowed medical practitioners to reject the possibility that any single marker of maturity could demonstrate a readiness for sexual activity.¹¹² Some popular medico-moral texts also drew upon wider moral and religious frameworks of thought in criticising youthful sexual activity even after boys and girls had reached puberty. Acton emphasised that ‘[p]uberty must not be just dawning; it must be in full vigour; hence the necessity of man’s controlling his sexual feelings at an early age’.¹¹³ Elizabeth Blackwell commented that ‘[i]t is impossible to reprobate too strongly the false views of physiology held by those who make no distinction between the natural healthy growth of these functions and their abuse’.¹¹⁴ Blackwell also clearly distinguished ‘puberty’ from ‘nubility’. She defined puberty as an age at which it was physically possible to procreate but when ‘the actual exercise of such faculty is highly injurious’.¹¹⁵ Nubility, she claimed, occurred in the early- to mid-twenties and was the life stage at which marriage and procreation could have healthy outcomes.¹¹⁶ Although Blackwell’s concept of ‘nubility’ was unique to her work, her emphasis on the gap between ‘biological’ and ‘social’ puberty was representative of wider medical literature from the period. Even before the rise of the eugenics movement, her work also drew upon and reinforced contemporary concerns about heredity and racial superiority. As Catherine Robson notes, Blackwell ‘tried to bring into play a new concept of “nubility,” which she claimed was a distinct physiological stage that came considerably later in life than puberty, and which, in its late arrival, was proof of the human race’s superiority over the

¹¹¹ See Ellis, *Studies in the Psychology of Sex*, vol. 3, p. 175; Johnson, ‘On an Injurious Habit’, p. 344.

¹¹² On the general distinction between puberty and preparedness for sex see Waites, *The Age of Consent*, p. 78.

¹¹³ Acton, *Functions and Disorders*, p. 14.

¹¹⁴ Blackwell, *The Human Element in Sex*, pp. 26-27.

¹¹⁵ Blackwell, *The Moral Education of the Young*, pp. 11-12.

¹¹⁶ Blackwell, *The Moral Education of the Young*, pp. 11-12.

rest of creation'.¹¹⁷ This section will go on to show that Blackwell was not alone in using physiological explanations to justify the 'injurious' nature of sex at puberty, nor in connecting physiology with ideas about heredity and race.

The female pubescent was a focus of contemporary anxieties about sex, for many of the same reasons outlined above about the repercussions of being a 'fallen' girl. For females, the danger was deemed to be not only physical. When discussing the rape of girls 'after puberty', Taylor emphasised that 'a young female at this age may sustain all the injury, morally and physically, which the perpetration of the crime can possibly bring down upon her, whatever may have been the degree of penetration'.¹¹⁸ Medical literature on pregnancy particularly highlights these gendered medico-moral concerns about sexual behaviour at puberty. Anthropologist Alice Schlegel notes that the possibility of pregnancy partly explains the importance placed upon female chastity at puberty, particularly in cultures where 'bastardy has serious deleterious outcomes for families'.¹¹⁹ Bastardy in Victorian and Edwardian England fitted this model, as it had 'deleterious' outcomes for a family's reputation or finances. A girl also had to be both physically mature and sexually active to be impregnated, thus the subjects of illegitimacy and precocity often overlapped. In 1902 *The Lancet* reported on the delivery of a child by a 14-year-old girl, which it published under the heading 'Note on a Case of Precocious Conception with Subsequent Delivery at Full Term'.¹²⁰ This case was labelled 'precocious' in spite of the girl having been capable of reproduction for almost two years, as the article stated that she had begun menstruation between the ages of 12 and 13. Chapter Two of this thesis shows that menstruation at the age of 12 was considered within the 'normal' range. The 'precocious' label therefore referred to the girl being precociously pregnant before marriage, rather than being precociously physically developed.

As in Blackwell's work on 'nubility' most medical texts justified claims about such precocious pregnancies in physiological terms. They drew upon broader concerns about

¹¹⁷ Catherine Robson, *Men in Wonderland: The Lost Girlhood of the Victorian Gentleman* (Princeton, N.J.; Woodstock: Princeton University Press, 2001), p. 172.

¹¹⁸ Taylor, *Medical Jurisprudence*, 4th edn, p. 583. Minor changes to this quote were made during the editions under study, such as 'girl' instead of 'young female' in the 1866 edition. However, the meaning of the quote remained essentially unchanged throughout the period under study.

¹¹⁹ Schlegel, 'The Cultural Management of Adolescent Sexuality', p. 178.

¹²⁰ James Milner, 'Note on a Case of Precocious Conception with Subsequent Delivery at Full Term', *The Lancet*, 7 June 1902, 1601-02, p. 1601.

heredity and commented that pubescent girls were likely to bear sickly children or to miscarry. As Marjorie Levine-Clark notes, '[n]ational fitness and public health were intimately related to the reproductive capacities of working-class women' in the Victorian period.¹²¹ In 1833 Michael Ryan, the editor of *The London Medical and Surgical Journal*, had written that:

Buffon held this position, "the natural state of man after puberty is marriage;" but this is evidently untenable, because the human body is not fully developed at this period of life, the different functions are not perfect, as the organs are only in the progress of their growth, the offspring would be infirm and delicate, and the sexes totally incompetent to perform the various important duties of parents. It is at the adult age only that the mind and body have arrived at perfection; and therefore moralists and legislators have fixed this age as the most fit for marriage ... It is also a moral and medical precept, that both male and female should observe the strictest continence until the adult age, so that the great end of marriage, the propagation of healthful infants, should be accomplished.¹²²

Despite describing 'a moral and medical precept', claims such as those made by Ryan were seemingly grounded more in morality. They sat uneasily alongside case reports in medical journals, which regularly cited examples of successful full-term pregnancies in pubescent girls. Another issue of *The Lancet*, for example, reported that one 'girl, who was only fourteen years and five months old, was delivered of a fully matured child on Nov. 2nd last, and in another case the girl, though only fifteen, was several months pregnant'.¹²³ Use of the word 'only' in this article implied a moral judgement that these girls were too young for pregnancy, but this judgement was not supported by the apparently healthy outcome for mother and child. Despite emphasising that precocious menstruation and pregnancy only occurred 'exceptionally', the Manchester toxicologist John Dixon Mann dedicated an entire page of his medical jurisprudence textbook to reporting recorded pregnancies in young girls and noted that some produced 'fine healthy' children.¹²⁴ This disjuncture was never explicitly addressed or explained by medical or scientific authors, who simply emphasised that such pregnancies were rare in general and even more exceptional when they involved healthy offspring.

¹²¹ Marjorie Levine-Clark, *Beyond the Reproductive Body: The Politics of Women's Health and Work in Early Victorian England* (Columbus: Ohio State University Press, 2004), p. 34.

¹²² Michael Ryan, 'Lectures on the Physical Education and Diseases of Infants and Children', *London Medical and Surgical Journal* 72 (1833), 683-87, p. 686.

¹²³ 'Liverpool (From Our Own Correspondent)', *The Lancet*, 14 December 1895, 1542, p. 1542.

¹²⁴ John Dixon Mann, *Forensic Medicine and Toxicology*, 4th edn (London: Taylor & Francis, 1908 [1893]), pp. 92-93.

The most widely-disseminated medical journals and textbooks aligned the capacity for healthy pregnancy with the ideal marital age and used physiological justifications to do so. Medical practitioners drew upon and consolidated existing trends in marriage patterns by recommending that women married in their early twenties, which was the most common marital age even though girls could legally marry at 12 and boys at 14 with parental permission.¹²⁵ In 1889 *The Lancet* cited Dr Matthews Duncan, a lecturer on midwifery, as stating that '[t]he period at which fertility is not only surest in its occurrence, but safest and most happy in its results, is ... between twenty and twenty-five years for women, for men about five years later'.¹²⁶ Duncan attempted to justify this clear disparity between ages of sexual maturity and ideal reproduction with physiological rather than moral arguments. He commented that, for men and women below the age of twenty, 'sexual development which, if it is in a sense complete, has often proved inadequate to any unusual strain'.¹²⁷ The widespread influence of such ideas is evident by their citation in texts for broad and specialist markets, both within and beyond physiology. For example, Duncan had been previously cited by the British alienist Thomas Smith Clouston in his 1880 *Edinburgh Medical Journal* article 'Puberty and Adolescence Medico-Psychologically Considered'.¹²⁸ However, as already noted, very little physiological evidence was given to support claims about the health repercussions of youthful pregnancy. Medical writers seemingly used physiological arguments selectively to validate moral stances on sexual behaviour.

Texts aimed at both lay and professional markets also emphasised that uncontrolled and extra-marital sexual activity was wasteful unless it was for the purposes of reproduction,

¹²⁵ The legal marital age of 12 for girls and 14 for boys had long roots in Canon law; see Nick S. Davidson, 'Response to William G. Naphy, "Under-Age" Sexual Activity in Reformation Geneva' in *Children and Sexuality: The Greeks to the Great War*, ed. George Rousseau (London; New York: Palgrave Macmillan, 2007), 134-41, pp. 134-36. However, few members of any social group married at this age. Although average marital ages had dropped over the centuries preceding the Victorian era, Michael Anderson notes that the mean national marriage age rose again during the period under study from 24.4 for men and 22.9 for women in the 1850s to 26.7 and 24.4 respectively in the late 1910s; For the decline in marriage ages since the early modern period see: Barry Reay, *Microhistories: Demography, Society, and Culture in Rural England, 1800-1930* (Cambridge: Cambridge University Press, 1996), p. 41; and Michael Anderson, 'The Social Implications of Demographic Change' in *The Cambridge Social History of Britain 1750-1950*, ed. F. M. L. Thompson, vol. 2 (Cambridge: Cambridge University Press, 1990), 1-70, p. 32.

¹²⁶ 'The Lancet: London', *The Lancet*, 23 March 1889, 584-87, p. 585.

¹²⁷ 'The Lancet: London', p. 585.

¹²⁸ T. S. Clouston, 'Puberty and Adolescence Medico-Psychologically Considered', *Edinburgh Medical Journal* 26 (1880), 5-17, p. 12.

which echoed discussions about the wasteful nature of male masturbation.¹²⁹ Even once a boy or girl was sexually mature, they were discouraged from ‘wasting’ sexual energy or reproductive capacities by engaging in masturbation or extra-marital sex. A girl or boy was thus theoretically expected to be chaste and to resist ‘self abuse’ until their sexual energy was given an appropriate outlet in marriage, which might not occur for up to a decade after the onset of puberty. One marriage manual by an anonymous ‘medical expert’, which reached two editions between 1907 and 1911, stated that ‘the sexual department is a storage battery of vitality ... which may be used partly for the legitimate purpose of reproduction and the remainder for developing the other departments, or it may be wasted in lustful practices’.¹³⁰ By the end of the period under study such ideas were also drawn upon beyond the medical profession in eugenicist literature. In an issue of *Eugenics Review* from 1913, teachers wrote about the need to train a boy that his new sexual and bodily force ‘should not be wasted ... It affects not only the individual, but the community and the race’.¹³¹ Again, medical texts often both drew upon and consolidated anxieties about national efficiency and heredity, particularly after the turn of the century.

Although some medical practitioners complained about their colleagues encouraging ‘the early indulgence of the passions, on the false, wicked, and untenable grounds that self-restraint is incompatible with health’, the colleagues in question were seemingly no more than ‘straw men’.¹³² No general or specialist medical text of the time openly advocated extra-marital sex or masturbation. Medical writers emphasised that, once beyond the disorderly sexual desires of puberty, male and female adults should have developed the capacity to control or hide their sexual urges. Some commercially successful texts aimed at the lay public even claimed that women lacked sexual desires completely, with the most widely-cited example being William Acton’s statement that ‘women (happily for them) are not very much troubled with sexual feeling of any

¹²⁹ On waste and masturbation see Jean L’Esperance, ‘Doctors and Women in Nineteenth-Century Society: Sexuality and Role’ in *Health Care and Popular Medicine in Nineteenth Century England: Essays in the Social History of Medicine*, ed. John Woodward and David Richards (London: Croom Helm, 1977), 105-27, pp. 107-11.

¹³⁰ *Advice to the Married and Those Contemplating Marriage of Both Sexes: A Book for the People of Valuable Information and Advice, to Teach the Married and Marriageable how to Conduct Themselves*, 2nd edn (London: E. Seale, 1911 [1907]), p. 4.

¹³¹ J. H. Badley, ‘How the Difficulties in Teaching Eugenics May Be Overcome’, *Eugenics Review* 5 (1913), 12-18, p. 12.

¹³² John J. Nason, ‘An Address on Sanitation in Some of its Aspects’, *BMJ*, 5 July 1884, 6-10, p. 8.

kind'.¹³³ However, Michael Mason rightly notes that 'as a claim about a woman's sexual response Acton's remark is ... without a parallel in the sexual literature of the day'.¹³⁴ Within the profession, medical practitioners more commonly emphasised that women had a degree of sexual desire but that after puberty they would have the capacity to hide it. Rather than being perceived as non-existent in medical literature, female sexual desires were widely considered to be common but potentially either stronger or weaker than those of males depending on the medical text in question.¹³⁵ Whether female sexual urges were deemed stronger or weaker than those of men was seemingly irrelevant to the reception of such ideas. Their 'currency' lay not in the discussions about their strength, as was the case in literature on childhood, but in the almost universal emphasis on the importance of controlling or hiding sexual urges outside marriage.

Self-control was described in terms of the male qualities of 'will' or 'reason' and the feminine traits of 'modesty' or 'reserve'.¹³⁶ These forms of mental self-control provided a semi-medical basis for authors' moral claims. Although 'willpower' was expected to be refined through training and education, medical authors also conceptualised it as a developmental issue. Blackwell commented that '[t]he years from sixteen to twenty-one are critical years for youth ... [E]very additional year will enlarge the mental capacity, and may confirm the power of Will' and the physician Charles Bell stated that '[t]he age of puberty, as it is called, at which this discharge [menstruation] first appears, is also accompanied by many important mental and bodily changes. Its approach is indicated by increasing reserve in the young female'.¹³⁷ As M. Jeanne Peterson notes, Victorian medical practitioners 'expected that females who had undergone normal puberty would

¹³³ For two of the many citations of this Acton comment see Lucy Bland, *Banishing the Beast: English Feminism and Sexual Morality 1885-1914* (London: Penguin, 1995), p. 49; and Jackson, *The Real Facts of Life*, p. 67.

¹³⁴ Mason, *The Making of Victorian Sexuality*, p. 195.

¹³⁵ Blackwell stated that women had 'physical instincts as strong as those of men'; Blackwell, *The Moral Education of the Young*, p. 75. Acton was even reported as stating that 'Mr. Coote truly observed that, in some cases also, the sexual passion was very strong in women'; 'The Medical Aspects of Prostitution', *BMJ*, 17 February 1858, p. 186. In contrast, a medical contributor to the *Edinburgh Medical Journal* wrote that 'in man the sexual passion is stronger than in woman'; James Miller, *Prostitution considered in Relation to its Cause and Cure* (London: Simpkin, Marshall & Co., 1859), p. 10 in London, The Women's Library, Acton: Social Evil Extracts Part 3, 1853-1875, 3AMS/M/07.

¹³⁶ This division between male 'will' and female 'modesty' is undoubtedly simplistic to an extent but was prevalent in contemporary medical literature and has been identified in historiography such as Bland, *Banishing the Beast*, p. 56.

¹³⁷ Blackwell, *The Moral Education of the Young in Relation to Sex*, 6th edn, p. 62; Charles Bell, 'The Constitution and Diseases of Women, Part II', *Edinburgh Medical and Surgical Journal* 62 (1844), 311-30, p. 329.

display marked modesty, presumably because they were self-conscious about changes in their bodies'.¹³⁸ Many medical authors conceptualised the ability to hide and control sexual desires not only as a form of social propriety but also as a facet of development, which sprang from physiological changes rather than being a purely psychological issue. Such an approach provided a scientific explanation for the expectation that males and females would control their sexual urges by the time of full sexual maturity, at least before marriage. It also meant that such ideas were not limited to specialist literature on the mind.

While all authors disapproved of extra-marital sex, medical literature for the lay public was the most overtly moralistic in tone. The 1911 edition of the marriage manual by an anonymous 'medical expert' stated that '[s]exual intercourse, conception, and the development of children is [sic] the natural outcome of marriage'.¹³⁹ Acton's popular work was similarly didactic in tone, instructing his readers on the 'attendant evils' of fornication and the importance of abstinence 'for the world'.¹⁴⁰ His collection of extracts on the 'Social Evil', which informed the book's ideas, contained a cutting of similarly moralistic work on prostitution by the surgeon James Miller, who wrote that fornication without love and marriage was a 'heinous' sin.¹⁴¹ This language can be viewed partly as a deliberate commercial tactic, as the most moralistic medical literature was also the most popular with the lay public. Acton's work was originally aimed at medical colleagues, but Michael Mason notes that its editions became more 'lay-oriented' over time.¹⁴² Despite this lay popularity, Acton was saved from rejection by the medical community because he included 'lengthy quotes in foreign tongues' in order to maintain some respectability and because he emphasised the dangerous nature of disorderly sex.¹⁴³

Even within marriage, medical texts generally advocated moderation, although some medical practitioners controversially allowed for the use of contraception within marital relations. The physician George R. Drysdale did so in his extremely successful

¹³⁸ M. J. Peterson, 'Precocious Puberty in the Victorian Medical Gaze', *Nineteenth-Century Gender Studies* 4 (2008) <<http://www.ncgsjournal.com/issue42/peterson.htm>> (accessed 29 November 2011).

¹³⁹ *Advice to the Married*, p. 7.

¹⁴⁰ Acton, *Functions and Disorders*, pp. 13-14.

¹⁴¹ Miller, *Prostitution*, p. 19.

¹⁴² Mason, *The Making of Victorian Sexuality*, pp. 187, 209.

¹⁴³ Hall, "'The English Have Hot-Water Bottles'", p. 351.

Elements of Social Science. His work was grounded in a ‘neo-Malthusian’ approach to population control through birth control rather than abstinence and echoed older, unfashionable ideas about the health value of sexual intercourse for removing ‘blockages’.¹⁴⁴ According to Stephen Garton these ideas had some ‘currency’ beyond scientific communities amongst fellow neo-Malthusians, such as Dyer, and ‘spread quickly to the middle classes’.¹⁴⁵ However, no ‘social currency’ was universal. Neo-Malthusian ideas were resisted by eugenicists at the turn of the century, who thought that ‘birth control was a social menace’ because it was only used by middle-class women not by the ‘degenerate’ classes.¹⁴⁶ Drysdale’s ideas were also by no means representative of or widely accepted within professional thought, which may explain his decision to publish the book as an anonymous ‘Student of Medicine’ until his death in 1904.¹⁴⁷ However, Drysdale’s book maintained respectability because his work on contraception was only a minor proportion of the text.¹⁴⁸ Elsewhere in the book he adhered to important contemporary moral thought, including a strong anti-masturbation stance, and only supported the idea of ‘exercising’ the generative organs in adulthood in conjunction with warning heavily against their excessive use.¹⁴⁹ His work was also very clearly and carefully targeted at a professional market. Other authors were criticised when they presented similar ideas about contraception in a way that was deemed less socially and professionally acceptable. According to Lesley Hall, H. A. Albutt’s *The Wife’s Handbook* (1886):

[A]ddressed to the lay public, at a price placing it within the reach of all but the poorest classes, did not condemn, but rather recommended, the use of contraception in certain circumstances. According to the *British Medical Journal* in 1889, Albutt “might have ventilated his views without let or hindrance from professional authority had he been contented to address them to medical men instead of to the public”. It seems improbable that he would have

¹⁴⁴ Stephen Garton, *Histories of Sexuality* (London: Equinox, 2004), p. 101; King, *The Disease of Virgins*, p. 84.

¹⁴⁵ Garton, *Histories of Sexuality*, p. 106.

¹⁴⁶ Garton, *Histories of Sexuality*, p. 107.

¹⁴⁷ Gowan Dawson, *Darwin, Literature and Victorian Respectability* (Cambridge: Cambridge University Press, 2007), p. 149.

¹⁴⁸ Angus McLaren describes the book as ‘one of the neo-Malthusian classics ... despite the fact that only six of its four hundred and forty-nine pages concerned contraception’; Angus McLaren, *Birth Control in Nineteenth-Century England* (London: Croom Helm, 1978), p. 114 n. 4. However, the influence of this section on contraception also should not be understated as it was apparently extracted from the work and sold as penny pamphlets; ‘Drysdale, George’, *Encyclopedia of Birth Control*, ed. Vern L. Bullough (Santa Barbara, CA: ABC-CLIO, 2001), 100-01, p. 101.

¹⁴⁹ Drysdale, *The Elements of Social Science*, p. 78; ‘Drysdale, George’, p. 101.

met a favourable reception had he done so; however, he might have avoided deletion from the Medical Register.¹⁵⁰

Some medical practitioners evidently felt that discussions of sexual behaviour should not be for public consumption, particularly if they advocated the use of contraception rather than moderation or abstinence. The acceptance or rejection of a medical author's approach to subjects such as contraception and marital abstinence were shaped by a work's proposed market, as well as by its content.

This analysis has shown that medical ideas about sexual development were not simply transferred to the sphere of sexual behaviour, in terms of sexual maturity marking preparedness for sexual activity. Medical texts and journals drew heavily on moral frameworks of thought in order to emphasise the importance of waiting until marital age for sexual activity and childbearing, particularly for women. However, they often couched moral anxieties in physiological language. This discursive approach may have been linked to the perceived value of scientific validation for moral concerns. It may also have been to avoid any question that medical practitioners were overstepping their territory, by speaking explicitly on non-medical matters. As the *BMJ* observed in 1910, '[t]he province of the doctor touches on that of the moralist at certain points so closely that a word or two must be said on the subject. There is a strong objection to the physician posing as a priest, or in any way trespassing on the province of the minister of the spirit'.¹⁵¹ However, Jacques Donzelot's description of the early-twentieth century as a 'moment of ultimate competition between two ways of managing sexuality: the priest's way ... and the doctor's way' is rather simplistic.¹⁵² Moral and medical approaches to sexual behaviour were often complementary rather than inherently antagonistic.

Overall, the section has supported conclusions drawn above by highlighting how medical literature fitted with and developed contemporary ideas about sexual maturity and behaviour. It has shown that the most commercially and professionally successful medical thinkers reinforced middle-class expectations, for example about abstinence outside marital relations and the dangers of disorderly pubescent sexualities. It has

¹⁵⁰ Hall, "'The English Have Hot-Water Bottles'", p. 353.

¹⁵¹ 'The Function of the Medical Profession', *BMJ*, 5 February 1910, 336-37, p. 337.

¹⁵² Jacques Donzelot, *The Policing of Families*, trans. Robert Hurley (London: Hutchinson, 1980 [1977]), p. 174. Donzelot drew upon the ideas of Michel Foucault on this matter; Turner, *Medical Power*, p. 11.

further demonstrated the centrality of female sexual maturity to contemporary anxieties, which builds on the first section's conclusions about precocity. The main difference after puberty was that the threat to girls apparently came from within, which meant that they *all* required guidance and protection from themselves as well as from outside influences. This analysis has also raised a new issue, in terms of the interest that some members of the medical profession took in the messages that reached lay people. The output of medical writers who did not support existing moral codes, or who sought to spread dangerous knowledge amongst the working-classes, could be restricted by members of their own profession. Medicine was neither a coherent 'dominant discourse' nor a passive one. Members of the profession could control the sexual knowledge that reached lay people but only did so in a way that consolidated existing societal norms.

Conclusions

In 1904, Havelock Ellis wrote that '[s]tatements about the sexual impulses of women often tell us less about women than about the persons who make them'.¹⁵³ This chapter has shown that such a comment has widespread implications for the study of medical ideas about sexual maturity, as it can be applied more broadly to sexual development as a whole in both sexes and in any historical period. As Robert A. Nye notes, shifts in medical thought about sexual maturity do not represent a simple linear progression towards 'knowledge about the cycle of sexual maturation', but rather provide an opportunity to understand how 'each age has mixed its scientific knowledge with its cultural preoccupations'.¹⁵⁴ Although Nye drew attention to this valuable methodological issue in 1999, few historians have interrogated the subject of puberty and its heterogeneous medical meanings in such a way. This chapter has made some steps towards filling these gaps in scholarship, by considering how different medical ideas about sexual maturity drew upon or connected to 'cultural preoccupations'.

The most successful medical literature of the late-nineteenth and early-twentieth centuries, in terms of both the number of editions and positive citations within and beyond medical communities, drew upon and consolidated broader moral frameworks

¹⁵³ Ellis, *Studies in the Psychology of Sex*, vol. 3, p. 156.

¹⁵⁴ Robert A. Nye, 'Developmental Biology and Psychology' in *Sexuality*, ed. Robert A. Nye (Oxford; New York: Oxford University Press, 1999), 253-54, p. 254.

of contemporary thought about gender, age, class and sex. Although the specific ‘social currency’ of medical thought changed between contexts, there were some common trends across the period under study. Medical ideas which drew upon common middle-class concerns and which linked morality with physiology rather than psychology were the most widely disseminated within the profession. Such ideas were also the most likely to be picked up by other social groups, particularly social purity campaigners. These overlaps between medical and lay knowledge were not mere coincidence as, for example, the thesis later shows that there were also practical links between medical authors such as Blackwell and social purity groups.¹⁵⁵ The ‘social currency’ of such ideas was also grounded in common interests rather than being the outcome of a ‘dominant discourse’ and its impact. As Annemarie Mol notes in the context of laboratory science, but also applicable to medical ideas:

If it spreads this is because there are actors outside the laboratory who associate themselves with it. And they may pick through what is on offer and take bits and pieces. They do not get overwhelmed by a massive structure or a coherent episteme.¹⁵⁶

In line with Mol’s comments, social purity campaigners and eugenicists often drew upon the ‘bits and pieces’ of medical thought about sexual maturity and behaviour that suited their particular agendas. Medical practitioners and authors had likewise taken ‘bits and pieces’ of wider contemporary moral thought when they initially formulated their ideas for dissemination. The relationship between medical literature and middle-class society was evidently not mono-directional. These conclusions about medical theory are particularly significant for the second half of this thesis, which shows that the nature and reception of medical testimony in sexual offence trials was shaped by similar contemporary frameworks of thought to those identified in this chapter.

The chapter has identified few changes in medical theories of sexual development over the Victorian and Edwardian periods, at least in terms of the medical ideas that carried ‘social currency’. Most new theories about sexual maturity emerged from nascent medical disciplines such as psychiatry and sexology, which remained on the periphery of social and professional thought. This is not to deny the importance of specialist or ‘niche’ literature in subverting and challenging more mainstream ideas. However,

¹⁵⁵ See Chapter Three on medical roles in the ‘coalition of forces’ that promoted legislative change in the 1880s.

¹⁵⁶ Mol, *The Body Multiple*, p. 64.

mainstream medicine is more relevant to the subject matter of this thesis, as general practitioners had greater roles than specialists in the legal system.¹⁵⁷ Physiology consistently formed the basis of mainstream medical literature on sexual development throughout the Victorian and Edwardian periods and was largely resilient to the influx of new specialist ideas. This dominance of physiology was partly because sex and sexual desire were generally conceptualised in somatic terms. However, the chapter has also shown that the period under study should not be viewed as entirely homogeneous. Physiological ideas were utilised by medical authors in a range of ways and found ‘social currency’ with different social groups over time. Such variability was not clearly divided along lines such as ‘progressive’ or ‘conservative’ medical thought. Instead the application of physiology to literature on sexual development varied on an individual basis, according to factors such as the intended readership of books and the religious inclinations of medical authors. Such variability is further demonstrated in the next chapter, which shows that many medical practitioners drew upon physiology selectively to support individual agendas on sexual consent legislation.

This analysis has set up some themes that will be returned to throughout the thesis. In addition to the non-dominant nature of medical discourses, it has demonstrated the important but problematic role of sexual maturity as a marker of the transition from childhood to adulthood. The chapter has also shown that working-class pubescent females were a particular focus of contemporary anxieties. When a girl’s body did not develop in tandem with her mind, as was deemed to be the case with both precocious and ‘normal’ puberty, she was expected to require both protection and control. This social group is a focus of much of the rest of the thesis, both because of the conclusions drawn in this chapter and the attention given to girls in medical and legal practice. These conclusions make it possible to examine how broad medical concerns about female sexual maturity operated in more specific contexts, particularly sexual consent legislation and criminal trials. The next chapter pays attention to the first of these and to the question of when sexual maturity was expected to occur. It considers the apparent contradiction between medical notions of puberty as a lengthy and variable process, as outlined briefly in this chapter, and the legal turning points required for age-of-consent legislation.

¹⁵⁷ See Chapter Four of this thesis on the limited use of medical specialists in the justice system.

‘The Plastic Period of Development’: Ages of Puberty and Sexual Consent¹

I refer to the changes which normally occur at puberty. The onset of the functional activity of the ovaries and the associated secondary sexual characteristics which become evident at this time change the girl into a woman.

British Medical Journal, 15 November 1913²

In 1913 this *British Medical Journal* (*BMJ*) article highlighted the perceived importance of puberty as a marker of the transition from childhood to adulthood. As the previous chapter argued, puberty was not only conceptualised as the onset of ‘manhood’ and ‘womanhood’ but also as a time when girls in particular needed both protection and control. The significance of such an understanding of the pubescent life stage for debates about sexual consent was multifaceted, being apparently an age of both sexual capacity and danger. This chapter moves on from the investigation of the social and medical significance of puberty as a life stage, to examine medical literature on the expected ‘normal’ age(s) of puberty and related discussions on issues of sexual consent. The chapter shows that medical ideas about typical or ‘normal’ ages of puberty, heterogeneous and problematic in themselves, had to be reframed to suit the demands of the law. Rather than trying to impose ideas about the variable nature of ‘normal’ sexual development upon the law, many medical authors adapted the principles of physiology for the legal sphere. They selectively drew upon ideas about ‘normal’ ages of puberty that suited the requirements of age-of-consent legislation and their individual positions on the subject of sexual consent. Even on a theoretical level, medical discussions about sexual consent legislation involved a process of negotiation and compromise with the law.

This chapter focuses on medical ideas about ages of puberty and their relationship to legal ages of sexual consent. Although the nature and passage of sexual consent

¹ ‘London: School Children’, *British Medical Journal* (*BMJ*), 29 January 1910, 287, p. 287.

² W. Blair Bell, ‘The Relation of the Internal Secretions to the Female Characteristics and Functions in Health and Disease’, *BMJ*, 15 November 1913, 1274-80, pp. 1275-76.

legislation are primarily considered in the next chapter on legal reforms, it is useful to outline the structure of sexual consent legislation in order to situate the following analysis. Because of its high-profile nature the chapter's main evidence is drawn from debates surrounding the 1885 Criminal Law Amendment Act (CLAA), which eventually incorporated a felony clause covering girls up to the age of 13 and a misdemeanour clause covering girls aged between 13 and 16.³ Consent was removed as a defence for carnal knowledge of girls covered by either clause, but the maximum punishment was higher for men who committed felonies by assaulting the youngest girls. Medical authors never had to select a single recommended age for sexual consent, as they could suggest separate ages for the felony and misdemeanour clauses. The law therefore was not *entirely* rigid, in terms of requiring a single point of transition from girlhood to womanhood. In some ways it allowed medical practitioners to incorporate their ideas about puberty as a lengthy and variable process, but still required clear-cut parameters between 'normal' and 'abnormal' ages of development. The law's two-tier system was far more rigid than the medical ideas about puberty. This chapter pays attention to ideas about ages of puberty and how they were reframed for such a two-tier system, particularly how medical authors adapted ideas about puberty to suit the requirements of Parliament and legislation.

Blurring the Boundaries: Puberty

In the period under study medical authors wrote extensively on typical ages of puberty, often drawing upon statistical surveys of the subject from the mid-nineteenth century onwards. However, this section demonstrates that statistical studies of puberty's indicators were used to challenge rather than to reinforce the concept of 'normal' or typical patterns of sexual development. Authors of high-profile medical literature across a range of genres and medical statisticians focused on menarche because of the difficulty of pinpointing the emergence of other bodily signs.⁴ They therefore often failed to consider the ages at which the nervous and mental aspects of puberty

³ This piece of legislation was the highest profile age-of-consent legislation and therefore the focus of most medical debates, but it was not the only piece of legislation during the period under study. The exact age limits of the misdemeanour and felony clauses varied greatly over time. See Chapter Three for a closer discussion of relevant legislation on sexual consent.

⁴ The *Oxford English Dictionary* locates the first use of the word 'menarche' at the turn of the century. Victorian and Edwardian medical authors more commonly used phrases such as 'commencement of menstruation'. However, as 'menarche' carries the same meaning ('first menstrual period; the age at which this occurs') and is more concise it has been used throughout this chapter. 'Menarche, n.', OED Online (Oxford: Oxford University Press, 2012).

developed. Furthermore, medical authors emphasised the unreliability of averages and used statistics to show the absence of any clear division between typical and atypical ages of bodily maturity and menarche. Overall, the section demonstrates that medical attempts to use statistics to clarify ages of puberty further confused an already complicated question. There was therefore no simple means to apply ideas about puberty to the more rigid question of the age of sexual consent, even bearing in mind that sexual consent was a two-tier system. These conclusions set up the second section of the chapter, which goes on to consider how medical authors attempted to resolve such problems when they chose to give their input on legal questions.

Science philosopher Ian Hacking claims that a new notion of ‘normal’ as typical was propagated by the rise of statistics in the nineteenth century.⁵ He argues that by the late-Victorian period the word ‘normal’ had three overlapping meanings: typical, healthy and ideal. The concept of ‘normality’ was also interwoven with the complex issue of ‘nature’, as the terms were often used interchangeably.⁶ ‘Natural’ sexual development was deemed to be both healthy and ideal in terms of occurring in the absence of undesirable environmental influences. The rhetoric of ‘unnaturalness’ and notion of *abnormality* also overlapped in relation to broader social anxieties about sexual behaviour, for example about non-reproductive sex between men or between adults and children.⁷ Despite these discursive and conceptual interconnections, it was the notion of ‘normal’ as ‘typical’ that came to dominate medical texts on sexual maturity and sexual consent in the late-Victorian period. As Oliver Lovesey argues, late-nineteenth-century medical research moved ‘away from a focus on exceptional cases in favour of statistically significant samples’.⁸ Victorian and Edwardian medical writers increasingly

⁵ Ian Hacking, *The Taming of Chance* (Cambridge: Cambridge University Press, 1990), p. 160.

⁶ For discussions of the multiple and complex historical meanings of nature, for example as established during the Enlightenment, see Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries* (New York; London: Harvester Wheatsheaf, 1989), p. 5; and Carolyn Merchant, *The Death of Nature: Women, Ecology, and the Scientific Revolution* (New York: Harper & Row, 1989), p. xxiii.

⁷ As Waltraud Ernst notes ‘[h]omosexuality, for example, has throughout the nineteenth century and by some even up until recently been morally condemned as ‘unnatural’, despite the fact that the notion of it as a disease and ‘abnormality’ had been mooted from the late nineteenth century onwards. This shows that the earlier terms such as the natural and unnatural have penetrated well into the modern area, existing alongside newer ones such as the normal and the abnormal’; Waltraud Ernst, ‘The Normal and the Abnormal: Reflections on Norms and Normativity’ in *Histories of the Normal and the Abnormal: Social and Cultural Histories of Norms and Normality*, ed. Waltraud Ernst (Abingdon; New York: Routledge, 2006), 1-25, pp. 3-4.

⁸ Oliver Lovesey, ‘Reconstructing Tess’, *Studies in English Literature 1500-1900* 43 (2003), 913-38, p. 918.

sought to identify ‘normal’ or typical patterns of child development and sexual maturity through mass statistical studies as “‘the child’ came into being as a scientific object’.⁹ The following analysis focuses on such statistical studies and considers how they influenced medical ideas about typical ages of puberty. It provides a case study of how the nineteenth-century redefinition of ‘normal’ identified by Hacking operated in practice. As Anna G. Creadick notes, it is crucial to understand ‘how normality has *functioned* in a specific context’ rather than assuming that any general conclusions can be drawn about its meaning in a given time or place.¹⁰ In the context of puberty, new statistical definitions of ‘normality’ actually undermined attempts to identify typical ages of sexual maturity.

Before considering typical ages of puberty, it is important to pay attention to which signs were cited by medical practitioners and statisticians as measurable indicators of the age of sexual maturity. Not all bodily indicators of puberty were considered of equal significance and it must be remembered that frameworks for understanding the sexual body have changed across time and place.¹¹ Jeffrey Weeks has noted the importance of avoiding falling into a ‘latent essentialism’ regarding the body, as definitions of the sexual body are shaped by social, political and professional contexts.¹² As Joanna Bourke observes, ‘[c]ertain body parts or practices *become* sexual through classification and regulation’.¹³ It is therefore crucial to consider which body parts ‘became’ sexual in

⁹ Adriana S. Benzaquén, ‘Childhood, History and the Sciences of Childhood’ in *Multiple Lenses, Multiple Images: Perspectives on the Child across Time, Space, and Disciplines*, ed. Hillel Goelman, Sheila K. Marshall and Sally Ross (Toronto, ON: University of Toronto Press, 2004), 14-37, p. 14. On the Child Study movement and growing interest in measuring or observing child development see: André Turmel, *A Historical Sociology of Childhood* (Cambridge: Cambridge University Press, 2008), p. 84; James Wong, ‘Critical Ontology and the Case of Child Development’, *Canadian Journal of Political Science* 37 (2004), 863-82, pp. 873-76; Hugh Cunningham, *The Children of the Poor: Representations of Childhood since the Seventeenth Century* (Oxford; Cambridge, MA: Blackwell, 1991), pp. 192-97; and Sally Shuttleworth, *The Mind of the Child: Child Development in Literature, Science and Medicine, 1840-1900* (Oxford: Oxford University Press, 2010), p. 9. For more general literature on the rise of statistical social surveys in the nineteenth century see Monica Flegel, *Conceptualizing Cruelty to Children in Nineteenth-Century England* (Farnham; Burlington: Ashgate, 2009), p. 29; Eileen Yeo, ‘Social Surveys in the Eighteenth and Nineteenth Centuries’ in *The Cambridge History of Science: The Modern Social Sciences*, ed. Theodore M. Porter and Dorothy Ross (Cambridge: Cambridge University Press, 2003), 83-99; and Fran Tonkiss, ‘History of Social Statistics and the Social Survey’ in *Researching Society and Culture*, ed. Clive Searle, 2nd edn (London: SAGE Publications Ltd, 2004 [1998]), pp. 85-98.

¹⁰ Anna G. Creadick, *Perfectly Average: The Pursuit of Normality in Postwar America* (Amherst; Boston: University of Massachusetts Press, 2010), p. 142. Emphasis in original.

¹¹ Anna Davin, ‘What is a Child?’ in *Childhood in Question: Children, Parents and the State*, ed. Anthony Fletcher and Stephen Hussey (Manchester: Manchester University Press, 1999), 15-36, p. 17.

¹² Jeffrey Weeks, *Sex, Politics and Society: The Regulation of Sexuality since 1800* (London: Longman, 1981), p. 10.

¹³ Joanna Bourke, *Rape: A History from 1860 to the Present Day* (London: Virago, 2007), p. 10.

the contexts under study and why the body was given more attention than other aspects of sexual maturity, such as the ability to experience pleasure and the capacity to understand sex. In posing these questions, it becomes possible to understand why the female body and specifically menarche became focal points for medical literature about ages of puberty.

Puberty has long been cited as a life stage at which sex and gender differences fully emerged.¹⁴ Girls and boys were both expected to undergo significant bodily changes. However, medical practitioners struggled to pinpoint a clear marker of the age at which male sexual maturity occurred. In the mid-nineteenth century the physiologist William Carpenter wrote of a range of male secondary sexual characteristics, as ‘the chin and the pubes become covered with hair; the larynx enlarges, and the voice becomes lower in pitch, as well as rougher and more powerful’.¹⁵ These ideas changed little over time. G. Stanley Hall, whose work was widely distributed in England in the early-twentieth century, similarly noted the importance of secondary sexual indicators in both sexes. Even as a psychologist, Hall paid extensive attention to the bodily indicators of maturity and wrote that:

[P]uberty literally means becoming hairy. Hair first develops in the pubic region at about fourteen in boys and thirteen in girls, generally before menstruation, later under the arm-pits just before the period of most rapid development of the breasts, and last comes the beard at the age of eighteen or nineteen.¹⁶

According to Hall, these secondary indicators emerged over a lengthy period of time and thus presented no clear means of measuring a ‘normal’ or typical age of sexual development. The reproductive capacity in boys was additionally marked by the emission of mature spermatozoa which could impregnate a female, but this was equally problematic as a sign because semen could apparently be produced without spermatozoa.¹⁷ As Carpenter noted, ‘[t]he power of procreation does not usually exist in

¹⁴ For one discussion of the Victorian perception of a ‘neutral condition’ before puberty, and some of the debates around it, see Jill L. Matus, *Unstable Bodies: Victorian Representations of Sexuality and Maternity* (Manchester: Manchester University Press, 1995), pp. 26-27, 40, 50 n. 9.

¹⁵ William B. Carpenter, *Principles of Human Physiology: With their Chief Applications to Psychology, Pathology, Therapeutics, Hygiene & Forensic Medicine*, 5th edn (London: John Churchill, 1855 [1842]), p. 792.

¹⁶ G. Stanley Hall, *Adolescence: Its Psychology and its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education*, vol. 1 (London; New York: Appleton, 1904), p. 415.

¹⁷ On the importance of spermatozoa see Jean L’Esperance, ‘Doctors and Women in Nineteenth-Century Society: Sexuality and Role’ in *Health Care and Popular Medicine in Nineteenth Century England: Essays in the Social History of Medicine*, ed. John Woodward and David Richards (London: Croom

the Human Male, before the age of from 14 to 16 years; and it may be considered probable that no Spermatozoa are produced until that period, although a fluid is secreted by the testes'.¹⁸ Mainstream medical literature ranging from *The Lancet* to William Acton's lay-oriented work also noted that boys could have partial erections, nocturnal emissions and the production of a 'glairy fluid' before puberty.¹⁹ Without a microscope it was therefore deemed impossible to distinguish between precocious sexual maturity, emerging 'normal' signs of sexual maturity and the full capacity to sustain an erection and impregnate a female. These difficulties in pinpointing a typical age for male bodily maturity meant that boys were only a very limited part of medical discussions about statistics and puberty. As attention was given to females in most contemporary discussions of both puberty and sexual consent, a subject that this chapter turns to in its second half, the following analysis takes a similar focus.

As with males, medical writers generally agreed that the end point of female bodily development was the capacity to reproduce. An 1889 editorial in *The Lancet* commented that 'safety in childbearing ... is the true test of maturity'.²⁰ Although there was some disagreement between those who believed that 'the uterus is the woman' and those who considered ovaries to be the more important defining characteristic of womanhood, menstruation was consistently cited as the most important outward indicator of the capacity for reproduction.²¹ The onset of menstruation, menarche, was considered to be a clearer indicator of maturity than the first male emissions of semen. As Alfred Swaine Taylor noted in *A Manual of Medical Jurisprudence*, '[i]n the female, the procreative power is supposed not to exist until after the commencement of menstruation, and to cease upon the cessation of this periodical secretion'.²² Even precocious menstruation in young girls was expected to bring with it the potential capacity for pregnancy, particularly if it occurred at regular intervals rather than being

Helm, 1977), 105-27, p. 105; and William A. Guy and David Ferrier, *Principles of Forensic Medicine*, 5th edn (London: H. Renshaw, 1881 [1844]), p. 66.

¹⁸ Carpenter, *Principles of Human Physiology*, 5th edn, p. 792.

¹⁹ Shuttleworth, *The Mind of the Child*, p. 195; William Acton, *The Functions and Disorders of the Reproductive Organs in Youth, in Adult Age, and in Advanced Life. Considered in their Physiological, Social and Psychological Relations* (London: John Churchill, 1857), p. 55; 'Medical Society of London', *The Lancet*, 6 December 1890, 1221, p. 1221.

²⁰ 'The Lancet', *The Lancet*, 23 March 1889, 585, p. 585.

²¹ 'Sixty-Fifth Annual Meeting of the British Medical Association', *BMJ*, 25 September 1897, 757-87, p. 780; Bell, 'Internal Secretions', p. 1274; H. Macnaughton-Jones, 'The Relation of Puberty and the Menopause to Neurasthenia', *The Lancet*, 29 March 1913, 879-81, p. 880.

²² Alfred Swaine Taylor, *A Manual of Medical Jurisprudence*, 4th edn (London: J. & A. Churchill, 1852 [1844]), pp. 564-65. Emphasis in original. This quote was unchanged across all editions.

an isolated occurrence. In 1908, *The Lancet* presented a case report of ‘a child who began to menstruate when in her second year ... Ovules were discharged as in normal menstruation and such children have been known to become pregnant’.²³ Menarche also had a symbolic value both as an indicator of womanhood and as a form of ‘pollution’ that needed controlling.²⁴ It thus gave statisticians a measurable and symbolic focal point and became a central part of efforts to identify age patterns of typical sexual development.

Although the age of menarche was relatively easy to pinpoint, it was not as straightforward a marker of maturity as first appears. The role of menarche as a marker of the ability to reproduce was not absolutely certain, despite a consensus that it was more reliable than other bodily indicators. Although it was deemed the clearest *outward* indicator of reproductive faculties, medical journals and textbooks emphasised that ‘the outward and visible sign of menstruation may not accompany the maturation of the egg, and yet all the physiological effects of ovulation be present’ and that ‘it appears probable that the changes in the ovaries and uterus may go on at the regular monthly periods, and yet there be no discharge of blood from the uterus’.²⁵ The possibility that pregnancy could occur before menarche was also highlighted by paediatrician Charles West and by Augustus W. Addinsell, a physician to the London Temperance Hospital, in his report on a case of ‘pre-menstrual pregnancy’ for *The Lancet* in 1905.²⁶ Many physiologists and authors who drew on physiology, which included most works on puberty in the period under study, also claimed that menarche was not representative of mature reproductive capacities. Although the body was *capable* of child-bearing, they argued, it required time to develop to full strength.²⁷ This approach was a continuation

²³ ‘Precocious Menstruation’, *The Lancet*, 15 February 1908, 518, p. 518. As Chapter One showed, in such cases medical writers recognised the possibility for a young girl to carry a child but emphasised it would be injurious to both mother and baby.

²⁴ See anthropological and historiographical work on the significance of blood across time and place, such as: Thomas Buckley and Alma Gottlieb, ‘A Critical Appraisal of Theories of Menstrual Symbolism’ in *Blood Magic: The Anthropology of Menstruation*, ed. Thomas Buckley and Alma Gottlieb (Berkeley, CA; London: University of California Press, 1988), 1-54, p. 3; and Jacalyn Duffin, *History of Medicine: A Scandalously Short Introduction* (Toronto: University of Toronto Press, 1999), p. 168.

²⁵ Macnaughton-Jones, ‘The Relation of Puberty and the Menopause to Neurasthenia’, p. 880; H. Aubrey Husband, *The Student’s Handbook of Forensic Medicine and Medical Police* (Edinburgh; London: E. & S. Livingstone; Simpkin, Marshall & Co., 1874), p. 69.

²⁶ Charles West, *Lectures on the Diseases of Women: Part I – Diseases of the Uterus* (London: J. Churchill, 1856), p. 28; Augustus W. Addinsell, ‘Pre-Menstrual Pregnancy in a Girl Aged 13 Years’, *The Lancet*, 25 March 1905, 791-92, p. 791.

²⁷ See the discussion in Chapter One of the separation between menarche and safe procreation by many medical authors, even though it was arguably grounded more in moral ideas than physiological evidence.

of early modern ideas when, according to Cathy McClive, sexual maturity was associated with regular menstruation rather than menarche alone.²⁸ The emphasis on menarche by medical writers and statisticians evidently was not only based on its role as a marker of a girl's ability to reproduce, but also on the relative ease with which the date of its onset could be pinpointed in comparison with other bodily indicators.

Menstruation was also not deemed to be the sole indicator of puberty or even of the capacity for child-bearing. It was interwoven with the development of secondary sexual characteristics as an indicator of reproductive capacities. In his report for *The Lancet* cited above, Addinsell wrote that '[t]he signs of sexual maturity in the female are well known to be development of the mammary glands, growth of pubic hair, and finally menstruation'.²⁹ Although secondary sexual characteristics were not considered to be clear indicators of the ability to reproduce, as they had been in previous centuries, medical texts evidently viewed menstruation as the final stage of a long process of bodily maturation rather than a turning point.³⁰ The first chapter of this thesis also showed that bodily indicators such as menstruation were conceptualised as part of a long development process at puberty which involved genital maturity, the development of a capacity to understand sex and the emergence of nervous sensations and pleasure. In 1895, a *BMJ* editorial on 'The Training of Girls' even explicitly criticised the notion that 'menstruation dominates a woman's whole existence, an expression which ... seems to ignore the psychological side of womanly sexual development'.³¹ However, statisticians and medical authors focused on menarche when evaluating typical age(s) of puberty. In the context of a multifaceted issue such as puberty, this specificity was problematic in itself.

Medical authors generally evaded trying to identify the ages at which nervous or mental aspects of sexual development reached maturity because of the difficulties of such questions. They were interwoven with social issues, such as knowledge, and were

²⁸ Cathy McClive, 'Menstrual Knowledge and Medical Practice in Early Modern France, c. 1555-1761' in *Menstruation: A Cultural History*, ed. Andrew Shail and Gillian Howie (Basingstoke: Palgrave Macmillan, 2005), 76-89, p. 86.

²⁹ Addinsell, 'Pre-Menstrual Pregnancy', p. 791.

³⁰ Jane Sharp (1671) apparently directly linked 'hair coming forth' to the ability to procreate; see Sarah Toulalan, "'Unripe" Bodies: Children and Sex in Early Modern England' in *Bodies, Sex and Desire from the Renaissance to the Present*, ed. Kate Fisher and Sarah Toulalan (Basingstoke: Palgrave MacMillan, 2011), 131-50, p. 136.

³¹ 'The Training of Girls', *BMJ*, 7 December 1895, 1442, p. 1442.

difficult to pinpoint because they lacked external manifestations. The focus on bodily signs was also because the principles of physiology and to a lesser extent gynaecology dominated discussions about puberty, as even the sensory and mental aspects of puberty were expected to have an initial stimulus in the genital organs.³² The only attempts to analyse when girls achieved the capacity for sexual pleasure or the ability to understand sex were limited in scope and were *not* made by physiologists or medical statisticians. Havelock Ellis attempted to consider the subject of capacity for sexual pleasure, drawing on his background in sexology and his general focus on sexual ‘instincts’ rather than the sexual body. He interviewed 12 women and commented that:

In 2 cases distinct sexual feeling was experienced spontaneously at the age of 7 and 8, but the complete orgasm only occurred some years after puberty; in 5 cases sexual feeling appeared spontaneously for a few months to a year after the appearance of menstruation ... [I]n another case sexual feeling first appeared shortly after menstruation began, but not spontaneously, being called out by a lover’s advances; in the remaining 4 cases sexual emotion never became definite and conscious until adult life.³³

Ellis’s sample was small and he only divided women by life stage such as ‘puberty’ rather than engaging with the specific subject of their age. As the previous chapter showed, his notion that ‘sexual feeling’ could occur ‘spontaneously’ at the age of seven was also not representative of broader professional or social thought.

In relation to the capacity to understand sex, some medical educators attempted to measure the age at which a child was capable of receiving sex education. They used the cultural issue of knowledge to consider the developmental issues of curiosity and comprehension. In an article from 1910, for example, a science lecturer wrote that:

[C]hildren from 10-12 can easily be made to understand the outlines of the process of fertilisation ... [T]he terms male and female, sexual organs, sexes, need not be introduced with young children before the period of adolescence. No meaning is then attached to them.³⁴

However, discussions of the age at which a girl or boy achieved the mental capacity to understand sex were largely limited to these debates about sex education. No statistical surveys of mental maturity were attempted, even in a limited form such as Ellis’s study of sexual ‘feeling’. When Thomas Clouston considered ages of mental development at

³² See Chapter One for an explanation of how genital development was expected to stimulate other changes.

³³ Havelock Ellis, *Studies in the Psychology of Sex*, vol. 3 (Philadelphia: F. A. Davis, 1904 [1903]), p. 170.

³⁴ ‘Sex-Teaching in Girls’ Schools’, *Eugenics Review* 2 (1910), 145-46, p. 145.

puberty, drawing upon his professional background as an alienist, he left the degree of the alleged discrepancy between physiological and psychological maturity undefined.³⁵ He merely noted that '[i]t takes several years for the full development of the size and form of the body that is normal and typical for each sex, and it takes still longer for the complete evolution of the masculine and feminine psychical characteristics'.³⁶

The above analysis has explained why medical practitioners tended to focus on menarche when attempting to pinpoint a typical age of female sexual maturity, despite never conceptualising puberty as a turning point. It is now possible to turn to the question of what the 'normal' age of sexual maturity was deemed to be. Most statistical studies cited average ages of between 14 and 15 for menarche depending on whether they cited the mean or modal average.³⁷ General physiology texts and medical jurisprudence textbooks commonly drew upon such studies, particularly the work of medical statisticians such as Charles Roberts, John Roberton, Francis Hogg and James Whitehead.³⁸ Taylor's popular medical jurisprudence textbook cited statistical surveys by Hogg, 'Dr. Rüttel' and 'Dr. Cohnstein' and drew the conclusion that 'in this country, the most frequent age for the commencement of menstruation may be taken at 15 years'.³⁹ These ages corresponded to those cited in early modern texts before the rise of statistical forms of 'normality'.⁴⁰ As this chapter goes on to show, mass statistical

³⁵ Although the age discrepancy was never clearly defined, the apparently later nature of mental development was widely accepted within and beyond the medical profession. The second half of this chapter and Chapter Three show that such comments about the later development of mental capacity were drawn upon by medical practitioners and Members of Parliament alike when they wished to promote higher ages of sexual consent.

³⁶ T. S. Clouston, 'Puberty and Adolescence Medico-Psychologically Considered', *Edinburgh Medical Journal* 26 (1880), 5-17, p. 6.

³⁷ For a summary of the history of medical surveys of menarche in Britain and the range of average ages that they pinpointed in the period under study, which only varied by minute degrees, see J. M. Tanner, *A History of the Study of Human Growth* (Cambridge: Cambridge University Press, 1981), pp. 288-93.

³⁸ For an example of a citation of Roberts' work see Edwin Diller Starbuck, 'A Study of Conversion', *American Journal of Psychology* 8 (1897), 268-308, p. 271. For an example of a citation of Roberton's work, which states that it treats subjects 'such as deeply to interest every medical man', see 'Bibliographical Notices: John Roberton, *Essays and Notes on the Physiology and Diseases of Women, and on Practical Midwifery* (London: 1851)', *American Journal of the Medical Sciences* 22 (1851), 179-96, p. 179. For an example of a citation of Hogg's work see Alfred Swaine Taylor, *The Principles and Practice of Medical Jurisprudence*, ed. Thomas Stevenson, 4th edn, vol. 2 (London: J. & A. Churchill, 1894 [1865]), p. 304. For an example of a citation of Whitehead's work see West, *Lectures on the Diseases of Women*, p. 27.

³⁹ Taylor, *Principles and Practice*, 4th edn, p. 304; Taylor, *Medical Jurisprudence*, 10th edn (London: J. & A. Churchill, 1879 [1844]), p. 582. An earlier edition had similarly stated that 'The menstrual function is commonly established in females in this climate between the ages of fourteen and sixteen'; Taylor, *Medical Jurisprudence*, 4th edn, pp. 564-65.

⁴⁰ See Hannah Newton, *The Sick Child in Early Modern England, 1580-1720* (Oxford: Oxford University Press), p. 8; Toulalan, "'Unripe" Bodies', pp. 136-37.

studies did not provide a means to reassess the average age of menarche cited in early modern texts but rather stimulated questions about the reliability of averages in general. Unlike writings on the female body, medical authors continued in the early modern tradition of citing typical ages for the male reproductive capacity *without* any statistical evidence to corroborate their claims. Taylor wrote that ‘[t]he age of puberty in a healthy male in this country varies from 14 to 17 years; its appearance is, however, affected by climate, constitution, and the moral circumstances under which the individual is placed: in some cases it is not fully developed until the age of 21’.⁴¹ Blackwell similarly wrote that a boy would usually have the physical capacity for reproduction by the age of 16 or 17 and that ‘we observe that the power of reproduction commences at an earlier age in women than in men’.⁴² Medical writers thus paid some attention to the subject of male ages of sexual maturity, but such comments were briefer and vaguer than comparable discussions of female puberty. Male puberty was also generally discussed in a comparative sense in terms of being situated against ‘earlier’ female puberty, an issue that was later drawn upon by some opponents to sexual consent legislation.⁴³

In the Victorian and Edwardian years there was still a school of medical writing that was grounded in anecdotes or studies of ‘a few favored [sic] children’ rather than statistics, but it was increasingly in the minority with regard to the subject of female puberty.⁴⁴ Despite this statistical turn and the increasingly specific discussions of average ages of menarche in medical texts, medical authors often used such statistics to destabilise the notion of ‘normal’ or typical patterns of sexual development. Most medical authors actually actively discouraged the clear delineation of developmental categories. A few years before the period under study for this thesis, the 1833 *Cyclopaedia of Practical Medicine* had stated that ‘individuals differ so much, that similar ages do not necessarily indicate corresponding stages of development either in

⁴¹ Taylor, *Medical Jurisprudence*, 4th edn, p. 558. This statement was unchanged throughout all editions of the textbook.

⁴² Elizabeth Blackwell, *The Moral Education of the Young in Relation to Sex*, 6th edn (London: Hatchards, 1882 [1878]), p. 64; Elizabeth Blackwell, *The Human Element in Sex: A Medical Inquiry into the Relation of Sexual Physiology to Christian Morality* (London: J. & A. Churchill, 1894), p. 47.

⁴³ See the discussion of Charles Roberts’s opposition to legislative change in the second section of this chapter and the following chapter’s discussion of opposition to the law from within Parliament. Medical and parliamentary opponents to legislative change alike commented on the potential blackmail that might result from these gender differences.

⁴⁴ Ian Hacking, ‘Normal People’ in *Modes of Thought: Explorations in Culture and Cognition*, ed. Nancy Torrance and David R. Olson (Cambridge: Cambridge University Press, 1996), 59-71, p. 69.

bodily or mental powers'.⁴⁵ This text typified the tone of medical literature across most genres well into the twentieth century, in which averages were generally cited with accompanying caveats about the variable and gradual nature of sexual development. Although this thesis goes on to show that caveats were often dropped selectively outside the scientific sphere, they were commonplace in medical texts when discussing ages of puberty.⁴⁶ Rather than using statistical averages to define a 'normal' or typical age of menarche, medical authors commonly cited them alongside wider discussion about problems with their representativeness.

These problems apparently took three main forms. Firstly, authors recognised that there was little consistency in methods of data collection or definitions of menarche. When John Robertson, a surgeon at a Manchester Lying-In Hospital, explained how he gathered his data on ages of the commencement of menstruation in the early- and mid-nineteenth century he noted that:

The question as to the age of menstruation was put, indiscriminately, to a certain number of pregnant married women on their coming to the hospital, to deliver in their letters of recommendation as home patients ... [T]he word of the woman is, on any extended scale of investigation, the only testimony to be obtained.⁴⁷

Robertson was explicit about the problematic methodology of a statistical enquiry on ages of menarche. It was an inherently difficult subject for study as it was based solely on the individual memories, candour and definitions of menarche provided usually by an unsystematic sample. The reliability of new statistical techniques for assessing real patterns of sexual maturity was thus questionable, particularly in light of the social stigma that surrounded any admission of reaching puberty precociously.

Secondly, as briefly noted in the previous chapter's discussion of precocity, average ages of puberty apparently varied between and within social groups. As Hacking notes, 'there might be a distribution of rates of development of children sorted along some

⁴⁵ John Forbes, Alexander Tweedie and John Conolly (eds), *The Cyclopaedia of Practical Medicine* (London: Sherwood, Gilbert and Piper, and Baldwin and Cradock, 1833), p. 68.

⁴⁶ The caveats were often dropped by both non-medics and medics, depending on the circumstances. To cite just one of many possible examples, the authors of the 1851 census claimed that 'physiologists divide human life into four periods ... the second at puberty, which is achieved at fifteen'; *The Census of Great Britain in 1851* (London: Longman, Brown, Green, and Longmans, 1854), p. 28. See also the use of averages by medical men involved in debates about sexual consent legislation, discussed in this chapter's final section, and the use of averages by others in Parliament as discussed in Chapter Three.

⁴⁷ John Robertson, *Essays and Notes on the Physiology and Diseases of Women* (London: John Churchill, 1851), p. 28.

lines or other' rather than the 'normal' being a universally applicable concept.⁴⁸ The physician Addinsell was representative in his discussion of what these 'lines' were considered to be when he wrote that puberty's onset was influenced by 'a variety of causes, climate, race, nutrition, growth, &c'.⁴⁹ Medical writers often stated that menarche was earlier in the wealthy, despite otherwise claiming that precocity was a working-class phenomenon because 'abnormally' early development resulted from disease or environmental influences. For example, Carpenter wrote that '[t]he mental and bodily habits of the individual have also considerable influence upon the time of its occurrence; girls brought-up in the midst of luxury or sensual indulgence, undergoing this change earlier than those reared in hardihood and self-denial'.⁵⁰ The anthropometrist and former children's hospital practitioner Charles Roberts supported such claims when he compared samples of Italian 'wealthy' and 'country' women, finding that the former group reached menarche at an average age of 14.5 and the latter at 15.5.⁵¹ Medical authors and especially physiologists also claimed that menarche came earlier for those in hot environments, even though earlier in the century John Roberton had used a 'comparative view of the age of female puberty in 597 natives of Hindostan and 2,169 natives of England' to argue that the ideas about climate and menarche were grounded more in prejudices about race than in physiological evidence.⁵² Evidently no average age of menstruation was ever considered to be representative of the population as a whole.

Finally, and perhaps most importantly, most medical journals and textbooks on physiology or forensic medicine cited averages with caveats about the inclusion of

⁴⁸ Hacking, 'Normal People', p. 68.

⁴⁹ Addinsell, 'Pre-Menstrual Pregnancy', p. 791. For other examples of medical texts that propagated such ideas about the influence of class, race or environment see C. Seitz, 'Diseases of Puberty' in *The Diseases of Children: A Work for the Practising Physician*, ed. M. Pfaundler and A. Schlossmann, trans. John Howland, vol. 2 (Philadelphia; London: J. B. Lippincott, 1908), 111-30, p. 114; Blackwell, *The Human Element in Sex*, p. 26; *Advice to the Married and Those Contemplating Marriage of Both Sexes: A Book for the People of Valuable Information and Advice, to Teach the Married and Marriageable how to Conduct Themselves*, 2nd edn (London: E. Seale, 1911 [1907]), p. 6; Taylor, *Medical Jurisprudence*, 8th edn (London: J. & A. Churchill, 1866 [1844]), p. 582; Macnaughton-Jones, 'The Relation of Puberty', p. 879.

⁵⁰ Carpenter, *Principles of Human Physiology*, 5th edn, p. 797.

⁵¹ Charles Roberts, 'The Physical Maturity of Women', *The Lancet*, 25 July 1885, 149-50, p. 150.

⁵² Michael Mason, *The Making of Victorian Sexuality* (Oxford; New York: Oxford University Press, 1994), p. 332; John Roberton, 'On the Alleged Influence of Climate on Female Puberty in Greece', *Edinburgh Medical and Surgical Journal* 62 (1844), 1-22, pp. 1-10; 'Bibliographical Notices: John Roberton', pp. 179-80.

‘exceptionally extreme cases’ to calculate them.⁵³ As large-scale statistical studies increased, particularly for females, medical journals and textbooks actually increasingly emphasised the unreliability of averages. Robertson used his study of menarche in 450 women to declare in 1851 that puberty ‘occurs in a more extended range of ages and is more equally distributed throughout that range, than authors have alleged’.⁵⁴ Most medical literature took a similar stance on the issue of averages by the late-nineteenth and early-twentieth centuries, under the influence of a few large-scale statistical studies. Medical authors across key genres such as physiology and forensic medicine began to demonstrate a degree of coherence in their emphasis on the misleading nature of mean and modal ages of puberty. Taylor’s high-profile medical jurisprudence work also emphasised the great range of ages at which healthy puberty could occur when he cited his average age for menarche as 15. He noted that ‘[t]he earliest and latest period in a large number of cases were respectively 9 and 23 years’.⁵⁵ Medical speakers at the Thirteenth International Congress of Medicine were evidently not exceptional in stating that puberty could occur in healthy males and females as young as 13 and as old as 22, with those at the outer limits considered atypical but not necessarily sufficiently exceptional to be a cause of concern.⁵⁶

The work of surgeon Charles Roberts is worthy of particular attention as a case study of links between the statistical movement, research on puberty and the problematisation of child-adult age boundaries. Roberts was a member of the Anthropometric Committee of the British Association for the Advancement of Science, 1875-83, which conducted one of the first large-scale surveys of ‘physiological and mental variation between individuals, social and ethnic groups’ by analysing variations in the dimensions of human bodies.⁵⁷ He wrote *A Manual of Anthropometry* in 1878, which was ‘the science of the measurement and analysis of variation in the physical dimensions of the human body’ and he was well-versed in statistical techniques for measuring bodily indicators of development.⁵⁸ Simon Szreter notes that:

⁵³ J. Henry Bennet, ‘On Healthy and Morbid Menstruation’, *The Lancet*, 3 April 1852, 328-29, p. 328.

⁵⁴ Robertson, *Essays and Notes*, p. 30. These statistics had previously been published in essay form.

⁵⁵ In the *Medical Jurisprudence* series this comment first appeared in Taylor, *Medical Jurisprudence*, 10th edn, p. 649, although it had been in *Principles and Practice* from 1873 onwards.

⁵⁶ ‘The Thirteenth International Congress of Medicine: Mental Disturbances of Puberty’, *The Lancet*, 18 August 1900, p. 533. See also West, *Lectures on the Diseases of Women*, pp. 26-35.

⁵⁷ Simon Szreter, *Fertility, Class and Gender in Britain, 1860-1940* (Cambridge: Cambridge University Press, 1996), pp. 129-30.

⁵⁸ Szreter, *Fertility, Class and Gender in Britain*, p. 131.

[T]he goal of Roberts's empirical work ... was still the elucidation of the descriptive average or typical form of "the English nation" and not the prescriptive "most perfect form", which he had carefully distinguished at the outset of his work as a separate concept.⁵⁹

This approach resulted from the influence of Roberts's mentor Adolphe Quetelet, whose influential 1835 work on the *l'homme moyen* or the 'average man' was the first to bring 'the idea of "normal distribution" to bear on the human form' by examining weight distribution.⁶⁰ Although Szreter argues that Roberts became increasingly interested in eugenicist approaches to studies of the ideal body in his work on the Anthropometric Committee, this shift was not apparent in his work on puberty and he continued to focus on typical patterns of sexual development.⁶¹ In 1885 Roberts wrote about 'The Physical Maturity of Women' in a 'descriptive' sense in *The Lancet* and emphasised that medical practitioners were 'deluded by mere averages' as only 75 per cent of women had started menstruation by the age of 16.⁶² Perhaps most significantly, Roberts explicitly applied the statistical 'law of error' and asserted that:

When we are told that the average age for the function of menstruation to commence is fourteen years and nine months, we get an idea that most girls arrive at puberty at this age, while in truth only nineteen or twenty in every hundred, or 20 per cent., do so, 80 per cent. being distributed over the five or six preceding and five or six succeeding ages in a certain definite manner.⁶³

His work clearly illustrates the influence of wider trends in statistical and developmental studies on the specific question of puberty. It also demonstrates how statistics confused rather than clarified questions about average ages of menstruation, by showing the range of menarche ages rather than focusing on mean or modal values.

Having considered the 'normal', it must be situated against the 'abnormal'. In her work on the history of hermaphrodites, Alice Domurat Dreger rightly notes that 'we tend to assume that the normal ... existed before we encountered the abnormal, but it is really

⁵⁹ Szreter, *Fertility, Class and Gender in Britain*, pp. 134-37.

⁶⁰ The Gaussian (Normal) Distribution or bell curve emerged to depict the distribution of heads in coin tossing. It therefore was a purely mathematical concept until Quetelet took man as the object of such a statistical study. For a thorough history of the bell curve see Lynn Fendler and Irfan Muzaffar, 'The History of the Bell Curve: Sorting and the Idea of Normal', *Educational Theory* 58 (2008), 70-82. On Quetelet see also: Creadick, *Perfectly Average*, p. 144; and Lars Grue and Arvid Heiberg, 'Notes on the History of Normality – Reflections on the Work of Quetelet and Galton', *Scandinavian Journal of Disability Research* 8 (2006), 232-46, pp. 234-35.

⁶¹ Szreter, *Fertility, Class and Gender in Britain*, p. 137.

⁶² Roberts, 'The Physical Maturity of Women', p. 149.

⁶³ Roberts, 'The Physical Maturity of Women', p. 149. See also the positive citation of this article in 'The Criminal Law Amendment Bill', *The Lancet*, 8 August 1885, 252, p. 252.

only when we are faced with something that we think is “abnormal” that we find ourselves struggling to articulate what “normal” is’.⁶⁴ Although medical authors cited a range of possible ages for the onset of menarche, they still emphasised that there were ages at which puberty was considered ‘abnormal’ in terms of *not* being typical, healthy or ideal. Ludmilla Jordanova’s comments in her work on the eighteenth century are equally applicable here, as she notes that although medicine acknowledged ‘the plasticity of human beings, there were considered to be limits on the extent to which people could be changed’.⁶⁵ However, there were no consistent dividing lines between typical and atypical ages of puberty. Although there was a medical notion of a ‘proper time’ for sexual development, in opposition to precocious or delayed puberty, it was not a clear-cut concept.⁶⁶ For example, *The Lancet* and *BMJ* reported case studies of ‘precocious menstruation’ and ‘precocious puberty’ from infancy up to the age of 11.⁶⁷ However, not all girls who menstruated at 11 years old were *automatically* deemed to be precocious. Indeed the physician Charles Bell, who worked at a maternity hospital in Edinburgh, had commented in 1844 that ‘[r]epeated instances have come under my own observation of women in whom the catamenia had appeared before their eleventh year, and continued to return regularly afterwards’.⁶⁸ The division between precocious and expected ages of sexual development was evidently not a clear dichotomy, as the statistical abnormality of precocity was relative rather than absolute.

The upper limits of expected menstruation ages were similarly problematic in terms of defining boundaries between ‘normal’/‘abnormal’ and typical/atypical ages of puberty. Dreger notes that ‘menstruation seemed so very real a feminine trait, that the very absence of it was something to be “seen”; the absence of it seemed to have a presence as a sign’.⁶⁹ Medical authors therefore also paid attention to the age at which menarche was ‘abnormal’ in terms of being late or absent. Physician J. H. Bennet wrote in *The Lancet* that delayed menstruation was a concern in ‘the young females who reach the

⁶⁴ Alice Domurat Dreger, *Hermaphrodites and the Medical Invention of Sex* (Cambridge, MA; London: Harvard University Press, 1998), p. 5.

⁶⁵ Jordanova, *Sexual Visions*, p. 27.

⁶⁶ George R. Murray, ‘Address in Medicine on some Aspects of Internal Secretion in Diseases’, *The Lancet*, 26 July 1913, 204, p. 204.

⁶⁷ ‘Notes, Short Comments, and Answers to Correspondents: Early Menstruation’, *The Lancet*, 11 March 1871, 366, p. 366; ‘Precocious Menstruation’, p. 518; ‘Clinical Society of London’, *The Lancet*, 5 May 1906, 1245-46, p. 1246.

⁶⁸ Charles Bell, ‘The Constitution and Diseases of Women, Part II’, *Edinburgh Medical and Surgical Journal* 62 (1844), 311-30, p. 323.

⁶⁹ Dreger, *Hermaphrodites and the Medical Invention of Sex*, p. 97.

age of eighteen or more without being menstruated', but that 'its non-appearance after the average age of fourteen or fifteen is not to be considered a morbid state'.⁷⁰ Bennet's work thus identified ages at which the absence of menstruation was *less* likely, but pinpointed no clear-cut boundary between 'normal' and 'abnormal' ages of menarche. This issue of late menstruation is not worthy of any extensive attention here because it had little relevance to debates about sexual consent, which drew much more on anxieties about precocity. However, it is noteworthy that literature on early and delayed menarche alike emphasised the broad and flexible nature of menarche and its 'normal' age parameters.

The best visual representation of medical literature on ages of menarche is the so-called bell curve, or Gaussian curve. Although graphs were rarely utilised in the contexts under study, authors paid great attention to the subject of statistical distribution. The bell curve had also been used in international medical literature on the subject of weight distribution by the turn of the century, including graphical depictions of Charles Roberts's work on anthropometry.⁷¹ It is therefore appropriate to draw upon visual techniques to demonstrate the absence of a clear boundary between 'normal' and 'abnormal' ages of menarche. As examples, Figures 2.1 and 2.2 depict a generic bell curve and two influential studies of average ages of menarche plotted onto a smoothed line graph for comparison. Although these medical authors originally presented their statistics in tabular rather than graphical form, it is evident that their statistical distribution tied in with the continuum concept of a bell curve rather than having any clear-cut boundaries between typical and atypical ages of menstruation.

⁷⁰ Bennet, 'On Healthy and Morbid Menstruation', p. 328.

⁷¹ Starbuck, 'A Study of Conversion', p. 272. Although Roberts's article in *The Lancet* did not include a bell curve, it did have a graphical 'curve' to represent the comparable bodily growth of girls and boys at different ages; see Roberts, 'The Physical Maturity of Women', p. 149.

Figure 2.1. A Non-Specific Bell (Gaussian) Curve.

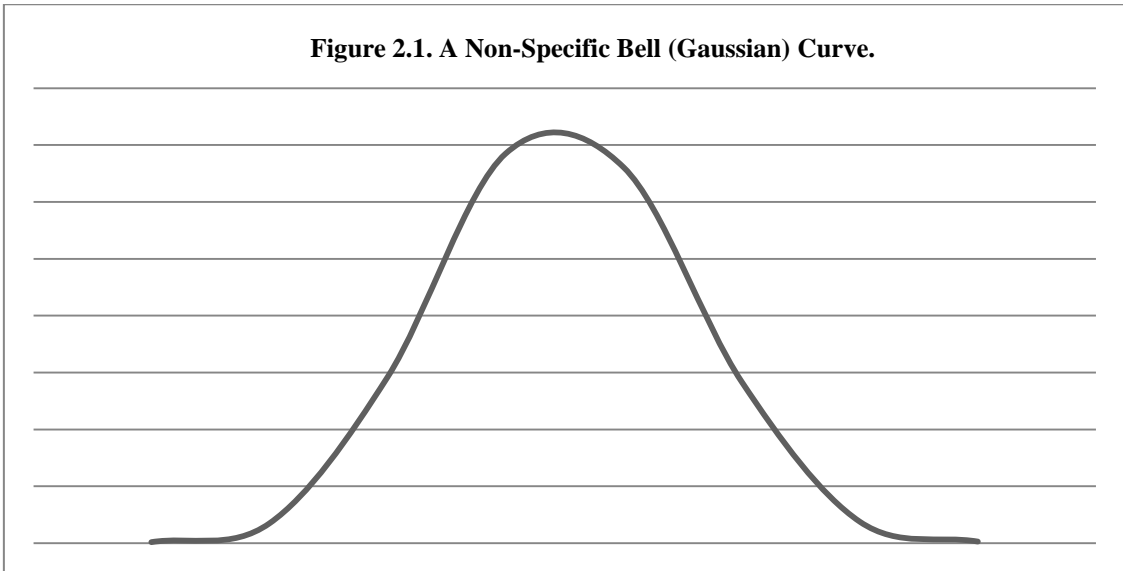
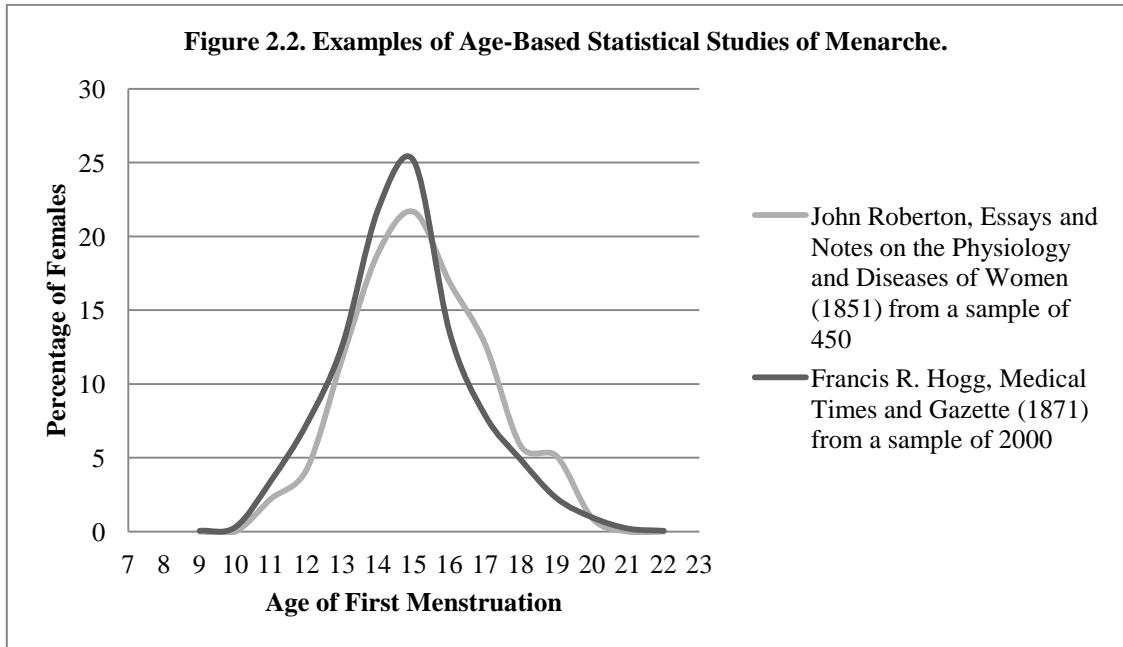


Figure 2.2. Examples of Age-Based Statistical Studies of Menarche.



These graphs indicate that two influential studies, John Robertson’s sample of 450 women in 1851 and Francis Hogg’s sample of 2000 women in 1871, were close to the bell curve shape. They also demonstrate that the ages of 14 and 15 were at the centre of the curve and were automatically perceived as ‘normal’ or typical ages for the onset of menstruation, which correlates with the discussion of averages at the start of this section. In contrast, cases in which the first signs of sexual development emerged at infancy or above the age of 25 were located outside the curves’ extreme limits and would automatically have been considered exceptional cases. However, to cite some more problematic examples, girls who developed their first signs of puberty at the ages of 11 or 19 lay in the middle of a continuum between typicality and exceptionality. This

situation explains the somewhat inconsistent medical literature on precocity outlined above. In boundary cases, labels of typicality or exceptionality were determined on a case-by-case basis and influenced by factors ranging from a child's class or environment to the predisposition of any medical practitioner who wrote up their case for publication. The use of statistical approaches in the form of the bell curve evidently did not clarify distinctions between ages of typical and atypical menarche, but instead problematised them by presenting statistical distribution as a continuum. As Georges Canguilhem argues, in his seminal text on the concept of 'normality', the 'establishment of one of Quetelet's curves does not solve the problem of the normal for a given characteristic ... [S]tatistics offer no means for deciding whether a divergence is normal or abnormal'.⁷²

This analysis has firmly moved away from older scholarly claims that 'the Victorians retained the traditional notion of an abrupt transition from childhood to adulthood'.⁷³ It has demonstrated that the rise of statistical notions of 'normality' resulted in medical authors problematising rather than clarifying the question of child-adult age boundaries. Medical texts highlighted the problems of using menarche as a single sign of sexual maturity because menstruation did not always mark a capacity for reproduction and because focusing on menarche neglected other aspects of puberty, particularly the capacity for pleasure and the ability to comprehend sex. Although many medical authors used average ages of first menstruation in their writings on puberty, because menarche was relatively straightforward to pinpoint, they generally did so with caution. Statisticians, popular medical journals, physiology books and forensic medicine textbooks all highlighted the unreliability of averages. They also used statistics to emphasise the range of ages at which puberty could occur and the lack of clear-cut divisions between 'normal' and 'abnormal' ages of puberty. Overall this section has shown that puberty was conceptualised as a lengthy and variable process, which raises doubts about the extent to which it could be utilised to determine an inflexible two-tier legal age of sexual consent. This issue will be examined in the next section of the chapter.

⁷² Georges Canguilhem, *The Normal and the Pathological*, trans. Carolyn R. Fawcett (New York: Zone Books, 1989), pp. 154-55.

⁷³ F. Barry Smith, 'Sexuality in Britain, 1800-1900: Some Suggested Revisions' in *A Widening Sphere: Changing Roles of Victorian Women*, ed. Martha Vicinus (London: Methuen, 1980), 182-98, p. 196.

Redefining the Lines: Sexual Consent

To this point, the chapter has demonstrated that mainstream medical texts and journals often emphasised that there was a significant degree of variation in the ages at which boys and especially girls reached puberty. Such tolerance of ambiguity did not fit easily with the rigid requirements of age-of-consent legislation. As Stephen Robertson notes, ‘different individuals experienced [menstruation and puberty] at different ages – a fluid situation at odds with the arbitrary line drawn by whatever age was incorporated into law’.⁷⁴ Although the next chapter argues that the age of consent was a carefully negotiated decision, rather than an ‘arbitrary’ one, Robertson is correct in noting the apparent incompatibilities between medical and legal definitions of the boundary between childhood and adulthood. This section considers such incompatibilities and demonstrates how medical ideas about puberty were reframed to suit legal requirements, specifically age-of-consent legislation. It focuses on medical literature in order to consider how medical *theories* about sexual consent compared with theories on sexual maturity, as the next chapter examines more practical medical roles in shaping sexual consent laws.

The section identifies two key trends in medical efforts to participate in debates about sexual consent: firstly, medical practitioners often adapted ideas about puberty by referring either to single or two-tier ages of sexual maturity in order to suit the more rigid boundaries between childhood and adulthood required in legislation; secondly, they often restricted their recommendations to the physiological aspects of consent. The latter trend can be related both to the somatic notion of sexuality in the period and to the greater ease with which medical practitioners could carve a sphere of legal ‘expertise’ in relation to physiology than psychology. However, the analysis also shows that such trends were general rather than absolute. Medical practitioners operated within legislative frameworks with a degree of autonomy by utilising ideas about ‘normal’ puberty selectively to support their various positions on legislative change. The variable nature of medical ideas about puberty meant that authors could draw upon a range of statistical interpretations of ‘normal’ or typical sexual development, so long as they fitted the requirements of the law for a relatively rigid definition of adulthood. Such

⁷⁴ Stephen Robertson, ‘Age of Consent Laws’ in *Children and Youth in History: Item #230* <<http://chnm.gmu.edu/cyh/teaching-modules/230>> (accessed 28 February 2011).

reframing of medical ideas for the legal sphere provides further evidence to support the overall claim of this thesis, that medical influence was negotiated rather than inherently dominant.

It is not entirely clear why certain medical authors sought an input on the subject of sexual consent legislation, or why medical practitioners who drew on the same statistical studies gave different recommendations about the age of sexual consent. There was little opportunity for divisions along specialist lines, as most of the medical practitioners who weighed in on the question of sexual consent were generalist surgeons and physicians. No ‘alienist’ or psychologist in the period even attempted any input on the subject. This absence was partly because discussions of puberty in general focused on the body and partly because medico-legal ‘expertise’ on the mind was still contested by the law. For example, the late-nineteenth century was marked by debates about whether the insanity defence was a matter of ‘common sense’ or science.⁷⁵ Conversely, physiology was readily accepted in the courts and in Parliament as a scientific matter. Medical authors’ stances also varied little according to the expected markets for their work. Although Lucy Bland argues that *The Lancet* promoted the cultivation of purity at home rather than through the law whereas the *BMJ* ‘called for immediate legislation’, there were significant distinctions between the recommendations on sexual consent legislation made by contributors to the same journals.⁷⁶ An explanation for the varied medical advice about sexual consent seemingly lies not in any logical division along the lines of specialism or target readership, but rather in practitioners’ personal motivations and professional experience. Such motivations are the hardest to reach, but this section considers how medical authors’ work within and outside medical practice shaped their individual ideas about sexual consent where possible. It highlights how professional experience as wide-ranging as anthropometric work and employment as Justices of the Peace could influence medical stances on sexual consent legislation and thereby inform medical authors’ selective interpretation of statistical studies about puberty.⁷⁷

⁷⁵ For example see James Crichton-Browne, ‘A Lecture on Responsibility and Disease’, *The Lancet*, 4 August 1888, 195-200, p. 196; Roger Smith, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981).

⁷⁶ Lucy Bland, *Banishing the Beast: English Feminism and Sexual Morality 1885-1914* (London: Penguin, 1995), pp. 58-59.

⁷⁷ See also Chapter Three for a discussion of some of the practical networks between medical practitioners and groups that promoted legislative change, which shows that medical views on the age of consent could vary according to the groups with which they associated themselves.

The notion of sexual consent, at least in the context of age-of-consent debates, was grounded more in medical ideas about maturity than behaviour. In 1908, the Royal Commissioners on the Care and Control of the Feeble-Minded referred retrospectively to the motives for the 1885 CLAA, stating as follows:

What should be the law? I think an answer is to be found in the precedents of the criminal law concerning offences upon children of tender age who presumably cannot give an intelligent consent or who, on grounds of public policy, ought not to be allowed to consent to their own defilement. Their immaturity, their inexperience, and their weakness of mind or body call for protection, and the law in response imposes upon them a statutory disability to give their consent ... The power of consenting to unlawful defilement ... on the grounds stated has been taken from girls under sixteen.⁷⁸

This statement draws attention to a common contemporary trend of describing the ‘power’ to consent as being ‘taken away’ from girls under the age of consent rather than being given to those above it.⁷⁹ This language is a significant part of understanding what consent meant in the context of late-nineteenth- and early-twentieth-century legislation, as the age of consent did not represent a recommended or appropriate age for sexual activity. Instead, below the legal age of consent, girls were considered incapable of consenting or lacked the ‘power’ to consent. Emphasis on ‘incapacity’ was also echoed in medical and feminist literature of the period.⁸⁰ As James Kincaid notes, ‘the age of consent ... establishes even more firmly at the center [sic] of the child a kind of purity, an absence and an incapacity, an inability to do’.⁸¹ The capacity to consent to sexual activity was therefore linked more to medical ideas about ages of puberty, in terms of competence, than to the higher recommended ages for sexual activity at marriage.

Sociologist Matthew Waites notes that there are multiple ‘kinds of competence’, some of which are more social than medical.⁸² Louise Jackson has similarly observed that discussions about the age of consent in 1885 raised ‘three central questions: When, in sexual terms, did a girl become a woman? What was the difference between girl child and woman? What marked the transformation? Answers were discussed in terms of

⁷⁸ British Parliamentary Papers (BPP), Report of the Royal Commission on the Care and Control of the Feeble-minded, 1908, p. 500.

⁷⁹ For another example of the same terminology see BPP, Report from the Select Committee of the House of Lords on the Law Relating to the Protection of Young Girls, 1881, p. 91.

⁸⁰ For example see Roberts, ‘The Physical Maturity of Women’, p. 149; ‘Untitled’, *The Shield*, 7 October 1871, 676, p. 676.

⁸¹ James Kincaid, *Child-Loving: The Erotic Child and Victorian Culture* (New York: Routledge, 1992), p. 70.

⁸² Matthew Waites, *The Age of Consent: Young People, Sexuality and Citizenship* (New York: Palgrave Macmillan, 2005), p. 21.

physical, mental, social and moral development'.⁸³ Jackson's claims are supported by the Royal Commissioners' comments, cited above, about 'immaturity ... inexperience, and ... weakness of mind or body' as forms of competence. As capacity was such a varied concept, it is important to consider exactly which kinds of competence were relevant or of interest to medical practitioners. 'Inexperience' was a form of social competence, but medical ideas about puberty had relevance to certain important competencies such as the bodily capacity to engage in or resist sexual activity and the mental capacity to understand sexual activity. However, this chapter goes on to show that many medical practitioners kept to the subject of physiological rather than mental development unless they were promoting higher ages of sexual consent. Such conclusions have parallels with those drawn above about medical literature on puberty, which was similarly grounded in the principles of physiology.

One of the main focal points of medical literature on sexual consent was physiological development, which ties in with the issues of physical 'immaturity' and 'weakness of ... body' cited above. The majority of such literature focused on links between female puberty and the law, but male development and ages of sexual consent were not entirely ignored. Some journal articles and textbooks made efforts to relate male puberty to the law by arguing that, although the typical male did not reach sexual maturity until above the age of 14, it was *possible* for a boy to achieve and sustain erections at an earlier age. These comments were made in relation to the rule that a boy under the age of 14 was impotent in law, therefore could not be charged with rape. The *BMJ* commented in 1878 that '[a]t present, there is a presumption of law that a boy under fourteen is incompetent. This has been shown by experience to be false in fact'.⁸⁴ As Taylor similarly complained over 30 years later:

[A] boy under the age of fourteen years is presumed in law to be incapable of committing a rape ... the law presumes him to be impotent. Recorded cases, however, show that boys of this age are not always impotent. Instances of precocious puberty are, it is well known, very frequent.⁸⁵

In the context of boys, medical authors drew upon and emphasised the commonality of 'precocious puberty' and the variability of puberty ages in order to challenge the existing law. It is significant that they were ultimately unsuccessful in achieving any

⁸³ Louise A. Jackson, *Child Sexual Abuse in Victorian England* (London: Routledge, 2000), p. 17.

⁸⁴ 'The New Criminal Code in Relation to Medical Evidence: Killing of Unborn Children: Abortion: Rape', *BMJ*, 20 July 1878, 106, p. 106.

⁸⁵ Taylor, *Medical Jurisprudence*, 8th edn, p. 571.

changes.⁸⁶ Medical practitioners and authors *needed* to adapt their ideas about puberty to fit more rigid legal requirements and were more successful in doing so in the context of female victims than male offenders.

On the subject of female puberty, the ideas outlined in the chapter's first section were often reframed in the legal context. The same journals that published articles questioning the representativeness of average ages of puberty, as discussed above, also published articles in the 1880s that drew upon the exact same averages in the context of sexual consent debates. Despite the problematic nature of statistics, 'normal' or typical patterns of development were deemed to have a particular relevance to discussions about sexual consent because the law was grounded in a notion of protecting the majority. In an important article published in *The Lancet* in August 1885, Frederick Lowndes discussed 'what, medically speaking, should be the limits of age in the Bill now before Parliament'.⁸⁷ Like most medical practitioners who wrote on sexual consent Lowndes was a generalist, although he had some experience as a surgeon to the Liverpool Lock Hospital and Liverpool Police. Such experience may have informed his decision to seek an input on the subject of age-of-consent legislation and to take a protectionist stance. However, Lowndes's writings drew less on his experience with victims of sexual crime than they did on the texts and statistical studies outlined above. He came to the conclusion that:

Most surgeons who have had these cases brought to their notice will agree that carnal knowledge of a girl under the age of puberty is a cruel outrage, which ought to be considered a felony and severely punished. Now, what is the most usual age of puberty in females judging from the commencement of menstruation? In Taylor's "Medical Jurisprudence" third edition, p. 295, I find it given as fifteen years. Perhaps in this country the most frequent age for the commencement of menstruation may be taken at fifteen years ... It appears to me, therefore, that in demanding the age of fourteen as the limit of the felony clause we are making a perfectly reasonable request, one which is fully warranted by the above statistics and our present experience. In fact, if anything, the age is too low, and might be made fifteen if the object of the Bill is to prevent the repetition of cruel outrages.⁸⁸

⁸⁶ See Chapter Three for a discussion of the law on the presumption of male impotency in law, which was not removed even in the light of medical evidence to support such changes.

⁸⁷ F. W. Lowndes, 'The Criminal Law Amendment Bill', *The Lancet*, 1 August 1885, 221-22, p. 221.

⁸⁸ Lowndes, 'The Criminal Law Amendment Bill', p. 221.

His reference to sex below the age of puberty as a ‘cruel outrage’ reflects Taylor’s work, which referred to such an ‘outrage’ as being ‘morally and physically’ injurious.⁸⁹ However, medical literature on age-of-consent legislation focused on the latter type of injury and on the immature body rather than mind. Although Lowndes recognised the range of ages at which puberty could occur and cited the statistical distribution found by researchers such as Hogg, he still used the average age of 14 or 15 as the recommended upper limit of the felony clause. He wrote that:

All these opinions and statistics accord, as it appears to me, with present experience, instances of precocity, though frequent, being still the exceptions which prove the rule. And it must not be forgotten that the cases of exceptionally late menstruation more than counterbalance those exceptionally early.⁹⁰

Lowndes’s article provides an important illustration of how medical ideas were adapted to fit legal demands for a ‘hard and fast line of demarcation’ between ‘childhood and manhood’, in the words of Hugh Gamon’s 1907 work on *The London Police Court Today & Tomorrow*.⁹¹ Although the first section of this chapter demonstrated that average ages of puberty were widely dismissed as unrepresentative in medical literature, Lowndes utilised them as recommended ages for the felony clause because of the requirements of the law. His dismissal of cases of precocity as ‘exceptions’ is also significant in the light of Taylor’s comments about boys cited above, which emphasised the *common* nature of precocity in order to reject the legal claim that a boy under the age of 14 was always impotent. The concept of precocity itself was evidently flexible and could be shaped both to the demands of the law and to the agenda of the individual drawing upon it. This conclusion is further supported in the next chapter, which demonstrates that the concept of precocity was also utilised selectively by members of the House of Lords and Members of Parliament.

A single contributor cannot be considered representative, but Lowndes was not alone and other medical practitioners applied problematic statistical averages to the age of sexual consent. This approach was also used in the context of the misdemeanour clause, despite its higher limit. Ten years later after Lowndes’s article, *The Lancet*’s Liverpool correspondent stated that ‘[a]s it is well known that the majority of females do not attain puberty till the age of fifteen, the provisions of the more recent Act have reasonable

⁸⁹ Taylor, *Medical Jurisprudence*, 4th edn, p. 583.

⁹⁰ Lowndes, ‘The Criminal Law Amendment Bill’, p. 221.

⁹¹ H. R. P. Gamon, *The London Police Court Today & Tomorrow* (London: J. M. Dent & Co., 1907), p. 197.

grounds for their enactment'.⁹² This correspondent was referring to the misdemeanour clause of the 1885 CLAA, which had removed consent as a defence for carnal knowledge of girls under 16 years old. The next chapter's analysis of medical roles in Parliament shows that Dr Farquharson, the only medical Member of Parliament involved in age-of-consent debates in 1885, also referred to average ages of menarche. The 'grey areas' between adulthood and childhood, which were a prominent part of medical literature on puberty, were thus largely removed in the legal sphere both in theory and in practice.⁹³

The only exception to this general medical emphasis on averages was Charles Roberts, whose statistical discussion of the 'law of error' cited in the chapter's first section was part of an article on proposed age-of-consent legislation. While his approach differed from the bulk of medical literature on sexual consent laws, it was not out of place in the wider context of medical authors selecting the aspects of physiology that supported their personal attitudes to sexual consent. Roberts stated that:

[J]udging from the physiological facts, the girls [of fifteen] who have attained to the physical maturity of boys of from seventeen to nineteen years of age and to the functional maturity of womanhood will probably prove very troublesome wards of the state, and some disagreeable or unfair litigation and punishment may result from the adoption of the Bill in its present form.⁹⁴

In this extract Roberts considered the issue of menarche, which he referred to as the 'functional maturity of womanhood', and drew upon his knowledge of the different growth rates of boys and girls. Roberts based his article on development 'curves' rather than statistical averages, which was possible because he *opposed* legislative change. He therefore had no need to recommend ages for the two-tier sexual consent law, in which case 'hard and fast' lines would have been required.⁹⁵ Roberts's opposition to the 1885 CLAA was seemingly grounded in his anthropometric experience and consequent close knowledge of gender differences in sexual development rates. He justified his opposition on the basis of concerns about boys being seduced by physically mature younger 'girls of the lower classes' and then being prosecuted unfairly.⁹⁶ His reasons

⁹² 'Liverpool (From Our Own Correspondent)', *The Lancet*, 14 December 1895, 542, p. 542.

⁹³ The term 'grey area' is taken from Wendy Stainton Rogers and Rex Stainton Rogers, 'What is Good and Bad Sex for Children?' in *Moral Agendas for Children's Welfare*, ed. Michael King (London; New York: Routledge, 1999), 179-97, p. 180.

⁹⁴ Roberts, 'The Physical Maturity of Women', p. 149.

⁹⁵ Gamon, *The London Police Court*, p. 197.

⁹⁶ Roberts, 'The Physical Maturity of Women', p. 149.

were thus both social and medical, as they linked to broader contemporary anxieties about issues such as precocity and blackmail. Although all medical authors framed or reframed their discussions of puberty and sexual development for the legal sphere, the exact nature of their physiological claims evidently varied depending on the argument that each author wanted to put forward.

In addition to the use of average ages of puberty, there was a general trend for medical writers to focus on its physiological aspects. Although some medical journals reported on relevant moral and social issues, they were less common than those written by authors who self-limited their recommendations to the subject of physiology alone. Even medical practitioners who linked sexual consent to moral issues such as juvenile prostitution generally related such comments to the subject of physical maturity. In 1885 M. J. Hastings Stewart, the resident medical officer of a Lock Hospital with a particular interest in using sexual consent legislation to prevent prostitution and venereal diseases, wrote a report in *BMJ* which linked the age of prostitutes' seduction to physiological models of development. He stated that:

[I]t is between the ages of 17 and 18 especially that girls are apt to succumb to the false attractions of a 'gay life' ... Why not recognise at once the physiological immaturity of the girl up to the age of 18, and, if possible, beyond it, namely, that of 21?⁹⁷

Stewart claimed that the upper age of physiological maturity matched that at which girls were most likely to 'fall'. He selected the upper age parameters of 'normal' physiological maturity, which corresponded to the oldest ages cited for healthy menarche, to promote a higher age for the misdemeanour clause. Like many other medical authors, he emphasised a single age for sexual maturity that supported his own agenda.

In the years following the 1885 CLAA, other medical writers similarly linked juvenile prostitution with physiology to promote a higher age of sexual consent. When *The Lancet* supported a motion to suppress juvenile prostitution, made at the 1899 Brussels Conference on the Prevention of Syphilis, it noted the following reasons for doing so:

[T]he Criminal Law Amendment Act of 1885 raised the "felony age" to 13 years and the 'misdemeanour age' to 16 years. Such, however, is the persistence of vice and the depravity of human nature that, in spite of this law and in spite of

⁹⁷ 'Lock Hospital Statistics', *BMJ*, 25 July 1885, 162-63, p. 162.

police vigilance, girls of 16 years of age and under are to be seen nightly in the streets of large towns and cities; their appearance and manners showing them to be, though young in years, yet hardened in vice. Bearing in mind that the commencement of menstruation does not take place in the large proportion of females till the age of 15 years and, in many cases, not till a later age, there is every reason to try to prevent so far as is possible girls from beginning so hateful a life at least before the age of 18 years.⁹⁸

This editorial's statistical claims about ages of 'commencement of menstruation' were technically accurate. However, it focused on the 'many cases' of menarche that occurred after the age of 15 rather than the 'many cases' that occurred before the age of 15. The statistical distribution of menarche would certainly have been known by *The Lancet* editor, particularly as Roberts's high-profile work had been published in the journal the previous decade. It therefore seems reasonable to claim that the statistical skew of this article was a deliberate editorial decision to promote the journal's agenda relating to changing the law surrounding juvenile prostitution, which included the possibility of raising the age of consent to prevent it. Medical literature on sexual consent legislation evidently was not homogeneous but there were similarities in medical writers' and journal editors' careful use of physiological concepts that validated their own arguments. When compared to the complex medical ideas about puberty outlined in the first section of this chapter, most of these arguments can be viewed as simplifications in response to legal requirements or to promote specific agendas.

Physical strength was a second aspect of bodily (in)capacity which had relevance to medicine. Although weight gain was never cited as a primary feature of sexual development, it was an issue of some importance in the context of age-of-consent legislation. Girls over the age of consent needed to show signs of resistance for a successful court case. It was presumed in law that younger girls were either ignorant of the act, therefore did not understand that they should resist, or too physically weak to be capable of resistance. The mental and physical strength to resist a sexual assault was therefore an important legal aspect of capacity, particularly for females. However, the subject of weight gain was given far less attention in medical literature on sexual consent than the issues related to puberty discussed above. Only Roberts paid attention to general bodily growth, as part of his anthropometric approach and knowledge of development 'curves'. He provided further physiological evidence to oppose legal

⁹⁸ 'The Brussels Conference on the Prevention of Syphilis', *The Lancet*, 23 September 1899, p. 847.

changes by claiming that ‘as far as body growth determines maturity, a girl of twelve years of age (the youngest age referred to in the Criminal Law Amendment Bill) is equal to a boy of fifteen years and a half’.⁹⁹ He also explicitly linked girls’ weight gain and bodily growth at puberty to ‘rapid changes in the mind and social habits, changes which indicate greater maturity of girls within their own sphere of life than in boys of corresponding ages’.¹⁰⁰ Despite touching on issues of mental development, he was very careful to claim that his discussion was purely physiological so that it did not challenge parliamentary authority. He wrote that:

[W]hether girls of the lower classes, whom the new law is specially designed to protect, who have attained to the age and conditions of puberty, are or are not capable of judging of their relations to the other sex, or at what age (if it ever arrives) such wisdom is developed, I am unable to form an opinion ... This, however, is a question for Parliament to decide.¹⁰¹

Despite being unusual in his use of statistical distributions and broad opposition of reform, Roberts was representative of wider medical literature in his focus on bodily development and deference to the law. Like many of his peers he used physiological justifications for his opinions and emphasised the importance of scientific aspects of the age-of-consent question, without ever claiming that they were the only criteria for competency.

The analysis to this point has focused on medical discussions of physiology in consequence of the emphasis that was placed on the body, particularly the sexual body, in medical literature on sexual consent. Although psychological issues were considered by medical practitioners in other legal contexts, such as insanity pleas in court, they were rarely addressed in the context of sexual consent debates. A few medical authors touched upon psychological aspects of consent but avoided in-depth discussion of social issues such as sexual experience or precocious sexual behaviour, at least in the context of proposed age-of-consent legislation. Instead, they made occasional reference to mental immaturity in terms of a lack of capacity to understand sex under the recommended age of sexual consent. In 1885, Lowndes wrote that:

In asking that the age of sixteen should be the limit of the misdemeanour clause nothing can be more just, since it would be affording the protection of the law to many immature girls whose consent could only be given in sheer ignorance of

⁹⁹ Roberts, ‘The Physical Maturity of Women’, p. 149.

¹⁰⁰ Roberts, ‘The Physical Maturity of Women’, p. 149.

¹⁰¹ Roberts, ‘The Physical Maturity of Women’, pp. 149-50.

what they were doing. Here, again, there are many forcible reasons for extending the age to eighteen.¹⁰²

Notably, on the basis of psychological immaturity, Lowndes recommended a higher age of consent than he did on the basis of physiological immaturity as noted above. This approach tied in with a later statement made in the *BMJ* in 1912, regarding the White Slave Traffic Bill, that ‘psychical development is later than physical, so from a psycho-physical point of view “responsibility” cannot be said to be obtained before physical growth is complete’.¹⁰³ As psychical maturity was expected to follow physiological maturity, medical authors typically referred to mental development when they were trying to promote higher ages of sexual consent. Stephen Robertson claims that this approach was international in the early-twentieth century:

[B]y 1920, Anglo-American legislators had responded by increasing the age of consent to 16 years, and even as high as 18 years. While those ages were well beyond the normal age of menstruation, proponents justified them on scientific grounds that psychological maturity came later than physiological maturity.¹⁰⁴

However, such approaches were exceptions rather than the rule in the medical texts and journals studied for this thesis. Although the body was a focus of medical literature on puberty and sex in general, this emphasis was seemingly even greater in medical literature that commented on legal issues relating to consent.

This section has indicated that contributors to medical journals used physiology selectively to support their positions on the law, most commonly by claiming that average ages of menarche were typical or representative. As the first section of this chapter showed, such an approach had been widely discredited in other medical writings on puberty. Medical practitioners also self-limited the remit of their ‘expertise’ by focusing on physiological matters in the legal sphere, even more so than elsewhere. Medical writers less commonly touched upon the issue of mental capacity, which was not an inherently medical issue and was problematically interwoven with social questions about knowledge and experience. These conclusions, although drawn mainly from debates about sexual consent in the 1880s, were applicable to the period as a whole. Although campaigns to raise the age of sexual consent continued into the early-twentieth century, when psychiatry and psychology were gaining more recognition as

¹⁰² Lowndes, ‘The Criminal Law Amendment Bill’, p. 221.

¹⁰³ ‘The White Slave Traffic Bill’, *BMJ*, 5 October 1912, 969, p. 969.

¹⁰⁴ Robertson, ‘Age of Consent Laws’.

areas of medical specialism, medical journals only discussed mental capacity sporadically and continued to ground their discussions of juvenile prostitution in physiology. Perhaps most importantly, this analysis has reinforced the overall thesis claim that medicine needed to negotiate its place in the legal sphere. Medical ideas on sexual consent had to fit the requirements of legislative frameworks, particularly the need for a ‘hard and fast’ definition of the age of adulthood.¹⁰⁵ However, medical practitioners also had a degree of autonomy and operated within such frameworks to their own ends which varied from promoting higher ages of consent to opposing legal change.

Conclusions

This chapter has shown that Victorian and Edwardian medical notions of ‘normality’, in the sense of typicality, were not inherently ‘normalising’ in the Foucauldian sense.¹⁰⁶ Although there were overlaps between the issues of ‘normal’ and ‘ideal’ in the context of menstruation ages, medical authors were amongst the first to problematise their own claims about statistical typicality and the hazy parameters of ‘normal’ sexual development. There is therefore little evidence in the context of medical studies of sexual development to support historiographical claims, as typified by Christopher Lawrence, that medicine constructed the ‘Victorian world’ through ‘defining and demonstrating *normality*’.¹⁰⁷ Conversely, medical notions of ‘normal’ or average sexual development did not have consistent or unmediated influence throughout all spheres of the ‘Victorian world’. Not only did medical authors emphasise the limited value of statistics on menarche, but writers commonly reframed their ideas about sexual development for the purpose of seeking influence in new spheres such as the legal. These attempts were not without some degree of success, at least on a theoretical level, as medical authors successfully adapted to different frameworks of thought.

These conclusions have implications for the rest of the thesis. Most crucially, they demonstrate that medical authors had no automatic right to influence in the legal sphere, an issue which is relevant to the parliamentary and judicial contexts studied in

¹⁰⁵ Gamon, *The London Police Court*, p. 197.

¹⁰⁶ For an overview of Foucault’s concept of ‘normalisation’ see Annemarie Mol, *The Body Multiple: Ontology in Medical Practice* (Durham, NC; London: Duke University Press, 2003), pp. 56-57.

¹⁰⁷ Christopher Lawrence, *Medicine in the Making of Modern Britain, 1700-1920* (London: Routledge, 1994), p. 46. Emphasis in original.

subsequent chapters. The chapter has also raised some broader issues about the place of medical practitioners and medical ideas in the period under study, as some medical writers sought to inhabit a range of social and professional worlds. Despite their influence not being automatic, many medical authors evidently wanted some input on questions relating to sexual consent. The next chapter will question whether medical practitioners were successful in achieving the desired influence in the judicial sphere, either directly or indirectly.

‘A Long and Weary Road’: Legal Changes in the Age of Sexual Consent¹

“Great God!” they cried, “What has this blabber done?”
 “Blazoned the sin of Modern Babylon”
 “To all beneath the never-setting Sun!” ...
 Time-honoured institutions at stake;
 The Brothels, so long sacred to the rake;
 The Vested Interests began to quake.

G. Massey, ‘Greeting to W. T. Stead’, 1886.²

Gerald Massey’s 1886 poem ‘Greeting to W. T. Stead’ is part of an extensive literature, both historical and historiographical, that describes how Stead’s 1885 ‘Maiden Tribute of Modern Babylon’ articles apparently forced a complacent English Parliament to raise the age of sexual consent for young girls. The compelling *Pall Mall Gazette* exposé of the ‘white slave trade’ has dominated scholarship on Victorian age-of-consent legislation.³ In consequence of this focus on Stead’s campaign and the extra-parliamentary pressure associated with it, few historians have attempted to go beyond describing the 1885 Criminal Law Amendment Act (CLAA) as a ‘compromise’ between campaigners who sought high and low ages of consent. Deborah Gorham is representative of this trend in describing the legislation as ‘a compromise between widely divergent points of view’ in its use of 16 as the upper limit of the misdemeanour

¹ The full quote reads as follows: ‘It is by a long and a weary road that approach is ever gained to perfect legislation. Many a pitfall must be avoided, and many a toilsome steep climbed; but every sound principle developed and accepted may be regarded as a landing-place, whence a fresh ascent may be effected to still surer ground’; ‘The Lancet’, *The Lancet*, 11 July 1857, 39-41, p. 39.

² Unpublished poem ‘Greeting to W. T. Stead’ printed in J. O. Baylen, ‘Gerald Massey’s “Greeting to W. H. [sic] Stead” an Unpublished Poem’, *Victorian Periodicals Newsletter* 11 (1978), 80-82, p. 81.

³ For example see the approaches to the history of the 1885 Criminal Law Amendment Act (CLAA) taken in: Deborah Gorham, ‘The “Maiden Tribute of Modern Babylon” Re-examined: Child Prostitution and the Idea of Childhood in Late-Victorian England’, *Victorian Studies* 21 (1978), 353-79; Sheila Jeffreys, *The Spinster and her Enemies: Feminism and Sexuality 1880-1930* (London: Pandora, 1985); Raymond L. Schultz, *Crusader in Babylon: W. T. Stead and the Pall Mall Gazette* (Lincoln: University of Nebraska Press, 1972); Charles Terrot, *The Maiden Tribute: A Study of the White Slave Traffic of the Nineteenth Century* (London: Frederick Muller Ltd, 1959); and Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late Victorian London* (London: Virago Press, 1992).

clause.⁴ Although contemporaries also commonly used the term ‘compromise’ to describe the 1885 CLAA, it would be a mistake to consider that the nature of age-of-consent legislation is sufficiently explained by such a vague term.⁵ This chapter seeks to disentangle the different aspects of the ‘compromise’ or negotiation, with particular attention to processes of medico-legal interaction. Its aim is not to answer the question of ‘why was legislation passed?’ but rather to provide a case study of one, of many, processes that contributed to the ‘compromise’.⁶ It thereby emphasises the importance of understanding historical law-making on both micro- and macro-levels, while also reinforcing claims made throughout the thesis about the negotiated nature of medical roles in shaping the law on sexual consent.

There were many influences on Victorian and Edwardian sexual consent legislation, as wide-ranging as: perceived increases in sexual crime; slow redefinitions of key concerns, such as incest; and the increasing tolerance of state intervention, particularly with respect to childhood.⁷ However, the chapter focuses entirely on medical roles in law-making in order to avoid restrictive questions about the ‘most’ or ‘least’ influential forces. As sociologist Nick Lee notes, it is important that policy is not viewed as simply ‘the settling of dust after the battle of beliefs has been won, and ... a reflection of the new ““dominant discourse””’.⁸ The chapter instead focuses on medicine as a ‘non-dominant discourse’ and its negotiations with higher-profile reforming bodies, in order

⁴ Gorham, ‘The “Maiden Tribute of Modern Babylon” Re-examined’, p. 364. This description of the legislation as a ‘compromise’ is also common beyond the discipline of history, as exemplified by Brian Hogan, ‘On Modernising the Law of Sexual Offences’ in *Reshaping the Criminal Law: Essays in Honour of Glanville Williams*, ed. P. R. Glazebrook (London: Stevens & Sons, 1978), 174-89, p. 179.

⁵ For example see British Parliamentary Papers (BPP), Report of the Royal Commissioners on the Care and Control of the Feeble-Minded, 1908, p. 501; HL Deb. (3rd series), 24 June 1884, vol. 289, c. 1216.

⁶ As incest and age-of-consent clauses were often determined at an earlier date and then re-introduced, the final reasons for the passage of legislation are arguably less relevant to this thesis than the debates surrounding their nature. The rejection of early versions of the 1885 Criminal Law Amendment Act (CLAA), for example, was linked to concerns about police powers rather than to the age-of-consent clauses; ‘The Criminal Law Amendment Bill’, *The Shield*, 6 June 1885, 73-75, p. 73; ‘Notes and Comments’, *The Shield*, 19 July 1884, 121, p. 121.

⁷ On perceived increases in sexual crime, see V. A. C. Gatrell, ‘The Decline of Theft and Violence in Victorian and Edwardian England’ in *Crime and the Law: The Social History of Crime in Western Europe since 1500*, ed. V. A. C. Gatrell, Bruce Lenman and Geoffrey Parker (London: Europa, 1980), 243-310, p. 286. On attitudes towards consanguineous marriages, see David Warren Sabean, ‘From Clan to Kindred: Kinship and the Circulation of Property in Premodern and Modern Europe’ in *Heredity Produced: At the Crossroads of Biology, Politics, and Culture, 1500-1870*, ed. Staffan Müller-Wille and Hans-Jörg Rheinberger (Cambridge, MA: MIT Press, 2007), 37-60, p. 50. On the increasing tolerance of state intervention see M. J. D. Roberts, *Making English Morals: Voluntary Association and Moral Reform in England, 1787-1886* (Cambridge: Cambridge University Press, 2004).

⁸ Nick Lee, ‘Faith in the Body? Childhood, Subjecthood and Sociological Enquiry’ in *The Body, Childhood and Society*, ed. Alan Prout (New York: St. Martin's Press, 2000), 149-71, p. 161.

to understand some of the processes by which frameworks of thought about sexual consent legislation were developed and propagated. It shows that, in addition to some direct medical roles in law-making outside and inside Parliament, reformers and Members of Parliament (MPs) drew upon medically-based ideas about bodily and mental maturity. However, medical roles were not straightforward. The chapter's arguments support sociologist Matthew Waites's comments that 'policy-makers and politicians have strategically and selectively employed "science" in the public sphere to manage conflicts over age of consent laws'.⁹ It also notes that, in line with conclusions drawn in the previous chapter of this thesis, medical practitioners and reformers alike constructed medical 'expertise' in terms of physiology and adapted ideas surrounding puberty to support their own agendas. The differences between medical and law-making professions thus were not as clear cut as first appears. Medico-legal and medico-moral frameworks of thought were grounded in common interests and negotiated spheres of 'expertise', often from long-term interactions and networks of exchange. Physiology also was not cut off from broader social and moral anxieties, but rather was inextricably bound together with them.

In order to present these arguments the chapter first examines interactions between medical practitioners and extra-parliamentary pressure groups, particularly those which promoted legislative change in the 1880s. It then considers medical roles in shaping legislative change through case law and the courts, as a bridge between extra-parliamentary groups and Parliament. Finally, the chapter focuses on the use of medical concepts within Parliament. The question of age is central to the following analysis, as it is to the whole thesis. The main pieces of legislation to be examined will therefore be those in which the age of sexual consent was altered: the 1875 Offences Against the Person Act (OAPA) in which the carnal knowledge of girls was classified as a felony if they were under the age of 12 (raised from 10) and as a misdemeanour if they were under the age of 13 (raised from 12); the 1880 CLAA, in which consent was removed as a defence for prisoners who committed indecent assaults against boys or girls under the age of 13; and the 1885 CLAA, in which the aforementioned felony clause for carnal knowledge was raised to 13 and the misdemeanour clause was raised to 16.¹⁰ The 1908

⁹ Matthew Waites, *The Age of Consent: Young People, Sexuality and Citizenship* (Basingstoke; New York: Palgrave Macmillan, 2005), p. 211.

¹⁰ The 1861 Offences against the Person Act is not included here because it consolidated the existing law on the age of sexual consent and therefore did not involve debates as to where the age should be placed.

Punishment of Incest Act is also considered because it had some age-based elements and included lineal relationships such as father-daughter or uncle-niece incest, even though the law was primarily passed to criminalise incest between consenting adults because children were already protected by the 1885 CLAA.¹¹ The law surrounding incest is therefore included in the chapter when questions about age or parental authority were raised in debates, but it is not a focus of the analysis. As in the previous chapter's discussion of sexual consent, the focus of this chapter inevitably falls on the 1885 CLAA due to the proliferation of literature and debates surrounding its passage. Most age-of-consent legislation and anxieties about incest also focused on girls, with the exception of the 1880 CLAA.¹² The analysis therefore concentrates on sexual consent legislation for female victims of sexual crime. However, it makes occasional reference to age-based concerns surrounding male victims and offenders where relevant, as in debates about the capacity of boys under the age of 14 to commit rape and the 1885 Labouchère amendment to the CLAA which criminalised 'gross indecency' between males.

Pressure: Medicine and Morality

According to Frank Mort in *Dangerous Sexualities: Medico-Moral Politics in England since 1830*:

In July 1885 the Salvation Army launched a nationwide purity campaign. In less than three weeks the army gathered nearly four thousand signatures for a petition demanding a new Criminal Law Amendment Act, raising the age of consent to eighteen ... Yet one grouping was conspicuously absent from these campaigns. The medical profession did not contribute to the new crusades, nor was there

¹¹ The popular notion that incest legislation was promoted by turn-of-the-century eugenicist concerns about the health of offspring from consanguineous marriages has been convincingly dismissed in the historiographical literature, which instead emphasises the role of moral anxieties about one-room housing and the severance from ecclesiastical definitions of incest resulting from the 1907 Deceased Wife's Sister Act; Victor Bailey and Sheila Blackburn, 'The Punishment of Incest Act 1908: A Case Study of Law Creation', *Criminal Law Review* (1979), 708-18. For another discussion of the legislation's causes see Sybil Wolfram, 'Eugenics and the Punishment of Incest Act 1908', *Criminal Law Review* (1983), 308-16. For an example of a scholar who links the 1908 Incest Act to sexual offences against children, thus supports this chapter's claim that the law had some age-based aspects even though it was not driven by the question of age, see Adam Kuper, 'Incest, Cousin Marriage, and the Origin of the Human Sciences in Nineteenth-Century England', *Past and Present* 174 (2002), 158-83, p. 182.

¹² The age of consent for male heterosexual intercourse did not match that for girls until 2001; Mark Clapson, *Routledge Companion to Britain in the Twentieth Century* (Oxford; New York: Routledge, 2009), p. 65. Indecent assault legislation also was not adapted to match carnal knowledge charges, at the age of 16 for boys and girls, until 1922; Louise A. Jackson, *Child Sexual Abuse in Victorian England* (London: Routledge, 2000), p. 14.

any resurrection of the medico-moral alliance. The balance of forces around sexuality had definitely shifted.¹³

This claim that medicine was ‘conspicuously absent’ from campaigns represents a broader scholarly trend, as historians have hitherto paid little attention to the roles of medical practitioners in promoting or shaping age-of-consent legislation. George Behlmer, for example, dismisses the role of medical practitioners by stating that ‘private philanthropy, not the medical profession was directing the late-nineteenth-century campaign against child abuse’.¹⁴ However, such approaches overlook the ways in which medical practitioners were involved in and supported extra-parliamentary pressure groups in promoting legislative change. This section examines the medico-moral networks by which ideas about sexual consent were exchanged and shaped. It shows that medical practitioners were more directly involved in many extra-parliamentary law-making processes than historians have recognised. However, medical practitioners did not form their own pressure groups and generally worked within the parameters set by other extra-parliamentary bodies. The section’s analysis also demonstrates that medical ideas were picked up and used by reformers, but that such ideas were used selectively and not always in the way that medical authors originally intended. Medical ideas were deemed sufficiently valuable to be drawn upon widely by different groups, although they were not imposed ‘from above’ by a coherent medical profession. Medical roles need to be studied and understood rather than dismissed as non-existent or negligible.

Pressure group crusades for higher ages of sexual consent have been widely discussed in scholarly literature and therefore will not be considered here in any detail. However, it is worth noting that there was no single pro-legislation movement but rather a metropolitan and provincial ‘coalition of forces’ such as: the Ladies’ National Association for the Repeal of the Contagious Diseases Act (LNA); the Moral Reform Union (MRU); the National Vigilance Association (NVA); the Salvation Army (SA); the Social Purity Alliance (SPA); Nonconformist religious groups and clergymen; and

¹³ Frank Mort, *Dangerous Sexualities: Medico-Moral Politics in England Since 1830*, 2nd edn (London: Routledge, 2000 [1987]), pp. 81-83.

¹⁴ George K. Behlmer, *Child Abuse and Moral Reform in England, 1870-1908* (Stanford: Stanford University Press, 1982), p. 225. See also George Rousseau’s problematic claim that the groups which ‘combined forces’ in the 1880s used ‘a different form of reasoning from that found during this period in the medical establishment’, making reference to Freud as though his ideas were representative; George Rousseau, ‘Introduction’ in *Reformation Geneva* in *Children and Sexuality: The Greeks to the Great War*, ed. George Rousseau (London; New York: Palgrave Macmillan, 2007), 1-40, p. 12.

the National Society for the Prevention of Cruelty to Children (NSPCC).¹⁵ Although these groups were unified in their pressure on government for age-of-consent and incest legislation, they had internal differences and a variety of agendas. Jeffrey Weeks notes that there were ‘two separate but overlapping strands in the social-purity alliance’, those who viewed legislation as a means to enforce morality and those who promoted freedom of choice.¹⁶ Internal divisions of this kind meant that social purity organisations were relatively receptive to medical thought in the long term, but there was some discord between reformists who promoted personal freedom and medical practitioners who supported the state regulation of prostitutes through the 1860s Contagious Diseases Acts (CDAs).¹⁷ Within the ‘coalition of forces’ to promote legislative change, individuals and organisations also did not necessarily seek the same balance of protection and/or control. Social purity campaigners such as Ellice Hopkins emphasised the need to control girls’ morality at the ‘dangerous years’ of 16 and 17, whereas others emphasised that their motive was child protection.¹⁸ One group of first-wave feminists stated that ‘we quite refuse to call such little victims “prostitutes” or “harlots,” as does Miss Hopkins. They are not the sinners, but the villains who outrage them’.¹⁹ Despite their differences, both main strands within the social-purity alliance worked with medical practitioners and used medical rhetoric from the 1880s onwards.

¹⁵ Mort, *Dangerous Sexualities*, p. 85; Brian Harrison, ‘State Intervention and Moral Reform in Nineteenth-Century England’ in *Pressure from Without in Early Victorian England*, ed. Patricia Hollis (London: Edward Arnold, 1974), 289-322, pp. 320-21. This coalition of pressure groups was not specific to England, as similar child protection movements developed on both sides of the Atlantic and in Europe; Rachel G. Fuchs, ‘The State’ in *A Cultural History of Childhood and Family in the Age of Empire*, ed. Colin Heywood (Oxford: Berg, 2010), 129-48, p. 142.

¹⁶ Jeffrey Weeks, *Sex, Politics and Society: The Regulation of Sexuality since 1800* (London: Longman, 1981), p. 87.

¹⁷ Ronald Pearsall, *Public Purity, Private Shame: Victorian Sexual Hypocrisy Exposed* (London: Weidenfeld and Nicolson, 1976), p. 277; Patricia Ward D’Itri, *Cross Currents in the International Women’s Movement, 1848-1948* (Bowling Green, OH: Bowling Green State University Popular Press, 1999), p. 30.

¹⁸ BPP, Report from the Selection Committee of the House of Lords on the Law Relating to the Protection of Young Girls, 1882, pp. 6-11. See also Hopkins’s comments in ‘The Criminal Law Amendment Bill’, *The Standard*, 9 July 1883, 3, p. 3.

¹⁹ ‘Protests Against the Industrial Schools Acts Amendment Act, 1880’, *The Shield*, 7 April 1883, 91-92, p. 91. The article was not signed by members of an official movement in this case, but by Louisa Carbutt, Hannah Ford, Alice Scatcher and Celia Walker. Louisa Carbutt was a mistress of a girl’s school in Cheshire and Alice Scatcher was a ‘Radical-Liberal suffragist’. Describing these women as representative of a first-wave feminist approach therefore seems appropriate; Sandra Stanley Holton, “‘To Educate Women into Rebellion’: Elizabeth Cady Stanton and the Creation of a Transatlantic Network of Radical Suffragists”, *American Historical Review* 99 (1994), 1112-36, p. 1127; Christina de Bellaigue, ‘The Development of Teaching as a Profession for Women before 1870’, *The Historical Journal* 44 (2001), 963-88, p. 968.

Some medical practitioners had long-term links with pressure groups that predated the specific agenda of legislative reform. The most common links of this kind were with religious organisations, thus there were personal as well as professional motives behind medical activism. For example, Elizabeth Blackwell's first-wave feminist and Christian principles led her to a role as a founding member of the feminist and social purity group the MRU in 1881.²⁰ Blackwell continued to be a prominent part of the MRU and was still publishing pamphlets with them, to promote rescue work rather than the 'state regulation of vice', in the 1890s.²¹ The MRU was unusual in bridging the strands described by Weeks, as it was a social purity group which also promoted the feminist principles of personal freedom. As already noted in Chapter One of this thesis, Blackwell's literature on precocity fitted well with general social purity principles and may have guided her involvement in and positive reception by such an organisation. It was also only possible for Blackwell to work closely with feminist and moral groups because she had long opposed the CDAs. The original motives for this medico-moral collaboration related more to issues surrounding prostitution than child protection, but prostitution also had some relevance to sexual consent laws.²² As shown in the previous chapter and in the analysis of parliamentary debates below, discussions about when girls succumbed to prostitution were part of debates about the age of sexual consent. The MRU was also a part of the wider 'coalition of forces' that put pressure on government, as it openly supported and provided information for W. T. Stead's exposé of the 'white slave trade' and advocated the introduction of harsher penalties in the 1885 CLAA.²³

Blackwell's relatively prominent role in the MRU and general reforming zeal, even if it was not explicitly targeted at sexual consent legislation, were not typical of the Victorian medical profession. However, many other medical practitioners of the period made early links with smaller moral organisations. Many of these organisations joined the 'coalition of forces' to promote legislative change, even if only at local levels. The 1882 Report of the London Young Women's Institute Union and Christian Association commented that '[o]ur warm acknowledgments are offered for the gratuitous medical

²⁰ Roberts, *Making English Morals*, p. 262.

²¹ London, The Women's Library, Christian Duty in Regard to Vice. A Letter Addressed to the Brussels International Congress against State Regulation of Vice, with the Hearty Sympathy of Dr Elizabeth Blackwell [n.d., c. 1891], 3/HJW/A/4/1399a.

²² Lucy Bland, "'Purifying' the Public World: Feminist Vigilantes in Late Victorian England," *Women's History Review* 1 (1992), 397-412, p. 407.

²³ 'The Truth about our Secret Commission', *Pall Mall Gazette*, 9 July 1885, 1-2, p. 2; 'Public Opinion on the Subject', *Pall Mall Gazette*, 11 July 1885, 1-4, p. 2.

assistance of Dr. Heywood Smith and Dr. Gilbert Smith, whose services are always felt to be invaluable to the Association'.²⁴ This small organisation had been started in 1850 to help young unmarried women who migrated to the cities from the countryside, with a strong religious emphasis.²⁵ It later focused on a few key cities, including London. The two medical practitioners were both connected to the Institute by its London location but did not necessarily share their motives for working with the organisation. Heywood Smith was a gynaecologist and president of the British Gynaecological Society. He is perhaps best known for later being embroiled in the 'Maiden Tribute of Modern Babylon' scandal, as he conducted a vaginal examination to confirm the virginity of a 13-year-old girl 'abducted' by W. T. Stead.²⁶ Heywood Smith followed the conventions of gynaecology at the time by emphasising the dangers of pubescent girls losing control over themselves, particularly in the form of nymphomania.²⁷ His motivations for involvement in campaigns may have related less to a protectionist agenda and more to the control of dangerous sexualities, particularly of the young unmarried girls that the society focused upon. Gilbert Smith worked in a less specialist area of medicine as assistant physician to the London Hospital and vice president of the Medical Society of London.²⁸ He emphasised his religious motives more clearly than Heywood Smith, describing the small organisation as a 'widespread blessing to the neighbourhood'.²⁹ It is clear that even within a small local organisation, the motives behind medico-moral alliances were variable and personal.

In addition to these long-term links between medical practitioners and religious or moral organisations, other medico-moral alliances were created by the short-term motivation of promoting legislative change. Many feminist groups were initially mistrustful of the medical profession's CDA supporters, but became receptive to their involvement in campaigns for legislative change from the 1870s onwards. Some medical practitioners also did not seek any collaboration with moral organisations until the specific shared agenda of age-of-consent legislation arose. Such new coalitions were

²⁴ *Report for the Year 1882 of the London Young Women's Institute Union and Christian Association* (London: Printed by W. Clowes and Sons Ltd, 1883), p. 15.

²⁵ J. Gordon Melton, *Encyclopedia of Protestantism* (New York: Infobase Publishing, 2005), p. 592.

²⁶ Heywood Smith, 'Correspondence: The Armstrong Case', *The Lancet*, 21 November 1885, 972-73; 'The Royal College of Physicians and Dr Heywood Smith', *The Lancet*, 26 December 1885, 1209-10.

²⁷ Carol Groneman, 'Nymphomania: The Historical Construction of Female Sexuality', *Signs* 19 (1994), 337-67, p. 353.

²⁸ 'Medical Society of London', *BMJ*, 7 March 1891, 547-48, p. 547.

²⁹ 'London Young Women's Institute Union and Christian Association', *The Sunday at Home* 29 (1882), 624, p. 624.

therefore not controlled either by medical practitioners or moral organisations, but rather were based on the recognition that combining forces aided both medical and moral campaigns if the two had a shared agenda. A thaw in relations between feminists and the medical profession was indicated in a report on an early version of the 1875 OAPA, which raised the age of sexual consent to 13, entitled the ‘Seduction Laws Amendment Bill’. The report commented that:

[A]t a meeting held yesterday, at the rooms of the Social Science Association, in support of the Bill, the strongest supporters and opponents of the Contagious Diseases Acts sat side by side, having “buried the hatchet,” and determined to demand unanimously this amendment of the law.³⁰

The Social Science Association (SSA) existed from 1857 to 1886 and was interwoven with the British Medical Association throughout this period. It was a form of pressure group which consisted of a range of medical practitioners, scientists, statisticians and intellectuals.³¹ In this instance, the SSA worked together with feminist and social purity groups to promote the 1875 OAPA. It is likely that one of the SSA members referred to in the above article was the surgeon John Brendon Curgenven, who drafted early versions of the OAPA and was also secretary to the Association for Promoting the Extension of the Contagious Diseases Act of 1866. As this chapter goes on to show in its final section, Curgenven promoted legislative change in 1875 in order to reduce infanticide rates rather than on the basis of a protectionist agenda. His place in medico-moral collaborations was therefore based on short-term expediency rather than long-term common interests. It is significant that Curgenven’s suggestions on state regulation of ‘baby farming’ had led to extensive feminist resistance to the earliest versions of the bastardy and sexual consent law that eventually led to the OAPA, particularly from those members of the ‘coalition of forces’ who promoted personal freedom.³² The medico-moral alliance only arose when Curgenven presented ideas that supported pressure groups’ agendas, which shows that not *all* medical ideas were considered authoritative or even valuable by moral organisations. As Lawrence Goldman notes, the SSA could only ‘suggest but not control reform’ on public health and the same applied

³⁰ *Seduction Laws Amendment Bill: Report of the Debate on this Bill in the House of Commons* (Manchester: Alexander Ireland and Co., printers, 1873), p. 7.

³¹ Lawrence Goldman, *Science, Reform, and Politics in Victorian Britain: The Social Science Association, 1857-1886* (Cambridge: Cambridge University Press, 2002), pp. 1-3, 186-88, 200. For more on the Social Science Association see: Lawrence Goldman, ‘The Social Science Association, 1857-1886: A Context for Mid-Victorian Liberalism’, *English Historical Review* 101 (1986), 95-134, p. 96; and Stefan Petrow, *Policing Morals: The Metropolitan Police and the Home Office 1870-1914* (Oxford: Clarendon Press, 1994), p. 50.

³² Behlmer, *Child Abuse and Moral Reform*, p. 33.

to the law on sexual consent.³³ However, scientific support for moral campaigns was also evidently deemed to carry some weight. Medico-moral alliances were thus grounded in negotiation and perceptions of mutual benefit, rather than either side being entirely dictated to by the other.

Such medico-moral alliances were consolidated and developed from the turn of the century, as antagonism surrounding the CDAs faded and new links were forged with eugenicists. Even Frank Mort, who was cited above as claiming that medical practitioners played little part in the campaigns of the 1880s, recognises such shifts. He notes that:

By the first decade of the twentieth century the majority of medics saw any return to enforced regulation of venereal diseases as out of the question ... The changed stance on sexual diseases paved the way for a partial reconciliation between purity feminists and medics over the twin issues of morality and health ... The growing dialogue with medics heightened the moral input into medical discourse. Helen Wilson, daughter of the repeal campaigner and editor of the *Shield*, was herself a trained doctor, as was the purist and eugenicist, Mary Scharlieb.³⁴

This chapter has shown that the ‘partial reconciliation’ noted by Mort actually occurred at a much earlier date. However, he is right in observing that medico-moral links strengthened in the early-twentieth century. The example of Dr Helen Wilson is important, as she was appointed as editor of *The Shield* in 1909.³⁵ This alliance between a medical practitioner and such a publication, which had been started to promote the repeal of the CDAs in the nineteenth century, was only possible because of Wilson’s long-held position against the CDAs and similar state legislation. Her stance against the CDAs stemmed from the influence of her father, the CDA repeal campaigner and MP Henry Wilson.³⁶ Medico-moral networks thus could be familial as well as political.

Other medical practitioners contributed to campaigns to promote higher ages of sexual consent on an individual and short-term basis, rather than having any extensive involvement with moral organisations or medico-moral networks. Many of the national memorials presented to Parliament were signed by medical practitioners, as typified by

³³ Goldman, *Science, Reform, and Politics in Victorian Britain*, p. 196.

³⁴ Mort, *Dangerous Sexualities*, p. 141.

³⁵ Dr Helen Wilson’s work is referred to in HL Deb. (5th series), 29 April 1914, vol. 15, c. 1119.

³⁶ Julia Ann Laite, ‘The Association for Moral and Social Hygiene: Abolitionism and Prostitution Law in Britain (1915-1959)’, *Women’s History Review* 17 (2008), 207-23, p. 210.

a memorial from Aberdeen in 1884 which stated that ‘[y]our memorialists therefore earnestly pray you to use all your influence in Parliament to secure the immediate introduction of the [Criminal Law Amendment] Bill, & its successful passage through Parliament in the course of the present session’ and which had three medical signatories out of 50.³⁷ One of these signatories worked at the Aberdeen Royal Infirmary, another was a surgeon and lecturer on clinical surgery and the third was a professor of physiology. They were therefore all local medical practitioners who worked on the body rather than the mind, thus were representative of the medical practitioners who most commonly engaged with debates about sexual consent. In similar memorials from Edinburgh and Blackburn, medical practitioners constituted 18 and 13 per cent of the total signatories respectively.³⁸ Again, these signatories were local hospital physicians or surgeons. Many medical practitioners thus supported local and small-scale movements, but did not necessarily initiate or provide a driving force for them. Purely medical extra-parliamentary pressure did not become visible until towards the end of the period under study. It was not until 1912 that a ‘women doctors’ memorial’ with 120 signatures was presented in support of a bill to raise the age of consent further to 17.³⁹ Fully medical alliances of this kind were rare and were not one of the most visible external pressures on Parliament. However, their role should not be dismissed entirely. Medical individuals and small medical groups combined forces with the bigger coalition of extra-parliamentary pressure groups, although they never dictated the terms of the campaigns.

To this point the analysis has considered medical roles in moral networks and extra-parliamentary pressure, thereby showing that medical practitioners had a range of both direct and indirect roles in campaigns for age-of-consent legislation. It has also shown that such networks were often built on the notion of mutual benefit and common interest, whether in the form of long-term religious concerns or short-term expediency. It is now useful to turn to the productive aspects of such networks, as they were not only built on common concerns but they also influenced lay and medical views on sexual consent through processes of knowledge exchange. Medical involvement in moral

³⁷ Kew, National Archives (NA), Memorials Urging the Better Protection of Minors, 22 February 1884, HO 45/9546/59343G/37.

³⁸ These statistics relate to 11 signatories in Edinburgh and 30 in Blackburn; NA, Memorials Urging the Better Protection of Minors.

³⁹ ‘Medical Women and the White Slave Traffic’, *The Lancet*, 3 August 1912, 344, p. 344.

networks often informed their future career choices, involvement in campaigns and publication patterns. For example, following Dr Helen Wilson's appointment as editor of *The Shield* she became president of the Association for Moral and Social Hygiene in 1915, which campaigned to raise the age of sexual consent further as part of the suppression of prostitution.⁴⁰ Although such efforts were ultimately unsuccessful, it remains significant that she began to promote age-of-consent legislation after some years working with moral associations. Elizabeth Blackwell provides another example of such processes of knowledge exchange. She did not explicitly campaign on the issue of sexual consent, but her connections with the MRU influenced her professional ideas more broadly. In the 1880s and 1890s she focused increasingly on rescue work and advocated medical interventions on legal reforms relating to prostitution, writing in her 1894 book that '[t]he most serious of all the subjects on which the advice of the medical profession is required concerns the legislative enactments or municipal regulations which affect the relations of the sexes'.⁴¹ She also began to publish on the importance of using female medical practitioners for intimate examinations in non-medical feminist magazines such as *The Dawn*, which indicates the extent to which medico-moral networks influenced her professional behaviour.⁴² While it is more difficult to assess the impact of medico-moral networks on the ideas of lower-profile practitioners, it is significant that Wilson and Blackwell increasingly turned to rescue work when they worked with feminist organisations. They also both promoted legislative change to protect and reform 'fallen' women, even though only Wilson did so through age-of-consent legislation.

The influence of medico-moral networks on medical attitudes to sexual consent was also related to short-term contexts, as well as to long-term processes of knowledge exchange. For example, at public meetings medical practitioners often promoted the higher ages of sexual consent that campaigners wanted. In August 1885, *The Lancet*

⁴⁰ Laite, 'The Association for Moral and Social Hygiene', p. 209.

⁴¹ Elizabeth Blackwell, 'Rescue Work in Relation to Prostitution and Disease' in *The Sexuality Debates*, ed. Sheila Jeffreys (London; New York: Routledge, 1987 [1881]), 100-10; London, The Women's Library, Christian Duty in Regard to Vice. A Letter Addressed to the Brussels International Congress against State Regulation of Vice, with the Hearty Sympathy of Dr Elizabeth Blackwell, c. 1891, 3/HJW/A/4/1399a; Elizabeth Blackwell, *The Human Element in Sex: A Medical Inquiry into the Relation of Sexual Physiology to Christian Morality* (London: J. & A. Churchill, 1894), p. 70.

⁴² Elizabeth Blackwell, 'Women Physicians and the Regulation Of Vice', *The Dawn*, 1 May 1895, 13, p. 13.

reported on a Liverpool public meeting of the city's inhabitants organised by the mayor and noted that:

There was a very large attendance, the proceedings excited great interest, and there was apparently a very strong feeling that the ages in the felony and misdemeanour clauses should be raised to fourteen and eighteen respectively; also that the Act so amended should be passed this session. A considerable number of the members of the medical profession signed the requisition to the Mayor and attended the meeting, thus tacitly showing that on medical grounds they approved of the proposed amendments.⁴³

It was also reported that at a similar time at a meeting in Leeds, 'a leading physician of the town' responded to the *Pall Mall Gazette* revelations by supporting a similar resolution for the age of consent to be raised to eighteen.⁴⁴ As the previous chapter showed that not all medical writers supported raising the age of consent so high, it seems that such medical ideas were partly produced by the context of public meetings. Such medical practitioners may have also attended such meetings *because* they were pre-inclined to support a higher age of sexual consent, thus networks of knowledge production were often processes of reinforcement rather than the creation of entirely new ideas. These examples also show that extra-parliamentary pressure could take the form of a groundswell of popular opinion and 'intense moral furore', not just the establishment of formal organisations for that purpose.⁴⁵

Knowledge production was not a mono-directional process, as campaigners were also influenced by medical ideas. Although Blackwell herself was not active in campaigning in 1885, it is likely that her ideas about prostitution contributed to the MRU's stance on sexual consent legislation. Margaret Jackson notes that the MRU did not directly cite Blackwell's ideas in their campaigns but that:

[T]he conventions of the time regarding the citing of sources were extremely loose, and it was not at all unusual for writers, feminist or otherwise, to refer to or borrow from other writers, including well-known medical, scientific, or political authorities, without actually naming them.⁴⁶

Jackson also highlights some of the other networks by which Blackwell's ideas on prostitution and sexual morality spread, particularly noting how she discussed them at

⁴³ 'The Criminal Law Amendment Bill and the Better Protection of Women and Children', *The Lancet*, 1 August 1885, 226, p. 226.

⁴⁴ 'The New Crusade', *Pall Mall Gazette*, 31 July 1885, 6, p. 6.

⁴⁵ Leon Radzinowicz and Roger Hood, *A History of English Criminal Law and its Administration from 1750*, vol. 5 (London: Stevens, 1986), p. 118.

⁴⁶ Margaret Jackson, *The Real Facts of Life: Feminism and the Politics of Sexuality c. 1850-1940* (London: Taylor & Francis, 1994), p. 80.

the ‘Men and Women’s Club, a mixed “progressive” discussion group which included in its membership Olive Schreiner and other feminists’.⁴⁷ It seems likely that Blackwell’s ideas at least formed a part of a wider feminist and social purity thought about sex and morality, even if not explicitly on the subject of age of consent. However, Blackwell’s influence was specific to the MRU rather than to the social purity or reformist movements in general. Judith Walkowitz notes that ‘[c]onservative suffragists like Millicent Fawcett and Elizabeth Blackwell ... remained within the ranks of social purity, but they never controlled the direction of the movement’.⁴⁸ Medical practitioners like Blackwell therefore could have significant roles in knowledge production at a micro-level, but such roles were increasingly mediated when individual groups like the MRU were integrated with larger networks.

While Blackwell’s influence on moral ideas surrounding sexual consent was only implicit, other campaigners for sexual consent legislation explicitly drew upon medical ideas. In his ‘Maiden Tribute of Modern Babylon’ exposé, W. T. Stead directly cited ‘Dr. Lowndes, who was recommended to me by Mr. Cavendish Bentinck as a leading surgeon of Liverpool’.⁴⁹ Lowndes’ position on sexual consent legislation was considered in depth in the previous chapter, therefore will not be repeated here. However, these links provide important evidence that medical practitioners who wrote about the 1885 CLAA in medical journals often also had a practical involvement in campaigns. Medical theory and practice thus were not separable. Stead noted that Lowndes was a ‘great supporter of the C. D. Acts’ and had particular experience in relation to the subjects of prostitution and venereal diseases, which he drew upon in his discussion of sexual consent legislation.⁵⁰ As the conflict between medical and feminist agendas had begun to be reconciled by the 1880s, Stead could highlight Lowndes’s experience rather than viewing his support of the CDAs as a reason for medico-moral conflict. In the *Pall Mall Gazette* articles Stead noted that there were physiological reasons to support a higher age of sexual consent, directly quoting Lowndes as follows:

[M]any members of the medical profession, including myself, would wish to see an extension of the age in females under which it should be a misdemeanour for any male to have carnal knowledge ... All the cases of abnormal precocity we

⁴⁷ Jackson, *The Real Facts of Life*, p. 80.

⁴⁸ Judith Walkowitz, ‘The Politics of Prostitution’, *Signs* 6 (1980), 123-35, p. 130.

⁴⁹ ‘The Maiden Tribute of Modern Babylon – III’, *Pall Mall Gazette*, 8 July 1885, 1-5, p. 3.

⁵⁰ ‘The Maiden Tribute of Modern Babylon – III’, p. 3.

have heard of, such as mothers at eleven, &c., are very exceptional, and it seems to me that carnal knowledge of any female under puberty is a cruel outrage.⁵¹

Stead thus utilised medical authority to promote raising the age of sexual consent to protect girls ‘under puberty’, which he located at 16 years old. Stead also went on to link medical and social concerns himself, echoing medical literature on venereal diseases as he did so. He noted that child prostitutes ‘are far more likely to transmit disease than a full-grown woman. Scientifically, therefore, the close time should be extended until the woman has at least completed sixteen years of life’.⁵² Stead evidently found value in the rhetoric of medical practitioners who linked moral concerns about prostitution with the need to extend sexual consent legislation. His use of medical thought was selective, to promote a pre-existing agenda. However, this is not to say that medical practitioners had no genuine role in the construction and dissemination of knowledge in moral campaigns. Medico-moral interactions were productive, although often only in the sense of reinforcing and strengthening pre-existing ideas about sexual consent on both sides of the alliance.

Other campaigners used medicine as a strategic tool in the public arena without medical input. Ellice Hopkins claimed that her ideas were rooted in medical authority in order to reinforce her own arguments, without any direct validation of such claims by medical practitioners. She gave evidence to the Select Committee on the Protection of Young Girls that:

I consider that unless we protect our girls beyond the age of 16, the age at which most of our girls go wrong, we have done little or nothing; that is the dangerous age, and this is borne out not only by my statement as a worker, but by the authority of medical men.⁵³

Hopkins’s statement on the ‘authority of medical men’ was selective. As the previous chapter showed, *some* medical practitioners linked the subject of when ‘girls go wrong’ with physiological development but this was done either on an individual basis or in efforts to promote specific legislation. It was therefore an overstatement to describe ‘medical men’ as a homogeneous category. Although Hopkins’s reference to the ‘authority of medical men’ was not entirely accurate, it remains significant that she found value in the notion of scientific support for her moral position. However, the

⁵¹ ‘The Maiden Tribute of Modern Babylon – III’, p. 3.

⁵² ‘The Maiden Tribute of Modern Babylon – III’, p. 3.

⁵³ BPP, Protection of Young Girls, 1882, pp. 6-11.

influence of medical thought on such moral campaigns should not be overstated. In 1884 a memorial by the Committee and Working Associates of the London Young Women's Christian Association stated that 'the age at which it should be penal to seduce a girl, should be raised from thirteen to eighteen years; these are just the years when girls in our cities are peculiarly open to danger and ignorant of the ways of the world'.⁵⁴ Although this memorial advocated legislative change on similar grounds to Hopkins, by focusing on the moral 'dangers' posed to girls, they focused on the social issues of knowledge and 'ignorance' rather than drawing upon scientific rhetoric. While medical ideas were evidently deemed to have some value in moral campaigns, they were not drawn upon in any consistent way.

Finally, it is useful to note how some of the long-term practical links between medical practitioners and moral organisations aided the production of knowledge about sexual consent and sexual crime. Records of the NSPCC provide some evidence of such processes, as long-term connections with medical practitioners informed their policy and campaigns for legislative change. They recruited medical practitioners to work for local branches of the NSPCC throughout the late-nineteenth century.⁵⁵ Through repeated interactions with these medical practitioners, the NSPCC became aware of problems surrounding medical examinations in incest cases. For example, the following case was cited in a leaflet from 1900: 'Wolverhampton. 21/10/98 – Carnal Knowledge by father of daughter, aged 10 years. No action taken ... Her condition could not be legally certified as only her father could give consent to examination, she herself being too young to do so'.⁵⁶ The NSPCC noted that the offender in incest cases could prevent a medical examination, as parental consent was required for medical examinations of children under the age of 14.⁵⁷ They utilised such issues to promote legislative change at the turn of the century, thus based their campaign for incest legislation on medical

⁵⁴ Kew, NA, Memorial for the Young Women's Christian Association on the Protection of Minors, February 1884, HO 45/9546/59343G/36.

⁵⁵ For example, the Medical Officer Dr. T. D. Cook worked for the Torquay and District Branch of the NSPCC in the 1890s; Nicholas Malton, 'RE: NSPCC inform enquiry service', email to Victoria Bates, 19 February 2010. The NSPCC report for 1898-99 also showed that the society paid out £2,316 0s. 8d. in medical fees. NSPCC, *The Power of the Parent: A Factor of the State, Being the Report for 1898-9* (London: NSPCC, 1899), p. 67.

⁵⁶ Kew, NA, Proposed Bill to Deal with Incest and Other Cognate Offences, 1893-1901, HO 45/9747/A57406.

⁵⁷ NA, Proposed Bill to Deal with Incest; Bailey and Blackburn, 'The Punishment of Incest Act 1908', p. 709. The age of 14 was part of broader legal requirements for parents to provide permission for medical attendance under this age, see 'The Protection of Female Children', *The Shield*, 16 November 1874, 231-32, p. 231.

issues and drew upon knowledge gained from their interactions with medical practitioners.

This section has demonstrated the value of moving beyond considering extra-parliamentary pressures in terms of ‘most important’ and ‘least important’. Across and throughout the period under study, networks of exchange between pressure groups and medicine operated on both theoretical and practical levels. Some medical practitioners worked with pressure groups directly to promote new sexual consent legislation, while others influenced thinking on legislative change more obliquely through long-term links with social purity, protectionist, religious and/or feminist organisations. Medical ideas were also, in turn, shaped by these alliances. Medico-moral interactions often served to reinforce both groups’ existing stances on sexual consent, but were still important processes by which knowledge was shaped and disseminated. These conclusions indicate that the role of medical practitioners in legislative change should not be oversimplified. Historians can productively understand interactions between extra-parliamentary pressures and medicine as a ‘non-dominant discourse’ in the late-nineteenth century.

Process: Case Law and the Courts

Feminist, social purity and protectionist groups dominated extra-parliamentary pressure in the 1880s. Other processes of law-making outside Parliament operated more evenly across the period under study but received less publicity. One of the most significant of these took place in the courts and through case law, processes which should be understood both as extra-parliamentary ‘pressures’ and facets of English law-making. Roger Smith states that ‘[c]ase law, or law as the product of historical evolution, makes the Anglo-American system distinctive’.⁵⁸ It therefore cannot be overlooked in any analysis of law-making processes. This section turns to the question of how sexual consent law was defined and shaped by court decisions. It shows that medical roles in law-making through the courts were non-dominant and negotiated, as they had been in the extra-parliamentary arena. There is evidence that medical practitioners directly shaped some case law decisions and that medical ideas about physiology circulated

⁵⁸ Roger Smith, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981), p. 71. For a contemporary discussion of the importance of case law see A. V. Dicey, *Lectures on the Relation Between Law & Public Opinion in England During the Nineteenth Century* (London; New York: Macmillan & Co. Ltd, 1905), pp. 359-61.

amongst magistrates. However, medical practitioners had little control over the ways in which their ideas were utilised and were openly ignored in some contexts. Medical ideas influenced the common law but were mediated by the courts, rather than imposed upon them.

One of the key roles of case law was clarifying the meaning of consent, which was rarely fully explained within the legislation itself. In 1870 a Central Criminal Court case determined that parental influence could negate a child's consent, which was still a potential legal defence for men accused of indecently assaulting girls and boys of all ages at this time. The judge decided that a jury did not have to accept 'consent extorted by terror or induced by the influence of a person in whose power [a girl aged between 10 and 12] feels herself'.⁵⁹ This case involved medical evidence, although the medical witness had only provided evidence that 'penetration had taken place to some extent' and was not a driving force in the verdict about fear, familial relations and consent.⁶⁰ Despite the ostensible lack of any direct medical role in determining the case law decision, the judge's comments about terror as a mitigating factor overlapped with Alfred Swaine Taylor's comments that adult women could be 'rendered powerless by terror'.⁶¹ As noted in the Introduction to this thesis, medical practitioners and lawyers alike used textbooks such as Taylor's. Although not a clear matter of the impact of one profession on the other, there was evidently a shared medico-legal rhetoric surrounding the links between fear and consent.

The medical notion that rape was impossible on an adult woman, except in the circumstances of great fear or exhaustion, was drawn upon elsewhere in case law but not always to support a complainant's case. At the very end of the period under study a woman claimed in a Scottish divorce case that her adultery had been rape, to which the judge replied that:

The only evidence offered with regard to the possibility of a rape being effected by a single man on a grown-up woman is that of Dr Davidson, and is to the effect that with a normal man and normal woman it would be particularly difficult for the man to have even partial penetration so long as the woman

⁵⁹ R v Woodhurst (1870) Cox CLC 443.

⁶⁰ R v Woodhurst (1870).

⁶¹ Alfred Swaine Taylor, *Manual of Medical Jurisprudence*, 8th edn (London: J. & A. Churchill, 1866 [1844]), p. 607. The wording is specific to this edition, but the same point was made throughout the editions in the period under study.

refused her consent. Indeed Dr Davidson doubts if it would be possible so long as she was in her senses, and he gives his reason for his opinion.⁶²

Being a Scottish case it is possible that the medical practitioner referred to here was the surgeon Samuel Davidson of Aberdeenshire. He was twice president of the Aberdeen, Banff, and Kincardine Branch of the British Medical Association and had worked alongside Francis Ogston both in that role and in the context of a rape and murder case in the mid-nineteenth century.⁶³ Although Davidson passed away in 1895, his ideas were cited in 1914 to provide scientific validation for this judge's conclusion that the woman was not raped and thus his decision to allow a divorce.⁶⁴ Scottish law and English law are of course not directly comparable, as Scottish common law was not binding in England. However, this thesis goes on to show that similar expectations about adult women being able to resist rape also shaped magistrate, judge and jury decisions in English courts.⁶⁵ Medical ideas were less restricted by geographical boundaries than legal ones, and the ideas cited in this case were certainly representative of those found in English texts such as Taylor's work.⁶⁶ This case also provides a representative example of how judges throughout the United Kingdom and across a range of types of criminal trial drew upon medical ideas both indirectly and directly to define the question of consent.

There were some English cases in which the medical role in defining consent was a clear influence upon a judge's decision. In a case law decision from 1866 involving an 'idiot' female complainant aged 16, 'the medical man stated she was a fully developed woman, and that strong animal instincts might exist, notwithstanding her imbecile condition'.⁶⁷ The report did not state exactly who the 'medical man' was or his professional background. As this thesis later shows that specialists were rare in trials for sexual offences in the Victorian and Edwardian years, it is likely that he was speaking as a generalist.⁶⁸ His ideas certainly corresponded to physiological ideas about the age

⁶² Stewart v Stewart (1914) 2 SLT 310.

⁶³ Francis Ogston, 'Report of a Trial for Rape and Murder, with Medico-Legal Remarks on the Cause of Death', *London Medical Gazette* 10 (1850), 38-40 and 73-79, pp. 38 and 73-74; 'Aberdeen, Banff, and Kincardine Branch', *BMJ*, 7 December 1895, 1458, p. 1458.

⁶⁴ 'Aberdeen, Banff, and Kincardine Branch', p. 1458.

⁶⁵ See Chapters Five and Six of this thesis, which pay attention to 'rape myths' related to resistance.

⁶⁶ Taylor wrote that 'it does not appear probable that intercourse could be accomplished against the consent of a healthy adult female', with the exception of certain conditions such as fear discussed above; Taylor, *Medical Jurisprudence*, 8th edn, p. 607.

⁶⁷ R v Fletcher (1866) LR 1 CCR 39.

⁶⁸ See Chapter Four for a discussion of the types of medical practitioners who testified in court.

of bodily maturity and the medical notion that sexual desire without the ‘will’ to control it was a dangerous force. In consequence of this testimony, the judge directed that ‘a consent produced by mere animal instinct would be sufficient to prevent the act from constituting a rape’.⁶⁹ He quashed the guilty verdict on appeal and stated that ‘[u]pon an indictment for rape there must be some evidence that the act was without the consent of the woman, even where she is an idiot’.⁷⁰ Although this decision was overturned in 1885, as the CLAA protected ‘imbecile’ girls, it demonstrates a degree of medical belief that ‘animal instincts’ were more important as indicators of capacity for sexual intercourse than psychological development. However, such ideas were later applied without direct medical involvement. In a case from 1873 involving a 14-year-old girl with ‘mental incapacity’, the case report made no reference to a medical witness but the judge directed that ‘if from animal instinct she yielded to the prisoner without resistance, or if the prisoner from her state and condition had reason to think she was consenting, they ought to acquit him’.⁷¹ It is unclear whether this judge was drawing on the earlier case law decision or on wider contemporary thought about sexual instincts. Either way, the case highlights how medical ideas could be circulated throughout non-medical contexts and in the absence of any direct medical input or control.

As with extra-parliamentary pressure groups, judges often lifted medical concepts from literature that did not discuss age-of-consent legislation and applied them out of context. Racial issues present one such example, as indicated by the following case tried at the Court of Criminal Appeal in 1913. The case involved a 12-year-old female victim who was of a ‘different race’. The judge’s comments indicate that she was from a country with a hot climate, but the exact racial dimensions of the case were not explained. He stated that:

The appellant was convicted under s. 4 of the Criminal Law Amendment Act, 1885. All cases of that kind are very grave, but it must be remembered that the people concerned in this case are of a race which develop at an earlier age than English people ... Both the man and the girl are of a different race to the people judging them and applying the law of England to them. Trying not to be rendered indignant by the fact that the girl was rendered pregnant, which was not

⁶⁹ R v Fletcher (1866).

⁷⁰ R v Fletcher (1866).

⁷¹ The prisoner was found guilty, but it remains significant that the issue of ‘animal instincts’ was cited as part of the judge’s deliberations; R v Barratt (1873) LR 2 CCR 81.

the offence, we feel that the justice of the case would be met by a sentence of five years' penal servitude. Sentence reduced.⁷²

The issue of sexual maturity was used by this judge to set a lower penalty for carnal knowledge of girls of a different 'race', who he claimed came to sexual maturity earlier. Although in this case the girl's pregnancy was considered to be a 'grave' outcome of the crime, the fact that she was capable of being impregnated also worked as evidence against her by proving her physical precocity. The medical literature discussed in the previous chapter paid attention to the apparently earlier sexual maturity of girls from hot climates, but the question was not applied to the legal context because the law theoretically required a 'hard and fast' line.⁷³ However, this judge drew upon medical ideas about the more variable aspects of puberty in order to justify his decision to shorten the prisoner's sentence. Such uses of medical rhetoric seem to have been personal to this particular judge, which indicates how medical ideas could be drawn upon selectively to validate a range of professional and moral positions on the subject of sexual consent. The original Central Criminal Court judge had given a high sentence because he was 'rendered indignant' by the girl's pregnancy, but the Court of Appeal judge implied that the pregnancy was evidence of the girl's race-based early development and that it mitigated rather than exacerbated the prisoner's crime.⁷⁴ These medically-based ideas were used selectively and without direct medical input, but were evidently deemed to hold some value.

Judges drew less commonly on medical evidence relating to male puberty in court, as the law surrounding the incapacity of boys to commit rape under the age of 14 was explicit in legislation. It therefore could not subtly be revised or clarified through case law. In the 'R v Jordan and Cowmeadow' case of 1839 a medical witness had testified that a young male prisoner was physically capable of sexual intercourse, but Mr Justice Williams emphasised that '[a] boy under 14 years of age cannot, by law, be convicted of feloniously carnally knowing and abusing a girl under ten years old, even though it be proved that he has arrived at the full state of puberty'.⁷⁵ This decision was drawn upon with regard to rape charges into the late-nineteenth century and beyond, as exemplified

⁷² Simmonds (1914) 9 Cr App R 51.

⁷³ H. R. P. Gamon, *The London Police Court Today & Tomorrow* (London: J. M. Dent & Co., 1907), p. 197.

⁷⁴ Simmonds (1914).

⁷⁵ R v Jordan and Cowmeadow (1839) 9 C and P 118.

by the following letter from the Clerk to Justices, Maryport (Cumbria) to the Chief Magistrate, Maryport, on 25 July 1890:

Two boys aged respectively 9 and 11 appear to have committed a rape upon a child of the age of 5 years, actual penetration, according to the statement of a doctor who has examined the child, having taken place. By the Criminal Law Amendment Act 1885 any person having carnal connection with a girl under 13 years is declared to be guilty of felony. The words “any person” would apparently include males of any age, but ... according to a note (D) at the foot of page 916 of Stone’s Justice Manuel by Kennett ... “An infant under the age of 14 years is presumed by law unable to commit a Rape. See also R v Jordan 9 C. & P. 118 where Williams J. held that a Boy under 14 could not be convicted of carnally knowing and abusing a girl although it was proved he had arrived at puberty.”⁷⁶

Partly in consequence of the 1839 case law decision discussed above, which consolidated the legal rules outlined within sexual consent legislation, these boys were ‘severely chastised by their parents’ rather than being taken to court. Such case law rulings also created an implicit age of consent for the passive partner in cases of penetrative sex between males, as boys under the age of 14 could not be prosecuted for sodomy.⁷⁷ Although boys over the age of seven and thus over the age of criminal responsibility could be tried as accomplices to such a crime, it was rare.⁷⁸ In trials for suspected sodomy between two males when only one was under the age of 14, the older party was usually the only person to be charged even if the younger boy admitted to having been a willing participant.⁷⁹ As Kim M. Phillips and Barry Reay note, these age-based approaches to the offender and victim in cases of male-male sex can be traced back to the medieval period when ‘[t]he cultural assumption was that the older partner was the penetrator and the younger the penetrated, even if the age difference was minimal’.⁸⁰ The law was not changed on this issue until 1993, despite Victorian and

⁷⁶ Kew, NA, Rape by Boys aged 9 and 11, 1890, HO 45/9721/A51769.

⁷⁷ Taylor defined sodomy as ‘the unnatural connection of a man with mankind ... If this crime be committed on a boy under fourteen years, it is felony in the agent only’; Taylor, *Medical Jurisprudence*, 8th edn, p. 617.

⁷⁸ The prosecution of a young boy as an accomplice was never pursued in any of the cases from London or south-west England studied in the second half of this thesis.

⁷⁹ For example, in Middlesex in 1865 a 12-year-old boy admitted to having allowed a prisoner to enter ‘my hole with his private part – only some of it went into my hole ... he has done this 8 or 9 times before on other days’. Only the prisoner was charged with ‘attempting to commit an abominable crime’ and was found guilty, despite the boy’s apparent lack of resistance; London, London Metropolitan Archives (LMA), Pre-Trial Statements, Henry Allen tried at the Middlesex Sessions on 13 February 1865 for attempting to commit an abominable crime, MJ/SP/E/1865/003.

⁸⁰ Kim M. Phillips and Barry Reay, *Sex before Sexuality: A Premodern History* (Cambridge: Polity Press, 2011), p. 71.

Edwardian medical practitioners emphasising that a boy could be physically capable of playing an active role in penetrative sexual intercourse before the age of 14.⁸¹

The reception of medical ideas varied from judge to judge. While in 1839 Mr Justice Williams adhered to and consolidated the law on male impotency, medical ideas about sexual development may have later inspired other judges to challenge the law. In the 1850s judges were consulted by the Lord Chancellor on this legal point, as it was noted that the roots of the law surrounding young male offenders came from an old legal rule that ejaculation had to be proved to constitute rape.⁸² By the Victorian period any degree of penetration constituted rape, which meant that in theory a boy did not need to have reached full sexual maturity to perpetrate the crime. Within these observations, Mr Justice Coleridge commented that '[w]hen rape or buggery may be committed by penetration only, why should an infant under 14 be held incapable of doing what he may be proved to have done?'⁸³ As this 'proof' of penetration and the capacity for erections most commonly came from medical practitioners, it seems that judges were drawing on their extensive interaction with medical testimony in the courtroom in making such comments. In the 1850s, however, these consultations came to nothing.

The only other effort to introduce a bill to remove the legal presumption of boys' impotency was also made by a judge, James Fitzjames Stephen. He introduced a clause to change the law on male capacity for sex in the Criminal Code of 1880, which he drafted. Stephen did not explain his exact motives for this suggestion but, as he was a high-profile author of legal books and a judge, he would certainly have been aware of the case from 1839 and of the existence of medical evidence that contradicted the existing state of the law.⁸⁴ His clause was strongly supported by members of the medical profession, including by Alfred Swaine Taylor who was seemingly so confident

⁸¹ This presumption was not removed from law until the *Sexual Offences Act 1993*; Michael Jefferson, *Criminal Law*, 8th edn (Harlow: Pearson Longman, 2007 [1992]), p. 572. For an example of medical literature which emphasised that boys were capable of rape see Taylor, *Medical Jurisprudence*, 8th edn, p. 571.

⁸² BPP, Copies of the Lord Chancellor's Letters to the Judges and of their Answers, Respecting the Criminal Law Bills of the Last Session (1854) [303], pp. 10-15.

⁸³ BPP, Copies of the Lord Chancellor's Letters, p. 15

⁸⁴ Stephen explained some of his processes and motives for the Code in two publications but, due to the length of the bill, he did not explain his processes for deciding each clause; J. F. Stephen, 'A Penal Code', *The Fortnightly Review* 28 (1877), 362-76; James Fitzjames Stephen, 'The Criminal Code (1879)', *The Nineteenth Century* 7 (1880), 136-60. For an example of his other work see James Fitzjames Stephen, *A History of the Criminal Law of England* (New York: Burt Franklin, 1883).

about its success that the 1879 *Manual of Medical Jurisprudence* reported that ‘[u]nder the new Criminal Code it is provided that there shall henceforth be no presumption of law as to the age at which a boy becomes capable of committing a rape’.⁸⁵ However, Taylor’s faith was misplaced. Because the Code was intended only as a consolidating act, Stephen’s attempt to insert a clause to provide that there would ‘henceforth be no presumption of law as to the age at which a boy becomes capable of committing rape’ was promptly removed in committee.⁸⁶ The clause also never resurfaced when opportunities to change the law *were* possible. There were limitations to the influence of medical ideas about the male body and the extent of links between medical practitioners, courts and legislative change in relation to males. However, this attempt at legislative change remains important in highlighting how medical ideas or medical practitioners’ testimony in the courtroom could prompt a receptive judge to reconsider sexual consent legislation.

This discussion of consultations in the 1850s and Stephen’s Criminal Code highlights a further law-making role of the courts, in terms of bringing legal loopholes to the attention of Parliament. Judicial decisions about parental authority, one of which is cited above, similarly pre-empted and stimulated legislative change on the subject of incest. When an early draft of the Incest Bill went to the Home Office Criminal Department for observations, the written minutes stated that ‘in cases of incest the law of rape is in practice at the present time extended much further than would be supposed from the text-books ... A general law making incest a criminal offence would remove any such inequality’.⁸⁷ The proposed Incest Bill was thus somewhat reactive in terms of being designed to formalise the existing treatment of incest cases in the courts, as judges were apparently already interpreting the law with some discretion in order to be able to

⁸⁵ Taylor, *A Manual of Medical Jurisprudence*, 10th edn (London: J. & A. Churchill, 1879 [1844]), p. 604. On the support of the medical press for the clause see also ‘The New Criminal Code in Relation to Medical Evidence: Killing of Unborn Children: Abortion: Rape’, *BMJ*, 20 July 1878, 106, p. 106.

⁸⁶ The clause was present in a version of the bill in 1878 but was removed in committee; see the difference between BPP, Criminal Code (Indictable Offences) Bill (1878) [178] s. 165 and BPP, Criminal Code (Indictable Offences) Bill (1878-79) [170] s. 207. Although no explicit reason was given for the change of this clause, the report of the Royal Commission emphasised that the bill’s purpose was codification and each of their recommendations was attached to an *existing* law or piece of case law; BPP, Report of the Royal Commission Appointed to Consider the Law Relating to Indictable Offences, 1878-79. In the long run, the bill was withdrawn but by this time the clause had already been removed; for a detailed discussion of the different Criminal Code Bills’ development and progress see David Bentley, *English Criminal Justice in the Nineteenth Century* (London: Hambledon Press, 1998), pp. 174-76, 293.

⁸⁷ Kew, NA, Incest (Punishment) Bill, 1899, HO 45/10177/B29425/1. See also a Judge’s Memorandum on Incest cited in Bailey and Blackburn, ‘The Punishment of Incest Act 1908’, p. 714.

impose severe penalties. Although legislation was not passed at this time, as the Criminal Department also questioned whether it could be implemented universally, there were evidently links between courts and law-making on questions of sexual consent and incest.

The courts also highlighted legal loopholes relating to indecent assault legislation. Before 1880 consent was a defence for prisoners accused of indecently assaulting children, even though it was not a defence in cases of carnal knowledge and attempted carnal knowledge. Judicial observations on this discrepancy played a significant part in promoting the 1880 CLAA, which removed consent as a defence for those accused of indecent assault on children up to the age of 13.⁸⁸ According to Home Office documents:

[The MP for Leicester] asked the Secretary of State for the Home Department whether his attention had been called to another case of indecent assault on a little girl of six years of age, lately brought before the Stockport Magistrates and where no conviction could be obtained on account of the prisoner pleading consent, the mayor in discharging him declaring that it was a “miscarriage of justice” and whether he would consider the possibility of passing at once a short act to remedy this obvious oversight in the statute.⁸⁹

The legal loophole was quickly closed in consequence, with the process of legislative change having originated in the courts. The idea that a girl of six had no capacity to consent may have developed from the law on the age of criminal responsibility, as no child under the age of seven years old could be prosecuted for any offence.⁹⁰ No medical justifications were given for changing the law, but there had been a medical witness in the Stockport case who found that the girl had no signs of injury. Magistrates thus had extensive contact with medical witnesses and their notion that a six-year-old girl could not consent also tied in with medically-based thought, even if not explicitly from medical practitioners themselves. One JP for Middlesex certainly echoed medical thinking when he wrote, in relation to this proposed legislative change, that ‘[n]o child of 6 years or under 12 years can give any consent’.⁹¹

⁸⁸ Kew, NA, Law Relating to Indecent Assaults on Children, 1880, HO 45/9597/95696/1; ‘Protection to Children’, *Englishwoman’s Review*, 16 August 1880, 368-69, p. 369.

⁸⁹ NA, Law Relating to Indecent Assaults on Children.

⁹⁰ The age of criminal responsibility was seven from the seventeenth century until 1933, when it was raised to ten; Waites, *The Age of Consent*, p. 61; Diana Gittins, ‘The Historical Construction of Childhood’ in *An Introduction to Childhood Studies*, ed. Mary Jane Kehily, 2nd edn (Maidenhead: Open University Press, 2009 [2004]), 35-49, p. 37.

⁹¹ NA, Law Relating to Indecent Assaults on Children. Emphasis in original.

This section has shown that there was no simple cause-and-effect relationship between medical knowledge and common law decisions. In some cases medical ideas directly shaped case law and helped to define sexual consent. In others, judges made no explicit reference to the medical roots of their decisions but made comments which overlapped extensively with medical ideas about development, consent and resistance. Some case law decisions even went completely against the medical evidence, as in rape cases involving boys under the age of 14. The reasons for this variability are multifaceted. To some extent the use of medical ideas varied on an individual basis, as judges utilised scientific rhetoric differently and selectively to justify their decisions. Medicine was perceived to hold some value in adding weight to a given position on the subject of sexual consent, even if medical practitioners could not always control the ways in which their ideas were utilised. On another level, there was a genuine limit to what common law itself could change. Consent was never clearly explained in legislation and could be defined through process and the courts. However, issues such as the impotency of boys and the use of consent as a defence in indecent assault cases had to be changed through Parliament. Even members of the judiciary could only influence but not control such processes. The final section of this chapter considers the only group who truly could control the nature of legislation, MPs and Lords. It focuses on how medical concepts were drawn upon in the drafting and passage of legislation, as direct medical input was almost entirely absent at the highest levels of law-making.

Politics: Parliament, Lords and the Law

In July 1885, surgeon Charles Roberts complained in *The Lancet* that in the CLAA ‘an important physiological question is being dealt with, without, so far as appears in the discussions, any physiological knowledge being brought to bear on it’.⁹² In 1893, an editorial in *The Lancet* similarly noted ‘the utter disregard with which skilled medical opinion is treated in the drafting of bills dealing with lunacy, rape, impotency, contagious diseases and the like’.⁹³ Although this section shows that ‘utter disregard’ was an overstatement, many members of the medical profession evidently felt that physiological issues warranted greater attention in drafting legislation than they were granted. This section focuses on the legislation drafting process through parliamentary

⁹² Charles Roberts, ‘The Physical Maturity of Women’, *The Lancet*, 25 July 1885, 149-50, p. 149.

⁹³ ‘Annotations: “Ne Sutor Ultra Crepidam”’, *The Lancet*, 28 January 1893, 207-08, p. 207.

Select Committees and government Royal Commissions, before considering law-making within Parliament. It shows that, in line with conclusions drawn in the previous sections, more attention was paid to physiological concepts in debates and drafting processes than Roberts claimed. However, direct medical roles were limited and medical ideas were often utilised selectively by other parties to support their own positions on proposed legal changes. Notions of mental capacity were also discussed as matters of common sense in parliamentary debates, rather than as medical issues. Such an approach consolidated the theoretical spheres of ‘expertise’ set up by medical practitioners themselves, as outlined in the previous chapter, although in practice physiological concerns were inseparable from broader moral and legal issues.

This section focuses even more on the 1885 CLAA than the other sections of analysis, because parliamentary debates surrounding its clauses and its passage were the most extensive during the period under study. It discusses how different members of the law-making process within Parliament drew upon medical ideas in order to validate their individual positions on sexual consent legislation. This reference to ‘individual’ rather than political positions is not an oversight. Sexual consent legislation was not a partisan issue in the period under study and therefore the stances of MPs and members of the House of Lords on the subject of age-of-consent legislation were largely personal. Undoubtedly such positions were also shaped by factors including class background, particularly in relation to concerns about blackmail, and professional experience, such as that of MPs or members of the House of Lords who worked in the courts as magistrates. However, this chapter’s discussion of MPs and members of the House of Lords in individual terms rather than in connection to their parties is representative of approaches to sexual consent legislation in the period. As *The Times* noted in 1885, ‘the Liberals and the Conservatives were struggling for [the CLAA’s] authorship’.⁹⁴ There were more variations between individuals than between political parties or between the House of Commons and House of Lords.

Any examination of parliamentary activity must begin with the processes of drafting legislation. Much of this process was conducted through government Royal Commissions and parliamentary Select Committees, many of which discussed sexual

⁹⁴ ‘The Criminal Law Amendment Act’, *The Times*, 18 August 1885, 10, p. 10. On the non-partisan nature of this legislation see also Harrison, ‘State Intervention and Moral Reform’, pp. 294-97.

consent and incest despite not being originally designed for that purpose. Late-nineteenth-century Royal Commissions on diverse subjects such as rural employment, housing conditions and venereal diseases occasionally called upon medical practitioners to give their opinions on the cause and prevalence of incest.⁹⁵ However, such medical roles were both rare and limited in extent. Medical witnesses needed to answer questions that suited the agenda or requirements of Royal Commissions. In the enquiries on housing and disease, for example, medical witnesses focused on links between incest and living/working environment rather than addressing the issue of sexual offences against children. The 1881 Select Committee of the House of Lords on the Law Relating to the Protection of Young Girls, in which medical practitioners would have been permitted to discuss the age-specific aspects of sexual crime, did not call any medical witnesses.⁹⁶

Non-medical witnesses to Select Committees and Royal Commissions broadly supported medical thinking, but did not attribute their ideas to the medical profession. They paid little attention to physiology and focused on the subjects of mental capacity and knowledge, which were treated largely as matters of common sense. Mr Shaen, a judge who worked closely with the National Association for the Repeal of the Contagious Diseases Acts, gave evidence to the 1871 Royal Commission upon the Administration and Operation of the Contagious Diseases Acts that:

Very often I have prosecuted cases where the children have been as young as six, at which age, of course, they would be absolutely ignorant of the nature of everything of that kind, and incapable of resisting. They do not know how to resist. Therefore I would make it a misdemeanour to act indecently to a young child under sixteen in any way which, if it were towards a woman who resisted, would be an indecent assault.⁹⁷

The fact that Shaen worked both in the courts and with CDA repeal groups demonstrates the widespread interconnections that existed between the law-making

⁹⁵ The term ‘medical practitioners’ is used here broadly, as such witnesses included provincial surgeons, Medical Officers of Health and hospital matrons. For example see the evidence of: Dr Ash in BPP, Commission on the Employment of Children, Young Persons, and Women in Agriculture, 1867, p. 160; Dr John Woodman and Mr David Davies M.R.C.S. in BPP, First Report of Her Majesty’s Commissioners for Inquiring into the Housing of the Working Classes, 1885, p. 272; and Miss Garrett, matron of the hospital of women and children, in BPP, Appendix to the First Report of the Royal Commission on Venereal Diseases, 1914, p. 297.

⁹⁶ BPP, Report from the Select Committee of the House of Lords on the Law Relating to the Protection of Young Girls, 1881.

⁹⁷ BPP, Report of the Royal Commission upon the Administration and Operation of the Contagious Diseases Acts, p. 714; ‘The Causes of Prostitution’, *The Shield*, 28 March 1874, 98-99, p. 98.

processes studied in this chapter. Shaen had experience in the courts with medical witnesses but made no explicit reference to the medical roots of his ideas, seemingly because he related the incapacity to resist to a lack of understanding rather than to a lack of strength. Questions relating to mental competency were similarly treated as matters of common sense rather than medical issues in the final recommendations of the 1881 Select Committee on the Law Relating to the Protection of Young Girls. As *The Englishwoman's Review* later noted, 'the House of Lords Committee (Report 1882) and the Government Bill of 1883 proposed sixteen; saying that, in most cases, a girl of sixteen knows what she is doing'.⁹⁸ Even though the ability to understand sex was discussed as part of medical literature on puberty, medical 'expertise' was more clearly established on physiological than psychological matters. However, it must be remembered that the medical profession helped to define and maintain these spheres of influence. The previous chapter showed that mainstream medical literature, which generally constructed sexuality in somatic terms anyway, paid even less attention to the subject of the mind when discussing sexual consent.

Charles Roberts was seemingly right in highlighting the limited attention given to 'physiological knowledge' in the preparation of sexual consent legislation, at least in the earliest stages of the drafting process. Medical practitioners were rarely consulted in the most important Select Committees and Royal Commissions, while other witnesses on the committees generally focused upon 'common sense' matters of mental capacity. However, Select Committees and Royal Commissions only presented recommendations for legislative change. There was therefore another possible role for medical practitioners in the actual drafting process, although this was also extremely rare. The only evidence of direct medical involvement is found in occasional references to *BMJ* editor Ernest Hart's role as Chairman of the 'highly influential' Parliamentary Bills Committee of the British Medical Association, which incorporated an overlooked role in drafting the 1875 OAPA.⁹⁹ As noted in the *BMJ* in 1885:

It will be remembered that Sir W. T. Charley's Act, which raised the age of protection, and which was drawn with the advice and assistance of Mr. Ernest Hart and Mr. J. B. Curgenven, proposed to fix the age higher than the limit of

⁹⁸ 'The Protection of Minors', *Englishwoman's Review*, 15 March 1884, 105-08, p. 105.

⁹⁹ 'Proceedings at the Presentation of a Portrait of Mr. Ernest Hart', *BMJ*, 14 April 1883, 734-36, p. 735; Stephen Lock, John Last and George Dunea (eds), *The Oxford Illustrated Companion to Medicine*, 3rd edn (Oxford: Oxford University Press, 2001 [1986]), p. 70.

13, which the Government and Parliament ultimately insisted on as the maximum.¹⁰⁰

The surgeon John Brendon Curgenvén cited in this extract also worked on the Parliamentary Bills Committee alongside Hart, which meant that they had an opportunity to shape the 1875 OAPA. This role was possible because of the OAPA's roots as a bastardy law, an issue which both of them had worked on extensively since the 1860s and which was considered medical because of its links with infanticide and baby farming.¹⁰¹ Although the bill was known as 'Charley's Act', after the MP and judge who introduced it, Lionel Rose claims that the initial bastardy law in 1871 was 'Curgenvén's brainchild'.¹⁰² Hart and Curgenvén had initially drafted a bastardy act that raised the age of consent to 14, a recommendation which was intended to lower infanticide rates but which also had 'physiological grounds' as an age of sexual consent according to the *BMJ*.¹⁰³ The proposed age of 14 also supported the final recommendations made by the 1871 Royal Commission upon the Administration and Operation of the Contagious Diseases Acts, which was cited above in relation to Mr Shaen's testimony.¹⁰⁴ Despite the age of 14 being suggested by medical and non-medical men alike, the clause was dropped and then diluted as the bill was repeatedly withdrawn, reformulated and reintroduced during the early 1870s.¹⁰⁵ The Bastardy Act was eventually passed separately, with the OAPA gaining unproblematic passage with the lower age of consent of 13. Hart and Curgenvén evidently did not control the final shape of the act. However, they had a uniquely important medical input into a piece of Victorian sexual consent legislation.

After the initial drafting process, direct medical roles in shaping the nature and passage of legislation remained limited but not entirely absent. Michael Mason notes that some medical figures had 'active political affiliations', including *The Lancet's* editor Thomas

¹⁰⁰ 'Lock Hospital Statistics', *BMJ*, 25 July 1885, 162-63, pp. 162-63.

¹⁰¹ Hart and Curgenvén were both on the committee of the Society for the Protection of Infant Life and the Harveian Medical Society of London's committee to investigate infanticide; 'Infanticide: The Committee of the Harveian Society', *BMJ*, 29 September 1866, 367, p. 367.

¹⁰² Lionel Rose, *The Massacre of the Innocents: Infanticide in Britain 1800-1939* (London: Routledge & Kegan Paul, 1986), p. 108.

¹⁰³ 'Lock Hospital Statistics', p. 163.

¹⁰⁴ BPP, Contagious Diseases Acts, p. 17.

¹⁰⁵ Because this bill was interwoven with the bastardy laws, it underwent a complex process of reformulation and committee review. The age of consent clause was originally a part of bastardy legislation but was eventually separated and took its own form. For a detail description of the processes by which this legislation was formed and changed over time, see Rose, *The Massacre of the Innocents*, pp. 108-17.

Wakley who was a Radical MP for Finsbury at the start of the period under study.¹⁰⁶ Five of 643 MPs recorded in Debrett's 1870 *Illustrated Heraldic and Biographical House of Commons, and the Judicial Bench* were qualified non-practising medical practitioners and one was a qualified active medical practitioner.¹⁰⁷ Only two of these medical MPs directly contributed to debates about sexual consent legislation, neither of whom were in active professional practice: Dr Robert Farquharson M. D., a previous hospital physician who was a JP and MP for West Aberdeenshire from 1880-1906; and William Chapple M. D., who had been a medical practitioner in New Zealand and was the MP for Stirlingshire from 1910 to 1918.¹⁰⁸ It is noteworthy that all five non-practising medical practitioners and 474 of the 643 recorded MPs cited above were also JPs.¹⁰⁹ 41 MPs also had other positions in the courts, for examples as barristers or solicitors.¹¹⁰ Medicine, the courts and Parliament were part of networks which provided opportunities for the exchange and sharing of knowledge even beyond the explicit context of sexual consent debates.

Dr Chapple took a uniquely active approach as a medical Member of Parliament, by introducing a sexual consent bill as a private member in 1913 and again in 1914. His *Bill to Make Further Provision for the Protection of Women and Girls* sought to raise the felony clause for the female age of consent to 14 years old and the misdemeanour clause to 17 years old.¹¹¹ His motives were not entirely philanthropic, nor even medical; Angus McLaren notes that Chapple's apparent desire to protect 'imbeciles' was related more to worries about the consequences of illegitimacy for the state than their capacity to consent.¹¹² However, it remains significant that a medical MP attempted to intervene directly on the issue of the age of consent. The bill was one of many failed efforts to raise the age of consent for females further in the early-twentieth century, many of which were grounded in anxieties about the 'white slave trade' in the 1910s.¹¹³ While its

¹⁰⁶ Michael Mason, *The Making of Victorian Sexuality* (Oxford; New York: OUP, 1994), p. 178.

¹⁰⁷ Debrett's *Illustrated Heraldic and Biographical House of Commons, and the Judicial Bench*, ed. Robert Mair (London: Dean & Son, 1870).

¹⁰⁸ Debrett's *Illustrated Heraldic and Biographical House of Commons, and the Judicial Bench*, ed. Robert Mair (London: Dean & Son, 1886), p. 50; Debrett's *Illustrated Heraldic and Biographical House of Commons, and the Judicial Bench*, ed. Arthur G. M. Hesilrige (London: Dean & Son, 1916), p. 33.

¹⁰⁹ Debrett's *Illustrated Heraldic* (1870).

¹¹⁰ Debrett's *Illustrated Heraldic* (1870).

¹¹¹ Protection of Women and Girls Bill (1913) [132]; Protection of Women and Girls Bill (1914) [32].

¹¹² Angus McLaren, *The Trials of Masculinity: Policing Sexual Boundaries, 1870-1930* (Chicago: University of Chicago Press, 1997), p. 22.

¹¹³ The origins and development of a movement to promote an even higher legal age of consent in the 1910s can be traced in the following documents, presented here in date order: Kew, NA, Criminal Law

lack of success therefore cannot be attributed to the fact that it was introduced by a medical practitioner, its medical associations evidently did not give the proposed legislation any more credibility than if it had been introduced by a non-medical private member. Medicine carried no inherent authority in Parliament on these issues.

The MP Dr Farquharson was more representative of the medical profession, in terms of participating in debates about sexual consent rather than seeking to drive legislative change. He participated in parliamentary discussions about the 1885 CLAA and demonstrated a similar approach to the medical authors discussed in Chapter Two of this thesis, in terms of drawing heavily on average ages of puberty and on physiology rather than psychology. With regard to the misdemeanour clause of the 1885 CLAA he commented that ‘girls often came to maturity at 14½, and if they took 16 they would cover all exceptional cases. If, however, they extended the age to 17, women were then perfectly well able to protect themselves’.¹¹⁴ Farquharson was seemingly referring to menarche when he said ‘maturity’, an approach which tied in closely with medical literature on sexual maturity and sexual consent.¹¹⁵ Although Farquharson stated that the age of 16 included all ‘exceptional’ cases, the previous chapter demonstrated widespread medical belief that typical and healthy ‘exceptional’ cases of puberty could occur into the early twenties. His comments were seemingly adapted to suit the requirements of Parliament in terms of providing a clear-cut recommended age of sexual consent, but were grounded in medical thought and drew upon the principles of physiology.

Other than these two medical men, debates about consent were conducted by MPs and members of the House of Lords without medical backgrounds. However, medical rhetoric extended beyond medical voices. Parliamentary debates drew more upon physiology than Select Committees and Royal Commissions, which might have been the consequence of the networks of medico-legal exchange discussed above. In the

Amendment – White Slave Traffic, 1908-1913, HO 45/10576/178486; Kew, NA, Criminal Law Amendment, 1909-1913, HO 45/10568/175440; BPP, Criminal Law Amendment Bill (1910) [54]; BPP, Criminal Law Amendment Bill (1909) [147]; BPP, Prevention of Immorality Bill (1910) [179]; BPP, Prevention of Immorality Bill (1912-13) [28]; BPP, Prevention of Immorality Bill (1911) [40]; BPP, Protection of Women and Girls Bills (1913 and 1914) [132]; Kew, NA, Criminal Law Amendment Bill, 1913-1914, HO 45/10705/239070; Kew, NA, Criminal Law Amendment Bill, 1914-1917, HO 45/10711/244320.

¹¹⁴ HC Deb. (3rd series), 31 July 1885, vol. 300, cc. 774-75.

¹¹⁵ See earlier discussions of the symbolic and medical importance of menarche, in Chapter Two of this thesis.

context of the felony clause, the printed Hansard debates show that in the process of revising the CLA Bill in committee Mr Macartney argued that:

[I]t was said that the age of puberty was between 13 and 15. The average between those ages was 14; but to avoid being unable, in many cases, to tell the difference between 13 and 14, he thought it would be wise to adopt the younger age – namely, 13.¹¹⁶

Like Dr Farquharson and the medical authors discussed in the previous chapter, Macartney utilised average ages of puberty to suggest an appropriate age of sexual consent. Although he did not cite medical practitioners directly, his comment that ‘*it was said* that the age of puberty was between 13 and 15’ seemed to indicate that he was not simply drawing on common sense but rather on research about bodily development.¹¹⁷

Not all MPs agreed on the proposed felony limit of 13. In the same debates in which Macartney put forward his opinions, for example, the Liberal MP for Dewsbury Mr Serjeant Simon stated that:

There was this distinction between the felony and misdemeanour – that in the former the female was immature, both in body and mind, and the man guilty of it must be of brutal nature. He believed, even at the age of 15, a girl was not always able to understand the consequences, because she was deficient in mind; and the same reason applied in a stronger degree to the age of 14. Although there were some females prematurely developed, yet it was no uncommon thing for development to be deferred to between the ages of 15 and 16. But at the age of 14 the girl was but a child, and he said that at that age there was neither knowledge nor passion; if there were, it was the result of unusual precocity.¹¹⁸

Simon emphasised the links between physical development, mental development and social issues such as knowledge. Because mental maturity apparently came later than bodily maturity, he could use such ideas to promote a slightly higher age for the felony clause than Macartney. However, this meant that he moved further away from medical approaches to sexual consent legislation which had focused on the body. This is not to say that Simon did not draw upon medical rhetoric, as he spoke about bodily immaturity and used the notion of ‘unusual precocity’ to emphasise that a girl would typically mature at an older age. However, he also stated that ‘*[h]e believed ... a girl was not always able to understand the consequences*’ and thus treated the mind as an issue grounded in common sense rather than citing any evidence from medical practitioners

¹¹⁶ HC Deb. (3rd series), 31 July 1885, vol. 300, c. 721.

¹¹⁷ HC Deb. (3rd series), 31 July 1885, vol. 300, c. 721. Emphasis added.

¹¹⁸ HC Deb. (3rd series), 31 July 1885, vol. 300, c. 717.

or elsewhere.¹¹⁹ The difference between ‘he believed’ in the context of the mind and ‘it was said’ in the context of Macartney’s discussion of the body was arguably not merely discursive, but marked a significant difference in the nature of knowledge about the body and mind. However, in the context of the felony clause such discussions of mental maturity were rare and Parliament adopted the age limit of 13 with little debate.¹²⁰ It is therefore not unreasonable to claim that the felony clause was at least partly grounded in physiological concerns, as the bodily ‘immaturity’ of girls below that age had been repeatedly emphasised both in medical literature and in Parliament.

Although there was a very slight degree of disagreement over where the felony clause should be placed, it was limited in comparison to the heated debates over the misdemeanour clause which marked the upper age of consent.¹²¹ In the 1885 legislation, this clause was eventually set at 16 years old. According to a Hansard report of Sir William Harcourt’s comments in 1885, ‘some people had thought 15 too low, and some, he believed, had thought 16 too high’.¹²² These greater anxieties about the misdemeanour clause were due to its particular links with social concerns about prostitution, ‘fallen’ girls and marriage. As the age of 16 is the clause of the 1885 CLAA most commonly cited by historians as a ‘compromise’, it is important to situate medicine within such processes of negotiation. As already noted, the MP Dr Farquharson presented some purely physiological justifications for the age of 16 to be the upper limit of the misdemeanour clause. However, he was a lone medical voice in these debates and other MPs and members of the House of Lords paid greater attention to broader social concerns surrounding girls at the age of puberty. Medical concerns were not entirely absent from such discussions, but rather were interwoven with moral questions. It is therefore necessary to reassess Louise Jackson’s claim that the ‘importance of mental/moral development was ... closely elaborated as a separate issue

¹¹⁹ HC Deb. (3rd series), 31 July 1885, vol. 300, c. 717. Emphasis added.

¹²⁰ The upper limit for the age at which carnal knowledge was considered a felony was only altered once in Parliament during the various earlier versions of the 1885 CLAA, from 12 to 13 years old, by a majority of 18; see the difference between Criminal Law Amendment Bill (1884-5) [159] and Criminal Law Amendment Bill (1884-5) [257]; ‘The Criminal Law Amendment Bill’, *Pall Mall Gazette*, 1 August 1885, p. 10.

¹²¹ Unlike the felony clause, the misdemeanour age-of-consent clause was amended more than once. In consequence of various parliamentary debates, the clause was dropped from 16 to 15 in 1884 and then raised to 16 again in 1885. The final amendment was passed by a majority of 108 in the House of Commons.

¹²² HC Deb. (3rd series), 22 May 1885, vol. 298, c. 1177.

from that of bodily development' in parliamentary debates about sexual consent legislation.¹²³

During debates about the 1885 CLAA in the House of Commons, the Secretary of State merged the issues of marriage and physiology by asserting that:

Below [the age of 16] very few marriages took place, and they might, therefore, assume that girls under that age were looked on as immature, and as having not arrived at the age of puberty. These, then, were the girls they desired to protect in the Bill.¹²⁴

His choice of language is potentially revealing. He stated that 'girls ... *were looked upon*' as immature, which indicated that these ideas about maturity and puberty were not his own.¹²⁵ This echoes the above discussion of Macartney's use of 'it was said'. Puberty and physiology therefore were not treated purely as matters of common sense. The Secretary of State's attention to the question of marriage was also significant, particularly in light of the final form of the 1885 CLAA. The legislation referred to 'unlawful' carnal knowledge below the age of 16 and, in a publication explaining the 1885 CLAA to members of the legal professions, Frederick Mead noted that '[s]exual intercourse is unlawful where no valid marriage exists ... A girl of twelve and a boy of fourteen are capable of contracting a valid marriage'.¹²⁶ Such an approach allowed for marriages within the misdemeanour age group, which resolved any broader moral and religious questions surrounding a rise in illegitimacy if girls were not permitted to marry if they 'fell' early.

Other MPs and members of the House of Lords focused more on control than protection. They also merged medical and moral questions but, unlike the Secretary of State, claimed that puberty took place earlier than 16 and that such girls were the most likely to 'fall'. The Conservative MP Mr Staveley Hill commented that:

[I]n this country a girl was supposed to have reached the age of puberty when she was between 12 and 13. There was no period in a girl's life, especially where she had not been properly brought up, or cared for by her parents and

¹²³ Jackson, *Child Sexual Abuse*, p. 17.

¹²⁴ HC Deb. (3rd series), 31 July 1885, vol. 300, cc. 769-71.

¹²⁵ HC Deb. (3rd series), 31 July 1885, vol. 300, cc. 769-71. Emphasis added.

¹²⁶ Frederick Mead, *The Criminal Law Amendment Act, 1885, with Introduction, Notes and Index* (London: Shaw & Sons, 1885), p. 25.

guardians, at which she was more likely to be led astray than when between the ages of 15 and 16 years.¹²⁷

As with many MPs speaking on physiology, Hill used the language ‘supposed to have’ which indicated that he was drawing on opinions beyond his own. However, he did not cite the statistical averages for puberty identified in medical literature or by the medical MP Dr Farquharson. Hill claimed that a girl ‘was supposed to have’ reached puberty at the age of 12 or 13, which was actually at the lower end of ‘normal’ according to medical literature. He therefore emphasised the dangers of this period, when a girl was apparently physically mature but vulnerable to moral corruption. Hill and the Secretary of State thus both supported 16 as an age of consent, but on the basis of different medico-moral claims. Hill’s comments were comparable to the social purity emphasis on the ‘dangerous’ period of puberty at which a sexually mature girl could be led astray, whereas the Secretary of State quoted above took a protectionist approach and emphasised that girls below the age of 16 were not sexually mature. Both of these claims could be supported by medical evidence, as the previous chapter showed that physiologists emphasised the variable and lengthy nature of puberty. By citing a single age for puberty within a wide possible range, rather than acknowledging this variability, the very concept of puberty provided a means for MPs or members of the House of Lords to draw upon it selectively to support their own moral agendas. Such a selective use of medical ideas was tolerated or even encouraged by the profession, as medical authors and MPs similarly adapted their ideas about puberty to suit the ‘hard and fast’ requirements of the law.¹²⁸

The apparently later nature of mental development provided a means to promote higher limits for the misdemeanour clause. MPs and members of the House of Lords treated such issues related to the mind and mental capacity as common sense rather than medical matters, which echoed the approach taken by Mr Serjeant Simon in relation to the felony clause. In May 1884 Lord Mount Temple, for example, supported an unsuccessful amendment to increase the age of consent to 17 and commented that girls at [t]he age of 16 did not develop the faculties of discretion, will-force, and knowledge

¹²⁷ HC Deb. (3rd series), 6 August 1885, vol. 300, c. 1392.

¹²⁸ Gamon, *The London Police Court*, p. 197.

of the world, required to appreciate the dangers to which they were exposed'.¹²⁹ His comments implied that there was a typical age at which a girl was expected to develop the mental capacity to resist seducers. Although his ideas linked to medical thought on the 'will' and the relatively late nature of mental development, Mount Temple did not make any reference to being guided by medical ideas. Instead he linked issues of mental development to social concerns, for example relating 'will-force' to 'knowledge'. Chapter Two showed that this separation of mental development and medicine was actually encouraged by the medical profession, as many medical authors attempted to gain influence in the legal sphere by limiting their 'expertise' to the subjects of physiological maturity and capacity. Medical spheres of 'expertise' were thus negotiated, rather than decided either by the law or by medicine.

The analysis so far has shown that MPs and members of the House of Lords utilised different interpretations of puberty to support their own stances on legislative change. This conclusion is further strengthened by the observation that opponents of the 1885 CLAA also drew upon medical ideas to validate their positions. The MP for Stockport, Mr Hopwood, vigorously opposed the 1885 CLAA's age-of-consent clauses. His opposition from within the House of Commons was not unusual, despite a popular misconception that only aristocratic 'rakes' obstructed the passage of age-of-consent legislation.¹³⁰ Although members of the House of Lords demonstrated specific anxieties about blackmail and the laws surrounding prostitution, it is noteworthy that the 1885 CLAA only passed on its third introduction after being passed twice by the House of Lords and failing to receive due attention in the House of Commons on both occasions.¹³¹ Hopwood used scientific rhetoric to support his criticisms of the misdemeanour clause and thus indicated some belief in the value of medical ideas, despite commenting that he 'did not think so much of medical evidence' in criminal trials.¹³² He complained that 'cases ... constantly occurred in which girls under 16 were a hundred times more culpable than the youths whom, in reality, they seduced – cases where the girls were more advanced and matured, both in body and mind'.¹³³ Hopwood

¹²⁹ The amendment was rejected by 140 to 23; 'Criminal Law Amendment Bill', *Englishwoman's Review*, 14 July 1883, 324-25, p. 324; 'Imperial Parliament: House of Lords - Monday', *John Bull*, 30 June 1883, 404, p. 404; HL Deb. (3rd series), 15 May 1884, vol. 288, c. 404.

¹³⁰ See the reference to 'rakes' in the poem at the start of this chapter.

¹³¹ Weeks, *Sex, Politics and Society*, p. 88.

¹³² HC Deb. (3rd series), 31 July 1885, vol. 300, c. 730.

¹³³ HC Deb. (3rd series), 31 July 1885, vol. 300, c. 767.

thus drew upon medical ideas about girls maturing physically in advance of boys and used them to support his ultimately unsuccessful argument that the gender-specific nature of the legislation was unfair.¹³⁴ Hopwood also used the medico-moral issue of precocity to emphasise the dangers of extortion by sexually developed and sexually aware young girls, particularly working-class girls in urban environments.¹³⁵ His arguments thus echoed those of the medical practitioner and anthropometrist Charles Roberts, who had similarly opposed legislative change on the basis of gender difference.¹³⁶

The issue of precocity requires closer attention as an important medically-based issue that was drawn upon extensively in parliamentary debates, particularly those relating to the misdemeanour clause. In line with Mr Serjeant Simon's comments cited above, precocity was considered 'unusual' in girls under the felony age but commonplace in girls in the misdemeanour category. The links between puberty, precocity and fears of blackmail and false charges were common in both medical and parliamentary rhetoric. The MP for Devonport, Captain Price, commented on the danger of blackmail that would be posed if a man was seduced by 'a precocious, well-advanced, and well-developed girl'.¹³⁷ The Earl of Milltown similarly highlighted the dangers posed by '[g]irls of bad character under 16, but looking much older', which implied that 'bad character' and physiological precocity went hand-in-hand.¹³⁸ He was representative of the general trend for concerns about blackmail and precocity to be highlighted in the House of Lords because, as Jeffrey Weeks notes, '[f]or many upper-class men, prostitution appeared both necessary and inevitable; and their objections to raising the age of consent often arose from the fear that either they or their sons might be threatened by new legislation'.¹³⁹ These comments echoed those made by medical practitioners, including Frederick Lowndes who was not an MP but who had direct lines

¹³⁴ An amendment to include boys failed with almost no debate, although some groups continued to support its principles; see Kew, NA, *The Protection of Women and Children*, 15 February 1884, HO 45/9546/59343G/21.

¹³⁵ 'Criminal Law Amendment Bill – Mr. Hopwood's Speech and Amendment', *The Shield*, 18 July 1885, 108-10, pp. 108-10.

¹³⁶ See Chapter Two for a detailed discussion of Charles Roberts's ideas about sexual maturity and his opposition to new sexual consent laws.

¹³⁷ HC Deb. (3rd series), 3 August 1885, vol. 300, c. 898.

¹³⁸ HL Deb. (3rd series), 23 June 1883, vol. 280, c. 1390.

¹³⁹ Weeks, *Sex, Politics and Society*, p. 87.

of communication with Parliament.¹⁴⁰ As already noted Lowndes advocated raising the age of the misdemeanour clause to 16, but he did so while emphasising the importance of medical examinations because ‘the proposed alterations offer increased facilities for the preferring of false charges by precocious females, in the hope of extorting “hush money”’.¹⁴¹ While the medico-moral issue of precocity provided MPs or members of the House of Lords with a useful means to highlight such concerns, these similarities should not be interpreted as a straightforward indicator of the impact of medicine on Parliament. Concerns about blackmail had long been held and were shared by medicine and the law in the nineteenth century, therefore should be viewed as a point of commonality rather than the impact of one profession upon another.¹⁴²

Concerns about precocity shaped the outcome of the 1885 CLAA’s misdemeanour clause as, although the age of 16 was ultimately accepted, it incorporated the following statement to exclude precocious girls:

[I]t shall be a sufficient defence to any charge under sub-section one of this section if it shall be made to appear to the court or jury before whom the charge shall be brought that the person so charged had reasonable cause to believe that the girl was of or above the age of sixteen years.¹⁴³

Significantly, an attempt to introduce a similar sentence into the felony clause was rejected with little debate, possibly because the youthful appearance of girls under that age was deemed impossible to doubt.¹⁴⁴ Medical rhetoric was evident in such discussions of physical precocity, but it should be noted that the definition of precocity used in Parliament was somewhat specific to the legal context. Although some MPs and members of the House of Lords implied that the ideas they cited had medical backing, their application of the term differed significantly from that of medical authors. The ages pinpointed by medical authors as precocious did not correspond to those named in Parliament. The previous chapter demonstrated that medical authors described sexual development as *most* typical within the age range of 13 to 15, and only labelled

¹⁴⁰ As noted above, W. T. Stead stated that the Conservative MP Cavendish Bentinck had recommended that he speak to Frederick Lowndes while researching his ‘Maiden Tribute’ articles.

¹⁴¹ F. W. Lowndes, ‘The Criminal Law Amendment Bill’, *The Lancet*, 1 August 1885, 221-22, p. 222.

¹⁴² For the background to concerns about blackmail in the early modern period and beyond, as particularly evident in sodomy cases, see Angus McLaren, *Sexual Blackmail* (Cambridge, MA: Harvard University Press, 2002). Such concerns about blackmail were increasingly applied to precocious girls in consequence of the higher age of sexual consent in the 1880s, but were as much grounded in long-term class concerns about extortion as in short-term anxieties about new legislation. Although drawn upon by medical practitioners, these concerns evidently were not created by the medical profession.

¹⁴³ BPP, Criminal Law Amendment Act, 1885, 48 & 49 Vict. c. 69. s. 5.

¹⁴⁴ HC Deb. (3rd series), 31 July 1885, vol. 300, cc. 753-54.

physiological development as ‘precocious’ below the ages of 11 or 12 years old. As parliamentary references to precocity were made in the context of girls of around 15 years old, it seems reasonable to conclude that the term was defined in terms of precocious sexual knowledge or behaviour rather than precocious physiological development. However, MPs and members of the House of Lords evaded such distinctions and simply implied that physiological and behavioural precocity were consistently and directly comparable. Medical practitioners and authors had drawn some similar links between precocity of body and behaviour, but did not conflate the issues to the same extent. Medical ideas were drawn upon in a more simplistic form in parliamentary debates.

A final issue to consider in relation to individual MPs or members of the House of Lords and age-of-consent legislation is the Labouchère amendment to the 1885 CLAA. This famous clause criminalised ‘gross indecency’ against males of any age and is best known for its use in the suppression of homosexuality. However, its original inclusion may have been linked to the subject of child protection. In 1981, John Marshall first argued that the amendment was designed to prevent the corruption of youth as part of a general drive against ‘decadence’ rather than to criminalise consenting relationships between adults.¹⁴⁵ This view has gained increasing support from historians in the last twenty years, although the lack of supporting evidence makes the question of Labouchère’s motivations difficult to resolve entirely.¹⁴⁶ According to Angus McLaren, ‘Labouchère’s amendment to the Criminal Law Amendment Act of 1885, added in the first place to protect the young of both sexes from predatory older men, had the chief effect of hitting male same-sex relations’.¹⁴⁷ Joseph Bristow similarly argues that although the amendment responded to homosexual scandals of the 1880s, ‘[i]ts aim ...

¹⁴⁵ John Marshall, ‘Pansies, Perverts and Macho Men: Changing Conceptions of Male Homosexuality’ in *The Making of the Modern Homosexual*, ed. Kenneth Plummer (London: Hutchinson, 1981), 133-54, pp. 139-40.

¹⁴⁶ There is very limited surviving evidence to explain his amendment to criminalise ‘gross indecency’, which was accepted late in proceedings with little debate. Labouchère’s personal documents do not survive and he only provided explanations for his clause many years later in *Truth* magazine, which are worthy of little attention here because F. B. Smith convincingly shows that his ‘post hoc explanations’ were inconsistent and full of ‘misrememberings’. Smith suggests that Labouchère may have introduced the clause in an attempt to force the Government to refer the Bill to a Select Committee, because he supported the CLAA’s intentions but complained that it was ‘badly drawn up’. The notion that the amendment was designed to protect boys against corruption is therefore just one possible explanation for its inclusion, but one that has gained increasing popularity. F. B. Smith, ‘Labouchère’s Amendment to the Criminal Law Amendment Bill’, *Historical Studies* 17 (1976), 165-75, pp. 167-72.

¹⁴⁷ McLaren, *Trials of Masculinity*, p. 30.

was not so much to prohibit same-sex relations between adult males but more to deter the corruption of youth'.¹⁴⁸ As it was noted in parliamentary debates that boys under the age of 13 were already covered by indecent assault legislation, Labouchère's amendment may have been designed to extend protection to older boys.¹⁴⁹ Such an explanation is persuasive in light of the context in which the 'gross indecency' clause was introduced. As noted in Chapter One of this thesis, puberty was deemed a particularly dangerous time because boys apparently fell easily into habits of 'self-abuse' and lacked the 'will' to control their new sexual feelings. They were thus considered to be vulnerable to corruption by outside influences, which included pederasty. However, the limited debates surrounding this clause neither had an explicitly medical basis nor drew upon medical rhetoric. This absence in itself is worthy of note, as medical practitioners were relatively unsuccessful in gaining any input on the subject of male sexual consent. The intersection between females, puberty and sexual behaviour dominated parliamentary debates.

This section has shown that there was a greater medical role in formulating legislation on ages of sexual consent than many historians have recognised, particularly in relation to the 1885 CLAA. Direct medical roles in the creation and passage of this legislation were limited, but scientific ideas were often drawn upon by others to promote their various agendas. The analysis has also shown that the lines between bodily, mental and moral development became increasingly blurred in the context of the misdemeanour clause. Social issues of knowledge and experience were particularly raised with regard to girls in the 'grey area' between childhood and adulthood, with the issues of puberty and physiology becoming tied up with such debates.¹⁵⁰ These approaches drew upon wider social anxieties and were shared by members of the medical and parliamentary professions. The two professions also shared a tendency to link medical authority to the subject of the body rather than the mind, at least in the context of sexual consent legislation. This section has thus provided evidence to support one of the primary claims of this thesis, that medico-legal relations are best understood in terms of

¹⁴⁸ Joseph Bristow, 'Wilde, Dorian Gray, and Gross Indecency' in *Sexual Sameness: Textual Differences in Lesbian and Gay Writing*, ed. Joseph Bristow (London: Routledge, 1992), 44-63, p. 49.

¹⁴⁹ HC Deb. (3rd series), 6 August 1885, vol. 300, c. 1397-98.

¹⁵⁰ As already noted in a previous chapter, the term 'grey area' is taken from Wendy Stainton Rogers and Rex Stainton Rogers, 'What is Good and Bad Sex for Children?' in *Moral Agendas for Children's Welfare*, ed. Michael King (London; New York: Routledge, 1999), 179-97, p. 180.

collective knowledge and negotiated spheres of ‘expertise’ rather than the impact of one dominant profession on the other.

Conclusions

The role of the British state in defining and shaping childhood has long been a subject of historical study, particularly because of extensive late-nineteenth- and early-twentieth-century legislative interventions on child welfare. Sexual consent and incest legislation were part of this larger picture of reform, making it difficult to pinpoint any single or even primary reason for their passage. Despite the difficulties of identifying state motives for legislating on child protection at any given time, this chapter has demonstrated that the publicity and extensive records surrounding law-making processes can be used to consider other important questions. This analysis has proceeded on the notion that attempts to identify the ‘most’ or ‘least’ important motives for legislation have resulted in an oversimplification of some of the secondary influences on legislation formation. Medicine is one such influence, as the role of medical practitioners in shaping age-of-consent legislation has been commonly dismissed by historians. However, this analysis has demonstrated that medical roles in law-making were complex. Although medical practitioners often contributed to law-making, both pressure groups and representatives of the state had an influence over whether medical practitioners were consulted with regard to age-of-consent and incest legislation. Medical theory was also often drawn upon and reinterpreted for the parliamentary sphere without direct medical consultation, which meant that scientific validation was provided for ideas about sexual consent without explicit medical input. Despite the lack of medical control over the use of their ideas, it remains significant that the principles of physiology were drawn upon to add weight to arguments both for and against reform. Although the use of physiology was not consistent, such inconsistency was actually largely in line with the variable medical applications of physiology in the context of sexual consent debates. The variable nature of puberty allowed for it to be used in a multitude of ways. Medical practitioners, judges, law-makers and pressure groups often drew upon the notion of a ‘normal’ age of sexual maturity that supported their individual position on the subject of sexual consent legislation.

These conclusions have broader relevance for the study of legislation formation by demonstrating the value of understanding processes, rather than seeking to identify

‘most’ and ‘least’ important factors. Medical roles in law-making were diverse and negotiated but should not be eliminated from history on the basis of their secondary nature and complexity. Rather than posing questions about impact, it is arguably more fruitful to consider the processes and networks by which common pools of medico-legal and medico-moral knowledge were created and drawn upon. It is also useful to examine how spheres of scientific ‘expertise’, which were only clearly established in relation to the body, were constructed and maintained by both medicine and the law. The thesis also addresses these questions in its second half, which considers how sexual consent legislation operated in practice. Although moving onto a different subject matter, in terms of focusing on criminal trials, the second half of the thesis supports many of the methodological and conceptual conclusions drawn to this point. It shows that medical authority was negotiated rather than automatic, and that medical practitioners were part of shared cultures of knowledge rather than forming a separate, objective and homogeneous body that imposed scientific knowledge ‘from above’.

Part 2: Crime and the Courts

‘To a Doctor at Once’?: Suspected Sexual Crime and Pre-Trial Medicine¹

In her work on the history of ‘child sexual abuse’, Carol Smart rightly notes that ‘[i]n exploring how the medical profession dealt with adult sexual contact with children it is necessary to consider under what conditions a child or an abusive event might come to medical attention’.² Medical involvement in cases of suspected sexual crime did not begin in the courts, but rather depended on decisions made by the police and members of the general public before trial. These pre-trial processes are the focus of the following chapter, which examines cases of alleged sexual crime from the point of suspicion through to the decision to pursue a charge, but not yet the nature or reception of medical evidence in magistrates’ courts or at trials. It marks an analytical shift away from considering the construction of sexual consent legislation and towards examining how it operated in practice, an approach which is maintained throughout the second half of this thesis. The chapter presents two arguments throughout: firstly, that approaches to the use and reception of medical evidence were not fully systematic in the Victorian and Edwardian periods; and secondly, that deference to medical opinion was not automatic.

In the 1960s and 1970s, historians such as William Joseph Reader and Wilbur R. Miller conceptualised the nineteenth century as a period of medical and police professionalisation.³ Although the term ‘professionalisation’ is often used loosely by historians, it generally refers to a turn towards more unified and skilled professions.⁴ In the contexts studied for this chapter such ‘professionalisation’ would be expected to

¹ The full quote is ‘I directed the mother to take the girl to a doctor at once’. Taunton, Somerset Record Office (SRO), Pre-Trial Statements, George Tripp tried at the Somerset Quarter Sessions on 29 June 1876 for indecent assault, Q/SR/704.

² Carol Smart, ‘Reconsidering the Recent History of Child Sexual Abuse, 1910-1960’, *Journal of Social Policy* 29 (2000), 55-71, p. 57.

³ Wilbur R. Miller, *Cops and Bobbies: Police Authority in New York and London, 1830-1870* (Chicago: University of Chicago Press, 1977), pp. 2-4; William Joseph Reader, *Professional Men: The Rise of the Professional Classes in Nineteenth-Century England* (London: Weidenfeld and Nicolson, 1966), p. 66.

⁴ On defining ‘professionalisation’ see: Ian Inkster, ‘Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850’ in *Health Care and Popular Medicine in Nineteenth Century England: Essays in the Social History of Medicine*, ed. John Woodward and David Richards (London: Croom Helm, 1977), 128-63, p. 130; and John C. Burnham, ‘How the Idea of Profession Changed the Writing of Medical History’, *Medical History* suppl. no. 18 (1998), 1-195, pp. 7-8.

manifest itself in a greater use of medical ‘experts’ and a preference for ‘professional’ medical rather than lay examinations of suspected victims. In terms of more unified approaches, a ‘professionalised’ pre-trial context would also involve formal procedures by which the police consulted medical opinion irrespective of location. However, this chapter demonstrates the absence of many of these characteristics in late-Victorian and Edwardian England. The selection and use of medical practitioners by the police was often *ad hoc* and members of the working-class public did not systematically call upon or listen to the advice of medical practitioners. Medicine was one of many competing voices in guiding responses to suspected sexual crime, rather than being automatically deferred to because it was a scientific profession. The chapter can therefore be located within a revisionist historiographical school on police and medical ‘professionalisation’, which emphasises that the 1829 Metropolitan Police Act, 1856 County and Borough Police Act and 1858 Medical Act were not turning points after which more unified professions and systematic professional relationships emerged.⁵

In the cases under study for the second half of the thesis 602 medical practitioners gave pre-trial statements for 608 alleged victims; 429 from Middlesex and 179 from Gloucestershire, Somerset and Devon combined. These statements facilitate analysis of how and why medical evidence was used even before a case reached trial. Many pre-trial statements include depositions by the police or members of public who called, or refused to call, medical evidence. They therefore provide evidence of the processes by which decisions about the consultation of medical practitioners were made. As 97 per cent of the aforementioned medical statements involved females and 77 per cent of those were females under the age of sexual consent, most of the medical evidence discussed in this chapter relates to young girls.⁶ The youth of these alleged victims meant that the main decision-makers in the early stages of an investigation were the police and adult relatives of alleged victims, rather than complainants themselves. As this chapter shows that medical practitioners were always consulted in variable ways, even in similar circumstances, there is no analytical value in breaking their roles down

⁵ For example, see Jennifer Davis, ‘Prosecutions and their Context: The Use of the Criminal Law in Later Nineteenth-Century London’ in *Policing and Prosecution in Britain, 1750-1850*, ed. Douglas Hay and Francis Snyder (Oxford: Clarendon Press, 1989), 397-426.

⁶ This figure takes into consideration shifts in the age of sexual consent over time; three per cent were unknown and 20 per cent were above the age of sexual consent.

according to a complainant's age or gender.⁷ However, age is returned to as a category of analysis in the next chapter's discussion of the nature of medical evidence.

How? Approaching Medical Practitioners

This section considers how cases of suspected sexual crime came to medical attention, with a particular focus on who initially called medical practitioners and the circumstances in which they chose to do so. It demonstrates that there was no clear-cut process by which medical practitioners were called in to examine alleged victims in cases of a suspected sexual crime. This argument links to the historiography of professionalisation outlined above, as medical practitioners negotiated their roles on a case-by-case basis rather than following any systematic procedure. Although patterns of approaching medical practitioners differed between Middlesex and the south-west counties, no clear system for consulting medical practitioners can be identified in either region. This is not to claim that medical practitioners had little influence in the pre-trial process, as the final section of this chapter shows that the opposite could be true. However, deciding to approach a medical practitioner was not an automatic step for either the police or members of the general public.

Overall 722 medical practitioners were called in the 2213 depositions studied for this thesis, although 120 of these did not testify in court.⁸ Some broad factors increased the likelihood of a medical practitioner being approached for their opinion in cases of suspected sexual crime. In addition to the influence of a complainant's age, as noted in the introduction to this chapter, the type of sexual offence was of great importance in determining whether a medical practitioner was called to examine an alleged victim. Although this chapter shows that similar situations or perceived offences could lead to a range of possible outcomes, certain circumstances increased the overall likelihood of medical practitioners being consulted. In the context of male complainants, medical evidence was called in eight per cent of indecent assault cases and 20 per cent of

⁷ Attempts to conduct such analysis presented no patterns, therefore are of little value to this analysis beyond noting the significance of the *consistently* unsystematic and negotiated role of medical evidence in pre-trial processes irrespective of a complainant's age or gender.

⁸ 217 from Gloucestershire, Somerset and Devon; 505 from Middlesex. Some possible reasons why medical practitioners were not called to testify are considered in the first section of Chapter Five, which addresses magistrates' roles in shaping the selection and use of medical testimony.

attempted buggery and ‘assault with intent’ cases.⁹ 181 cases of indecent assault on males reached trial, but only 25 cases of attempted buggery and ‘assault with intent’. In the context of female complainants, medical evidence was called in 30 per cent of indecent assault cases, 40 per cent of attempted rape/carnal knowledge or ‘assault with intent’ cases and 96 per cent of carnal knowledge cases.¹⁰ As the overall ratio of indecent assault to attempted carnal knowledge/rape and ‘assault with intent’ cases was approximately 4:1 and the ratio of indecent assault to carnal knowledge cases was approximately 70:1, the nature of alleged offences is of primary importance in explaining the relatively low overall proportion of medical practitioners called in the Middlesex Sessions and south-west Quarter Sessions.¹¹ As the courts under study only tried misdemeanours, the cases considered in this thesis were relatively unlikely to include medical evidence. However, such cases have their own specific historical value. They enable a consideration of the motivations behind both the presence and the absence of medical evidence, which would not be possible with higher courts in which all cases included medical testimony.¹²

Figure 4.1 is a breakdown of all of the medical practitioners called in Middlesex and the south-west counties. It confirms the comment made in the introduction to this chapter that only a minor proportion of medical practitioners were called by complainants themselves. Due to the youth of many alleged victims in cases of suspected sexual crime, the responsibility for contacting the police or a medical practitioner generally fell upon their older relatives. In some cases relatives contacted a medical practitioner directly and in others they approached the police first, who then arranged a medical examination of the complainant. The graph demonstrates the importance of not always taking the comments of contemporary medical practitioners at face value, such as those who complained that ‘a few circumstances have contributed to prejudice the public

⁹ Sodomy cases are not included here because, as felonies, they did not reach the courts under study. These statistics and those for females are calculated by alleged victims, therefore a ‘case’ in which more than one medical practitioner was consulted is only counted as one. However, a case in which a medical practitioner was consulted twice for two different complainants is counted as two. It includes cases in which reference was made to a medical practitioner being consulted, but in which the medical practitioner was not eventually called to testify in court.

¹⁰ Rape is not included here because it was a felony therefore not tried in these courts, but carnal knowledge of a girl in the misdemeanour clause was tried in all of the courts under study.

¹¹ The respective figures were: 1581 indecent assault; 400 attempted rape/carnal knowledge; 23 rape/carnal knowledge.

¹² For example Louise Jackson’s sample of 230 Old Bailey sexual offence cases found that medical witnesses attended every trial; Louise A. Jackson, ‘Child Sexual Abuse and the Law: London 1870-1914’, unpublished doctoral thesis, Roehampton Institute (1997), p. 166.

against us’ and that ‘an undercurrent of prejudice against the profession ... universally exists’.¹³ It depicts willingness to consult medical practitioners amongst both the police and members of the public, more specifically the working-class public who constituted a majority of complainants at magistrates’ courts.

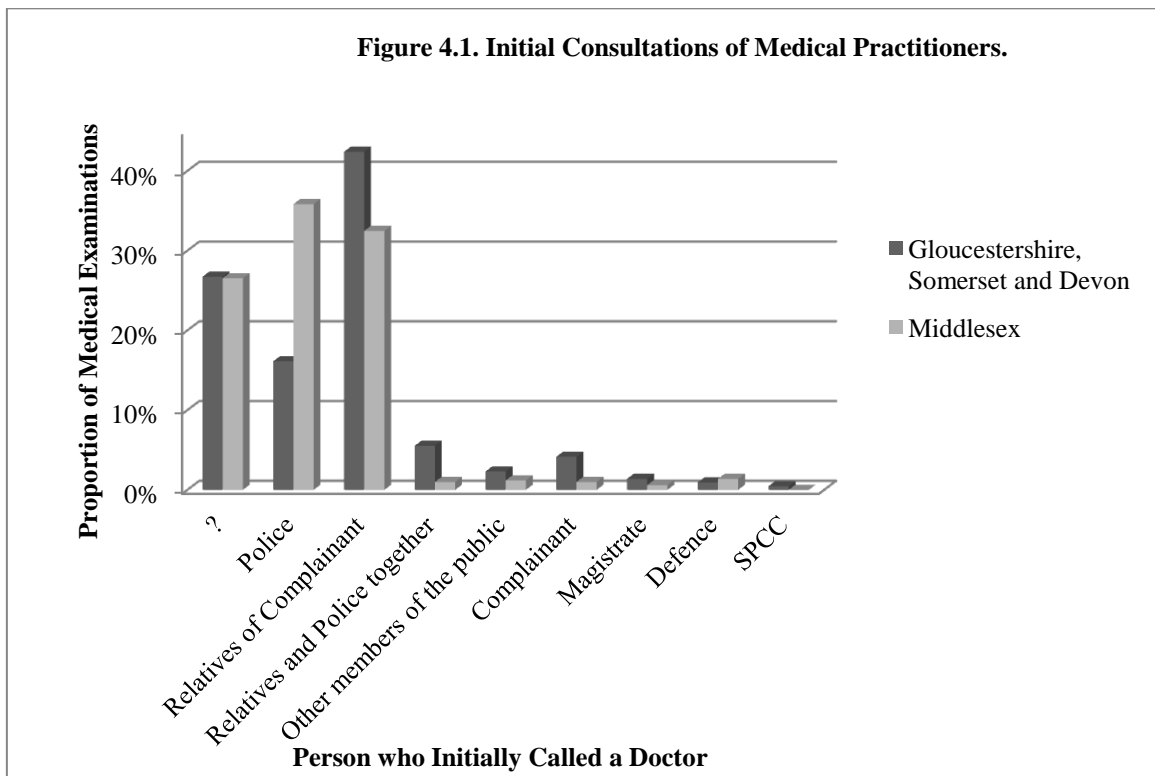


Figure 4.1 shows that a range of different minority groups could play roles in the initial consultation process. Medical practitioners were called in by people as wide-ranging as neighbours and defence lawyers. Although the statistically limited nature of such agents means that they will not be a focus of this chapter, their roles remain important indicators of the range of ways in which cases could come to medical attention. Taking magistrates as an example, their ostensibly rare involvement supports a comment made in an 1878 issue of *The Lancet* regarding medical witnesses’ ‘selection by the litigants, and not by the Court’.¹⁴ However, magistrates were prepared to call medical practitioners in cases in which they felt that the absence of medical testimony was

¹³ Lionel S. Beale, *Our Morality and the Moral Question: Chiefly from the Medical Side* (London: J. & A. Churchill, 1887), p. 165; Edward B. Foote, *Plain Home Talk About the Human System* (New York; London: Murray Hill Publishing Company; Charles Noble, 1870), p. 317. See also ‘Medicine, its Practice and its Public Relations’, *The Lancet*, 1 July 1905, 43-45, p. 43.

¹⁴ John Eric Erichsen, ‘On Surgical Evidence in Courts of Law, with Suggestions for its Improvement’, *The Lancet*, 4 May 1878, 637-39, p. 637.

inappropriate. In two cases from the 1860s, a London surgeon stated that ‘[a]t the request of the magistrate I examined the prosecutrix a few minutes ago’ and a Somerset surgeon commented that ‘I yesterday by desire of the magistrate Mr Thwaites examined the person of Emily Fisher’.¹⁵ Very occasionally cases also included examinations of prisoners’ mental states, when magistrates wanted to consider the legal issue of insanity defences.¹⁶ In other circumstances, magistrates refused to call in medical practitioners themselves but instructed complainants or their relatives to do so upon applying for a warrant. In a Gloucestershire indecent assault case in 1885, for example, a 13-year-old complainant stated that ‘I went to Dr Taylor in Thornbury on Thursday at the suggestion of the Magistrate’s Clerk to be examined’.¹⁷ It is useful to compare this case with another indecent assault trial that took place at a similar time and place. In a Somerset case of suspected indecent assault on an eight-year-old girl four years later, the magistrate instructed a complainant’s mother to conduct a medical examination herself.¹⁸ These two cases together indicate that connections between magistrates and medical witnesses were variable in any given time and place, as they encouraged the use of both professional and lay examinations. Overlaps between magistrate and public consultations of medical practitioners also complicate the picture presented by Figure 4.1, as statistics do not account for the possibility that some relatives of complainants were instructed to call medical practitioners by other agents in the judicial process.

The graph also demonstrates some regional variations in the initial consultation process. There was a small difference between the proportion of medical practitioners from Middlesex and the South West who were initially called by relatives of a complainant. However, the greatest point of distinction between the two regions relates to police roles in initial consultations. The proportion of Middlesex medical practitioners who were called by the police was more than double that of Gloucestershire, Somerset and

¹⁵ London, London Metropolitan Archives (LMA), Pre-Trial Statements, Oliver Mason tried at the Middlesex Sessions on 8 November 1865 for indecent assault, MJ/SP/E/1865/022; Taunton, SRO, Pre-Trial Statements, Frederick West tried at the Somerset Quarter Sessions on 17 January 1862 for assault with intent to commit a rape, Q/SR/645.

¹⁶ For example see London, LMA, Pre-Trial Statements, Luther Schnell tried at the Middlesex Sessions on 6 May 1884 for indecent assault, MJ/SP/E/1884/023; London, LMA, Pre-Trial Statements, William Ray tried at the Middlesex Sessions on 16 August 1887 for indecent assault, MJ/SP/E/1887/041.

¹⁷ Gloucester, Gloucestershire Archives (GA), Pre-Trial Statements, John Febrey tried at the Gloucestershire Quarter Sessions on 1 July 1885 for indecent assault, Q/SD/2/1885.

¹⁸ Taunton, SRO, Pre-Trial Statements, George Philpot tried at the Somerset Quarter Sessions in July 1889 for indecent assault, Q/SR/756.

Devon.¹⁹ The graph therefore raises the possibility that a more systematic relationship existed between the police and medical practitioners in Middlesex than in Gloucestershire, Somerset and Devon. This claim is partly corroborated by the chapter's later discussion of Metropolitan police surgeons. It also provides a possible explanation for the slightly lower overall proportion of medical evidence in south-west cases, as medical practitioners were called for 33 per cent of alleged victims in Middlesex and 27 per cent in Gloucestershire, Somerset and Devon. At least on a basic statistical level, this difference came primarily from the lower likelihood of the police calling upon medical advice in the provinces.

Qualitative evidence presents a less clear-cut picture than statistics alone. A closer analysis of pre-trial testimony shows that police and public roles in consulting medical practitioners were not entirely separable and thus raises the possibility that distinctions between Middlesex and the provinces were not as significant as first appears. In many cases from Gloucestershire, Somerset and Devon in which a member of the general public initially called in medical practitioners, the police went on to consult the same medical practitioner either to confirm the diagnosis or to request an examination of the prisoner. In a Gloucestershire case from 1895, the medical witness stated that 'Mrs Evans brought her boy Charles Evans to me on Sunday the 21st last about 2pm ... On the 21st in the evening at the request of Sergeant Curry I examined the prisoner at the Police Station'.²⁰ Although provincial police were less likely to *initially* consult medical practitioners than their Metropolitan counterparts, they showed signs of being more prepared to consult and use any medical practitioner introduced by members of the public.²¹ The police also sometimes played an indirect role in the recruitment of medical witnesses. It was very common for members of provincial police forces to advise relatives of complainants to consult a medical practitioner, rather than calling in medical advice themselves or rejecting the value of medical evidence completely. The police even recommended specific medical practitioners in some cases. In 1871 a witness in a

¹⁹ There is also a significant 'unknown' figure but, as the proportion of such cases is almost exactly the same for both regions, it is reasonable to compare statistics in this way.

²⁰ Gloucester, GA, Pre-Trial Statements, Albert Porter tried at the Gloucestershire Quarter Sessions in October 1895 for indecent assault on a male, Q/SD/2/1895.

²¹ Only four per cent of cases from Gloucestershire, Somerset and Devon involved two or more medical practitioners. The comparable proportion for Middlesex cases was 15 per cent; almost quadruple the provincial figure. Although both of these statistics are relatively low, they indicate that the Middlesex police were more likely to consult a new medical practitioner whereas provincial police may have been content to consult the medical practitioner called by a complainant's relatives, as in the Gloucestershire case cited.

Devon trial typified this process by commenting that a police sergeant ‘directed me to take [my daughter] to Dr Attwater at Bampton. I did so, and he examined her in my presence’.²² As a final example of the overlaps between police and public roles in consulting medical practitioners, the provincial police also sometimes acted as messengers on behalf of members of the public. Although a member of the public was technically the person who called for a medical practitioner in such situations, their actions were not separable from those of the police. In Somerset in June 1864, for example, the mother of a seven-year-old complainant ‘sent Police Constable John Waters for Mr Howse the Surgeon’ when she suspected that an indecent assault had been committed upon her daughter.²³ The provincial police role in initial consultations was not as limited as might be assumed from a statistical breakdown alone, but it was largely unsystematic.

As in the provincial sample there is evidence that the Middlesex police could encourage members of the general public to seek medical advice, even when the police did not consult medical practitioners themselves. Such relationships between the police, the public and medical practitioners were also often unsystematic. In two Middlesex cases from 1865 and 1875, upon hearing about an alleged indecent assault, police constables did not consult a medical practitioner but advised children’s relatives to do so.²⁴ As this chapter later shows, London and Middlesex police had access to divisional surgeons and therefore this advice was based on a choice rather than a default position. Relatives of complainants also sometimes called medical practitioners to the police station to examine their child, as illustrated by a Middlesex case of suspected indecent assault on a six-year-old girl in 1879 in which Dr Frederick Mullar stated that ‘I was called to examine this child at the station yesterday at the wish of her mother’.²⁵ As the police commonly suggested that parents called in a medical practitioner, it seems likely that there was a degree of police influence in this decision. Divisions between the key agents in pre-trial processes were evidently not clear cut in either region under study. The

²² Exeter, Devon Record Office (DRO), Pre-Trial Statements, John Fisher tried at the Devon Quarter Sessions on 29 June 1871 for indecent assault, QS/B/1871/Midsummer.

²³ Taunton, SRO, Pre-Trial Statements, George Clements tried at the Somerset Quarter Sessions on 29 June 1864 for indecent assault and assault with intent to carnally know, Q/SR/655.

²⁴ London, LMA, Pre-Trial Statements, Patrick Barron tried at the Middlesex Sessions on 24 September 1875 for indecent assault, MJ/SP/E/1875/017; London, LMA, Pre-Trial Statements, Nathan Pulham tried at the Middlesex Sessions on 13 February 1865 for indecent assault, MJ/SP/E/1865/003.

²⁵ London, LMA, Pre-Trial Statements, Alfred Clarke tried at the Middlesex Sessions on 11 September 1879 for indecent assault, MJ/SP/E/1879/22.

public and police were often mutually involved in interactions with medical practitioners in urban and rural regions alike, but the roles of all three parties varied from case to case.

Medical practitioners had limited authority in the initial clinical encounter because they were generally dependent on being approached in the first place and on being given permission to conduct intimate examinations. It is therefore also important to consider cases in which key agents in the pre-trial judicial processes opted *not* to call in medical practitioners, which was not always a decision based on the nature of an alleged offence alone. It can be difficult to evaluate the reasons for an absence of medical practitioners, particularly in the light of vague comments made in court such as ‘I didn’t think of sending her to the doctor’ and ‘I don’t know why I didn’t take her to a doctor before’.²⁶ However, in their pre-trial statements, relatives of complainants occasionally referred to factors that dissuaded them from calling in medical practitioners. One Somerset mother drew explicit connections between medicine and criminal prosecutions, by stating that ‘I did not think it necessary to have a doctor. I did not expect a prosecution to take place’.²⁷ Other parents apparently did not want to subject their children to further interference, whether they intended to pursue a prosecution or not. In a Gloucestershire deposition from 1885, the mother of an 11-year-old girl stated that ‘my husband objected’ to a medical examination.²⁸ In one Middlesex case from 1864, the mother of a 12-year-old complainant refused to allow an examination by a medical practitioner called by the accused man’s defence ‘because I thought one medical man was enough’.²⁹ These patterns were relatively consistent over time. Twenty years later, a Middlesex mother similarly refused a request by the defence to conduct an examination of her eight-year-old daughter in an indecent assault case because ‘I did not want my child to be exposed to anyone else and I had perfect confidence in the doctor who had examined her’.³⁰ Parents also had the right to ignore medical evidence when they were

²⁶ London, LMA, Pre-Trial Statements, John Howard tried at the Middlesex Sessions on 16 May 1884 for indecent assault, MJ/SP/E/1884/024; London, LMA, Pre-Trial Statements, Major Artley tried at the Middlesex Sessions on 25 September 1869 for indecent assault, MJ/SP/E/1869/016.

²⁷ Taunton, SRO, Pre-Trial Statements, George Stevens tried at the Somerset Quarter Sessions on 2 July 1913 for indecent assault, Q/SR/852.

²⁸ Gloucester, GA, Pre-Trial Statements, William Beasant tried at the Gloucestershire Quarter Sessions on 21 October 1885 for attempted rape, Q/SD/2/1885.

²⁹ London, LMA, Pre-Trial Statements, George Brooker tried at the Middlesex Sessions on 5 September 1864 for indecent assault, MJ/SP/E/1864/016.

³⁰ London, LMA, Pre-Trial Statements, Charles Robert Hallett tried at the Middlesex Sessions on 7 November 1884 for indecent assault, MJ/SP/E/1884/046.

left unsatisfied by a medical practitioner's opinion. In two Middlesex trials from the 1860s, for example, mothers of complainants stated that '[h]er aunt took her to Mr Hunt the Surgeon. I didn't feel satisfied and I took her to Mr Moore' and 'I took her to Mr Faxon, I wasn't satisfied, and on Thursday last I took her to Dr Renick'.³¹ The evidence of the former practitioner was not reported or called to court in either case, further demonstrating that the pre-trial roles of medical practitioners were not secure and that members of the public could 'shop around' for a medical practitioner.

When relatives of complainants opted not to consult medical practitioners, they sometimes took the alternative approach of conducting their own lay examinations of an alleged victim's body. In a Gloucestershire indecent assault case from 1888 the mother of a 17-year-old complainant commented that 'I examined her but I did not find any marks ... The Sister asked if I had taken my daughter to a doctor. I said "no it was not worthwhile"'.³² The use of lay instead of professional examinations also was not limited to cases in which lay people found no signs of violence. In a case of suspected indecent assault from Devon in 1883, the mother of a 14-year-old complainant stated that '[I] examined her. The child was very red and sore. I mean the private parts. I did not call in any doctor'.³³ 35 per cent of pre-trial statements from Gloucestershire, Somerset and Devon referred to lay medical examinations of the body or genitals.³⁴ The equivalent figure for Middlesex was 17 per cent.³⁵ This statistical discrepancy provides a possible explanation for the lower overall proportion of cases with medical evidence in the South West, as discussed above. There was seemingly a more widespread use of lay examinations and informal networks in the south-west counties, which tied in with issues such as the potential difficulties of travelling to see a medical practitioner. All of these lay examinations were conducted by women, most commonly female relatives of complainants and sometimes neighbours or mistresses of servants. In such cases lay people often acknowledged the limitations of their own interpretations of bodily signs but did not always call in medical practitioners. In a Gloucestershire case from 1896 a

³¹ London, LMA, Pre-Trial Statements, William Collins tried at the Middlesex Sessions on 23 May 1862 for indecent assault, MJ/SP/E/1862/009; London, LMA, Pre-Trial Statements, Edwin Jordan tried at the Middlesex Sessions on 22 January 1869 for indecent assault, MJ/SP/E/1869/002.

³² Gloucester, GA, Pre-Trial Statements, Robert Tandy tried at the Gloucestershire Quarter Sessions on 5 July 1888 for indecent assault, Q/SD/2/1888.

³³ Exeter, DRO, Pre-Trial Statements, George Baker tried at the Devon Quarter Sessions on 4 April 1883 for indecent assault, QS/B/1883/Easter.

³⁴ 277 out of 789.

³⁵ 243 out of 1424.

complainant's mother stated that '[m]y child appeared to me to be sore for a day or two after, but as far as I am a judge, I don't think the prisoner used anything but his hand'.³⁶ By stating 'as far as I am a judge', the mother in this case implicitly acknowledged the distinctions between lay and professional capacities to interpret signs of violence. However, nobody proceeded to call in a medical practitioner in this case.

In some cases with lay examinations, local community and traditional knowledge were used instead of professional advice because there was not yet any suspicion that an offence had taken place. In one Middlesex case of alleged indecent assault on an eight-year-old girl, for example, a neighbour of the child was informed that she was unwell and 'examined the prosecutrix ... found the parts very sore and I went and got her some medicine. I thought it was from the over heating of her blood'.³⁷ The child's grandmother similarly stated that '[t]he prosecutrix complained to me of being sore and I examined her and found her raw ... I thought the rawness was from the heat of her body'.³⁸ In this case local networks and lay knowledge about 'over heating', which was grounded in humoral models of the body, were drawn upon instead of medical advice. No medical practitioner was consulted and the alleged offence did not come to light until the girl made a complaint four months later. This example supports comments that have long been made by historians about the use of local networks in times of crisis in the late-nineteenth and early-twentieth centuries, in both London and the provinces.³⁹ Medical practitioners had to negotiate their roles in relation to such lay knowledge and use of local networks.

In other cases lay examinations were not conducted as an alternative to professional examinations but in addition to them. When used in this way members of the general public could complement medical practice by presenting a form of observation based on experience and the ability to situate a bodily state against a given 'norm' rather than observation based on 'expertise'. Figure 4.2 depicts the relationship between results of

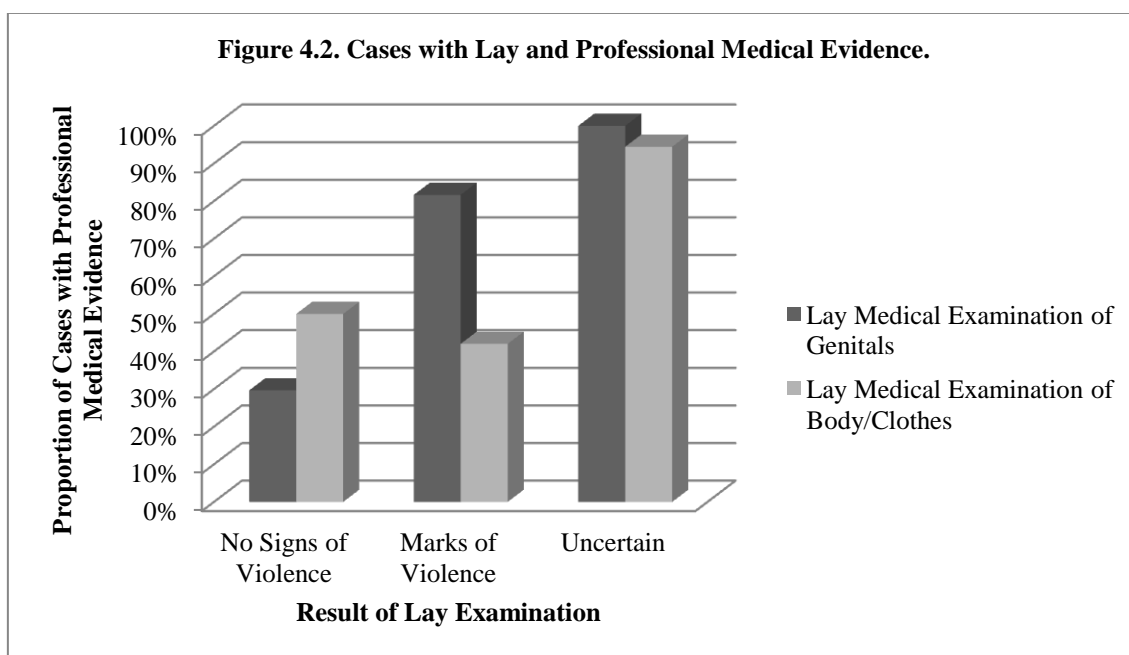
³⁶ Gloucester, GA, Pre-Trial Statements, George Watkins tried at the Gloucestershire Quarter Sessions in April 1896 for indecent assault, Q/SD/2/1896.

³⁷ London, LMA, Pre-Trial Statements, Isaac Garcia tried at the Middlesex Sessions on 5 October 1883 for indecent assault, MJ/SP/E/1883/041.

³⁸ LMA, Pre-Trial Statements, Isaac Garcia.

³⁹ Jerry White, *London in the Nineteenth Century* (London: Jonathan Cape, 2007), pp. 120-26; Jerry White, *London in the Twentieth Century* (London: Penguin Books, 2002), p. 120; Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999), p. 99; Brian Abel-Smith, *The Hospitals, 1800-1948: A Study in Social Administration in England and Wales* (London: Heinemann, 1964), p. 3.

lay medical examinations and the calling in of professional medical advice. It shows that medical advice was most commonly sought in addition to lay examinations in cases of uncertainty and when lay people noticed marks of violence on the genitals. Many medical practitioners were thus called in to corroborate or clarify lay examinations, both by the people who conducted the examination and by the police, rather than being viewed purely as an alternative to informal processes. In one such Middlesex case from 1865, a witness apparently examined her eight-year old daughter and ‘found she looked inflamed about the private parts ... I took her to the doctor’.⁴⁰ However, medical practitioners also were *not* consulted in nearly one-fifth of cases in which lay people observed signs of genital violence during their examinations. As noted above, even if they found signs of bodily harm some parents simply preferred to conduct their own informal examinations. The position of professional medical practitioners was evidently not secure. Although lay medical evidence was utilised to a lesser degree in Middlesex, local and informal networks were an important part of the pre-trial process in all areas and professional medical examinations were not necessarily the first response of a concerned parent.



The chapter’s analysis to this point partly supports Christopher Lawrence’s work on British medicine in the late-nineteenth century, which notes that ‘patients dictated

⁴⁰ London, LMA, Pre-Trial Statements, David Pearce tried at the Middlesex Sessions on 17 April 1865 for indecent assault, MJ/SP/E/1865/008.

terms' in the clinical encounter.⁴¹ However, Lawrence oversimplifies the relationship between medical practitioners and the public by reducing it to a case of one side 'dictating terms'. Medical practitioners negotiated their roles in pre-trial processes, rather than such roles either being automatic or being 'dictated' to them. Some medical practitioners approached the police or public about a suspected sexual offence rather than *vice versa*. In 1881 in Somerset, the mother of an alleged young victim of attempted carnal knowledge did not become suspicious until approached by a medical practitioner. She testified that her three-year-old daughter 'has been unwell since Christmas. She has had a discharge from her privates. She has been under the care of Mr House, Mr Farrant's assistant. Last Friday, Mr House told me something'.⁴² In consequence of information received by Mr House, seemingly in relation to the origin of her child's genital discharge, the mother made enquiries and eventually laid charges against the prisoner. Middlesex medical practitioners similarly drew the attention of parents to the possibility that a sexual offence had been committed. In a case of attempted carnal knowledge of a 10-year-old girl from 1867, the girl 'made no complaint, but became ill, and after the medical officer of the Haverstock-Hill Dispensary had treated her for some time, she disclosed the facts on 31st of December, and on the next day the prisoner was given into custody'.⁴³ In this case the girl was questioned in consequence of the medical practitioner discovering that she was suffering from syphilis. Cases in which medical practitioners discovered a crime were unusual, but their existence reinforces this chapter's claim that a suspected sexual assault could come to medical attention in a multitude of ways.

Although medical practitioners could become involved in pre-trial processes by discovering cases themselves, medical journals emphasised that medical practitioners had no right to take a case directly to the police. In March 1887 a *BMJ* correspondent asked whether a medical practitioner should 'inform the authorities' if he discovered that a 15-year-old girl had fallen pregnant.⁴⁴ The editor responded that 'we fail to recognise that it in any way devolves upon him to inform the authorities of the incident

⁴¹ Christopher Lawrence, *Medicine in the Making of Modern Britain, 1700-1920* (London: Routledge, 1994), p. 51.

⁴² Taunton, SRO, Pre-Trial Statements, George Turner not tried (no bill) at the Somerset Quarter Sessions in April 1881 for attempted carnal knowledge, Q/SR/723.

⁴³ 'Middlesex Sessions', *The Times*, 23 January 1867, 9, p. 9.

⁴⁴ 'Duties of Medical Practitioners under the Criminal Law Amendment Act', *British Medical Journal (BMJ)*, 5 March 1887, 546, p. 546.

in question. The moral obligation to do so, from our point of view, rests, *de facto*, with the aggrieved parents'.⁴⁵ It is therefore unsurprising that none of the cases studied for this thesis involved medical practitioners approaching the police directly, although there is evidence that attempts to do so were made elsewhere. In one Swansea Assizes case of a suspected incestuous offence against a child, it was reported that '[t]he information was not laid by the parents, but reported to the police by Dr Davies to whom the child had been taken for examination and treatment. The police therefore in the ordinary course took the matter up'.⁴⁶ When medical practitioners discovered a crime themselves they negotiated their pre-trial involvement in proceedings with a degree of agency, but were also dependent on the decisions taken by members of the general public and the police.

Medical practitioners not only had the agency to negotiate some involvement in pre-trial processes, but could also *remove* themselves from such processes at the earliest stages of an enquiry. Most medical practitioners had the right to refuse to conduct examinations and apparently commonly did so in cases of suspected genital injury. Although it is unclear whether any medical practitioners in Middlesex or the south-west counties took the advice given in journals and textbooks, it was certainly widespread practice to advise medical readers that they could reject unpleasant cases. These journals highlighted the inconvenience and costliness of court appearances related to such examinations.⁴⁷ In 1902, *The Lancet* reported a Suffolk indecent assault case in which 'each of the three medical men in the town where the child lived had refused to examine her on the ground that the fees allowed in connexion with criminal proceedings were inadequate'.⁴⁸ There are some indicators in trials from both regions under study that attempts to avoid attending court were a part of the negotiation process between the public and some medical practitioners, as in a 1902 Gloucestershire case where a child's mother testified that 'I telegraphed the doctor ... He examined the child. He said his evidence would not be of much use'.⁴⁹ Although surgeons who worked for the police

⁴⁵ 'Duties of Medical Practitioners', *BMJ*, p. 546.

⁴⁶ Kew, National Archives (NA), Letter from the Chief Constable (Swansea) to the Under Secretary Of State, 20 September 1899, HO 144/278/A61289.

⁴⁷ For example see Jukes de Styrup, *The Young Practitioner* (London: H.K. Lewis, 1890), p. 84; Frederick W. Lowndes, 'Venereal Diseases in Girls of Tender Age', *The Lancet*, 22 January 1887, 168-69, p. 168; 'The Home Office and Medical Witnesses' Fees', *The Lancet*, 4 May 1901, 1285-86, p. 1285.

⁴⁸ 'The Fees of Medical Witnesses in Criminal Cases', *The Lancet*, 12 July 1902, 85-86, p. 85.

⁴⁹ Gloucester, GA, Pre-Trial Statements, William Smith tried at the Gloucestershire Quarter Sessions on 15 October 1902 for indecent assault, Q/SD/2/1902.

apparently were ‘not quite so free ... to refuse all the filthy cases’ and were ‘practically compelled to take these very repulsive cases because the other practitioners decline to do so’, it is clear that nobody ‘dictated terms’ in the initial pre-trial encounter.⁵⁰

It is difficult to identify any clear patterns in the ways that cases of alleged sexual crime came to the attention of medical practitioners in Middlesex or Gloucestershire, Somerset and Devon. While the police undoubtedly played a greater and more systematic role in Middlesex, this section has shown that the extent of the professionalisation of the relationship between London medical practitioners and police should not be overstated. Members of the Metropolitan Police did not always call in a medical practitioner immediately upon being informed of an accusation, nor did they refuse to accept evidence from lay examinations in favour of professional examinations. The provincial police role was also greater than might be assumed from looking at statistics alone. Police in the south-west counties often worked with members of the general public and recommended medical practitioners to them, rather than removing themselves completely from involvement with medical aspects of criminal cases. The London-provincial divide was real but limited, as both regions demonstrated a variety of *ad hoc* processes of decision making that led to medical practitioners either being consulted or excluded from pre-trial processes.

Who? Choosing Medical Practitioners

Having considered how medical practitioners in general became aware of suspected criminal cases, this section examines which specific medical practitioners were approached to conduct examinations in cases of alleged sexual crime. It considers the influence of a medical practitioner’s qualifications or position, specialist knowledge, personal relationships, proximity from a complainant and price. This analysis reinforces the conclusions drawn above by demonstrating that divisions between police/public and London/provincial practice were not clear cut. Specific medical practitioners were rarely consulted solely on the basis of being ‘experts’ or specialists by either the police or the general public, but were selected for a range of highly variable personal and professional reasons. Trying to establish a hierarchy of factors that influenced the choice of a medical practitioner is unhelpful and arguably impossible, due to the range

⁵⁰ J. Chronnell, ‘Fees to Medical Witnesses at Assizes and Sessions’, *The Lancet*, 27 May 1899, 1455, p. 1455; ‘London: Saturday, May 6, 1899’, *The Lancet*, 6 May 1899, 1236-39, p. 1237.

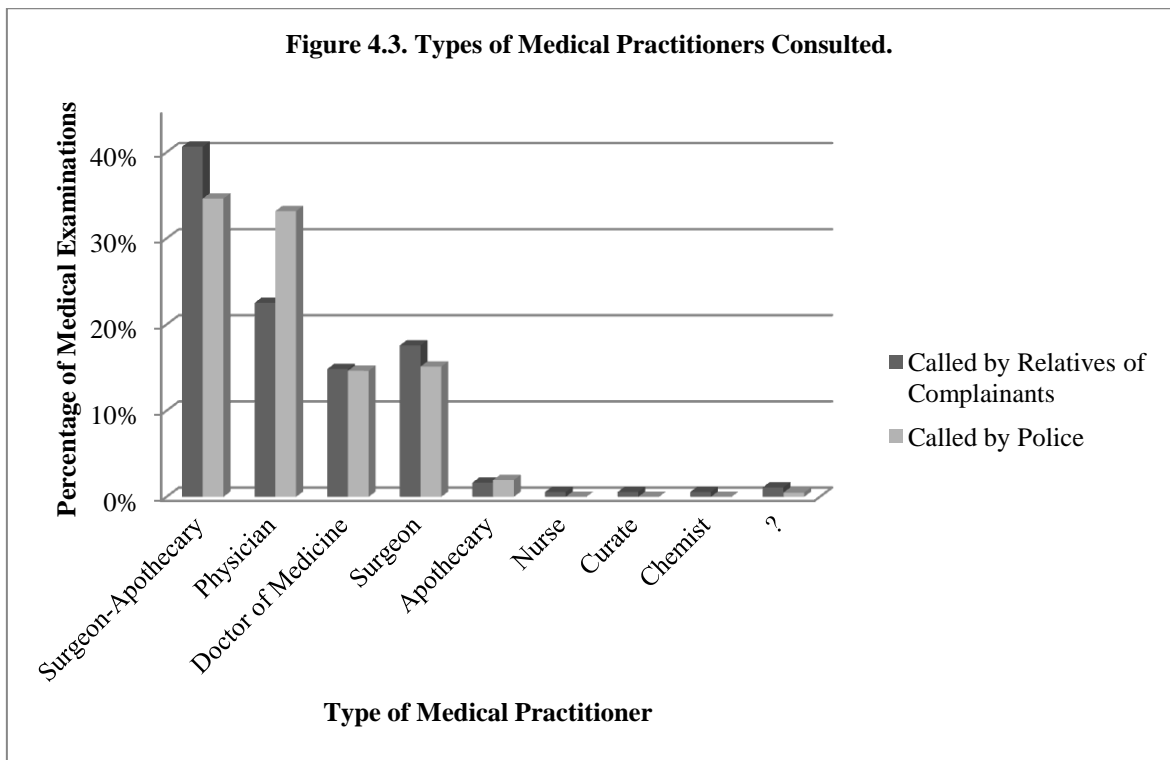
of different priorities that were held by individuals. However, this section argues that there is some value in noting that a medical practitioner's perceived 'expertise' was not the sole – or even the main – issue determining whether he was approached for advice during pre-trial investigations.

Members of the public and the police could exercise some autonomy in selecting medical practitioners. As Willemijn Ruberg notes in relation to lay medical examinations in Dutch rape cases, '[a]lthough mothers often wanted doctors to corroborate the sexual abuse, which testifies to the physicians' respected authority, women also had considerable agency when it came to choosing a doctor'.⁵¹ It is therefore significant that medical practitioners with the highest qualifications were not the most sought after in cases of suspected sexual crime, for either the police or members of the general working-class public. Figure 4.3 depicts the types of medical practitioners called in all areas under study, with a particular focus on comparing those consulted by complainants' relatives and by the police.⁵² These statistics and other discussions in this section refer only to the 602 medical practitioners who testified in court, because of the difficulty of finding biographical information about the other unnamed medical practitioners. The graph demonstrates that the highest proportion of medical practitioners called were dual qualified surgeon-apothecaries, the category of medical qualification that was usually held by general practitioners.⁵³

⁵¹ W. G. Ruberg, "'Mother Knows Best": The Transmission of Knowledge of the Female Body and Venereal Diseases in Nineteenth-Century Dutch Rape Cases' in *The Transmission of Health Practices (c. 1500 to 2000)*, ed. Martin Dinges and Robert Jütte (Stuttgart: Franz Steiner Verlag, 2001), 35-47, p. 40.

⁵² The analysis has been limited to these two groups for the purposes of clarity and comparison. Although some other categories of person (such as magistrates) occasionally called in medical practitioners, as discussed above, these two were by far the most prominent.

⁵³ For a brief overview of the early-twentieth-century transition from 'surgeon-apothecaries' to 'general practitioner' see Edward Shorter, 'Primary Care' in *The Cambridge Illustrated History of Medicine*, ed. Roy Porter (Cambridge: Cambridge University Press, 1996), 118-53, p. 126.



The graph shows little overall difference in the nature of medical practitioners consulted by the police and relatives of complainants. The only notable distinction between the two groups can be seen in the higher proportion of physicians called by the police, a finding which indicates that the police were more likely to recruit the most qualified medical practitioners. This hypothesis is partly borne out by the occasional use of non-registered medical practitioners by relatives of complainants, such as curates or nurses, but never by the police. However, such cases were extremely rare and overall distinctions between the medical practitioners called by police and relatives of complainants were not significant. Although medical practitioners called in by the police tended to have slightly higher qualifications than those called by complainants' relatives, neither group prioritised professional status as a motive for calling in a particular medical practitioner. The overall balance between surgeon-apothecaries or surgeons and those with the highest qualifications, physicians or Doctors of Medicine, was relatively even up to 1914.

The meaning of these qualifications must also be placed in a contemporary context. Recent historiography has largely rejected the notion of a Victorian tripartite medical organisation and instead emphasised that nineteenth-century professional divisions

between surgeons and physicians were ‘amorphous’ rather than ‘neatly differentiated’.⁵⁴ Michael Mason speaks for this extensive historiographical school of thought when he argues that:

[F]rom the very beginning of the nineteenth century the old division of the profession into physicians, surgeons, and apothecaries was becoming much less significant than the modern distinction between hospital-based medical men (consultants, who had bread-winning outside practices, and their trainees and assistants) and “general practitioners”.⁵⁵

Only 12 per cent of medical witnesses in Middlesex and the South West combined held hospital appointments.⁵⁶ Neither the police nor members of the general public called upon consultants with any frequency. In a few cases general practitioners referred cases to hospitals as part of the early stages of a referral system, but this was also rare and unsystematic.⁵⁷ When hospital practitioners *were* consulted it was often to seek treatment rather than specialist forensic advice.⁵⁸ In a broad sense, throughout the period and places under study, most cases of suspected sexual crime were therefore dealt with by general practitioners. Professional status cannot be viewed as a driving force for selection of medical practitioners in criminal cases, either by the police or by members of the general public.

The police and members of the public in both regions tended to consult male medical practitioners rather than female nurses or midwives. In one case from Somerset, a

⁵⁴ Peter W. J. Bartrip, *Mirror of Medicine: A History of the British Medical Journal* (Oxford: British Medical Journal and Clarendon Press, 1990), p. 5.

⁵⁵ Michael Mason, *The Making of Victorian Sexuality* (Oxford; New York: Oxford University Press, 1994), p.179. There is extensive scholarship to support Mason’s claims about the absence of a clear tripartite medical structure in the nineteenth century, although it is also important not to overstate the disparity between the structures of ‘old’ early modern and ‘new’ modern medical professions. See also: Ivan Waddington, ‘General Practitioners and Consultants in Early Nineteenth-Century England: The Sociology of an Intra-Professional Conflict’ in *Health Care and Popular Medicine in Nineteenth Century England*, ed. Woodward and Richards, 164-88, p. 168; Anne Hardy, *Health and Medicine in Britain since 1860* (Basingstoke: Palgrave, 2001), p. 14; and Lawrence, *Medicine in the Making of Modern Britain*, p. 50.

⁵⁶ This figure excludes less prestigious positions such as dispensaries, workhouse infirmaries or lying-in / maternity hospitals. However, even if all of these positions are included, the statistic remains relatively low at 22 per cent.

⁵⁷ For an example of a referral by a general practitioner to a hospital, see London, LMA, Pre-Trial Statements, John Martinitzi tried at the Middlesex Sessions on 22 March 1861, MJ/SP/E/1861/006. On the referral system see: Hardy, *Health and Medicine*, p. 14; and Rosemary Stevens, *Medical Practice in Modern England: The Impact of Specialization and State Medicine* (New Haven; London: Yale University Press, 1966), p. 36.

⁵⁸ For an example of a hospital practitioner being used in a treatment capacity see London, LMA, Pre-Trial Statements, Alfred Cox tried at the Middlesex Sessions on 24 May 1887, MJ/SP/E/1887/025. It is noteworthy that the medical practitioner who discovered an alleged sexual offence in the Somerset case, cited above, was a hospital practitioner who had been approached for treatment even before any accusation of a sexual offence had been made.

‘monthly nurse’ was consulted but only because she was the grandmother of a complainant.⁵⁹ This use of male general practitioners marked a shift from the early modern period in which females and midwives were more commonly consulted.⁶⁰ Nineteenth-century organisations like the National Vigilance Association actually strongly encouraged the use of women or female practitioners for examinations of girls’ genital areas.⁶¹ However, this policy was only followed to the degree that a female presence was required when male practitioners were conducting examinations in order to prevent indecent assault allegations against medical men. The only *active* female presence in such cases was the occasional involvement of female police searchers, who were used to examine four complainants across both regions and to observe a medical practitioner’s examination in an additional three cases. The first female police surgeon was not employed until 1927 in Manchester.⁶² Although David Vincent notes that in 1910 an official enquiry found that ‘wise women’ still worked in rural medical practice, it also apparently found that ‘this class of practice appears to be diminishing’.⁶³ This latter comment is supported by the fact that both the use of female medical practitioners and rural ‘quacks’ were almost completely absent from the cases studied for this thesis.⁶⁴ The use of medical practitioners was thus partly professionalised over time, in terms of knowledge being increasingly consolidated amongst registered male practitioners. However, this consolidation of male ‘expertise’ was not specific to sexual crime. It was the result of more general professional shifts towards the use of registered

⁵⁹ Taunton, SRO, Pre-Trial Statements, Alfred Tucker tried at the Somerset Quarter Sessions on 2 July 1890 for indecent assault, Q/SR/760.

⁶⁰ See, for example, a discussion of the uses of female midwives in early-eighteenth-century infanticide cases and the shift towards male medical witnesses from mid-century onwards in Mark Jackson, *New-Born Child Murder: Women, Illegitimacy and the Courts in Eighteenth-Century England* (Manchester: Manchester University Press, 1996), p. 70. On the extensive role of female medical practitioners in rural England in the early modern period see also William Kerwin, ‘Where Have You Gone, Margret Kennix? Seeking the Tradition of Healing Women in English Renaissance Drama’ in *Women Healers and Physicians: Climbing a Long Hill*, ed. Lillian R. Furst (Lexington: University Press of Kentucky, 1997), 93-113, p. 110. Willemijn Ruberg similarly notes that in the Dutch context ‘before the nineteenth century, midwives were ... responsible for examining women’s bodies when it came to pregnancy or rape’; Ruberg, “‘Mother Knows Best’”, p. 35.

⁶¹ Sheila Jeffreys, *The Spinster and her Enemies: Feminism and Sexuality 1880-1930* (London: Pandora, 1985), p. 60.

⁶² Jeffreys, *The Spinster and her Enemies*, p. 60.

⁶³ David Vincent, *Literacy and Popular Culture: England 1750-1914* (Cambridge: Cambridge University Press, 1989), p. 170.

⁶⁴ None of the medical practitioners in the cases under study for this thesis were female, with the exception of the nurse already cited. Records of the Medical Women’s Federation make reference to one case in which Dr Marion Elford was ‘in 1904 (or 5) ... medical witness in a case of criminal assault on a girl of 14’ in Lincoln, but such cases were rare and all women except for the medical practitioner in question were apparently instructed to leave the court; London, The Wellcome Library, Records of the Medical Women’s Federation: Women in Police Courts, 1913, SA/MWF/C/64.

surgeons rather than local ‘quacks’ or ‘wise women’. As already shown by Figure 4.3, even against this background of general but patchy professionalisation, professional status was not a primary consideration in the selection of medical practitioners in cases of a suspected sexual offence.

The issue of police surgeons provides the only significant point of disparity between medical practitioners called by the police and the general public. Police surgeons had been attached to most divisions of the Metropolitan Police since 1829, ostensibly to provide treatment for the police but also to examine prisoners or alleged victims of crime. Out of the 602 medical examinations considered in this section, 197 involved police surgeons and all but 14 of those were based in Middlesex. While the use of divisional surgeons of police was not completely absent in the provinces, particularly when police from bigger towns like Bristol were involved, their use by the Metropolitan Police was evidently far more extensive. As Jennifer Ward notes:

An organised system of police surgeons was slow to develop in the provinces ... Medical attention for the provincial police and medical witnessing in the police courts in non-serious cases seem to have been dealt with on an ad hoc basis and are little recorded.⁶⁵

Although the cases studied for this thesis indicate that provincial police surgeons both existed and were used, these roles were atypical. Police surgeons remained so rare in the provinces that in 1895 *The Lancet* reported the following speech made by the Home Secretary in response to a deputation from the United Kingdom Police Surgeons’ Association:

As to the lack in some important counties and boroughs of recognised, accessible, and generally known practitioners, not only for attendance on the force, but for cases where expert services were required, he would consider whether it was not desirable to call attention in a circular to the need of attaching to every police force some recognised police surgeon.⁶⁶

It is therefore tempting to conclude that London police took a greater interest in the ‘expertise’ of medical practitioners than the provincial police, because they often employed police surgeons and called upon them in cases of suspected sexual crime. However, even police surgeons’ roles were not systematic or consistent across Metropolitan Police forces. A surviving list of divisional surgeons for the K Division of

⁶⁵ Jennifer Ward, ‘Origins and Development of Forensic Medicine and Forensic Science in England 1823-1946’, unpublished doctoral thesis, Open University (1993).

⁶⁶ ‘The Grievances of Police Surgeons’, *The Lancet*, 19 January 1895, 194-95, p. 194.

the Metropolitan Police, which covered the Stepney region of Middlesex, included nine different medical practitioners who were each attached to a specific police station in 1892.⁶⁷ In the period 1850-89, only three of these police stations had called in their respective police surgeons in cases of suspected sexual crime.⁶⁸ However, those police stations that called upon their divisional surgeons did so regularly. Matthew Brownfield was called by the Poplar police, part of the K division, 12 times between 1864 and 1889. Some police stations used police surgeons systematically and regularly, others on an *ad hoc* basis and others not at all in criminal cases. As emphasised throughout this chapter, distinctions between Middlesex and the south-west counties were less significant than they first appear. The use of police surgeons in Middlesex was far more prevalent than in the provincial counties, but was by no means uniform or automatic.

Police surgeons' 'expertise' was also not as great as might be assumed, which further emphasises a need for caution when making claims about distinctions between London and provincial status of medical practitioners. As The Commissioner of Police of the Metropolis commented that 'the appointment is much sought after', police surgeons had to compete for their roles and therefore were by no means poorly qualified.⁶⁹ However, they were used widely in all kinds of criminal cases and were not specialists in cases of suspected sexual crime. George Bagster Phillips, the most commonly-used police surgeon in the cases studied for this thesis, was called upon in a range of criminal cases and is perhaps best known for conducting post-mortem examinations of 'Jack the Ripper' victims.⁷⁰ Undoubtedly police surgeons had more experience than other practitioners in suspected sexual assault cases, as they were the most likely to be consulted on multiple occasions. The only medical practitioner from Gloucestershire, Somerset and Devon who testified more than three times was a surgeon to Lawford's Gate Police Division, who gave evidence at the Gloucestershire Quarter Sessions seven times between 1891 and 1906. Similarly, the 21 Middlesex medical practitioners who gave evidence more than five times were all police surgeons. However, their medico-legal roles were broad and operated in conjunction with other disparate duties such as

⁶⁷ Kew, NA, Divisional Surgeons: Remuneration, 1893, HO 45/16016.

⁶⁸ After 1889, county boundary changes meant that this district was no longer part of Middlesex. Although some of these surgeons would have changed over the years, only one K division surgeon referred to in the depositions differed from the list provided in 1892.

⁶⁹ NA, Divisional Surgeons: Remuneration.

⁷⁰ Angus McLaren, *The Trials of Masculinity: Policing Sexual Boundaries, 1870-1930* (Chicago: University of Chicago Press, 1997), p. 281 n. 105.

treating sick police and assessing levels of drunkenness. The most-consulted medical practitioner in all cases under study testified at the Middlesex Sessions 13 times in 19 years, thus the degree of their on-the-job contact with suspected sexual assault cases was limited. Police surgeons were often not ‘experts’ but rather medical practitioners who had succeeded in consolidating their knowledge of medico-legal issues by gaining more regular practical experience of criminal cases.

Middlesex medical practitioners theoretically had access to superior resources, but there was still little formalisation of procedure or of laboratory work in cases of suspected sexual crime during the Victorian and Edwardian years. Although Ivan Crozier and Gethin Rees state that the microscope provided ‘[a] trump card that doctors could use in the establishment of medical expertise’ in nineteenth-century sexual assault cases, the trials examined for this study indicate that microscopic analysis was largely left to general practitioners who often lacked access to the necessary resources.⁷¹ Only six per cent of the provincial and four per cent of the Middlesex medical witnesses made any form of microscopic analysis. These rare cases involved the few medical practitioners who owned microscopes themselves or who had hospital appointments. London medical practitioners could potentially make use of professional specialist bodies like the Clinical Research Association for analysis of samples, such as suspected semen or discharges from venereal disease. This diagnostic strategy was utilised in a Central Criminal Court case from 1900, in which the gonorrhoeal gonococcus was identified after a sample of a complainant’s discharge was sent away for examination.⁷² The case has been cited by Louise Jackson as demonstrating a procedure that ‘revolutionised the interpretation of medical evidence’.⁷³ However, such diagnosis was not as widespread or ‘revolutionary’ as Jackson implies. A 1907 Metropolitan Police memorandum explicitly stated that, in sexual offence cases, ‘I think it would be undesirable to refer the analysis to bodies such as the Clinical Research Association’.⁷⁴ English police had no access to in-house forensic laboratories until the late 1930s, when the Metropolitan Police Laboratory and regional police laboratories funded by the Home Office were

⁷¹ Ivan Crozier and Gethin Rees, ‘Making a Space for Medical Expertise: Medical Knowledge of Sexual Assault and the Construction of Boundaries between Forensic Medicine and the Law in late Nineteenth-Century England’, *Law, Culture and the Humanities* 8 (2012), 285-304, p. 300.

⁷² Kew, NA, Florence Kennard tried at the Old Bailey on 12 March 1900 for Indecent Assault, CRIM 1/60/2.

⁷³ Jackson, ‘Child Sexual Abuse and the Law’, p. 170.

⁷⁴ Kew, NA, Expert Witnesses and Medical Fees, 1907, MEPO 2/314.

formed.⁷⁵ It was not until the 1980s that the police began to use specific ‘rape examination suites’, which formalised the collection of samples to be sent for laboratory examination and analysis in cases of suspected sexual crime.⁷⁶

The late-nineteenth-century alternative to these professional laboratory processes was for the Metropolitan Police to recruit a ‘medico-legal expert’ or a ‘forensic expert’ who was not a police surgeon.⁷⁷ This role indicates some London-specific formalisation of medical ‘expertise’ in criminal cases, but it only related to ‘exceptional’ cases of ‘a grave nature’.⁷⁸ In 1888 the position was allocated to Thomas Bond who was a lecturer in forensic medicine at Westminster Hospital, but he was only called to cases tried at the Central Criminal Court. Before this appointment and after Bond’s death in 1901 the onus for examinations of complainants in criminal cases continued to fall on general police surgeons, who openly acknowledged the limits of their own ‘expertise’. In 1907 the Metropolitan Police Chief Surgeon wrote a memo complaining that ‘since Mr Bond’s death ... no one has been definitely recognised as replacing him and inconvenience has occasionally arisen in consequence’.⁷⁹ He stated that ‘more expert testimony than the average Divisional Surgeon appears to me to become necessary’ in cases of sexual crime.⁸⁰ The Superintendent of the Metropolitan Police supported the Chief Surgeon’s comments, noting that ‘it would be a great advantage for us to have an expert to whom we could refer the more difficult cases’.⁸¹ He also observed that police surgeons lacked experience in cases of sexual crime and did not have the requisite time or skill to conduct microscopic examinations.⁸² However, there is no evidence that this ‘expert’ role was filled by 1914 and it certainly was never used in mid-level trials such as the Middlesex Sessions. The use of specialists thus remained largely unsystematic in cases of suspected sexual crime throughout the period under study.

⁷⁵ Brian Caddy and Peter Cobb, ‘Forensic Science’ in *Crime Scene to Court: The Essentials of Forensic Science*, ed. Peter White, 2nd edn (Cambridge: The Royal Society of Chemistry, 2004 [1998]), 1-20, pp. 5-6; William J. Tilstone, Kathleen A. Savage and Leigh A. Clark, *Forensic Science: An Encyclopedia of History, Methods, and Techniques* (Santa Barbara, CA: ABC-CLIO, 2006), p. 28.

⁷⁶ Jo Lovett, Linda Regan and Liz Kelly, *Sexual Assault Referral Centres: Developing Good Practice and Maximising Potentials*, Home Office Research Study 285 (London: HMSO, 2004), p. 5.

⁷⁷ Kew, NA, Letter from the Chief Surgeon, Metropolitan Police Force, to Sir C. Warren, 1 November 1888, HO 45/9685/A48384/8; Kew, NA, Expert Witnesses and Medical Fees, 1893, MEPO 2/314.

⁷⁸ Kew, NA, Expert Witnesses and Medical Fees, 1907.

⁷⁹ Although ‘A. J. Pepper, M.B., F.R.C.S.’ was suggested as a replacement in 1903, cases of suspected sexual crime apparently were not referred to him; NA, Expert Witnesses and Medical Fees, 1907.

⁸⁰ NA, Expert Witnesses and Medical Fees, 1907.

⁸¹ NA, Expert Witnesses and Medical Fees, 1907.

⁸² NA, Expert Witnesses and Medical Fees, 1907.

To this point the analysis has shown that, in the cases studied and more generally, both the police and members of the public called upon general practitioners rather than consulting specialist ‘experts’ to whose authority they automatically deferred. This use of generalists related to a broader suspicion of ‘the vice of specialism’ which, with the exception of a few key fields such as ophthalmology and gynaecology, was associated with quackery and only gradually integrated into mainstream practice in the early-twentieth century.⁸³ Even hospital consultants were typically generalists throughout the Victorian and Edwardian years.⁸⁴ As already discussed extensively in the first half of the thesis, psychiatry was a nascent specialism in the nineteenth century. In line with this general context, not a single alienist or specialist in mental health was consulted in the cases studied.⁸⁵ Other specialisms were similarly under-represented in the courts, even as they became gradually accepted outside them. Examining the *Medical Directory* for all medical practitioners who testified in the Middlesex and south-west trials indicates that few medical witnesses had specialist knowledge relevant to sexual crime. Only six *Medical Directory* entries for the 602 medical practitioners made reference to publications in the field of forensic medicine, of which five related to murder and one to sexual offences. A further 10 medical practitioners had published in the field of midwifery and childbirth, indicating a very small degree of gynaecological and obstetrical specialist knowledge. Occasional forms of specialism can be also identified in Middlesex cases in which, for example, a lecturer on chemistry was consulted in 1870. In the south-west counties, an assistant medical inspector of schoolchildren and a ‘prizemedallist in forensic medicine’ were consulted in 1911 and 1897 respectively. However, such cases were atypical and it remains unclear whether the ‘expertise’ of these practitioners was actually relevant to their selection.

⁸³ James Fernandez Clarke, *Autobiographical Recollections of the Medical Profession* (London: J. & A. Churchill, 1874), p. 67; Digby, *The Evolution of British General Practice*, pp. 289-90; Lawrence, *Medicine in the Making of Modern Britain*, p. 46; Julie-Marie Strange, “‘I Believe It to Be a Case Depending on Menstruation’”: Madness and Menstrual Taboo in British Medical Practice, c. 1840-1930’ in *Menstruation: A Cultural History*, ed. Andrew Shail and Gillian Howie (Basingstoke: Palgrave Macmillan, 2005), 102-16, p. 103.

⁸⁴ Stevens, *Medical Practice in Modern England*, p. 32.

⁸⁵ The few cases with an insanity defence involved either ‘common sense’ testimony about a prisoner’s mental state or the testimony of a medical generalist, such as a medical practitioner who had regularly treated the prisoner or a prison surgeon who had observed his behaviour.

The example of paediatrics is worthy of closer consideration, as a specialism that made some inroads into mainstream medicine during the period under study but that was not drawn upon extensively in cases involving sexual assaults of children. Although British paediatrics as a *profession* emerged in the nineteenth century, it had only partial success in shaping medical practice before the inter-war period.⁸⁶ During the Victorian and Edwardian periods, specialist children's hospitals and specialist practitioners in children's healthcare were emerging throughout the country.⁸⁷ Most major developments occurred in London, where 16 children's hospitals were founded between 1850 and 1910, but Anne Digby also notes the development of specialist children's hospitals in 24 provinces in the same period.⁸⁸ Children's wards were also developed in some general hospitals, such as in Exeter in 1860, which means that many of the parents and police in cases of children's illnesses or suspected sexual assault would have had access to specialists in child health.⁸⁹ However, the cases from Middlesex and the provinces indicate that this specialist knowledge was rarely drawn upon. Across both regions only 19 medical practitioners with experience in children's hospitals were ever consulted in cases involving complainants between the ages of two and 12, which was the age group classified as 'paediatric' by the London Hospital for Sick Children from 1851.⁹⁰ Only two cases indicate that medical practitioners were consulted specifically for their specialist knowledge of children rather than on the basis of other roles, for example as police surgeons. In one, a mother took her nine-year-old daughter to a Middlesex children's hospital in 1885 upon discovering a discharge on the girl's linen.⁹¹ In another Middlesex case, a Physician to the Samaritan Free Hospital for Women and Children testified in 1884 that 'I have had great experience in this branch'.⁹² Even in this case, however, the medical practitioner stated that his specialist knowledge was

⁸⁶ Stevens, *Medical Practice in Modern England*, p. 48.

⁸⁷ On the emergence of children's hospitals see: Elizabeth Lomax, *Small and Special: The Development of Hospitals for Children in Victorian Britain* (London: Wellcome Institute for the History of Medicine, 1996); and Eduard Seidler, 'An Historical Survey of Children's Hospitals' in *The Hospital in History*, ed. Lindsay Granshaw and Roy Porter (London: Routledge, 1989), 181-97.

⁸⁸ Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911* (Cambridge: Cambridge University Press, 2002), p. 286.

⁸⁹ Digby, *Making a Medical Living*, p. 286.

⁹⁰ Out of those who conducted 289 medical examinations of children in this age group in Middlesex: 273 had never held a position in a specialist children's institution; three had held a former but not a current position in a children's institution; two worked in a children's home; four worked in a women and children's hospital; and six worked in a children's hospital, infirmary or dispensary. The figures for 136 comparable cases in Gloucestershire, Somerset and Devon were: 132, three, zero, zero and one.

⁹¹ London, LMA, Pre-Trial Statements, Alfred Lynham tried at the Middlesex Sessions on 12 August 1885 for indecent assault, MJ/SP/E/1885/040.

⁹² LMA, Pre-Trial Statements, Charles Robert Hallett.

because ‘I am physician to ... the Female Protection Society’ rather than citing his experience with children.⁹³

As this analysis has conclusively shown that perceived ‘expertise’ or specialist knowledge were not the primary issues driving the selection of medical practitioners for consultation in cases of suspected sexual assault, it becomes important to consider other influencing factors. The subject of personal relationships raises the possibility of an alternative kind of medical authority, built through trust rather than perceived knowledge or experience. Christopher Lawrence argues that ‘[i]n the Victorian age, if he was lucky, a doctor might be adopted by a family of paying patients and, unless specialist help were required, he might be the only practitioner ever called to the household’.⁹⁴ Personal relationships were undoubtedly relevant to the selection of medical practitioners, particularly for members of the public and in sensitive cases involving examinations of children. The Devon mother of a 10-year-old complainant stated in 1870 that ‘Dr Laity now present is my doctor’ and another medical practitioner in a Somerset case from 1871 commented that ‘I have attended [the complainant] some years’.⁹⁵ Similarly, a mother in a Middlesex case from 1860 took her daughter to the same medical practitioner who had earlier attended her for scarlet fever and another Middlesex parent stated in 1869 that ‘I had her examined by our doctor’.⁹⁶ A few medical practitioners from both regions were also from medical families, such as the Somerset Farrants and the Middlesex Garmans, and may have been called upon as a result of being generally known in a region.⁹⁷ However, Anne Digby rightly emphasises that selecting one-off examples can ‘create a misleading stereotype that over-estimates the incidence of family based practice’.⁹⁸ The use of ‘family doctors’ was arguably as patchy as the influence of specialism or ‘expertise’, as members of the general public were equally likely to go to any local medical practitioner or to use a medical

⁹³ LMA, Pre-Trial Statements, Charles Robert Hallett.

⁹⁴ Lawrence, *Medicine in the Making of Modern Britain*, p. 52.

⁹⁵ Devon, DRO, Pre-Trial Statements, George Menheneot tried at the Devon Quarter Sessions on 20 October 1870 for carnal knowledge, QS/B/1870/Michaelmas; Taunton, SRO, Pre-Trial Statements, Abraham Escott tried at the Somerset Quarter Sessions on 28 June 1871 for assault with intent to commit a rape, Q/SR/684.

⁹⁶ London, LMA, Pre-Trial Statements, Thomas Swigg tried at the Middlesex Sessions on 27 April 1860 for attempted carnal knowledge, MJ/SP/E/1860/009; London, LMA, Pre-Trial Statements, Robert Lord tried at the Middlesex Sessions on 9 December 1869 for attempted carnal knowledge, MJ/SP/E/1869/025.

⁹⁷ Local medical families were common at this time, see Ann Adams, *The Budds of North Tawton: A 19th Century Devon Medical Family* (Addlestone: Hayne Books, 2010).

⁹⁸ Digby, *The Evolution of British General Practice*, p. 77.

practitioner recommended by the police. Some medical practitioners also indicated no former knowledge of a child. In one Gloucestershire case from 1869, a surgeon stated that '[a] little girl I believe to be Ellen Williams was brought by her mother to be examined'.⁹⁹ This case took place only a year before the two cases cited above in which provincial 'family doctors' were called, which shows that a range of relationships between medical practitioners and patients coexisted within similar contexts.

The choice of medical practitioner was not only linked to different forms of deference to medical opinion, such as 'expertise' or personal relationships, but also to pragmatic concerns. The cost of medical practitioners was an important practical consideration for members of the working classes, as Digby has noted the existence of 'widespread fear of the uncertain cost of a consultation' and commented that '[p]atients valued, but were not always prepared to pay for, the services of a general practitioner'.¹⁰⁰ Discussions of medical fees were not uncommon in pre-trial statements, as defendants often offered to pay for them in order to settle the matter, and in 1882 the grandmother of one Middlesex complainant explicitly stated that 'I went to the cheapest doctor'.¹⁰¹ The issue of cost may also explain why few members of working-class families sought a second medical opinion, unless they were particularly dissatisfied with the first consultation.¹⁰² Other practical issues such as proximity were also relevant to the selection of medical practitioners, although never as a sole consideration. As Joseph Melling and Bill Forsythe note in relation to the committal of people to asylums in the nineteenth century, 'physical distance ... did influence the calculations ... though we would stress the importance of a range of personal, family and institutional considerations which affected decisions'.¹⁰³ Clusters of medical practitioners often lived at similar distances from complainants in both Middlesex and the provinces, meaning that the selection of a medical practitioner could not have been based on distance

⁹⁹ Gloucester, GA, Pre-Trial Statements, John Hill tried at the Gloucestershire Quarter Sessions on 20 October 1869 for indecent assault, Q/SD/2/1869.

¹⁰⁰ Digby, *The Evolution of British General Practice*, p. 22.

¹⁰¹ London, LMA, Pre-Trial Statements, Edwin Kew tried at the Middlesex Sessions on 28 February 1882 for indecent assault, MJ/SP/E/1882/008.

¹⁰² See the first section of this chapter for examples of complainants' relatives who sought a second opinion when they felt unsatisfied with an initial medical examination.

¹⁰³ Joseph Melling and Bill Forsythe, *The Politics of Madness: The State, Insanity, and Society in England, 1845-1914* (London: Routledge, 2006), p. 77.

alone.¹⁰⁴ However, as all medical witnesses consulted by parents lived within two miles of Middlesex complainants and five miles of provincial complainants, distance was clearly an influence upon their choice of medical practitioner.¹⁰⁵ The fact that Middlesex parents often called upon medical practitioners who lived as nearby as the next street indicates that proximity was a significant consideration in a perceived emergency situation. Distance was an even greater concern for complainants who lived in remote areas because, although medical practitioners were increasingly mobile, most relatives of complainants still took their child for a physical examination rather than calling for a house visit.¹⁰⁶ In a Devon case from 1852 a curate who conducted a medical examination testified that:

I am the Curate of Hockworthy. On Wednesday afternoon last between 1 and 2 o'clock Elizabeth Milton brought her child Mary Ann Milton to me and requested me to examine her person which I did (there being no Surgeon living within 5 or 6 miles).¹⁰⁷

The mother's decision not to call a qualified medical practitioner in this case was explicitly based on distance, demonstrating that there was a maximum that some members of the public were willing or able to travel for professional care. The decision to call a curate rather than draw upon local networks may have been due to the clergy's trusted position within the local community and perceived general links between the priesthood and healing, as curates or priests did not commonly administer medicine in

¹⁰⁴ According to analysis of the *Medical Directory*, only 11 per cent of medical practitioners consulted in Gloucestershire, Somerset and Devon were the only medical practitioners in their location. When complainants from these south-west counties lived in a town with medical practitioners there was a mean average of 19 medical practitioners to choose from. When no medical practitioners lived in the same town and they were examined by a medical practitioner from elsewhere, there was a mean average of 13 medical practitioners to choose from in the selected location.

¹⁰⁵ An address was not available for either the medical practitioner or complainant in 7 Middlesex cases but in no cases called by relatives from Gloucestershire, Somerset and Devon, as the latter cases are calculated broadly by town/village rather than by specific address as in London. Of the 100 Middlesex medical practitioners known to have been called by relatives and for whom an address was available, 96 lived within one mile of the complainant and all lived within two miles. Similar calculations for the 75 comparable medical practitioners from Gloucestershire, Somerset and Devon show that 46 lived within a mile, 60 within two miles, 70 within three miles and all within five miles. Distance was not such a significant obstacle for the police, but pragmatic issues were relevant for all parties involved in the pre-trial process. The maximum distance travelled to or by medical practitioners called by the police was 2.8 miles in Middlesex and 5.3 in Gloucestershire, Somerset and Devon.

¹⁰⁶ Only 49 of the 602 medical examinations were conducted at a complainant's home. For discussions of nineteenth-century medical travel see: Irvine Loudon, 'Doctors and Their Transport, 1750-1914', *Medical History* 45 (2001), 185-206; Digby, *The Evolution of British General Practice*, pp. 144-47; and Digby, *Making a Medical Living*, p. 7.

¹⁰⁷ Exeter, DRO, Pre-Trial Statements, John Dorman tried at the Devon Quarter Sessions on 8 June 1852 for assault with intent to commit a rape, QS/B/1852/Midsummer.

the Victorian period.¹⁰⁸ As argued throughout this chapter the decision to validate a person's medical authority was taken on the basis of a range of factors, not only their 'expertise'.

In her doctoral thesis on Middlesex 'child sexual abuse' trials, Louise Jackson distinguished between 'police surgeons ... hospital house surgeons (who might provide a second medical verdict in especially difficult cases) ... [and] GP's in private practice (who might be called if the divisional surgeon was unavailable)'.¹⁰⁹ She has also elsewhere stated that '[u]ntil the 1860s, when police surgeons were regularly consulted, the responsibility lay with complainants to go in search of a doctor'.¹¹⁰ However, this section has argued that the impetus for calling a specific medical practitioner or type of medical practitioner was not as clear cut as Jackson implies.¹¹¹ There was no sudden shift towards a more systematic use of police surgeons in the 1860s, nor was there a procedure in which police surgeons were always consulted before hospital surgeons or GPs. Although the use of police surgeons was undoubtedly more widespread in London than in the provinces, their use varied between members of the police force. Members of the public were even less systematic in selecting medical practitioners as they were influenced by a changeable hierarchy of considerations such as personal relationships, proximity and cost. For both the police and members of the public, medical 'expertise' was not necessarily the primary motive behind calling upon certain medical practitioners. Furthermore, the distinction between the specific medico-legal knowledge of police surgeons and other practitioners was not as significant as might be expected. The partial nature of medical 'expertise' in pre-trial processes explains why deference was not automatic and why medical roles had to be negotiated. This question of how medical practitioners' opinions were used, or ignored, forms the final section of this chapter.

¹⁰⁸ Clergy had worked in medical practice in the medieval period but such roles were apparently eliminated from the year 1300 onwards, too long before the period under study to have any sense that such roles remained even informally; Michael R. McVaugh, *Medicine before the Plague: Practitioners and their Patients in the Crown of Aragon, 1285-1345* (Cambridge: Cambridge University Press, 2002 [1993]), p. 74; Katharine Park, 'Medicine and Society in Medieval Europe, 500-1500' in *Medicine in Society: Historical Essays*, ed. Andrew Wear (Cambridge: Cambridge University Press, 1992), 59-90, p. 77.

¹⁰⁹ Louise A. Jackson, 'Child Sexual Abuse and the Law', p. 66.

¹¹⁰ Louise A. Jackson, *Child Sexual Abuse in Victorian England* (London: Routledge, 2000), p. 78.

¹¹¹ Jackson's cases were only sampled at five-year intervals, partly explaining why these conclusions (from examining all cases during the time period) differ.

Why? Using Medical Practitioners

This section focuses on medical roles in shaping the various stages of decision making that preceded a case reaching trial, with particular attention to decisions about whether or not to pursue a prosecution. It largely leaves aside the specific content of medical practitioners' testimony, which is addressed in full detail in the next chapter, in order to examine these medical roles in a broad sense. It shows that medical advice could influence pre-trial processes in a range of formal and informal ways, the latter of which was part of a more general use of discretion by police and members of the public. Overall, the section's analysis consolidates other conclusions reached in this chapter by showing that medical roles in pre-trial decision making were not automatic. Medical advice was relevant throughout and in all regions, but was neither used in a consistent way nor prioritised over other considerations.

The police regularly took up prosecutions by the late-nineteenth century in the absence of a public prosecutor, but Jennifer Davis rightly notes that the majority of police prosecutions were for theft or 'victimless crimes'.¹¹² Conversely, in the kind of cases studied for this thesis, prosecutions were also commonly pursued by members of the working-class public. Although The Associate Institution for Enforcing and Improving the Laws for the Protection of Women prosecuted on behalf of the poorest complainants, members of the public generally still initiated proceedings and consulted medical practitioners in such cases.¹¹³ Due to the hidden nature of sexual offences, such crimes often came to the attention of relatives of complainants before the police or protection societies. Some relatives of complainants even applied for a summons at magistrates' courts before taking a case to the police station.¹¹⁴ Medical practitioners were part of these early processes of decision making, as 19 per cent of medical witnesses at the Middlesex Sessions and 18 per cent at the south-west counties' Quarter Sessions were approached before a criminal charge was taken to the police. Such a

¹¹² Davis, 'Prosecutions and Their Context', p. 420.

¹¹³ Only one medical witness from all of the cases under study was consulted directly by a child protection officer. For evidence that parents often still called medical practitioners and initiated proceedings in cases prosecuted by the Institution, see 'Middlesex Sessions', *The Times*, 29 September 1857, 9, p. 9. On the Associate Institution for Enforcing and Improving the Laws for the Protection of Women, see M. J. D. Roberts, *Making English Morals: Voluntary Association and Moral Reform in England, 1787-1886* (Cambridge: Cambridge University Press, 2004), p. 160.

¹¹⁴ A summons was generally necessary, as the police could only make an arrest without one if they personally had 'good reason to believe' that an assault had been committed; Davis, 'Prosecutions and Their Context', p. 400; Miller, *Cops and Bobbies*, p. 66.

strategy may have been linked to the problematic relationship between the ‘new police’ and some members of the working classes, who preferred to take matters into their own hands where possible.¹¹⁵ Members of the public also often showed little awareness of the possibility of police prosecutions, as one Gloucestershire mother commented in 1891 that she waited a month to take proceedings because ‘I hadn’t money to pay for the summons or warrant’ and a Middlesex mother stated in 1882 that ‘I didn’t lock him up as I thought it would cost me money’.¹¹⁶ Because both police and members of the public made choices about pursuing prosecutions, both groups will be considered in this analysis of how medical practitioners were used to guide such decisions.

Clive Emsley notes that ‘[d]iscretion in matters relating to crime began well before the legislators and the courts; and policemen were not, generally, the initiators of the processes designed to control criminal behaviour’.¹¹⁷ At the earliest stage of criminal proceedings, relatives of complainants often needed to decide whether to pursue a prosecution or to use their discretion to deal with cases informally. As Jennifer Davis has shown, ‘prosecuted law-breaking represented only a tiny proportion of similar behaviour which for various reasons never reached the courts’.¹¹⁸ Although it is difficult to find evidence for informal processes, some pre-trial statements highlight the ways in which medical practitioners were used outside the official judicial process. There are signs that members of the working-class public continued to resolve criminal cases informally throughout the period under study. A written statement by a Gloucester Police Superintendent in 1914, for example, described one case as follows:

¹¹⁵ For some of the many historical discussions of relationships between the public and the ‘new police’, which were problematic but not entirely grounded in conflict, see: Barbara Weinberger, ‘The Police and the Public in Mid-Nineteenth Century Warwickshire’ in *Policing and Punishment in Nineteenth-Century Britain*, ed. Victor Bailey (London: Croom Helm, 1981), 65-93, pp. 65-71; Louise A. Jackson, ‘Family, Community and the Regulation of Child Sexual Abuse: London, 1870-1914’ in *Childhood in Question: Children, Parents and the State*, ed. A. Fletcher and S. Hussey (Manchester: Manchester University Press, 1999), 133-51, p. 137; and V. A. C. Gatrell, ‘The Decline of Theft and Violence in Victorian and Edwardian England’ in *Crime and the Law: The Social History of Crime in Western Europe since 1500*, ed. V. A. C. Gatrell, Bruce Lenman and Geoffrey Parker (London: Europa, 1980), 238-70, p. 249.

¹¹⁶ Gloucester, GA, Pre-Trial Statements, William Groves, Frederick Ellway and William Baker tried at the Gloucestershire Quarter Sessions on 21 October 1891 for indecent assault, Q/SD/2/1891; London, LMA, Pre-Trial Statements, Edward Clark tried at the Middlesex Sessions on 10 August 1882 for indecent assault, MJ/SP/E/1882/033. For another similar example of references to cost see Gloucester, GA, Pre-Trial Statements, Henry Jones tried at the Gloucestershire Quarter Sessions on 3 January 1906 for indecent assault, Q/SD/2/1906.

¹¹⁷ Clive Emsley, *Crime and Society in England, 1750-1900*, 3rd edn (Harlow: Longman, 2005 [1987]), p. 16.

¹¹⁸ Davis, ‘Prosecutions and Their Context’, p. 400.

I called upon Mr Edward Pick of the Woodlands, Stinchcombe, who informed me that the above named man [Thomas] went to lodge with him in the early part of the year 1909. He had been there about 9 months when his son Albert, then 11 years of age, made a complaint to him of having been indecently assaulted by Thomas, in consequence of which he took him to Dr Dale Roberts of Dursley, who examined him, and found the lad's person was very red & sore from abuse. Mr Pick never reported the matter, but ordered Thomas to leave his premises at once which he did.¹¹⁹

The decision not to prosecute in this case may have been a consequence of the complainant being male and the crime in question being 'attempted buggery', as sodomitic acts were conceptualised as particularly shameful and 'unnatural' in the Victorian and Edwardian years.¹²⁰ As Louise Jackson notes, although all male-male and adult-child sex was deemed 'unnatural' in the late-nineteenth century, 'the assault of boy children was doubly "unnatural" because of the combined stigma of gender and age'.¹²¹ This case is only known about because it later reached trial by other means, but raises the possibility that similar cases may have gone unreported. It thus provides a partial explanation for the low proportion of cases at trial involving male victims, both with and without medical evidence. Although there is no evidence that the physician Dale Roberts actively encouraged informal sanctions, the boy's father used his testimony to inform a decision to evict the suspected offender from his premises rather than prosecute. Roberts may not have had control over how his observations were received or used, but in this case his word was taken as authoritative.

Similar trends can be identified in the context of incest cases, which were also seemingly more likely to be dealt with informally than other types of case. In one notable Devon case from 1871, an 11-year-old girl was apparently 'carnally known' by her brother who was 10 years older than her.¹²² Both being immediate blood relatives and children of the same mother, who may have feared the shame that such a case

¹¹⁹ Gloucester, GA, Pre-Trial Statements, Walter Thomas tried at the Gloucestershire Quarter Sessions on 21 October 1914 for attempted buggery, Q/SD/2/1914.

¹²⁰ Taylor's work stated that 'sodomy is commonly understood to signify unnatural intercourse between man and man'; Alfred Swaine Taylor, *The Principles and Practice of Medical Jurisprudence*, ed. Thomas Stevenson, 4th edn, vol. 2 (London: J. & A. Churchill, 1894 [1865]), p. 469.

¹²¹ Jackson, *Child Sexual Abuse*, p. 102.

¹²² Exeter, DRO, Pre-Trial Statements, Henry Clarke tried at the Devon Quarter Sessions on 19 October 1871 for carnal knowledge, QS/B/1871/Michaelmas.

would bring upon the family, a charge was not immediately pursued.¹²³ Instead, the mother testified that:

I took her to Cullompton to Mr Blanchard a Chemist who gave me some medicine for her, which I gave her. I saw some marks of corruption on her linen before I took her to Mr Blanchard's. I told the prisoner, who is my son, of it and he denied it. I don't remember what I said to him. I told him what the child told me. I said "Oh Harry what have you done, you've injured the girl". He denied it. I did not like to say anything about it to anyone. I told my son he had given his sister the disease ... I sent her out to Mrs Pearce to live afterwards. I thought she was then cured.¹²⁴

In this case a chemist was used to treat the girl rather than to examine her or to provide any support for a criminal case. The case eventually came to police attention in a complex way. The son of Mrs Pearce, who was seemingly no relative of the complainant or prisoner, acquired gonorrhoea and was taken to a local general practitioner for treatment. This medical practitioner then examined the girl and found that she also still had gonorrhoea, which brought the whole case to light. The question of how Mrs Pearce's 'little boy' acquired gonorrhoea was never addressed in this case, but it still provides an important example of the range of informal ways in which medical practitioners were used by members of the public after an alleged sexual crime. Although it is difficult to know the extent and nature of cases in which no formal prosecutions were pursued, in the Middlesex and south-west trials parents were apparently most likely to use medical advice to guide informal sanctions in cases involving pederasty and close family incest.

Medical practitioners also became part of negotiations between complainants' relatives and the accused in the context of other types of sexual crime. Two Middlesex pre-trial statements, both of which involved accusations against lodgers in the house of the complainant, reported that '[the prisoner] said if I took her to the doctors he would pay the expenses if I did not let it go any further' and that 'the prisoner said Pray Charlie don't lock me up, I'll pay anything, I'll pay the doctor's bills if you'll not lock me up'.¹²⁵ Such informal settlements between parties who knew each other were even

¹²³ On the 'exposure, shame, cowardliness and humiliation associated with incest' see Jackson, *Child Sexual Abuse*, p. 121.

¹²⁴ DRO, Pre-Trial Statements, Henry Clarke.

¹²⁵ London, LMA, Pre-Trial Statements, Robert White tried at the Middlesex Sessions on 22 January 1867 for carnal knowledge, MJ/SP/E/1867/002; London, LMA, Pre-Trial Statements, James Potter tried at the Middlesex Sessions on 18 June 1867 for indecent assault, MJ/SP/E/1867/011. For a south-west

actively encouraged by some medical practitioners. In one Middlesex case from 1869 involving an accusation against a local shopkeeper, a general practitioner testified that the ‘complainant told me she would not take £1000 to compromise the matter – I recommended casually a settlement, and £10 was mentioned. I suggested it myself’.¹²⁶ This example is important in demonstrating the lack of formality in medical pre-trial roles and the absence of any automatic medical recommendation of police intervention. Unfortunately, it is not possible to assess the extent of this practice as there is no record of cases in which a medical practitioner’s efforts to negotiate an informal settlement were successful. It must be remembered that informal sanctions were rejected in all of the cases cited here, as these witness statements are taken from cases which reached trial. The medical recommendation of a settlement in the Middlesex case was evidently ignored. Medical issues were not the sole or even the primary forces influencing decisions about negotiating settlements.

As an alternative to negotiating informal sanctions, members of the medical profession could encourage parental decisions to pursue prosecutions. In 1886 the mother in a case of suspected indecent assault found signs of violence during an examination of her daughter, but she only went to the police after being explicitly instructed to do so by a medical practitioner. She testified that:

[W]hen my little daughter Lilian aged 7 years old came in from school she complained to me that a big lad had been feeling up her clothes. I took the child up and looked at her clothes and found the drawers were stained with blood and the child’s private parts were lacerated and bleeding. The same evening I took the child to a doctor at King’s College Hospital and under his advice I went to the Police.¹²⁷

This medical advice was based on the doctor’s examination which he interpreted in light of the complainant’s story, as he testified to finding signs of genital injury and stated that ‘I could form no idea independent of the girl’s story as to how the abrasion was

example see Gloucester, GA, Pre-Trial Statements, James Preedy tried at the Gloucestershire Quarter Sessions on 9 January 1874 for carnal knowledge, Q/SD/2/1874.

¹²⁶ London, LMA, Pre-Trial Statements, John Roberts tried at the Middlesex Sessions in July 1869 for indecent assault, MJ/SP/E/1869/015.

¹²⁷ London, LMA, Pre-Trial Statements, John Nixon tried at the Middlesex Sessions on 15 February 1886 for indecent assault, MJ/SPE/1886/010. For similar examples of members of the public who approached the police on the basis of medical findings or advice, see: London, LMA, Pre-Trial Statements, William McQuiban tried at the Middlesex Sessions on 9 December 1874 for indecent assault, MJ/SP/E/1874/025; and London, LMA, Pre-Trial Statements, William Pile tried at the Middlesex Sessions on 26 August 1880 for indecent assault, MJ/SP/E/1880/026.

caused'.¹²⁸ When considered alongside the case in which a general practitioner encouraged informal sanctions, discussed above, it seems that hospital practitioners may have been more likely to recommend a formal response by suggesting that a parent went to the police. However, the limited evidence surrounding discretion and informal sanctions makes such conclusions inherently speculative.

Members of the public demonstrated personal agency in the use of medical practitioners, rather than simply deferring to medical advice. Relatives of complainants often laid charges even in cases where no signs of violence were identified. Out of the 113 cases in which relatives of complainants in both regions under study were known to have approached a medical practitioner before going to the police, 67 medical practitioners had found marks of violence, 18 medical practitioners had identified no signs of violence and 28 medical practitioners had stated that the signs were uncertain. There are two possible explanations for the decision to pursue charges when a medical practitioner found no evidence to corroborate a charge: either some members of the public openly ignored medical advice, or complainants' relatives used medical consultations to check the *extent* of the crime rather than to determine the veracity of an allegation. Occasionally relatives of complainants were explicit about their reasons for going to a medical practitioner in such instances. In a Middlesex case of suspected indecent assault on an 18-year-old girl, the girl's mother testified that '[s]he made a complaint about the defendant and on hearing it I immediately took her to Dr Scott and told him what prosecutrix told me ... Nobody advised me to apply for a summons. I did it on my own account'.¹²⁹ Dr Scott was an apothecary who had been consulted on the question of whether the girl was pregnant, which she apparently was not. In this case the mother was in no doubt that an offence had occurred because she had found her daughter 'lying across the Bed crying, I may say screaming', but consulted a medical practitioner to check the extent of the harm.¹³⁰ The decision to prosecute was evidently a multifaceted process that also took into consideration issues such as non-medical witness testimony.

¹²⁸ LMA, Pre-Trial Statements, John Nixon.

¹²⁹ London, LMA, Pre-Trial Statements, William Jones not tried (no bill) at the Middlesex Sessions in May 1889 for indecent assault, MJ/SPE/1889/022.

¹³⁰ LMA, Pre-Trial Statements, William Jones.

The pre-trial reception of medical advice by relatives of complainants followed no clear pattern, for example along the lines of medical roles or ‘expertise’. Nine of the general practitioners approached by members of the public prior to calling the police also worked as police surgeons yet seemingly either did not attempt to ensure, or did not succeed in ensuring, that charges were only pursued in cases with supporting medical evidence. Charges were filed in three of these nine cases after the police surgeon found marks of violence, in three after he found no marks of violence and in three when he found uncertain signs. Responses to police surgeons’ findings were thus as varied as responses to the advice given by all other general practitioners, including those with no specific or close connections to the police. The only sign of a pattern was in the context of cases involving hospital practitioners, which were the least likely to be taken to the police in the absence of signs of violence. Only two cases in which hospital practitioners found no signs of violence were taken to the police, out of 16 cases in which a complainant was examined at a hospital before an official charge was made. This statistic is partly because hospital practitioners were often used in a treatment rather than in a forensic capacity, meaning that there was a higher likelihood of complainants being taken to hospital when their relatives already knew that they were unwell. It also could tie in with the comments made above, about the possibility that hospital practitioners were more likely to give clear recommendations to parents about pursuing a formal charge when they *did* find signs of violence. Despite these slight differences between the pre-trial roles of general practitioners and hospital practitioners, medical advice was not used in any consistent way along the lines of professional situation.

This analysis of medical roles is complicated further by cases in which parents approached medical practitioners *with* the police before pursuing a charge. In one case from 1903, the mother of an eight-year-old Somerset complainant sought medical advice with a police constable before officially applying for an arrest warrant. She commented that the medical practitioner ‘did not give me his opinion. I obtained the warrant without knowing Dr Farrant’s opinion’.¹³¹ Dr Farrant, a general practitioner and Medical Officer of Health, apparently had observed marks of violence in this case. However, he only informed the police officer of his findings despite the child’s mother

¹³¹ Taunton, SRO, Pre-Trial Statements, John Henry Hayman tried at the Somerset Quarter Sessions on 1 July 1903 for indecent assault, Q/SR/812.

being the official prosecutor. Farrant's pre-trial testimony therefore had no impact on the mother's decision to prosecute, despite supporting her decision to do so.

Alternatively, as noted in the analysis of informal sanctions above, it is possible to find cases in which a medical practitioner informed a complainant's relatives about signs of violence but no prosecution was pursued. These cases highlight the varied and even contradictory ways in which medical influence was negotiated with other key agents in pre-trial processes.

It was not unusual for medical advice to be given to the police instead of to the general public, particularly when the police were official prosecutors. In 1902, a Somerset police sergeant explicitly cited the influence of a medical practitioner when discussing his decision to obtain a warrant in a case of alleged indecent assault on young girls. He stated under cross-examination that:

I cannot say whether Irene Plumley or Adie Plumley ever alleged that the defendant attempted to have connexion with them. I don't remember. My reason for including an offence as against the two Plumleys, as appears in the warrant, is because the doctor reported to me the result of his examination. He examined the children on the 3rd June.¹³²

In the apparent absence of any notable or memorable complaint by the two girls, this policeman drew *entirely* on the evidence of a general practitioner when making his decision to take out a warrant against the prisoner. Other prisoners were released at the police station in consequence of medical practitioners' findings, as the police could deal with cases informally or at a local level rather than automatically sending them for trial.¹³³ Although detailed records of such cases are rare, in one notable Middlesex case the mother of a six-year-old girl made a complaint to the police about the conduct of a lodger in 1869. A policeman apparently 'took [the prisoner] to Dr Phillips. From what he said, the prisoner was let go at the police station – in consequence of further directions I received I took the prisoner again'.¹³⁴ Dr Phillips did not testify in court and therefore his advice to the policeman cannot be retrieved, but evidently it was deemed sufficiently influential for the prisoner to be released without charge. This case provides yet another example of the varied ways in which medical practitioners could influence

¹³² Taunton, SRO, Pre-Trial Statements, Frederick William King tried at the Somerset Quarter Sessions on 1 July 1902 for indecent assault, Q/SR/812.

¹³³ Davis highlights how 'the Metropolitan Police made constant use of informal sanctions alongside those of arrest and prosecution'; Davis, 'Prosecutions and Their Context', p. 424.

¹³⁴ London, LMA, Pre-Trial Statements, George Spurgeon tried at the Middlesex Sessions on 23 June 1869 for indecent assault, MJ/SP/E/1869/013.

decisions about pursuing prosecutions for suspected sexual offences. However, as this prisoner was later arrested again, the case also highlights the limitations of medical influence. Medical advice alone was rarely decisive and therefore, as this chapter has argued throughout, its direct influence should not be exaggerated.

Once the decision to pursue a charge was taken, either by members of the public or the police, medical practitioners often had an opportunity to guide the charge under which a prisoner was tried.¹³⁵ The police could provide access to a prisoner for a medical examination if the prisoner consented, although a charge was rarely decided without an additional examination of the complainant.¹³⁶ William Guy and David Ferrier's forensic medicine textbook noted the importance of the two examinations in conjunction, stating that '[i]f the joint examination of the complainant and accused do not support the charge of rape, it may justify the charge of assault with intent to commit it; and another indictment may be preferred, charging the prisoner with the misdemeanour'.¹³⁷ Despite such an emphasis on 'joint' examinations, charges were seemingly influenced more by medical practitioners' examinations of complainants than prisoners. This role is illustrated by a Middlesex case from 1865 in which the mother of an 18-year-old complainant stated that 'I paid a medical gentleman [Mr Kean] half a crown for examining the girl. I made sure [the] defendant had committed a rape on the girl'.¹³⁸ Although the general practitioner Dr Kean actually testified that he only found slight swelling on the complainant's genitals which 'might have arisen from violence or natural causes', the mother seemingly interpreted this testimony as corroborative of the rape charge.¹³⁹ A police surgeon was then sent for the following day, who found no signs of violence.¹⁴⁰ The policeman stated that 'Dr Pearse was sent for and he examined the girl and the charge [of rape] was not taken'.¹⁴¹ This prisoner was instead tried for indecent assault, with the medical evidence being clearly prioritised over the mother's claim that it was a case of rape. It is also notable that the police in this case called upon and used their own surgeon's evidence, rather than receiving the slightly different

¹³⁵ The charge was usually decided at the police station before being accepted or rejected by the desk officer and later confirmed by magistrates in the police court; Miller, *Cops and Bobbies*, p. 66.

¹³⁶ Kew, NA, *Surgical Examination of Persons Charged with Rape*, 1886, HO 45/9662/A43067.

¹³⁷ William A. Guy and David Ferrier, *Principles of Forensic Medicine*, 5th edn (London: H. Renshaw, 1881 [1844]), p. 72.

¹³⁸ London, LMA, Pre-Trial Statements, Charles Hodges tried at the Middlesex Sessions on the 11 August 1865 for indecent assault, MJ/SP/E/1865/015.

¹³⁹ LMA, Pre-Trial Statements, Charles Hodges.

¹⁴⁰ LMA, Pre-Trial Statements, Charles Hodges.

¹⁴¹ LMA, Pre-Trial Statements, Charles Hodges.

testimony of another general practitioner. While the authority of police surgeons was not inherent, their evidence was seemingly given more weight than the testimony of other medical practitioners when determining charges.

In other cases, the use of police surgeons for determining charges was less straightforward. In a Middlesex case from 1866 a policeman testified that ‘I was sent with the child to the doctor, and from what the doctor said, I went with the child and apprehended the prisoner. I said it was for a rape on the child who was with me’.¹⁴² This policeman was guided by a medical practitioner, the surgeon to H division of police, both in his decision to prosecute and in deciding to charge the prisoner with rape. The surgeon testified that ‘I believe penetration had not taken place beyond the labia’, thus he had found signs of partial penetration which constituted rape at this time.¹⁴³ However, at some point in the pre-trial process the charge was downgraded to ‘assault with intent’. The reasoning behind this decision is not recorded, although the next chapter demonstrates that magistrates may have downgraded charges in light of issues such as conviction rates or the perceived respectability of prisoners. Whatever the motive for pursuing a lesser charge, this case highlights the limitations of medical roles in such contexts. While a police surgeon could influence the decision of policemen with whom he had close professional relationships, his evidence was not necessarily decisive when balanced against other factors such as conviction rates.

Although medical evidence about prisoners rarely determined the charge upon which they were tried, medical examinations of the accused are valuable for considering the question of partisanship. As already noted above, very few of the medical practitioners in the cases studied were called specifically for the defence or prosecution. Although Stephen P. Savage, Graham Moon, Kathleen Kelly and Yvonne Bradshaw note that police surgeons can be confronted with ‘competing loyalties’ between the ‘doctor-patient’ and ‘doctor-police’ relationship, there was little evidence of such problems in the cases under study.¹⁴⁴ Police surgeons were generally consulted in a forensic rather than therapeutic capacity, but were seemingly put under no obligation to provide

¹⁴² London, LMA, Pre-Trial Statements, Joseph Florey tried at the Middlesex Sessions on 25 April 1866 for assault with intent to carnally know, MJ/SP/E/1866/008.

¹⁴³ LMA, Pre-Trial Statements, Joseph Florey.

¹⁴⁴ Stephen P. Savage, Graham Moon, Kathleen Kelly and Yvonne Bradshaw, ‘Divided Loyalties? – The Police Surgeon and Criminal Justice’, *Policing and Society* 7 (1997), 79-98, p. 84.

evidence to support a prosecution even if they were called in by the police as prosecutors.¹⁴⁵ However, there were 11 trials from the two regions in which *only* a prisoner was examined. In four of these cases, the medical witness was called for the defence.¹⁴⁶ Such defence cases are particularly valuable for highlighting how the uses of medical practitioners could vary according to the agenda of the person consulting them. In all four, the medical practitioner had known the prisoner for many years and was called to support the defence case that they were of unsound or of ‘weak’ mind. They were used in a very different way to many of the medical practitioners discussed above, as their authority apparently came from long-term contact with a prisoner rather than an examination. For example, in 1868 the surgeon William Lewis testified that ‘I have known the prisoner since he was a boy ... I consider him deficient in intellectual power’.¹⁴⁷ As insanity pleas were extremely rare in the cases under study, it is significant to note that all medical practitioners called by the defence to examine prisoners raised doubts about prisoners’ sanity or intellectual capacities. While four cases is not a statistically significant sample, it seems that these medical practitioners were called upon to promote specific agendas. Such partisanship was strongly criticised in the medical press and was rare overall, but it further highlights the range of ways in which medical practitioners were consulted and used in the cases under study.¹⁴⁸ Defence lawyers provide a rare example of a professional group who used medical evidence in a relatively homogeneous way, but they were only one of many forces that shaped a criminal case before trial.

The analysis in this section has shown that medical testimony was used in a heterogeneous way, across all regions under study and throughout the Victorian and Edwardian periods. Pre-trial roles differed slightly between types of medical

¹⁴⁵ For a consideration of the ‘therapeutic and forensic’ roles see Savage et al, ‘Divided Loyalties?’, p. 81. Chapter Five shows that there was no significant disparity in tone or content between the testimony of police surgeons and other practitioners in court.

¹⁴⁶ Out of the eleven medical practitioners: four were called by the defence, two were called by magistrates, four by the police and one by an unknown party.

¹⁴⁷ London, LMA, Pre-Trial Statements, Alexander Watkins tried at the Middlesex Sessions on the 16 March 1868 for indecent assault, MJ/SP/E/1868/006.

¹⁴⁸ Lawson Tait was particularly vociferous on this issue, bemoaning a ‘class of medical practitioner, small in number I sincerely trust, whose ignorance, or carelessness – I fear greatly that sometimes I might use another and more awful phrase – whose need or avarice will lead him to do almost anything in the witness box. If I were alone in saying these terrible things you might justly perhaps refused to hear me further. But read what Taylor, Flint Smith, and Dixon Mann all say on this painful subject’; Lawson Tait, ‘An Analysis of the Evidence in Seventy Consecutive Cases of Charges made under the New Criminal Law Amendment Act’, *Provincial Medical Journal*, 1 May 1894, 226-35, p. 227.

practitioner, but the reception of medical advice at the earliest stages of the judicial process was largely unsystematic and determined on a case-by-case basis. Although there is little value in pinpointing the ‘most’ and ‘least’ important influences on decision making, this section has shown that medical advice was situated against other personal considerations, non-medical witness testimony and pragmatic concerns. Hierarchies of priorities varied between people and professions, with medicine being only one factor shaping the decision to prosecute and the charge under which a prisoner was tried.

Conclusions

Victorian and Edwardian medical pre-trial roles were variable, not only between Middlesex and the provinces but also between people and professionals within these regions at any given time. Although it is possible to identify some broad regional trends in the uses of medical advice, to seek such generalisations is arguably to misunderstand and dismiss the important complexities of medical pre-trial roles. David Taylor makes similar arguments for the police of the same period, as he states that:

Generalizing about popular responses to the police is fraught with difficulties. The complexities of Victorian and Edwardian society and the varied ways in which individuals and groups experienced the police meant that there was not a single middle-class or working-class perspective. Indeed, at an individual level experiences of the police could be contradictory.¹⁴⁹

There are many parallels between these comments and the conclusions drawn in this chapter. The heterogeneous use of medical practitioners before trial was thus part of a wider lack of coherence in popular attitudes towards and uses of the professions.

Medical practitioners were regularly, although not automatically, consulted to guide pre-trial decision making by a range of people and professional groups. This use in itself indicates that some degree of respect for medical opinion about suspected sexual offences existed in the late-nineteenth and early-twentieth centuries. However, beyond some willingness to approach medical practitioners, deference for the profession was rarely absolute. No medical practitioner, including police surgeons, had any automatic position in a hierarchy of factors shaping decisions about cases of suspected sexual crime.

¹⁴⁹ David Taylor, *Hooligans, Harlots, and Hangmen: Crime and Punishment in Victorian Britain* (Santa Barbara, CA: Praeger, 2010), p. 141.

These conclusions indicate that a medical practitioner's authority was not 'inherent in his occupational role rather than on the basis of his individually proven worth' in the nineteenth century, as Nicholas Jewson argued back in 1976.¹⁵⁰ Medical practitioners were not always treated as authorities on the subject of sexual crime in the Victorian and Edwardian, nor were they consulted on the basis of their perceived 'expertise'. When their advice was sought it was for reasons as far-ranging as personal relationships, moral authority and pragmatic issues. As late as 1914, medical authority was extensively negotiated rather than automatic. These conclusions about the lack of medical 'expertise' or inherent authority tie in with those drawn by scholars examining different types of crime. For example, Hilary Marland's work on insanity in nineteenth-century infanticide cases found that:

Many infanticide trials did not depend upon the evidence of a forensic expert or medical man experienced in treating insanity, but on the opinion of a surgeon or general practitioner and a collection of witnesses – neighbours, friends and passers-by – all of whom found it appropriate to comment.¹⁵¹

This chapter is in line with Marland's approach, which challenges teleological narratives of the growth of medical 'expertise' in the Victorian and Edwardian years. This approach is built on further in the next two chapters, which consider medical testimony in the courtroom. They show that medical practitioners similarly negotiated their positions in relation to magistrates, judges and juries.

¹⁵⁰ N. D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870', *Sociology* 10 (1976), 225-44, p. 235.

¹⁵¹ Hilary Marland, 'Getting Away with Murder? Puerperal Insanity, Infanticide and the Defence Plea' in *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550-2000*, ed. Mark Jackson (Aldershot: Ashgate, 2002), 168-93, p. 181.

‘Different Hues’: Medical Evidence in Court¹

In 1878 Douglas Maclagan, a Professor of Forensic Medicine from the University of Edinburgh, stated that ‘[m]edical questions assume a very different aspect, and reflect very different hues, when viewed in the glare of a court of justice, from what they do in the mild light of the hospital or the sick-room’.² Maclagan referred to the reception and nature of medical evidence in court, both of which are considered to some extent in this chapter. The chapter considers some factors that shaped medical testimony including adversarial processes, the reception and selection of medical evidence by magistrates or grand jurors before trial, and the personal or professional views of medical witnesses. It demonstrates that medical practitioners were more likely to reach trial when they helped to perpetuate and consolidate long-held stereotypes about the ‘real’ characteristics of victimhood, particularly in relation to female complainants. Medical witnesses also often testified on medico-moral matters such as character or chastity, in part because they were encouraged or permitted by the courts to do so. Such conclusions indicate that scientific and moral questions were blurred in the courtroom. They provide support for claims made by Ivan Crozier and Gethin Rees that ‘the production of new authority rests very heavily on established norms, not on total newness’.³ However, this chapter also shows that medical witnesses were not entirely dictated to by the law. They also drew heavily upon their own professional ideas about puberty and sexual development to interpret bodily signs. In demonstrating these points, the chapter builds on broader conclusions drawn throughout the thesis about the negotiated rather than inherent or non-existent nature of medical ‘expertise’.

This analysis often relates stereotypes of female victimhood to ‘rape myths’ and to ideas about ‘real rape’, two terms which are used throughout this and the next chapter of the thesis. ‘Real rape’ and ‘rape myths’ refer to long-held and broad societal ideas that

¹ Douglas Maclagan, ‘Address in Forensic Medicine’, *British Medical Journal (BMJ)*, 17 August 1878, 233-39, p. 233.

² Maclagan, ‘Address in Forensic Medicine’, p. 233.

³ Ivan Crozier and Gethin Rees, ‘Making a Space for Medical Expertise: Medical Knowledge of Sexual Assault and the Construction of Boundaries between Forensic Medicine and the Law in late Nineteenth-Century England’, *Law, Culture and the Humanities* 8 (2012), 285-304, p. 302.

informed the nature and reception of evidence in court, including medical testimony. The phrases, which have been used widely by scholars from a range of disciplinary backgrounds, are deliberately gendered by the use of ‘rape’ but sufficiently broad to be used here in relation to all sexual offences against women. Rees notes that “‘real rape’ typically involves an unsuspecting woman being attacked by a stranger, in an outdoor location at night, with the stranger employing force or a threat of force (with the use of a weapon), and the victim offering active resistance’.⁴ His work relates to the current day but this chapter shows that similar ‘real rape’ stereotypes operated in the Victorian and Edwardian periods, particularly in relation to the issue of active resistance. Joanna Bourke also pays extensive attention to historical gendered ‘rape myths’ in her work, including the idea that an adult woman could not be raped if she resisted and the notion that women had a propensity to lie.⁵ Such ‘myths’ were long-held and did not generally originate in the courts, but were reinforced by judicial processes and by medical testimony.

First Appearances: The Reception and Selection of Medical Evidence

In her study of Victorian Kent, Carolyn Conley discusses ‘[t]he discretionary powers of the magistrates’ in deciding whether a sexual offence charge reached trial.⁶ By implication, the same ‘discretionary powers’ influenced whether the medical testimony associated with such criminal cases reached trial. Decisions were made at the level of magistrates’ courts and by grand juries that resonated through the entire judicial process, therefore are sufficiently important to be examined separately from the trial itself. This section considers how and why certain types of cases reached trial while others, or even medical practitioners themselves, were dismissed at early stages of the court process. It shows that medical witnesses whose evidence consolidated stereotypes of chaste and respectable female victimhood were the most likely to reach trial, in part

⁴ Rees also notes that ‘[a]ttention rate studies have discovered that attacks similar to that described by the “real rape” discourse are actually quite rare’; Gethin Rees, “‘It is Not for Me to Say Whether Consent Was Given or Not’”: Forensic Medical Examiners’ Construction of “Neutral Reports” in Rape Cases’, *Social & Legal Studies* 19 (2010), 371-86, p. 372.

⁵ Joanna Bourke, *Rape: A History from 1860 to the Present Day* (London: Virago, 2007), pp. 21-49; Joanna Bourke, ‘Sexual Violation and Trauma in Perspective’, *Arbor-Ciencia Pensamiento Y Cultura* 743 (2010), 407-16, p. 410.

⁶ Carolyn A. Conley, *The Unwritten Law: Criminal Justice in Victorian Kent* (New York; Oxford: Oxford University Press, 1991), p. 42.

because such moral ideas were expected to influence a petty jury.⁷ Medical evidence therefore carried no inherent authority over magistrates and grand juries, but rather was selectively received and interpreted on the basis of its perceived relevance to broader social, legal and moral concerns.

Magistrates were no more homogeneous than any other professional group, as they drew upon personal preferences and ‘discretion’ when making decisions. However, they were largely elite members of society and therefore also drew upon some broader class-based concerns.⁸ Although variations between courts even within the same region were undoubtedly significant, it is possible to identify some common trends in the ways that magistrates drew upon wider contemporary thought about age, class and gender to inform their decisions. Evidence about proceedings in magistrates’ courts only survives in newspaper reports, therefore this analysis should be read as a preliminary rather than complete picture of the factors that influenced judicial decisions. Trial reports of any kind do not enable consideration of the personal as well as professional factors in pre-trial decision making, such as relationships between individual medical practitioners and magistrates. There is also no way of knowing how many cases tried or dismissed at magistrates’ courts in the regions under study were unreported. As newspapers only selectively reported court cases it cannot be assumed that the cases cited in the following discussion are all representative. However, this selectivity was arguably a part of the formulation of jurors’ expectations. Popular newspapers may have not just passively reiterated cases that corroborated ‘rape myths’, but were rather an active part of their propagation by selectively reporting cases that reinforced popular opinion on sexual crime. This issue will be considered further in the next chapter, which engages with the question of how petty juries appear to have received medical testimony and conceptualised sexual crime.

There was no clear-cut process by which cases were tried or dismissed summarily. In his 1858 text *The Practice of Magistrates’ Courts*, Thomas Saunders referred to the

⁷ A ‘petty jury’ was made up of twelve men who decided a trial outcome. It is more commonly referred to simply as a ‘jury’, but the use of ‘petty’ is necessary here to distinguish it from a grand jury.

⁸ For example, in Devon the magistrates were apparently made up of ‘Peers, Sons of Peers, Baronets, Squires, Landlords, Retired Officers from the Services, Clergymen and a few representatives from the higher professions, the Bar and Banking’; D. Roy Tucker, *The Development of Quarter Sessions Government in Devon in the Nineteenth Century* (London: s.n., 1948), p. 178. Chapter Three of this thesis also showed that a high proportion of Members of Parliament worked as Justices of the Peace.

decision to 'commit for trial' as 'a subject which is so entirely within the discretion of the justices, it is impossible to lay down general rules for their guidance'.⁹ Conley found that some Kent magistrates downgraded charges to try cases of rape summarily, as they officially could only use summary justice in cases of indecent assault and common assault.¹⁰ Although the limited surviving evidence in the regions under study prohibits finding any such cases, it seems likely that magistrates from Middlesex and the south-west counties also would have downgraded some charges.¹¹ They certainly tried cases summarily, particularly after their right to do so was expanded by the 1908 Children Act.¹² Louise Jackson's study of Hampstead Petty Sessions (Middlesex) for the period 1870-1914 found that 'personal opinion and parochial concern' played an important role in such summary justice.¹³ Three quarters of the cases of suspected sexual crime were dealt with summarily, of which 60 per cent were convicted and 40 per cent were dismissed.¹⁴ Similarly, Devon Constabulary returns from the period 1876-88 indicate that 27 per cent of indecent assault cases were tried summarily and 21 per cent were dismissed by magistrates.¹⁵ Although no rape cases were officially tried summarily, as they were not permitted to be tried as such without first reducing the charge, Devon magistrates also dismissed 26 per cent of alleged rape cases before trial.¹⁶ These statistics are slightly lower than those found by Jackson in Middlesex, but still represent a significant proportion of cases.

Medical evidence played the greatest role in summary justice when a case was dismissed rather than tried summarily, as the latter approach was often taken in perceived 'less serious' cases in which medical advice was less likely to be consulted. Medical testimony on bodily indicators of a sexual offence was seemingly most likely to inform a magistrate's decision to dismiss a case when it connected with broader

⁹ Thomas W. Saunders, *The Practice of Magistrates' Courts* (London: Law Times Office, 1858), p. 160.

¹⁰ Carolyn A. Conley, 'Rape and Justice in Victorian England', *Victorian Studies* 29 (1986), 519-36, p. 521.

¹¹ The charge could be reduced by a magistrate to any of the multiple charges contained on an indictment. For contemporary and historical references to cases being downgraded from indecent assault to common assault, see: Lawson Tait, 'An Analysis of the Evidence in Seventy Consecutive Cases of Charges made under the New Criminal Law Amendment Act', *Provincial Medical Journal*, 1 May 1894, 226-33, p. 228; and Charles Upchurch, *Before Wilde: Sex Between Men in Britain's Age of Reform* (Berkeley, CA; London: University of California Press, 2009), p. 110.

¹² David Taylor, *Hooligans, Harlots, and Hangmen* (Santa Barbara, CA: Praeger, 2010), pp. 108-11.

¹³ Louise A. Jackson, *Child Sexual Abuse in Victorian England* (London: Routledge, 2000), p. 23.

¹⁴ Jackson, *Child Sexual Abuse*, p. 23.

¹⁵ Exeter, Devon Record Office (DRO), Devon Constabulary: Return Showing the Number of Apprehensions Effected for the Years ending 31st December 1876-88, QS/4/1876-1888.

¹⁶ DRO, Devon Constabulary.

social stereotypes about sexual crime. Bodily signs of resistance, for example, tied in with the broader societal and legal expectation that a woman should demonstrate signs of having resisted an offence to the point of exhaustion before being overcome.

Violence and resistance were generally conflated in medical literature as, for example, Taylor's medico-legal texts indicated that marks of violence on the body would *only* occur if there was resistance. The 1910 version of *Principles and Practice of Medical Jurisprudence* stated that:

With respect to marks of violence on the body of a young child, these are seldom met with, because no resistance is commonly made by mere children. Bruises or contusions may, however, be occasionally found on the legs. The older the victim, up to our present limit, the greater the possibility of such marks on the body and the more the importance to be attached to them when found, or at least to the explanation of how they were produced.¹⁷

This work was representative of the tone of medical literature, in demonstrating no notion of an offender prone to violence for violence's sake. The onus was thus on a female over the age of sexual consent to prove that she had resisted, with the implication being that any violence was the consequence of her actions. Marks of resistance were not officially required by statute because the degree of evidence required to prove that a sexual act was 'against the will' was a matter for the court's discretion.¹⁸ However, newspapers repeatedly reported instances of magistrates drawing upon medical testimony in order to dismiss cases in which a female showed insufficient resistance. In a case of suspected rape on a young Gloucestershire 'servant' girl who was over the age of consent in July 1885, it was reported that:

Dr Andrew Currie deposed that there were no marks of violence upon the prosecutrix except that her arms were scratched somewhat. In his opinion prosecutrix could not have resisted very much, or there would have been greater evidence of injury. The bench dismissed the case.¹⁹

This case was not dismissed because of a lack of any signs of resistance, but because the *degree* of resistance was deemed insufficient. Medical evidence was seemingly decisive in this case, although the subjects of consent and resistance were not purely scientific matters. *The Bristol Mercury and Daily Post* reported in 1891 that a Somerset magistrate dismissed a case of suspected rape 'without hearing the medical or other witnesses' after a 17-year-old complainant admitted that she did not call for assistance

¹⁷ A. S. J. Taylor, *The Principles and Practice of Medical Jurisprudence*, ed. Thomas Stevenson, 6th edn, vol. 2 (London: J. & A. Churchill, 1910 [1865]), p. 130.

¹⁸ Conley, 'Rape and Justice in Victorian England', p. 520.

¹⁹ 'District News: Alleged Rape', *The Bristol Mercury and Daily Post*, 31 July 1885, 7, p. 7.

or immediately complain of the alleged assault. In this case, the apparent absence of resistance was proved by the girl's testimony herself rather than that of a medical practitioner.²⁰ Again, however, the dismissal of the case was based on the matter of resistance and consent. Magistrates' decisions to dismiss cases or commit them for trial turned on very similar issues, whether or not evidence was provided by an 'expert'.

A case reported by *Lloyd's Weekly Newspaper* in October 1862 is worth citing in depth because it exemplifies how medical ideas were intertwined with existing social anxieties about resistance and consent. By extension, it also touched upon issues related to character. According to the newspaper article, evidence was given at a Middlesex police court for an alleged rape on 'Esther Whiting, a precocious-looking girl, between fourteen and fifteen years of age' in which:

Dr. George Pearse, 10, Regent-street, Westminster, divisional surgeon, said he was called to the station between twelve and one on Tuesday morning and examined the prosecutrix, upon whom he found no marks of violence, nor were there the least indications that the offence had been recently committed; at the same time, however, there was no doubt that her ruin had been affected [sic] some time since. Witness added that she told him two facts which she had not mentioned to the magistrate, one being that the defendant had given her half-a-crown previous to committing the assault in the kitchen ... [Magistrate] Mr Paynter observed that it was quite clear no jury would convict upon such evidence, after the testimony of Dr. Pearse that the girl had not been violated recently, but at a more distant period ... The girl, it was said, had made no great resistance, had followed him into the kitchen, made no outcry nor attempt to escape, and accepted half-a-crown. All the facts were against her having spoken the truth, and conduced to the belief that there was not the slightest evidence against the defendant, whom he discharged.²¹

The police surgeon's evidence was not purely scientific, as he also made comment on the complainant's character and the consistency of her story. The girl's lack of resistance was legally relevant, as the age of consent was 12 in 1862, but medical evidence about her previous unchastity also seemingly played a part in the decision to dismiss this case. This precocious and unchaste girl exemplified dangerous working-class sexualities rather than a stereotype of childish or feminine victimhood, therefore her case never reached trial. As these anxieties surrounding precocity drew upon broader middle-class concerns, as outlined in the first chapter of this thesis, the courts

²⁰ 'Alleged Rape at Kilmersdon', *The Bristol Mercury and Daily Post*, 10 October 1891, 6, p. 6.

²¹ 'Unfounded Charge', *Lloyd's Weekly Newspaper*, 26 October 1862, 7, p. 7.

and medical witnesses were not cut off from wider frameworks of thought surrounding age and sex.

The subjects of consent and chastity were inextricably bound together, as unchaste girls were deemed more likely to have given consent. When a ‘decently-attired’ man was accused of raping a 14-year-old girl in 1858, a surgeon found that the girl had had sexual intercourse within 24 hours but he found no signs of violence or recent defloration. The magistrate therefore concluded that:

[F]rom what he could ascertain from the surgeon’s evidence it was not the first thing of the sort the girl had been corrupted with; and although the prisoner had done wrong, still he could not say a rape had been committed, as the girl had said nothing about the matter, had not called out, and did not scratch his face. – The prisoner was then discharged.²²

The difference between the prisoner’s apparent respectability and the working-class girl’s previous unchastity was evident in this newspaper report. Again, moral aspects of medical evidence such as the implication of previous unchastity were likely to be seized upon and utilised by magistrates. The number of cases involving medical testimony about unchastity was therefore significantly reduced before reaching court, meaning that juries were often presented with cases involving chaste girls who were stereotypical victims. It is significant that both girls in the cases cited above were aged 14 years old, which was close to the average age for menarche and a life stage at which they could apparently fall prey to their sexual instincts.

One of the most notable aspects of the report on the Esther Whiting case, the longest of the two case studies cited above about chastity and consent, is the magistrate’s reference to the fact that ‘it was quite clear no jury would convict’. He was not alone in this terminology or in pre-empting the jury. A case of alleged rape of a 13-year-old girl was dismissed from Lambeth Police Court in Middlesex in 1851 because a magistrate concluded that ‘[s]he had ... plenty of time and opportunity of calling out and resisting if she had thought proper ... No jury would convict on such evidence’.²³ Newspaper reports indicate that magistrates pre-empted juries in this way throughout both urban and rural courts, placing particular weight on issues linked to character and consent in

²² ‘Atrocious Cases’, *Lloyd’s Weekly Newspaper*, 25 July 1858, 9, p. 9.

²³ ‘Police Intelligence’, *Morning Chronicle*, 1 October 1851, 7, p. 7.

both. In another Middlesex case in which a medical practitioner's evidence played a part, *Reynolds's Newspaper* reported that:

[T]he surgeon who had examined the prosecutrix was then recalled, and gave such evidence as left no doubt that the prosecutrix could not have been so innocent as she had represented herself to be. [Magistrate] Mr. Cooke said no jury would convict on such evidence, and he should discharge the prisoner.²⁴

Again, medical testimony was received particularly favourably by magistrates when it touched upon moral questions and reinforced pre-existing social assumptions about character. The fact that this medical practitioner was recalled in order to be questioned on the subject of chastity also indicates that the blurring of medical, moral and legal boundaries was actively encouraged by some courts. Undoubtedly not all magistrates used their discretion in the same way, but such cases highlight some of the ways in which pre-trial processes shaped not only the reception of medical testimony but also the nature of medical evidence that reached trial.

As magistrates drew upon medical evidence selectively to reinforce existing ideas, medical ideas that challenged 'real rape' stereotypes or that did not correspond to judicial views on a case were not always received so positively. *The Lancet* claimed that a magistrate at Westminster Police Court refused to hear medical evidence in an 1875 indecent assault case, which was eventually tried at the Middlesex Sessions, because the surgeon stated 'that such evidence as he could give would be in favour of the prisoner'.²⁵ The journal complained that '[i]t is disturbing to think that under the very shadow of the Houses of Parliament a magistrate should seek evidence in such a loose fashion'.²⁶ Magistrates evidently did not show automatic deference to medical opinion. Even in some cases that were passed forward for trial, magistrates did not give medical practitioners the opportunity to testify. This trend not to bind medical witnesses over for trial was specific to the Middlesex cases, which highlights the importance of not overstating the degree to which medico-legal relations were formalised in London. In seven cases that reached the Middlesex Sessions, magistrates did not bind medical witnesses over to give evidence at trial after the medical practitioner testified to finding no signs of violence. A further two medical practitioners were not bound over to testify after giving evidence that neither clearly corroborated nor refuted the charge. Although

²⁴ 'Charge of Indecent Assault', *Reynolds's Newspaper*, 2 February 1868, 5, p. 5.

²⁵ 'A Magistrate and a Medical Witness', *The Lancet*, 9 October 1875, 539-40, p. 539.

²⁶ 'A Magistrate and a Medical Witness', p. 539.

these medical witnesses' testimony would have reached the jury in the form of written pre-trial statements, the decision not to put them on the stand was significant. In one case from 1883 in which the medical witness was not bound over, a Middlesex police surgeon testified that he had examined a 16-year-old girl and '[t]here was not the slightest trace of any injury. There is no hymen or any trace of one. The girl is pretty well developed'.²⁷ While this evidence somewhat corroborated the complaint, which was a case of alleged repeated incest in which evidence of recent defloration would not have been expected, references to the girl being 'well developed' also carried implicit moral messages about the links between the sexual body and sexual promiscuity. This chapter has shown that in similar situations some magistrates dismissed such a case, but others may have taken the alternative option of just dismissing the medical practitioner whose testimony destabilised the prosecution. This case was passed forward for trial on the basis of other corroborative evidence but the medical practitioner was not asked to testify. It could be argued that the medical evidence was simply inconsequential, but an alternative view is that the testimony was deemed unhelpful because the absence of signs of virginity and a 'well developed' body were not characteristics of 'real' victimhood in a 16-year-old girl.²⁸ Although medical practitioners did not necessarily seek to attend criminal trials, apparently viewing them as time 'woefully wasted', they did not have any control over these decisions.²⁹

Magistrates not only determined whether cases with medical testimony reached trial, but also the charge under which cases were tried. Although the charge was first decided by police, it was often changed during the judicial process in the light of a range of issues including medical testimony. If medical practitioners found marks of resistance on girls covered by the misdemeanour clause of age-of-consent legislation, magistrates could pass the case to London's Central Criminal Court or the provincial Assizes under a charge of rape rather than to the courts studied for this thesis under a charge of carnal knowledge. As *The Lancet* noted after the 1885 Criminal Law Amendment Act (CLAA), 'the question of consent or resistance will now become of great significance in constituting the difference between misdemeanour [carnal knowledge of girls aged 13 to

²⁷ London, London Metropolitan Archives (LMA), Pre-Trial Statements, George Garland tried at the Middlesex Sessions on 7 March 1883 for indecent assault, MJ/SP/E/1883/010.

²⁸ While a jury would theoretically have been capable of seeing for themselves if a complainant appeared mature, they would not have had the same close access to her body.

²⁹ H. A. Lediard, 'Our Criminal Procedure: Scientific Imperfections and Remedy', *The Lancet*, 18 October 1890, 812-14, p. 813.

16] and felony [rape of girls in the same age category]’.³⁰ Charges were also theoretically influenced by medical testimony about indicators of genital violence, because only penetration of the vulva was necessary to prove a charge of carnal knowledge or rape in English law.³¹ However, the influence of medical testimony on charges was not straightforward. Cases in which medical witnesses stated that ‘I believe there had been penetration of the vulva ... but not far enough to rupture the hymen’ or ‘I found that there had been a certain amount of penetration’ should technically have been tried as the felonies of rape or carnal knowledge of girls in the felony age category.³² Instead, they were often committed to the Middlesex Sessions or county Quarter Sessions as misdemeanours such as indecent assault or *attempted* carnal knowledge or rape.

The reasons for discrepancies between medical testimony and criminal charges are not entirely clear. Louise Jackson claims that many surgeons ‘tended to argue for lesser charges of indecent or common assault’, but there is no evidence that any medical witnesses explicitly supported a charge either way.³³ Medical practitioners were not always even aware of the legal repercussions of their testimony, as one wrote to *The Lancet* editor in 1843 to ask about the degree of penetration required to constitute a rape in law: ‘I should much like to know the precise legal definition of rape, according to the most recent Acts of Parliament. Any medical practitioner may be called upon for his evidence in these most unpleasant cases’.³⁴ The crucial question is arguably not whether medical practitioners ‘argued for’ lesser charges, but why medical depositions about partial penetration were disregarded despite being elicited in court and despite magistrates’ extensive legal experience or training. It is impossible to reconstruct the motives of magistrates fully, but there are some possible explanations for their decisions to disregard medical testimony about labial and vaginal penetration. One such explanation is the higher probability of gaining a conviction on lesser charges. In the period 1870-89, acquittal rates for rape and carnal knowledge in England and Wales

³⁰ ‘The Criminal Law Amendment Bill’, *The Lancet*, 8 August 1885, 252, p. 252.

³¹ Alfred Swaine Taylor, *A Manual of Medical Jurisprudence*, 8th edn (London: J. & A. Churchill, 1866 [1844]), p. 591; Francis Ogston, *Lectures on Medical Jurisprudence* (London: J. & A. Churchill, 1878), p. 90.

³² The felony age category applied to girls under 10 until 1875, under 12 until 1885 and from then onwards to girls under 13 years old; London, LMA, Pre-Trial Statements, Alfred Robinson tried at the Middlesex Sessions on 24 August 1874 for indecent assault, MJ/SP/E/1874/017; Exeter, DRO, John Fisher tried at the Devon Quarter Sessions on 29 June 1871 for indecent assault, QS/B/1871/Midsummer.

³³ Jackson, *Child Sexual Abuse*, pp. 78-79.

³⁴ John Adams, ‘What Acts are Essential to Constitute Rape?’, *The Lancet*, 25 March 1843, 933, p. 933.

were an average of 56 per cent higher than those for indecent assault and assault with intent.³⁵ This speculation is supported by some evidence from newspapers, such as a suspected carnal knowledge case from Wandsworth in 1888 involving an eight-year-old complainant in which a magistrate concluded that ‘no jury would convict of that offence; but he should commit [the prisoner for trial] for an indecent assault upon this little girl’.³⁶ Again, this magistrate’s decision was based on pre-empting the petty jury. Another possible reason for pursuing lesser charges related to the ‘respectability’ of the accused, as Carolyn Conley argues that in Victorian Kent:

[T]he decision as to whether the charge should be rape or attempted rape was rarely influenced by whether the act had actually been completed. Rather, the lesser charges were used when “respectable” men were accused of rape and the evidence was too serious for the case to be dismissed altogether.³⁷

The influence of medical testimony on magistrates’ decisions evidently was not straightforward, as they were influenced by a range of pragmatic as well as theoretical concerns.

The first point of judicial contact after a magistrates’ court was a grand jury of between 12 and 23 men, who also influenced the type of case and medical testimony that reached trial. Grand juries had no ability to try a case but, like magistrates, could dismiss them as ‘no bills’ if they felt that there was not a *prima facie* (first appearance) case for trial.³⁸ As this section goes on to identify many similarities between the approaches of grand jurors and magistrates to medical evidence, it is worth noting that the two roles were not entirely separable. Some men acted in both capacities over time or in different courts. Significantly, even medical men could act as both magistrates and grand jurors if they were retired or non-practising. In consequence, medical concerns gradually merged with those of magistrates and grand jurors in cases of suspected sexual crime. In a letter to the editor of the *Standard* newspaper on 10 May 1894 A. S. Myrtle, a Justice of the Peace and a Doctor of Medicine, wrote that:

you have dealt so openly with the gross abuses which the Criminal Law Amendment Act of 1885 has given rise to ... I also have sat as a Magistrate and

³⁵ British Parliamentary Papers (BPP), Judicial Statistics of England and Wales for 1870-1889 (London: H.M.S.O., 1871-1890).

³⁶ ‘Police Intelligence’, *Lloyd’s Weekly Newspaper*, 22 April 1888, 4, p. 4.

³⁷ Conley, *The Unwritten Law*, p. 83.

³⁸ All jurors had to be aged between 21 and 60 years old. The minimum property qualification varied according to the type of property. For a thorough explanation see John Frederick Archbold, *The New System of Criminal Procedure, Pleading and Evidence in Indictable Case* (London: Shaw and Sons, 1852), p. 157.

on the Grand Jury since the passing of the Act and have felt in the great majority of the charges brought before me that blackmailing, not justice, was the object of the girl and her friends, and that, in these circumstances, it would have been far better to have said at once “No bill,” than send the case for trial.³⁹

This doctor was particularly vociferous about his anxieties regarding blackmail, as he cited and supported the idiosyncratic works of Lawson Tait on the subject. However, concerns about false charges were also prevalent in broader medical and judicial thought. Medical men who sat on grand juries were thus a part of the so-called ‘vicious cycle’ by which courts anticipated and perpetuated stereotypes associated with sexual crime, such as the perceived tendency of women to lie.⁴⁰

Officially the same property qualifications were required to serve as a grand juror and petty juror, but evidence from the regions under study indicates that David Bentley is right in noting that ‘those selected were, by rateable value, of description of a better class than the ordinary common jurymen’.⁴¹ Few of the pre-trial statements include juror lists, but some surviving lists for two Devon Quarter Sessions in 1901 and 1903 show that just over half of grand jurors were gentlemen and esquires.⁴² Although these gentleman jurors had the final power to decide whether a *prima facie* case existed, their decisions were often guided by judges. At the Middlesex Sessions in May 1889, the chairman highlighted an indecent assault case in which he apparently:

[F]elt constrained to tell the grand jury that if nothing more than the facts as they appeared on the depositions was [sic] brought forward, he should, when the accused was tried, certainly advise the petty jury that it would be very unsafe to convict.⁴³

The grand jury consequently declared it to be a ‘no bill’ and the case was not passed forward for trial. Although in this case the chairman’s direction was due to a general lack of corroboration rather than to medical evidence, it is clear that a grand jury’s reception of any witness testimony was mediated.

³⁹ ‘The Criminal Law Amendment Act’, *The Standard*, 10 May 1894, 6, p. 6.

⁴⁰ Vanessa E. Munro and Liz Kelly, ‘A Vicious Cycle? Attrition and Conviction Patterns in Contemporary Rape Cases in England and Wales’ in *Rape: Challenging Contemporary Thinking*, ed. Miranda Horvath and Jennifer Brown (Cullompton: Willan Publishing, 2009), 281-300.

⁴¹ David Bentley, *English Criminal Justice in the Nineteenth Century* (London: Hambledon Press, 1998), p. 148

⁴² Exeter, DRO, Devon Epiphany Sessions: The Names of the Grand Jurors, 1901, QS/B/1901/Epiphany; Exeter, DRO, Devon Michaelmas Sessions: The Names of the Grand Jurors, 1903, QS/B/1903/Michaelmas.

⁴³ ‘County of London Sessions, May 25’, *The Times*, 27 May 1889, 8, p. 8.

Unlike magistrates' courts, systematic manuscript evidence survives for cases that were dismissed by grand juries. Overall, 161 out of 1700 cases in Middlesex and 119 out of 928 cases from Gloucestershire, Somerset and Devon were declared 'no bills' and rejected by a grand jury. This constituted nine and 13 per cent of cases respectively with an average 'no bill' rate of 11 per cent over both regions. Only 23 of these from Middlesex and 17 from the south-west counties had medical testimony, therefore the grand jury did not prevent a significant number of medical witnesses from reaching trial. This limited number of 'no bills' with medical testimony was likely the result of summary justice, as magistrates had often already dismissed cases with medical evidence to dispute a charge. However, evaluation of these grand jury cases remains an important part of understanding why certain types of medical evidence were less likely to reach trial. 'No bills' were found in 13 per cent of cases in which medical practitioners found no signs of genital violence, seven per cent of cases in which medical practitioners declared uncertainty about interpreting bodily signs, and two per cent of cases in which medical practitioners found signs of genital violence. The 'no bill' rate was therefore above the average rate of 11 per cent in cases where medical practitioners found no marks of genital violence and significantly below average in the cases where genital violence was found, which implies that medical testimony played some role in these decisions. Grand juries were also more likely to reject cases with medical testimony that proved an absence of bodily violence or resistance, as 'no bills' were found for eight per cent of cases in which medical practitioners found marks of violence or resistance on a complainant's body and 13 per cent of cases in which they explicitly noted the absence of such marks. These statistics were influenced little by the age of a complainant or by whether consent was a defence to the given charge. Grand juries therefore used their discretion to dismiss cases that lacked signs of resistance even when consent was not a valid legal defence. The sample size of 40 'no bills' with medical evidence is too small from which to draw any definite conclusions on this matter or to evaluate regional or age-based variations. However, this statistical analysis has provided some tentative evidence about the reception of medical testimony by grand jurors.

Statistics can be built upon with closer consideration of the nature of medical testimony in cases declared to be 'no bills'. Such analysis further demonstrates the influence of medico-moral issues on decisions about whether a case and its associated medical

testimony reached trial. In a Somerset case involving the alleged attempted rape of an 18-year-old complainant, a surgeon drew upon wider contemporary social and medical thought in testifying that ‘[i]t would have been completely impossible for a young man like the prisoner to have connexion with the prosecutrix while she was struggling and kicking without some signs of violence being visible’.⁴⁴ He also apparently found that ‘[t]he ordinary signs of virginity were destroyed and had been destroyed some time before that night’.⁴⁵ In combination, his testimony on the girl’s apparent lack of resistance and prior unchastity may have contributed to the decision for the case to be dismissed as a ‘no bill’. The particular influence of the medico-moral issue of unchastity on grand jury decisions is also indicated by other cases. In one ‘no bill’ from Gloucestershire, a Bristol police surgeon testified that he found blood stains in a case of suspected indecent assault on a 12-year-old girl. However, he observed that the ‘blood stains ... arose from menstrual discharge which is unusual in a girl of her age – the girl is largely developed’.⁴⁶ He also:

[F]ound the hymen ruptured but not of recent occurrence ... I believe she has had connexion with someone prior to the alleged assault. She was very fully developed – I should have judged her age to have been more than twelve years.⁴⁷

In these two sentences, the surgeon not only removed the relevance of blood stains and a ruptured hymen as corroborative evidence but also implied that the girl was precocious in both her sexual development and sexual behaviour. Although the medical practitioner in this case was a police surgeon, other cases cited in this chapter and Chapter One of this thesis show that concerns about precocity were commonplace throughout the medical profession both within and outside courts. The dismissal of such a case again served to reinforce stereotypes of the virginal young victim, which a precociously unchaste girl did not fit. No single cause can ever be identified as a reason for the dismissal of a bill, as a ‘no bill’ was also found in another Gloucestershire case involving a 12-year-old complainant in which a surgeon explicitly noted her *lack* of bodily precocity and testified that ‘[s]he is not so fully developed as girls of that age

⁴⁴ Taunton, Somerset Record Office (SRO), Pre-Trial Statements, Richard O’Brien and Robert Phelps not tried (no bill) at the Somerset Quarter Sessions in April 1885 for attempted rape, Q/SR/739.

⁴⁵ SRO, Pre-Trial Statements, Richard O’Brien and Robert Phelps.

⁴⁶ Gloucester, Gloucestershire Archives (GA), Pre-Trial Statements, John Doggett and George Young not tried (no bill) at the Gloucestershire Quarter Sessions in October 1894 for indecent assault, Q/SD/2/1894.

⁴⁷ GA, Pre-Trial Statements, John Doggett and George Young.

generally are'.⁴⁸ However, it remains significant that precocity and unchastity were regularly cited in relation to dismissed cases by newspapers and in pre-trial statements.

Although most concerns about chastity centred on female complainants, medical witnesses could also influence grand jury decisions when they found signs that male complainants were accustomed to homosexual intercourse. In a case of alleged indecent assault on a 12-year-old boy from 1897, a general practitioner called in by Devon police testified that 'he had been practicing sodomy for some time, there were two small fissures inside the anus and the anus was easily dilatable'.⁴⁹ According to the *Medical Directory* this practitioner was a 'prizemedallist in forensic medicine', but his testimony demonstrated no more specialist knowledge about the signs of sodomy than any of the most popular medical jurisprudence textbooks.⁵⁰ As consent had been removed as a defence in cases involving boys under the age of 13 in 1880, this surgeon's evidence about the boy's prior unchastity was not a legitimate legal defence. However, the case was rejected by the grand jury despite another witness testifying that he saw the prisoner commit the offence. Grand jurors were seemingly quick to dismiss cases with male complainants who had previously been sexually active with other males, in the same way that they judged an unchaste girl or woman to be an unreliable complainant. As a young boy of 12 was neither a child nor a man, the complainant in this case filled the same dangerous space in the courtroom as the precocious girls discussed above. Males of any age who practiced sodomy were also expected to have a particular propensity towards blackmail.⁵¹ It is therefore significant that not a single case including medical testimony that a boy or man was accustomed to sodomy reached the trial stage of proceedings.

This analysis indicates that medical evidence was drawn upon selectively by magistrates and grand juries to reinforce legal and long-held moral concerns, particularly about female resistance and false claims. Medical influence in the early stages of judicial

⁴⁸ Gloucester, GA, Pre-Trial Statements, William James not tried (no bill) at the Gloucestershire Quarter Sessions in August 1886 for indecent assault, Q/SD/2/1886.

⁴⁹ Exeter, DRO, Pre-Trial Statements, Joseph Groves not tried (no bill) at the Devon Quarter Sessions in April 1897 for indecent assault on a male, QS/B/1897/Easter.

⁵⁰ See the discussion in the second section of this chapter about the signs of sodomy in cases involving pre-pubescent boys, as discussed by Alfred Swaine Taylor.

⁵¹ Angus McLaren notes that '[a]s early as the 1730s references were made to the organized blackmail of sodomites in London ... Between 1885 and 1900 there was a surge in the reportage of attempts at blackmail'; Angus McLaren, *Sexual Blackmail* (Cambridge, MA: Harvard University Press, 2002), pp. 13-18.

processes was potentially significant but not automatic, as the perceived value of medical testimony lay in its subject matter rather than in medical ‘expertise’. Although much of this section’s evidence has been drawn from newspaper reports, the fact that national and local newspapers heavily reported such cases to readers that may have constituted grand or petty jurors is significant in itself. Even if newspapers were not reporting real patterns of court behaviour, they served to consolidate societal and judicial expectations about what a ‘real rape’ looked like. The conclusions drawn in this section connect to recent socio-legal theories about the ‘vicious cycle’ of rape trials, in which a ‘prosecutor, in determining whether a case should be forwarded to trial, pre-judges the jury’s beliefs about rape and is more likely to forward cases that are consistent with rape myths, leading to the reinforcement of said myths’.⁵² These processes are crucial for understanding the nature of medical evidence that reached trial, as magistrates and grand juries were not only more likely to ‘forward cases’ that corroborated ‘rape myths’ but also to bind over the medical witnesses associated with those cases to testify at trial. The nature of their evidence is the focus of the next section of this chapter.

Interpreting Appearances: Signs of Victimhood

Since the 1782 judgment of Lord Justice Mansfield in *Folkes v Chadd*, it had officially been accepted that ‘[t]he general opinion of scientific men upon proven facts may be given in evidence by men of science within their own science’.⁵³ However, the courts determined what was classified as a ‘science’ rather than a question of common sense or morality.⁵⁴ In his 1878 *Lectures on Medical Jurisprudence*, Francis Ogston referred to ‘Physical Proofs’ as the only kind of evidence that came ‘properly ... within the province of the medical jurist’.⁵⁵ There were two main forms of ‘physical proof’ in the context of suspected sexual crime: marks of violence on the genitals and marks of violence on the body. This section examines these two ‘physical proofs’ in turn, before

⁵² Munro and Kelly, ‘A Vicious Cycle?’, p. 295.

⁵³ The word ‘officially’ is important here, as Carol Jones notes that this practice existed before it was consolidated by the *Folkes v Chadd* judgement; Carol Jones, *Expert Witnesses: Science, Medicine and the Practice of Law* (Oxford: Clarendon Press, 1994), p. 57. On the judgement see also Roger Ballard, ‘Common Law and Common Sense: Juries, Justice and the Challenge of Ethnic Plurality’ in *Law and Ethnic Plurality: Socio-Legal Perspectives*, ed. Prakash Shah (Leiden: Martinus Nijhoff, 2007), 69-106, pp. 74-75.

⁵⁴ Roger Smith, *Trial by Medicine: Insanity and Responsibility in Victorian Trials* (Edinburgh: Edinburgh University Press, 1981), p. 77.

⁵⁵ Ogston, *Lectures on Medical Jurisprudence*, p. 124.

turning briefly to the question of testimony on mental capacity and character. In considering different types of scientific and non-scientific testimony, the analysis also highlights the inseparability of physiology and morality. It shows that the courts used discretion to allow, and sometimes even encourage, medical practitioners to interpret ‘physical proofs’ in a way that spoke to contemporary moral concerns. The judicial and adversarial processes consolidated a pool of shared medico-legal knowledge that complemented gendered victim stereotypes and class-based anxieties, often using a flexible definition of science in order to do so. However, the section also shows that medical witnesses were not entirely dictated to by the judicial system. They drew upon professional ideas about the gradual and variable nature of puberty to inform their interpretations of bodily signs.

The nature of medical testimony was not only shaped by a court’s definition of ‘science’, but also by the official rules of evidence. The most significant of these were the ‘hearsay’ and ‘ultimate issue’ rules, which meant that a medical practitioner was not entitled to testify on any matter that he had not seen or heard himself, nor was he entitled to use his findings to comment on the ultimate guilt or innocence of a prisoner.⁵⁶ Carol Jones notes that ‘[a] strong judicial interest in claiming and maintaining control over legal proceedings ... played a significant part in determining the boundaries of the expert witness role’.⁵⁷ As always, however, the implementation of such rules was at the discretion of the court and varied from place to place. *The Lancet* reported that a medical witness was reprimanded by a judge at a Winchester trial in 1895 for ‘attempting to decide the case’ by stating that ‘there was no evidence that penetration had occurred’.⁵⁸ However, this chapter will show that in Middlesex and the South West medical witnesses were often permitted and even actively encouraged to

⁵⁶ For a more detailed discussion of the development of rules of evidence and how they relate to expert testimony over time, see: Tony Ward, ‘Law, Common Sense and the Authority of Science: Expert Witnesses and Criminal Insanity in England, Ca. 1840-1940’, *Social & Legal Studies* 6 (1997), 343-62, pp. 345-47; Anthony Good, *Anthropology and Expertise in the Asylum Courts* (Abingdon; New York: Routledge, 2007), pp. 133-34; Anthony Good, ‘Cultural Evidence in Courts of Law’ in *The Objects of Evidence: Anthropological Approaches to the Production of Knowledge*, ed. Matthew Engelke (London: Royal Anthropological Society, 2008), 44-57, p. 45; Wilson Wall, *Forensic Science in Court: The Role of the Expert Witness* (Chichester; Hoboken, NJ: Wiley-Blackwell, 2009), p. 58; and Jones, *Expert Witnesses*, pp. 102-14.

⁵⁷ Jones, *Expert Witnesses*, p. 34.

⁵⁸ ‘Medical Witness and Judge’, *The Lancet*, 16 February 1895, 426, p. 426.

interpret the boundaries of their scientific testimony flexibly. As Jones also notes, there was ‘lax application of the ultimate issue rule, the opinion rule, and the hearsay rule’.⁵⁹

The nature of medical testimony was also guided by prosecution and defence counsel. However, the exact questions and answers posed to medical witnesses were usually omitted from pre-trial statements. The adversarial process is therefore a particularly difficult one to assess from the historical evidence available. For the purposes of this analysis, it is only possible to emphasise the importance of bearing in mind that every medical statement was an answer to a carefully constructed question. As Taylor noted, if a medical witness wanted to ‘volunteer evidence’ that had not been brought out in questioning then he had to apply to the magistrate or judge for permission.⁶⁰ As there is no evidence that any medical witness from the cases under study ever requested to give information in the way described by Taylor, the medical testimony analysed in this section seems to have been made in response to questions by prosecution and defence counsel or even by the prisoner himself if he stood undefended. Few medical practitioners in the cases studied for this thesis could be accused of partisanship because, as demonstrated in the previous chapter, they were generally called by the court as witnesses who had the first point of contact with a complainant rather than on behalf of the prosecution or defence. However, the process of being questioned by prosecution and defence counsel still influenced their testimony. 122 of the 602 medical practitioners who testified in the cases under study were cross-examined at the pre-trial level.

The lack of partisanship also manifested itself in the consultation of only a single ‘expert’ in most of the cases studied. Out of 642 complainants who were medically examined, only 28 were examined by more than one medical practitioner. There were few cases in which medical practitioners testified against each other, perhaps due to the perceived ‘less serious’ nature of the sexual offences tried at these courts compared to higher courts where multiple medical testimony was more common. When medical practitioners did appear together in a trial in the cases studied, they generally supported and corroborated each other. This approach served to strengthen the role of the expert

⁵⁹ Jones, *Expert Witnesses*, p. 125.

⁶⁰ Taylor, *Principles and Practice*, ed. Thomas Stevenson, 3rd edn, vol. 1 (London: J. & A. Churchill, 1883 [1865]), p. 29.

witness rather than presenting an, albeit arguably more realistic, version of science in which medical practitioners disagreed. While all professions involve some degree of heterogeneity, the following analysis demonstrates that there were some notable similarities between the depositions of different medical practitioners in court. This relatively uniform medico-legal approach was part of a wider construction of the role of expert witnesses, in which the judicial process encouraged medical testimony that complemented legal concerns and in which key advice texts such as Taylor's *Manual of Medical Jurisprudence* were effective in formulating a single framework for medical testimony that would be acceptable in the courtroom.

This single medico-legal framework contributed to the absence of any notable geographical disparities or temporal shifts in the nature of medical testimony.⁶¹ Such consistency can partly be explained by the dominance of Taylor's textbooks and by the early rejection of medical testimony that did not fit with medico-legal frameworks of thought, as outlined in the first section of this chapter. Medical jurisprudence texts were widely distributed throughout rural and urban regions, most of which drew heavily on Taylor and gave similar advice about interpreting bodily signs of sexual assault.⁶² Although medical practitioners undoubtedly acquired knowledge through both practice and reading, the previous chapter showed that there were few specialists in the cases under study and that police surgeons' experience of dealing with sexual crimes was not as extensive as might be expected. Consequently, there was no significant disparity between the tone and content of different medical witnesses' testimony. The lack of change over time can also be attributed to the slow processes by which new medical approaches entered textbooks and filtered down to general practitioners. To cite just one example, the Gram staining test for gonorrhoea was invented in 1884 but Taylor's medical jurisprudence textbooks articulated no faith in the process until 1905 and it was never used in the cases under study for this thesis.⁶³ As a result of such slow processes

⁶¹ While the nature of medical evidence was not *exactly* the same across time and place, any differences followed no identifiable pattern and can be best explained by individual variations between medical practitioners and the nature of cases.

⁶² See the thesis' Introduction, which cited both a Middlesex and a Gloucestershire surgeon who referred explicitly to using forensic medicine texts to guide their testimony

⁶³ Victoria Bates, "'So Far as I Can Define Without a Microscopical Examination": Venereal Disease Diagnosis in English Courts, 1850-1914', *Social History of Medicine* (forthcoming); Michael Worboys, 'Was there a Bacteriological Revolution in Late Nineteenth-Century Medicine?', *Studies in History and Philosophy of Biological and Biomedical Sciences* 38 (2007), 20-42; and Michael Worboys, 'Unsexing Gonorrhoea: Bacteriologists, Gynaecologists and Suffragists in Britain, 1860-1920', *Social History of Medicine* 17 (2004), 41-59.

of knowledge transfer, medical witnesses drew upon very similar medico-legal frameworks of thought to guide their testimony irrespective of location or of the specific date within the Victorian and Edwardian years. These medico-legal frameworks also involved some integration of moral matters into physiological thought, as it is now possible to demonstrate through some analysis of cases.

Most of the following analysis focuses on medical testimony about the body, as medical practitioners paid little attention to the emotional or psychological consequences of an alleged sexual crime. Lay witnesses regularly spoke about the emotional state of complainants following an alleged offence, but this subject matter was not deemed to be an issue for the 'expert' witness. Joanna Bourke rightly notes that the notion of long-term psychological trauma resulting from a sexual assault was not fully conceptualised until the late-twentieth century, at least not in mainstream medicine.⁶⁴ Although the medical profession had developed a notion of psychological trauma by the late-nineteenth century, most famously in relation to 'railway spine' in the 1860s, it was expected to take the form of nervous shock rather than a chronic state.⁶⁵ Medical witnesses demonstrated some 'expertise' in terms of being the only witnesses to speak on nervous conditions, but medical testimony even on such short-term traumatic states was rare in court. Medical practitioners only made reference to 15 out of 608 complainants having 'nervous shock' or 'nervous depression'.⁶⁶ Bourke also observes that female hysteria, which would later become interwoven with the issue of trauma, was generally conceptualised as a *cause* of false accusations rather than as a consequence of sexual crime in the late-nineteenth and early-twentieth centuries.⁶⁷ Evidence to support this claim is found in one of the few Middlesex trials in which a medical practitioner discussed hysteria, which took place in 1899 and involved a surgeon as the accused. He testified that '[h]ysterical people will make any charges

⁶⁴ Joanna Bourke, 'Gendering Fear: A History of the Traumatic Languages of Sexual Violence', paper presented at *The History of Stress: Medical Research and Contested Knowledge in the 20th Century* Public Lecture Series, 4 November 2009, Exeter (UK).

⁶⁵ Tim Armstrong, 'Two Types of Shock in Modernity', *Critical Quarterly* 42 (2000), 60-73, p. 61; Frederick Heaton Millham, 'Historical Paper in Surgery: A Brief History of Shock', *Surgery* 148 (2010), 1026-37, p. 1030.

⁶⁶ For example see London, LMA, Pre-Trial Statements, Jesse Cave tried at the Middlesex Sessions on 8 July 1879 for indecent assault, MJ/SP/E/1879/014; London, LMA, Pre-Trial Statements, George Hornsby tried at the Middlesex Sessions on 22 May 1879 for indecent assault, MJ/SP/E/1879/007; Gloucester, GA, Thomas Cobb tried at the Gloucestershire Quarter Sessions on 19 October 1898 for assault with intent, Q/SD/2/1898.

⁶⁷ Bourke, 'Sexual Violation and Trauma in Perspective', p. 408.

against anybody. Their imagination is great'.⁶⁸ Rather than being necessarily corroborative of a charge, *over* emotionality was thus viewed with some suspicion by medical practitioners.

Most medical witnesses focused on the subjects of moral or bodily harm, rather than the psychological consequences of sexual crime. As Taylor wrote, a young girl was expected to sustain 'injury, morally and physically' from a sexual offence.⁶⁹ Within the courtroom, medical practitioners focused particularly on the latter issue and thus on physiology rather than psychology. This emphasis on physiology was in part because of the greater visibility and measurability of bodily harm. It also tied in with approaches to medical 'expertise' on the subjects of sexual maturity and sexual consent, as discussed in the first half of this thesis. Medical witnesses presented a jury with a description of the abused body that theoretically allowed it to 'speak for itself' but, as this chapter will show, was actually both mediated and carefully constructed.⁷⁰ They also focused on bodily signs rather than symptoms such as pain.⁷¹ This focus was in some respect due to the limited ability of children to describe symptoms reliably and in part due to a general shift away from patient-centred diagnosis, which has been identified in scholarly works on the rise of the patient as 'object' rather than as 'subject'.⁷² This is not to say that the patient's voice was completely removed from all clinical encounters. However, the issue of symptoms was generally superfluous to the medico-legal 'script'.

⁶⁸ London, LMA, Pre-Trial Statements, William Jones not tried (no bill) at the Middlesex Sessions in May 1889 for indecent assault, MJ/SP/E/1889/022.

⁶⁹ Taylor, *Manual of Medical Jurisprudence*, 8th edn, p. 601.

⁷⁰ Nick Lee, 'Faith in the Body? Childhood, Subjecthood and Sociological Enquiry' in *The Body, Childhood and Society*, ed. Alan Prout (Basingstoke: Palgrave Macmillan, 2000), 149-71, p. 154.

⁷¹ Only 25 medical witnesses from the sample commented on symptoms, such as complaints of 'pain', while all others focused on genital signs and 'Physical Proofs'.

⁷² For some discussions on the patient as 'object' and the rise of clinical observation, see: Mary Wilson Carpenter, *Health, Medicine and Society in Victorian England* (Santa Barbara; Denver; Oxford: Praeger, 2010), p. 25; Anne Digby, *The Evolution of British General Practice, 1850-1948* (Oxford: Oxford University Press, 1999), p. 190; Mary E. Fissell, 'The Disappearance of the Patient's Narrative and the Invention of Hospital Medicine' in *British Medicine in an Age of Reform*, ed. Roger French and Andrew Wear (London; New York: Routledge, 1991), 92-109, p. 93; J. Gillis, 'Taking a Medical History in Childhood Illness: Representations of Parents in Pediatric Texts since 1850', *Bulletin of the History of Medicine* 79 (2005), 393-421; Lee, 'Faith in the Body?', p. 151; Roy Porter, 'Reforming the Patient in the Age of Reform: Thomas Beddoes and Medical Practice' in *British Medicine in an Age of Reform*, ed. French and Wear, 9-41, pp. 10-11; Lynn Sacco, *Unspeakable: Father-Daughter Incest in American History* (Baltimore, MD: Johns Hopkins University Press, 2010), p. 79; and Kevin P. Siena, *Veneral Disease, Hospitals and the Urban Poor: London's "Foul Wards," 1600-1800* (Rochester, NY: University of Rochester Press, 2004), p. 13.

Most medical testimony about genital violence focused on the female body. Injuries were expected to include, to quote the London physician Alfred Lee's 1882 pre-trial statement, 'abrasions ... laceration ... dilation of the vagina ... rupture of the labia ... blood stains ... inflammatory symptoms ... rupture of the hymen'.⁷³ All of these were identified as possible indicators of a crime in the cases under study, in addition to vaginal discharges from violence or venereal disease. As this analysis will go on to show, the interpretation of such injuries varied according to the age of the girl but they were cited regularly in relation to females of all ages. The limited discussion of male genital injury related not only to the overall rarity of cases involving males, but also to the expectation that the male body would display fewer signs of a sexual crime than the female body. The indecent touching of a man or boy apparently would not leave any lasting mark unless a venereal disease was transmitted, whereas the same offence upon a girl could cause some genital damage if a manual assault was also penetrative. Only cases involving anal penetration of pre-pubescent boys were expected to involve notable genital injury. According to Taylor's jurisprudence text, claims made by males were 'commonly sufficiently proved without medical evidence, except in the cases of young persons, when marks of physical violence will in general be sufficiently apparent'.⁷⁴ These 'marks of physical violence' on the genital area of young males were similar to those cited for females because, as Louise Jackson has observed regarding the girl's body, a male child's anus was expected to be naturally 'small and enclosed'.⁷⁵ It would therefore be examined for signs of recent violence such as laceration, bruising and blood just as a young girl's vagina would be. Taylor also noted the signs of 'one long habituated to these unnatural practices' in males, in order to distinguish them from the signs of violence, as 'a funnel-shaped state of the parts ... with the appearance of dilation ... and a destruction of the folded or puckered state of skin in this part'.⁷⁶ However, as noted above, cases with evidence that boys or men were accustomed to sodomy were generally dismissed by magistrates or grand juries before reaching trial.

⁷³ London, LMA, Pre-Trial Statements, George Walker tried at the Middlesex Sessions on 5 December 1882 for indecent assault, MJ/SP/E/1882/050.

⁷⁴ Taylor, *Manual of Medical Jurisprudence*, 4th edn (London: J. & A. Churchill, 1852 [1844]), p. 593. This quote was unchanged throughout all the editions, up to and including 1910.

⁷⁵ Louise A. Jackson, 'Child Sexual Abuse and the Law: London 1870-1914', unpublished doctoral thesis, Roehampton Institute (1997), p. 180.

⁷⁶ Taylor, *Manual of Medical Jurisprudence*, 9th edn (London: J. & A. Churchill, 1874 [1844]), p. 678. This statement was a new addition to the 9th edition but was retained throughout all the others up to 1910.

Overall, 42 per cent of medical practitioners who reached trial referred to finding marks of genital violence during their examinations of female complainants. Rather than a ‘real’ figure of genital violence, this statistic indicates that importance was placed on such signs in committing a case for trial. Figure 5.1 depicts medical testimony on genital injury in 217 cases involving female complainants that fulfil the following criteria: the complainant’s exact age is known; the complainant stated that a form of penetration had occurred; and medical witnesses gave an opinion on signs that they found in the genital area, such as marks of injury or vaginal discharge.⁷⁷ These criteria result in the exclusion of girls under the age of four, who were generally considered too young to testify as to whether penetration had occurred or not. However, the criteria are important because they narrow medical testimony down to cases in which signs of genital violence were corroborative of a complaint.⁷⁸ Otherwise, as one Somerset surgeon noted, the absence of marks of violence could be ‘consistent’ with a complaint if a girl ‘stated in her evidence that defendant did not hurt her’.⁷⁹ Because of the limited size of the sample, Figure 5.1 should only be viewed as a starting point for considering age-based trends in medical diagnosis.⁸⁰ However, the graph presents some trends that are worthy of further consideration. It depicts a gradual decline in the proportion of medical practitioners who testified to finding marks of violence as complainants grew older, particularly in girls over the age of 16. This decline was compensated for by a gradual increase in medical uncertainty about how to interpret genital signs and an increase in the number of cases in which no marks of violence were found. There are three possible explanations for these age-based trends, which this chapter will go on to consider in turn: firstly, that medical practitioners interpreted genital signs in the light of broader medical thought about the physiological changes that occurred at puberty;

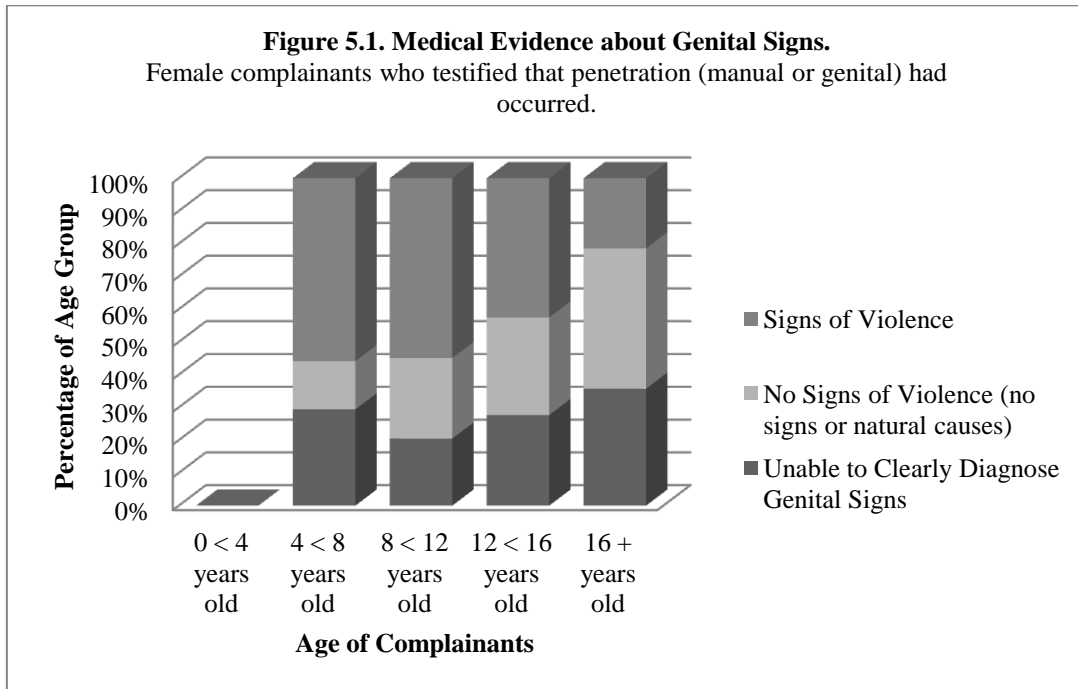
⁷⁷ Only four equivalent cases involving males reached trial, in which male complainants of a known age alleged that anal penetration had occurred and were examined by a medical practitioner. Medical evidence about male complainants is therefore excluded from this statistical analysis, but when this thesis later considers the reception of medical evidence about genital violence in *all* types of case it analyses both male and female complainants.

⁷⁸ The distinction between ‘complaint’ and ‘charge’ is intentional and important. These statistics have been calculated on the basis of the nature of a *complaint*, because the chapter has already shown that the complaint and the charge did not always correspond. Many cases of alleged manual or genital penetration were tried as ‘indecent assault’, for example. Selecting cases for statistical analysis on the basis of the complaint rather than the charge allows for the incorporation of all cases in which medical testimony about marks of genital violence would have been corroborative.

⁷⁹ Taunton, SRO, Pre-Trial Statements, Frederick William King tried at the Somerset Quarter Sessions on 1 July 1902 for indecent assault, Q/SR/812.

⁸⁰ The youngest and oldest age groups are particularly small, with only no girls under the age of four and only 14 over the age of 16. The age categories of 4<8, 8<12 and 12<16 years old are more statistically significant with samples of 34, 122 and 47 girls respectively.

secondly, that medical testimony was influenced by moral anxieties about the higher likelihood of false claims and previous unchastity as girls grew older; thirdly, that marks of resistance replaced marks of genital violence as the most important ‘physical proofs’ in cases involving pubescent and post-pubescent complainants.



The nature of medical testimony drew on physiological models of sexual maturity rather than only on legal definitions of sexual consent. Most medical practitioners in the cases under study utilised naked-eye diagnosis, which meant that the interpretation of genital signs was influenced by medical practitioners’ knowledge of the body and its state at different ages. Ogston noted that genital injury was expected to be most clear in the youngest complainants because of the ‘disproportion between the adult penis and imuberant female genitals’, whereas ‘where both parties are above puberty, it is obvious that the same disproportion may still exist, though in a less degree, and produce effects in the female proportionate in degree, though the same in kind’.⁸¹ Ogston’s work was representative of the tone of most contemporary books of medical jurisprudence, which emphasised that the inherent smallness of the child’s body meant that penetrative sex was impossible without significant damage. As noted in Chapter One, with respect

⁸¹ Ogston, *Lectures on Medical Jurisprudence*, p. 105.

to cases involving infants, some authors claimed that they could not be raped at all.⁸² In line with these ideas, in 1869 a Middlesex police surgeon testified that ‘[t]he child was 1 year and 10 months old and it would be impossible for the male organ ... to pass up the child’s person’.⁸³ As the female vagina opened and grew with puberty, the marks of damage after an alleged sexual crime were expected to be less. In a girl who was not a virgin, such signs were expected to be almost completely absent. This framework of thought placed emphasis on the age of a female complainant rather than the age of the male who committed an assault, as the presumption in law was that an offender capable of a penetrative sex act would be over the age of puberty and fully developed. The size of man’s genitals was sometimes taken into consideration with regard to assessing the expected injuries. In one Middlesex case of alleged indecent assault a medical practitioner noted that the prisoner was ‘large made’ in order to situate his findings that the young male complainant had no signs of anal injury, thus the issue of ‘disproportion’ was also relevant to males.⁸⁴ However, such evidence was limited to cases of alleged penetrative assaults by adult men on young boys which were very rare in the cases under study.

Ideas surrounding the female body at different ages shaped how medical practitioners interpreted a range of genital signs. The subject of blood will be considered here as an example, although similar patterns can be identified in the context of other genital signs such as vaginal discharges.⁸⁵ By the late-Victorian period it was deemed possible to differentiate menstrual from non-menstrual blood microscopically, as explained in Guy and Ferrier’s *Principles of Forensic Medicine*.⁸⁶ However, most general practitioners

⁸² Ogston, *Lectures on Medical Jurisprudence*, p. 91; Lisa Cardyn, ‘The Construction of Female Sexual Trauma in Turn-of-the-Century American Mental Medicine’ in *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930*, ed. Mark S. Micale and Paul Lerner (Cambridge: Cambridge University Press, 2001), 172-202, p. 198.

⁸³ London, LMA, Pre-Trial Statements, Charles Hutley tried at the Middlesex Sessions on 20 July 1869 for indecent assault, MJ/SP/E/1869/014.

⁸⁴ London, LMA, Pre-Trial Statements, Joseph Parks tried at the Middlesex Sessions on 2 April 1878 for indecent assault on a male, MJ/SP/E/1878/013.

⁸⁵ Vaginal discharges could have been interpreted as a dirt-based disease such as worms or leucorrhoea in children, a healthy secretion from the pubescent body, a result of inflammation caused by sexual assault, or a sexually transmitted infection such as gonorrhoea. Like blood stains, the interpretation of such discharges depended on a complainant’s state of sexual maturity and on interactions with lay knowledge; Bates, ‘Venereal Disease Diagnosis in English Court’; W. G. Ruberg, ‘“Mother Knows Best”: The Transmission of Knowledge of the Female Body and Venereal Diseases in Nineteenth-Century Dutch Rape Cases’ in *The Transmission of Health Practices (c. 1500 to 2000)*, ed. Martin Dinges and Robert Jütte (Stuttgart: Franz Steiner Verlag, 2001), 35-47.

⁸⁶ William A. Guy and David Ferrier, *Principles of Forensic Medicine*, 5th edn (London: H. Renshaw, 1881 [1844]), p. 66.

used naked-eye diagnosis to interpret genital blood stains because they lacked access to microscopes. Medical witnesses therefore needed to draw upon broader knowledge about the changing female body at puberty, particularly ages of menarche, in order to interpret blood stains. A Somerset general practitioner testified that stains on the drawers of an eight-year-old girl ‘might have resulted from natural causes but it is extremely unlikely. I have never seen a girl of that age suffering from her courses’.⁸⁷ Once a complainant reached the age of 16 or 17, the possibility of blood being ‘natural’ was automatic and medical witnesses made statements such as ‘[t]he blood might have been caused by a finger being inserted, or by her courses’ and ‘[t]he red stain on her drawers may have been from menstrual discharge’.⁸⁸ However, as Chapter Two showed, the age of menarche was expected to be variable and therefore medical practitioners demonstrated increasing uncertainty about the origin of blood stains in cases involving girls over the age of 12. As medical practitioners grew uncertain about the origins of blood stains in older girls they also drew on lay knowledge to help them in their interpretation, further demonstrating that medical knowledge was negotiated ‘from below’ rather than only being imposed ‘from above’. In a Gloucestershire case of ‘assault with intent’ on a 14-year-old girl in 1898 a general practitioner testified that ‘I ascertained she had never menstruated’, seemingly from the girl’s mother who testified that ‘menstruation has not commenced with her’.⁸⁹ The hazy nature of naked-eye diagnosis of many genital signs meant that medical practitioners drew on wider professional knowledge and models of sexual maturity as part of their process of interpretation. The degree to which medical testimony was shaped by the judicial context evidently was not absolute, as physiological adulthood did not necessarily correspond to legal adulthood.

The age-based nature of medical testimony about genital violence was possibly due not only to the issue of sexual maturity, but also to age-based questions about whether marks could have been self-inflicted or inflicted by a parent for the purposes of making

⁸⁷ Taunton, SRO, Pre-Trial Statements, John Henry Hayman tried at the Somerset Quarter Sessions on 1 July 1903 for indecent assault, Q/SR/812. Middlesex police surgeon Samuel Lloyd gave similar evidence for a girl of the same age in 1886, stating that ‘it is not usual to find blood from so young a child’; London, LMA, Pre-Trial Statements, Dorothy Lund and Albert Warcup tried at the Middlesex Sessions on 22 June 1886 for indecent assault, MJ/SPE/1886/031.

⁸⁸ London, LMA, Pre-Trial Statements, Robert Brown tried at the Middlesex Sessions on 19 January 1875 for indecent assault, MJ/SP/E/1875/002; Taunton, SRO, Pre-Trial Statements, Abraham Escott tried at the Somerset Quarter Sessions on 28 June 1871 for indecent assault, Q/SR/684.

⁸⁹ GA, Pre-Trial Statements, Thomas Cobb.

a false charge. In the 1880s feminists emphasised the inherent truthfulness of female children, meaning that there was an expectation that a jury would recognise the difference between a ‘normal’ truthful child and an artful precocious one.⁹⁰ However, ‘normal’ pubescent and post-pubescent women were expected to have a propensity to lie. Although Taylor raised concerns about false claims in the context of complainants of all ages, for example claiming that adults could ‘tutor’ innocent young children to lie, he emphasised that older complainants were the most likely to pursue malicious charges.⁹¹ Ogston likewise stated that ‘[w]e have seen that rape has been feigned in the case of children under puberty. After puberty it is much more common’.⁹² The defence counsel in a Gloucestershire case directly echoed this medical rhetoric when he mentioned, after it had transpired that the 13-year-old complainant in an indecent assault case had ‘passed from childhood into womanhood’, that ‘girls of that age were subject to strange lies and fancies which so possessed them that they were not accountable for what they did’.⁹³ Undoubtedly not every medical practitioner fitted within this trend, as Lawson Tait is well known for emphasising the likelihood of false claims by children.⁹⁴ However, medical, legal and wider social anxieties more commonly focused on girls at and above the age of puberty.

Planting the idea that a claim was false for the purposes of extortion or from spite was a common defence strategy in court, particularly in relation to precocious girls, therefore medical practitioners were often questioned as to their opinion on the subject. While other witnesses were forbidden from testifying on anything other than ‘fact’, members of the adversarial process turned the special ‘opinion’ privilege of ‘expert’ witnesses to their own advantage by guiding medical practitioners to speak on moral matters. Used in this way, the ‘expert’ witness consolidated rather than threatened judicial authority. In a Devon case from 1881 involving a 12-year-old female complainant, surgeon Isiah

⁹⁰ Louise Jackson, ‘The Child’s Word in Court: Cases of Sexual Abuse in London, 1870-1914’ in Margaret L. Arnot and Cornelia Osborne (eds), *Gender and Crime in Modern Europe* (London: UCL Press, 1999), 222-37, p. 228.

⁹¹ Taylor, *Manual of Medical Jurisprudence*, 4th edn, p. 580. This reference to children being ‘tutored’ was maintained in all editions, up to and including 1910 in *Principles and Practice*.

⁹² Ogston, *Lectures on Medical Jurisprudence*, p. 119. See also Taylor, *Medical Jurisprudence*, 4th edn, p. 576.

⁹³ ‘Thornbury: Police Court’, *The Bristol Mercury and Daily Post*, 10 June 1885, 7, p. 7.

⁹⁴ Jackson, ‘The Child’s Word in Court’, p. 277; Susan Edwards, ‘Discourses of Denial and Moral Panics: The Pornographisation of the Child in Art, the Written Word, Film and Photograph’ in *Behaving Badly: Social Panic and Moral Outrage – Victorian and Moral Parallels*, ed. Judith Rowbotham and Kim Stevenson (Aldershot: Ashgate, 2003), 177-93, p. 181; Tait, ‘An Analysis of the Evidence’, 226-35.

Butters stated under cross-examination by the court itself that ‘[i]t is improbable that the injuries would have been self-inflicted considering the pain it gave her’.⁹⁵ The questioning of medical witnesses on the issue of false claims was evidently not only tolerated but in some cases actively promoted by judicial authorities. The centrality of such medico-moral issues in court was encouraged by the judicial system as a point of intersection between the age-based concerns of medical practitioners and the judiciary. However, few medical practitioners in the cases that reached trial testified that they found evidence of self-inflicted injuries. This may have been linked to pre-trial trends, as cases with explicit ‘expert’ evidence that a claim was false were likely to have been dismissed.

The significant proportion of medical testimony that gave no clear interpretation of genital signs is also worthy of some note here, the extent of which is visible in Figure 5.1 above, as it touches upon the question of false charges. As Nancy Tuana notes, ignorance ‘is not a simple lack. It is often constructed, maintained, and disseminated and is linked to issues of cognitive authority, doubt, trust, silencing, and uncertainty’.⁹⁶ In his study of eighteenth-century infanticide trials, Mark Jackson found that uncertainties in medical testimony were actually useful for judges and juries because it allowed them to incorporate their own humanitarian and political concerns into the law.⁹⁷ Medical testimony therefore did not need to be clear and certain in order to be useful. In sexual assault trials, medical uncertainty was partly due to difficulties of diagnosis as the female body changed with age. However, ‘epistemologies of ignorance’ were also ‘maintained, and disseminated’ as a means for medical witnesses to evade the possibility of unintentionally supporting false charges. They created an opportunity for members of the court to highlight medical uncertainties, often to the advantage of defence counsel. In 1878 a general practitioner from Middlesex refused to ‘pledge my

⁹⁵ Exeter, DRO, Pre-Trial Statements, Richard Loye tried at the Devon Quarter Sessions on 29 June 1881 for indecent assault, QS/B/1881/Midsummer.

⁹⁶ Nancy Tuana, ‘Coming to Understand: Orgasm and the Epistemology of Ignorance’, *Hypatia* 19 (2004), 194-232, p. 194. I am grateful to Willemijn Ruberg for drawing my attention to this subject of ‘epistemologies of ignorance’ and for sending me an unpublished version of her article to do so; Willemijn Ruberg, ‘Trauma, Body and Mind: Forensic Medicine in Nineteenth Century Dutch Rape Cases’, *Journal of the History of Sexuality* (forthcoming). On the construction of uncertainty see also Rees, “‘Neutral Reports’ in Rape Cases”.

⁹⁷ Mark Jackson, *New-Born Child Murder: Women, Illegitimacy and the Courts in Eighteenth-Century England* (Manchester: Manchester University Press, 1996), p. 15.

reputation' on his findings of genital violence when pressed under cross-examination.⁹⁸ In an 1871 case involving a three-year-old girl, in which the pre-trial statement was unusual in recording questions posed to the medical witness, the prisoner cross-examined an army staff surgeon by asking '[c]ould not the child be tampered with before it was brought to you besides my interfering with it?' and the medical witness simply replied 'I could not say'.⁹⁹ These medical practitioners' uncertainty about the origin of genital marks of violence was part of the counsel's method of planting doubt about the veracity of claims, which in itself was a useful adversarial strategy. Although some scholars have claimed that 'experts' are under pressure to 'profess greater certainty than they really feel' in order to gain influence in court, these cases conversely indicate that agents of judicial processes tolerated and even took advantage of medical ambiguity.¹⁰⁰

Genital signs were also used to consider other medico-moral issues such as the subject of a complainant's virginity before an alleged assault, or rather the lack thereof. The subject of prior chastity was most prominent in cases involving females at and above the age of puberty, despite theoretically being irrelevant to a criminal charge in such instances.¹⁰¹ Although Taylor noted that 'the law protects a prostitute against involuntary connection just as it protects children and chaste women', Guy and Ferrier stated in *Principles of Forensic Medicine* that 'it is usual ... to endeavour to rebut the charge of rape by alleging previous unchastity – a question on which the medical examiner may have to express an opinion'.¹⁰² C. Graham Grant's forensic medicine textbook for police surgeons similarly emphasised that '[w]hether the victim is chaste or otherwise has no bearing on the legal aspect of the case, although it may influence the minds of the jury'.¹⁰³ Grant's distinction between the 'legal aspects' of a case and the jury's response is significant. It indicates that issues such as character could be irrelevant in law but both permitted and influential within the courtroom, thus that there

⁹⁸ London, LMA, Pre-Trial Statements, Alfred Granger tried at the Middlesex Sessions on 20 February 1878 for carnal knowledge, MJ/SP/E/1878/006.

⁹⁹ Gloucester, GA, Pre-Trial Statements, Peter Learly tried at the Gloucestershire Quarter Sessions on 27 June 1871 for indecent assault, Q/SD/2/1871.

¹⁰⁰ Good, *Anthropology and Expertise in the Asylum Courts*, p. 45.

¹⁰¹ The only case in which a boy's previous (un)chastity was discussed by a medical practitioner was ignored by the grand jury, as outlined in the chapter's first section.

¹⁰² Taylor, *Principles and Practice*, 6th edn, vol. 2, p. 116; Guy and Ferrier, *Principles of Forensic Medicine*, p. 61.

¹⁰³ C. Graham Grant, *Practical Forensic Medicine: A Police-Surgeon's Emergency Guide*, 2nd edn (London: H. K. Lewis, 1911 [1907]), p. 43.

was a difference between legislative and judicial frameworks of thought about sexual crime. Medical jurisprudence texts seemingly reacted more to the demands of the courtroom than to legislative requirements, which helped to create a shared pool of medico-legal knowledge that could operate successfully in practice rather than just in theory.

A brief analysis of medical discussions of the hymen and virginity demonstrates the importance placed on the subject of chastity by medical practitioners, courts and counsel. Evaluation of previous (un)chastity was most commonly achieved by examining the state of the hymen, although this was not deemed to be a straightforward process. Medical literature emphasised the need for general caution when interpreting such signs and provided multiple case studies of pregnant women with intact hymens or virgins with congenitally absent hymens.¹⁰⁴ Despite these limitations, Casper emphasised that ‘we must not be thereby led astray in determining the value of this sign, which is *the most valuable of all in a diagnostic point of view*’.¹⁰⁵ Like many medical authors Casper went on to note that the absence of a hymen with the presence of *carunculae myrtiformes* could be cited as a mark of genital violence, because these small fleshy remnants of a perforated hymen shrivelled over time. Conversely, therefore, the absence of a hymen without any signs of recent damage could be viewed as a sign of previous unchastity or of repeated sexual assaults over a long duration, as often claimed in incest cases.

In the cases studied for this thesis, medical witnesses explicitly interpreted the absence of a hymen as a sign of a girl being accustomed to sexual intercourse in five cases. As only one of these cases involved alleged incest and repeated long-term sexual contact, medical evidence about the absence of virginity was generally a negative comment on a complainant’s character rather than the corroboration of a charge. A further five cases in

¹⁰⁴ For contemporary examples of cases involving pregnant women with intact hymens and virgins with congenitally absent hymens, one of which was provided by an Exeter-based correspondent and thus links to the relative geographical uniformity described earlier, see: ‘Notes, Short Comments, and Answers to Correspondents’, *The Lancet*, 3 November 1888, 898-900, p. 899; ‘Physical Signs of Virginity’, *The Lancet*, 15 July 1865, 84, p. 84; and Taylor, *Manual of Medical Jurisprudence*, 8th edn, pp. 602-05. For an extensive discussion of the value and problems of the hymen as a sign see ‘The Physical Signs of Virginity’, *BMJ*, 5 January 1895, 27, p. 27. For a historiographical discussion of the problematic nature of the hymen in nineteenth-century medico-legal discourse see Crozier and Rees, ‘Making a Space for Medical Expertise’, pp. 301-03.

¹⁰⁵ Johann Ludwig Casper, *Handbook of Forensic Medicine*, trans. from 3rd edn by G. W. Balfour, vol. 2 (London: New Sydenham Society, 1862), pp. 279-80. Emphasis in original.

which a girl was found to be previously unchaste had been found a ‘no bill’ by the grand jury and it is likely that more were dismissed at the magistrates’ courts, if the newspaper reports considered in the first section were representative. On the other hand, some medical witnesses who found signs of genital violence emphasised that a girl had been a virgin before the alleged assault. In one such Middlesex case involving suspected carnal knowledge of an 11-year-old girl in 1869, which was a misdemeanour at this time, a physician testified to having found a ‘recent partial rupture’ of the girl’s hymen. When questioned by a magistrate, he stated that ‘I believe that up to within 48 hours of my examination of this child, she was a virgin’.¹⁰⁶ The fact that this physician was explicitly questioned by the highest member of the court as to the girl’s previous chastity demonstrates the importance of such evidence.

Medical interpretations of the hymen as a sign were influenced by the age of a complainant. The cases mentioned above, in which medical witnesses at trial attributed a complainant’s absent hymen to prior unchastity, involved complainants aged between 10 and 17. The younger the girl, the less likely medical witnesses were to attribute an absent hymen to unchastity. In 1868, a Middlesex police surgeon testified that ‘it is an unusual thing to have no hymen at that age [ten years old], it may be absent from natural causes’.¹⁰⁷ Despite finding an absent or imperfect hymen in girls as young as three, without the presence of *carunculae myrtiformes*, medical practitioners were more likely to attribute it to natural causes or ‘congenital’ absence in cases with the youngest complainants.¹⁰⁸ The possibility of very young girls consenting to having sexual partners was thus removed, at least in the majority of cases. In one exceptional case from Gloucestershire, a six-year-old girl was accused of being a ‘little whore’ by the prisoner and as ‘very forwards’ by a defence witness.¹⁰⁹ However, the medical witness testified to finding ‘nothing about [the] child’s parts to suggest she was a whore to a professional man’ and a newspaper described the prisoner’s claims as ‘extraordinary

¹⁰⁶ London, LMA, Pre-Trial Statements, Joseph Dungay tried at the Middlesex Sessions on 23 December 1869 for carnal knowledge, MJ/SP/E/1869/025.

¹⁰⁷ London, LMA, Pre-Trial Statements, William Judge tried at the Middlesex Sessions on 22 January 1868 for indecent assault, MJ/SP/E/1868/001.

¹⁰⁸ See London, LMA, Pre-Trial Statements, Robert Thornton tried at the Middlesex Sessions on 21 December 1876 for indecent assault, MJ/SP/E/1876/027.

¹⁰⁹ Gloucester, GA, Pre-Trial Statements, George Norman Robbins tried at the Gloucestershire Quarter Sessions on 18 March 1906 for indecent assault, Q/SD/2/1906.

allegations'.¹¹⁰ This case presents a solitary example of questions being posed about a girl's chastity below the age of ten, in which such allegations were deemed extremely unusual and refuted by the medical witness.

Questions about masturbation were more common than questions about chastity in cases involving young complainants, particularly in relation to the subject of genital injury. In one case from Somerset in 1903 a general practitioner refuted a suggestion by defence counsel that an eight-year-old girl could have caused her genital injuries by masturbating, by stating that '[t]here was no enlargement of the organ, which would have appeared had the child been in the habit of using excitement'.¹¹¹ The subject of masturbation was also raised in the context of boys approaching the age of expected puberty, which tied in with wider social anxieties about onanism. In one case involving a 13-year-old complainant, two medical practitioners testified under cross-examination that a part of the boy's penis was lacerated but that 'I do not think the appearance I saw could have been caused by the boy himself' and 'I do not think the state of the boy's penis could have been produced by self-abuse'.¹¹² These cases seemingly reached trial because the medical witnesses *refuted* any possibility that the children had caused their injuries by 'self abuse'. Young girls and boys were expected to be asexual if they were to be perceived as victims, which tied in with more general contemporary ideas surrounding 'normal' childhood and sex as discussed in Chapter One.

Evidence about chastity was a form of medico-moral testimony, which was seemingly permitted and sometimes even actively encouraged by courts. Such a medico-moral approach was also common in relation to the subjects of consent and resistance. Testimony on these subjects focused heavily on the post-pubescent female body because marks of violence were perceived as necessary to prove that an offence was 'against the will'. Indeed, signs of resistance became more important than signs of genital violence in cases involving post-pubescent girls. 40 per cent of cases with medical evidence and complainants over the age of 16 that reached trial included evidence about signs of bodily violence, almost double the proportion of such cases

¹¹⁰ GA, Pre-Trial Statements, George Norman Robbins; 'Gloucestershire Quarter Sessions', *Bristol Daily Mercury*, 28 June 1906, 7, p. 7.

¹¹¹ SRO, Pre-Trial Statements, John Henry Hayman.

¹¹² London, LMA, Pre-Trial Statements, George Kimpton tried at the Middlesex Sessions on 28 July 1875 for assault with intent to commit an unnatural crime, MJ/SP/E/1875/013.

with signs of genital violence.¹¹³ In the light of conclusions drawn in the chapter's first section, this statistic can be attributed to the pre-trial dismissal of many equivalent cases without supporting medical evidence of resistance. Statistics of this kind therefore primarily indicate the importance placed upon such evidence by the courts rather than *all* medical approaches to these issues. However, medical practitioners also had some agency in interpreting bodily signs and drew upon professional and moral thought in order to do so. For example, except in certain circumstances which will be returned to below, medical practitioners emphasised that it was impossible to rape an adult female who resisted to her utmost capacity. As one Devon general practitioner testified, in the context of a girl aged 17, 'I think it impossible for a man standing up to commit a rape on a girl who is conscious'.¹¹⁴ In a 'real rape' signs of violence and resistance were expected to be found on the body, rather than only on the genitals. As Taylor noted in his section on 'young females after puberty':

[I]n a true charge, we should expect to find not only marks of violence about the pudendum, but also injuries of greater or less extent upon the body and limbs ... As these marks of violence on the person are not likely to have been produced with the concurrence of the girl, they are considered to furnish some proof of the intercourse having been against her will.¹¹⁵

Although medical jurisprudence texts noted that resistance would also lead to the exacerbation of marks of violence on the genital area, the latter signs could also apparently occur in a virgin who made no resistance. Genital injury was therefore not considered a reliable marker of whether sexual contact had occurred by force. More commonly medical jurisprudence texts, along with medical practitioners in court, conflated the subject of resistance with the subject of bodily signs of violence.

As medical jurisprudence texts' advice about signs of resistance were defined by whether a girl had reached puberty, rather than by the legal age of sexual consent, medical testimony differed from the law in some respects. Taylor's statement that '[g]irls who have passed this age are considered to be capable of offering some resistance to the perpetration of the crime' originally referred to girls over the age of 12,

¹¹³ The latter statistic was 21 per cent.

¹¹⁴ Exeter, DRO, Pre-Trial Statements, Frederick Trembath tried at the Devon Quarter Sessions on 16 October 1889 for indecent assault, QS/2/1889/Michaelmas.

¹¹⁵ Taylor, *Manual of Medical Jurisprudence*, 8th edn, p. 601.

then over 13 in 1886 and over 16 in 1894.¹¹⁶ Not only were these changes belated, as the age of consent was raised to 16 in 1885, but in all other respects his advice stayed the same. Taylor continued to situate these statements in a section about girls ‘after puberty’, which contradicted the book’s references to more rigid ages of consent. The separation between medicine and the law on the subject of resistance was also evident in some court cases. In a trial from 1888 involving an alleged indecent assault on a 12-year-old girl, a Devon surgeon testified that ‘I examined her for bruises but I failed to find any ... she is a strong muscular girl who would not shew [sic] bruises unless some strong violence had been used’.¹¹⁷ This surgeon implied that the girl was physically capable of resistance, even though she was not deemed capable of consenting or resisting in the eyes of the law. As noted in the context of marks of genital violence, medical witnesses drew on broader physiological models of development in their testimony rather than just on the legal age of sexual consent. Such an approach was advocated in some jurisprudence textbooks, as in John Dixon Mann’s *Forensic Medicine and Toxicology* which recommended that a person’s development be assessed ‘by the individual rather than by the age’.¹¹⁸

Figure 5.2 provides a means to consider the relationship between medical testimony about signs of violence/resistance and sexual consent legislation. It compares medical testimony about bodily violence from indecent assault trials before and after the 1880 CLAA, which removed consent as a defence for prisoners in cases of indecent assault against boys and girls under the age of 13. The graph depicts medical testimony from 151 indecent cases involving complainants under the age of 13 before 7 September 1880, when the 1880 CLAA came into action, and 142 comparable cases from after this date. It demonstrates a rise in the number of cases which reached trial involving medical testimony about an *absence* of marks of violence or resistance, which increased from two to 23 after legal changes. Cases with medical testimony about an absence of signs of violence or resistance were possibly dismissed by magistrates or grand juries before 7 September 1880, when a child’s consent was a legal defence to an indecent assault

¹¹⁶ Taylor, *Manual of Medical Jurisprudence*, 8th edn, p. 601; Taylor, *Manual of Medical Jurisprudence*, 11th edn (London: J. & A. Churchill, 1886 [1844]), p. 699; Taylor, *Principles and Practice*, ed. Thomas Stevenson, 4th edn, vol. 2 (London: J. & A. Churchill, 1894 [1865]), p. 448.

¹¹⁷ Exeter, DRO, Pre-Trial Statements, William Helmore tried at the Devon Quarter Sessions on 17 October 1888 for indecent assault, QS/B/1888/Michaelmas.

¹¹⁸ John Dixon Mann, *Forensic Medicine and Toxicology*, 4th edn (London: Taylor & Francis, 1908 [1893]), p. 93.

charge. Changing sexual consent legislation seemingly had some influence on the nature of medical testimony, or at least the testimony that reached trial. However, these trends should not be oversimplified. The graph also presents a consistently high proportion of cases in which medical practitioners were not questioned at all about the presence or absence of bodily marks on young complainants, even when consent was a legitimate legal defence. The courts always focused more on consent and resistance in relation to pubescent or post-pubescent girls, which indicates that the legal relevance of marks of resistance and the importance placed upon them in the judicial process were not necessarily synonymous.

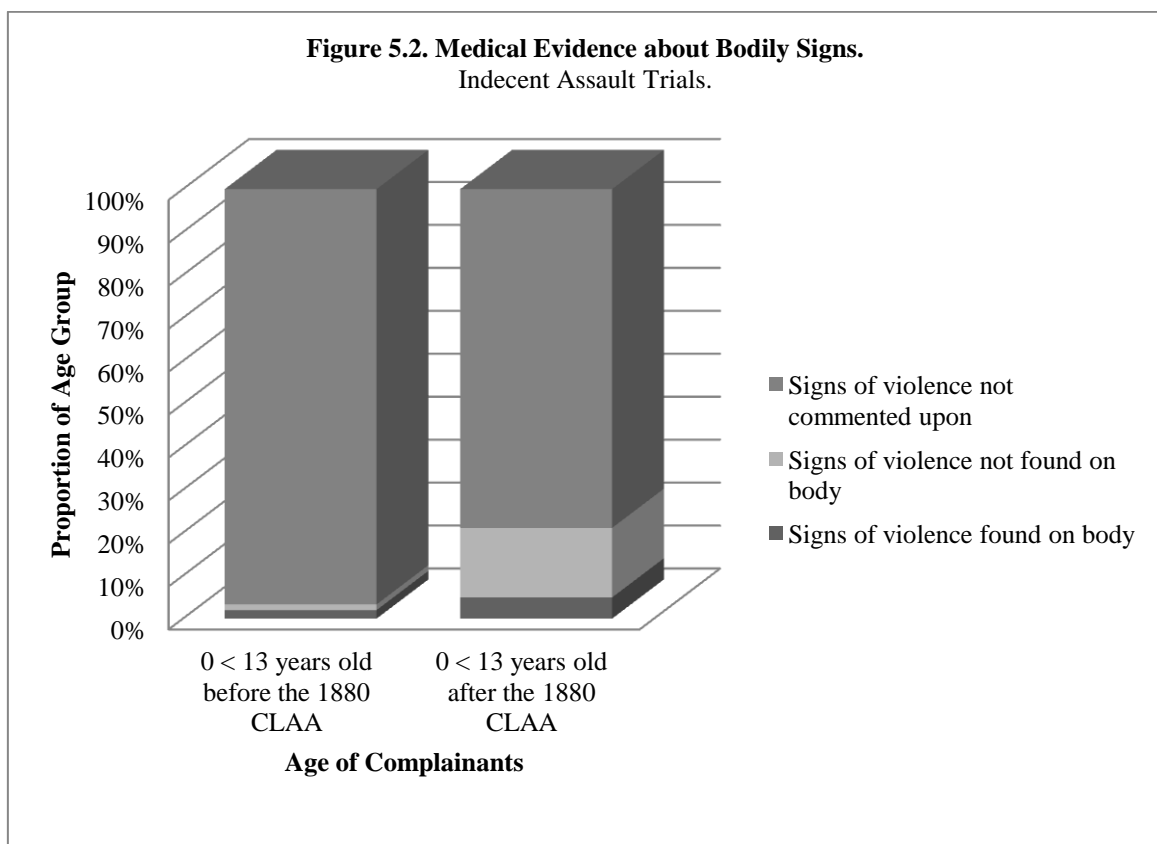


Figure 5.2 depicts a general lack of medical evidence about bodily violence in cases involving young complainants, in part because medical witnesses were not questioned on the subject. One explanation for this finding is that courts also took the psychological aspects of consent into consideration. As Stephen Robertson notes, in his work on rape in the United States from 1823 to 1930:

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.¹¹⁹

A similar pattern can be identified in British forensic medicine and court cases. Medical jurisprudence texts recognised that, in law, the issue of physical struggle was just one component of proving consent or resistance. They acknowledged that the absence of bodily marks of resistance could be the consequence of factors like fear, rather than representing consent.¹²⁰ However, many such issues were technically outside of the medical remit. The 1910 *Principles and Practice of Medical Jurisprudence*, for example, stated that resistance might be absent ‘under the influence of fear or other moral restraint or deception’ but that in ‘all such cases the age and mental condition (innocence) of the girl are the principal factors in deciding upon the guilt of the prisoner. Medical evidence cannot go beyond its province of attempting to say whether or not connection has taken place’.¹²¹

Other possible explanations for a lack of resistance were deemed to be more scientific, such as ‘insensibility’ and the influence of drugs. Discussions about ‘insensibility’ demonstrate how medical practitioners, counsel and judiciary interacted in the formulation of medical testimony and drew upon shared pools of medico-legal knowledge, rather than competing for ‘expertise’ on the subject. Female complainants often claimed that they had fallen ‘insensible’ during an attempted assault, a state which apparently provided an explanation for why they failed to resist and could be brought on by a range of circumstances from exhaustion to drugs.¹²² Medical practitioners who attended a prosecutrix immediately after an alleged offence were often called upon to give an opinion on this matter, particularly in relation to females above the age of sexual consent. In consequence of the widespread influence of standard medical jurisprudence works such as Taylor’s, legal counsel could pre-empt and encourage specific medical

¹¹⁹ Stephen Robertson, ‘Signs, Marks, and Private Parts: Doctors, Legal Discourses, and Evidence of Rape in the United States, 1823-1930’, *Journal of the History of Sexuality* 8 (1998), 345-88, p. 348.

¹²⁰ On the factors mitigating a lack of resistance see Taylor, *Medical Jurisprudence*, 4th edn, p. 587.

¹²¹ Taylor, *Principles and Practice*, 6th edn, vol. 2, p. 113.

¹²² In Gloucestershire a 20-year-old complainant testified that ‘I struggled against him very much and endeavoured with all my strength to push him off me, at last I became insensible and exhausted and do not know what happened afterwards’; Gloucester, GA, Pre-Trial Statements, Charles Cousins tried at the Gloucestershire Quarter Sessions on 6 January 1852 for assault with intent, Q/SD/2/1852. In Middlesex in 1860 a 16-year-old complainant testified that ‘he gave me a glass of wine, I turned from the bar while he got it; directly I drank it I became insensible and remember nothing more till I found myself in a coffee shop’; London, LMA, Pre-Trial Statements, George Church tried at the Middlesex Sessions on 22 March 1860 for assault with intent, MJ/SP/E/1860/006.

evidence. When one Middlesex complainant testified to falling insensible during an alleged sexual assault, *Reynolds's News* reported that:

Robert Scott, F. R. C. S. [Fellow of the Royal College of Surgeons], deposed that he lived at Arundel-terrace, Barnebury-road. He was sent for to see Miss Luff, whom he found in Carroll's parlour ... [there were] no indications of violence on the girl ... **Cross-examined** ... I do not know of a drug which would produce the immediate insensibility spoken of by the prosecutrix. Prussic acid will, but of course it is fatal. Aconite will produce insensibility. I know Taylor's *Jurisprudence* – it is a work of authority. Tincture of aconite will produce insensibility, but there are the intervals of screaming, and the patient remains for a long time under its influence. **Mr Sleigh** – Are not these the symptoms of the administration of aconite – flashing of fire from the eyes, giddiness in the head, and numbness of the extremities? **Witness** – Yes, they are. **Mr Sleigh** – The very symptoms this girl has described.¹²³

Another surgeon later conducted a second examination and found that bruises had developed on the complainant's body, which meant that proving her 'insensibility' was no longer necessary to justify a lack of resistance. However, the process by which the first medical witness's knowledge about 'insensibility' was elicited by counsel remains important. The prosecuting counsel (Mr Sleigh) drew upon Taylor's discussion of aconite, possibly from *Medical Jurisprudence* or *On Poisons in Relation to Medical Jurisprudence and Medicine*, in order to guide Dr Robert Scott towards implying that this drug could have been the cause of the girl's 'insensibility'.¹²⁴ The medical practitioner evidently was not simply an 'expert' who could enter the courtroom and impose his superior knowledge, as the prosecuting counsel in this case clearly shaped Scott's testimony. Because medical witnesses from all regions drew heavily on the same medico-legal texts, their knowledge could be shared, anticipated and selectively drawn upon by counsel. Taylor was right in noting 'the acquisition of much medico-legal knowledge by lawyers', not least from his own book.¹²⁵ Lawyers drew upon the medical knowledge put forward in key textbooks which, in turn, were updated to reflect the medico-legal knowledge held by counsel.

A few medical practitioners in the cases under study discussed a complainant's mental capacity to consent or resist, although without drawing upon any specialist 'expertise'

¹²³ 'Shocking Case of Violation', *Reynolds's Newspaper*, 14 September 1856, 14, p. 14. Emphasis added.

¹²⁴ Around the same time, Taylor had written that aconite consumption resulted in 'numbness and tingling in the mouth and throat, which are parched: - there is giddiness, with numbness and tingling in the limbs, a loss of power in the legs, frothing at the mouth, severe pain in the abdomen, following by vomiting and purging'; Alfred Swaine Taylor, *On Poisons in Relation to Medical Jurisprudence and Medicine*, 2nd edn (London: John Churchill, 1859 [1848]), p. 816.

¹²⁵ Taylor, *Principles and Practice*, vol. 1 (London: John Churchill, 1865), p. 19.

on the mind. Despite claiming that mental aspects of consent were ‘legal’ rather than ‘medical’ questions, medical witnesses began to incorporate such issues into their testimony and thereby formulated a pool of medico-legal rather than purely medical knowledge about sexual consent. Medical witnesses expanded, and were permitted to expand, their testimony on consent and resistance beyond the subject of physical violence. They never directly challenged the law by entering into discussions about legal technicalities such as the difference between ‘consent’, ‘non-resistance’ and ‘submission’ in court.¹²⁶ However, they occasionally touched upon the ‘legal’ issue of mental capacity. In one Middlesex case involving a 17-year-old girl of ‘weak intellect’, police surgeon Frederick Dodsworth testified under cross-examination that ‘I should say she has sufficient capacity to consent to any act’ and thus implicitly justified an expectation that she should have resisted.¹²⁷ This case seemingly reached trial on the basis of other corroborative evidence and such comments were rare, as the question of mental capacity was still challenged as a ‘common sense’ matter in the period under study.¹²⁸ However, it remains a useful example of how boundaries between medicine, law and common sense matters could be blurred rather than sharpened at the discretion of some courts.

Very occasionally medical practitioners stepped completely outside the scientific remit and commented directly on character. Such cases indicate that medical practitioners were deemed to be good judges of moral character, possibly because they had a rare combination of respectability and extensive contact with members of the working classes. Although character was not a common subject for medical evidence, general practitioners who knew a patient prior to an alleged offence were considered to be in a position to comment on such issues. In an ‘assault with intent’ case from 1870, regarding a complainant over the age of sexual consent, a Devon surgeon testified that ‘[s]he has been a patient of mine for the last two or three months ... I have always known her to be a person of good character’.¹²⁹ Medical practitioners even sometimes commented on the perceived honesty of complainants who they did not previously

¹²⁶ These issues were raised only in the process of deciding the ‘ultimate issue’, which are considered in the next chapter’s analysis of the definitions of consent used by judges.

¹²⁷ London, LMA, Pre-Trial Statements, Henry Martin tried at the Middlesex Sessions on 10 August 1886 for indecent assault, MJ/SP/E/1886/040.

¹²⁸ James Crichton-Browne, ‘A Lecture on Responsibility and Disease’, *The Lancet*, 4 August 1888, 195-200, p. 196.

¹²⁹ Exeter, DRO, Pre-Trial Statements, George Lange and John Sansome tried at the Devon Quarter Sessions on 29 June 1870 for assault with intent, QS/B/1870/Midsummer.

know. In a Gloucestershire case of alleged indecent assault in 1879, a 13-year-old complainant testified that ‘the doctor said that I was telling lies’.¹³⁰ In a Middlesex case involving a seven-year-old complainant, a surgeon testified that ‘I asked her if she knew what would happen if she told lies and she said she would go to hell’.¹³¹ This subject was theoretically a judicial not a medical one, as questions about the consequences of lying were generally posed by the court to determine testimonial competency in young complainants rather than by medical practitioners to differentiate between true and false charges. As Taylor noted, ‘I have never heard of the question [of testimonial competency] being referred to a medical practitioner. The child is always orally examined by the court’.¹³² However, as in the Middlesex case cited, non-scientific testimony of this kind was evidently allowed and even encouraged by some courts.

Following on from the first section’s evaluation of cases that did not reach trial, this analysis has shown how cases that *did* reach trial often involved medical testimony that consolidated existing stereotypes of female victimhood. The role of discretion in the justice system meant that there were always exceptions to any rule, but cases that deviated from models of ‘real rape’ were generally in the minority. This section has also sought to demonstrate the ways in which the age of complainants influenced medical testimony in court. In doing so, it has indicated that both medical witnesses and members of the legal profession operated with some autonomy within official legislative frameworks. Medical witnesses drew upon wider professional ideas about sexual maturity to guide their interpretation of bodily signs, while counsel often asked for medical opinions on subjects such as chastity and character that took a flexible definition of the ‘men of science within their own science’ rule. Medical witnesses had ‘expert’ status because they spoke mainly on the scientific issue of physiology, but the boundaries between physiology and morality were blurred as medical witnesses used their testimony on the body to address contemporary moral and legal concerns.

Conclusions

¹³⁰ Gloucester, GA, William Harcombe tried at the Gloucestershire Quarter Sessions on 2 April 1879 for indecent assault, Q/SD/2/1879.

¹³¹ London, LMA, Pre-Trial Statements, Joseph Harvey tried at the Middlesex Sessions on 28 January 1880 for indecent assault, MJ/SP/E/1880/001.

¹³² Taylor, *Manual of Medical Jurisprudence*, 10th edn (London: J. & A. Churchill, 1879 [1844]), p. 602.

In his 2004 book *Laws of Men and Laws of Nature: the History of Scientific Expert Testimony in England and America*, Tal Golan notes that:

[T]he courts have not been neutral gatekeepers that simply exclude unreliable scientific testimony but rather active partners in the production and maintenance of credible scientific evidence. Similarly, we should not be surprised to find that science has been no mere supplicant to the law, but, again, an influential partner in the production and maintenance of credible legal theories and practices for fact-finding and proof.¹³³

This chapter has examined some of these productive processes of exchange between medicine and the law in the construction of medical testimony on sexual crime. It has demonstrated the importance of judicial processes, including cross-examination and summary justice, in determining what medical evidence reached trial and the nature of that evidence. Although medical practitioners in court most commonly testified about physiological signs, they were often encouraged to use their testimony on such matters to touch upon issues such as consent and character. Medical testimony was most likely to reach trial when the victim depicted by medical witnesses was either innocent and childlike or feminine and chaste. There was no space in models of female victimhood for precocious or uncontrolled pubescent sexualities, nor for medical testimony that identified such traits in complainants. Medical witnesses thus drew upon many of the concerns outlined in Chapter One of this thesis, as anxieties about disorderly working-class sexualities informed their testimony on issues such as chastity, character and consent.

By highlighting how judicial processes shaped the nature of medical testimony, this chapter broadly supports Lesley Hall's claim that medical practitioners were a 'subsidiary element within the judicial process, structured by its parameters rather than those of medicine'.¹³⁴ However, the chapter's conclusions indicate that the place of medicine in legal contexts is best understood through by examining processes of sharing and negotiation, rather than questioning whether medicine or the law was 'subsidiary' to the other. While some scholars of socio-legal thought have claimed that medical practitioners need to carve out specific spheres of 'expertise' or conduct 'boundary work' in order to gain authority, evidence from the Middlesex and south-west trials

¹³³ Tal Golan, *Laws of Men and Laws of Nature: the History of Scientific Expert Testimony in England and America* (Cambridge, MA; London: Harvard University Press, 2004), p. 2.

¹³⁴ Lesley A. Hall, 'The Sexual Body' in *Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (Amsterdam: Harwood Academic, 2000), 261-75, p. 262.

indicates that the opposite was the case.¹³⁵ At a time when the position of the ‘expert’ in court was still unstable, medical witnesses were most likely to reach trial when their testimony posed no challenge to the status quo. The importance of the medico-moral ideas of consent, chastity and character outlined in this chapter lies in the fact that they were situated at the intersection between different interest groups. They drew upon common concerns that allowed medical and judicial ‘expertise’ to coexist, without medical practitioners needing to challenge legal authority on such issues. Although the nature of medical testimony that reached trial was shaped by pre-trial judicial processes, it was also informed by wider frameworks of thought about age, class, gender and sex that medical practitioners *shared* with magistrates and grand jurors. Treating any of these groups as merely ‘subsidiary’ thus overlooks the nuances and negotiated nature of medico-legal knowledge. These conclusions provide a starting point for the next and final chapter, which builds on these issues by considering whether judges and juries drew upon medical evidence when passing verdicts and sentences.

¹³⁵ Thomas F. Gieryn, ‘Boundary-Work and the Demarcation of Science from Non-Science: Strains and Interests in Professional Ideologies of Scientists’, *American Sociological Review* 48 (1983), 781-95; Crozier and Rees, ‘Making a Space for Medical Expertise’.

‘Easily to be Made and Hard to be Proved’: Trial Outcomes and Medical Evidence¹

Seventeenth-century judge Sir Matthew Hale famously wrote that ‘rape is a most detestable crime ... but it must be remembered, that it is an accusation easily to be made and hard to be proved, and harder to be defended by the party accused, though never so innocent’.² His words continued to be cited in textbooks and by judges for centuries in order to guide the reception of evidence in cases of suspected sexual crime.³ The statement was reformulated and reiterated to such an extent that Bruce Macfarlane has cited it as the ‘birth of a myth’ that consolidated long-held anxieties about false claims within and beyond Britain for hundreds of years.⁴ Such ‘rape myths’ not only framed the nature of evidence that reached trial, as discussed in Chapter Five, but could also influence the decisions of judges and juries at trial. This chapter attempts to consider some of the reasons behind trial verdicts, sentences and the reception of medical testimony in court. It indicates that jurors and judges responded to the same stereotypes of female victimhood that magistrates and counsel had anticipated and encouraged, with medical testimony having some bearing on such cases but by no means dictating their terms. It also seeks to go beyond the question of impact to consider some of the common wider social frameworks of thought that informed both the nature and

¹ Matthew Hale, *The History of the Pleas of the Crown*, rev. edition, vol. 1 (London: 1778 [1736]), p. 635. This text was published posthumously.

² This quote replaces ‘f’ with ‘s’ in words such as ‘deteftable’ and updates the spellings of ‘remembered’ and ‘tho’ for readability, but is taken from the original text; Hale, *The History of the Pleas of the Crown*, p. 635. This book has been cited by numerous historians and scholars, including the particularly visible cases of: Sandy Ramos, “‘A Most Detestable Crime’: Gender Identities and Sexual Violence in the District of Montreal, 1803-1843”, *Journal of the Canadian Historical Association* 12 (2001), 27-48; and Keith Burgess-Jackson (ed.), *A Most Detestable Crime: New Philosophical Essays On Rape* (New York: Oxford University Press, 1999).

³ When the Middlesex Sessions opened on 25 May 1889, chairman Mr Littler drew attention to a charge of indecent assault and ‘remarked that it had been said that these charges were very easily made, difficult to prove, and still more difficult to disprove’; ‘County of London Sessions, May 25’, *The Times*, 27 May 1889, 8, p. 8.

⁴ Bruce A. MacFarlane, ‘Historical Development of the Offence of Rape’, originally published in Josiah Wood and Richard Peck (eds), *100 Years of the Criminal Code in Canada: Essays Commemorating the Centenary of the Canadian Criminal Code* (Ottawa: Canadian Bar Association, 1993), p. 50 [pagination from online document] <www.canadiancriminallaw.com/articles/articles/pdf/Historical_Development_of_the_Offence_of_Rape.pdf> (accessed 2 May 2012).

reception of medical testimony. The chapter thereby connects back to ideas about the intersections between gender, class, age and sex considered in Chapter One.⁵

The chapter first considers the processes by which verdicts and sentences were decided, in order to demonstrate that trial outcomes were never merely the result of events inside the courtroom. It then pays close attention to how trial outcomes were influenced by medical and lay testimony about genital violence and consent in turn, because these were the key categories of evidence identified in the second section of Chapter Five. The chapter's subject matter must be approached with some caution, as it is almost impossible to pinpoint how any given testimony was received by a judge or jury. It is inherently difficult to unravel the component influences on a court case and Joel Eigen rightly notes that '[e]stimating the influence of historical contributors must therefore be a hazardous undertaking, especially because verdicts suggest more than they actually reveal'.⁶ Pre-trial statements do not include any accounts of cross-examination, no evidence from the actual trial and rarely the prisoner's defence. There is also little evidence about the aspects of trial outcomes that did not turn on 'facts'. For example, there are no records of whether trial outcomes were influenced by personal relationships between judges and witnesses. There are also no reports as to whether a medical practitioner's conduct shaped the reception of his testimony, an issue that was deemed sufficiently important to be highlighted in Taylor's textbooks as follows:

His demeanour should be that of an educated man, and suited to the serious occasion ... A medical witness must not show a testy disposition in having his professional qualifications, his experience, his means of knowledge, or the grounds for his opinions very closely investigated.⁷

To complicate matters further, not all forms of medical evidence were received in the same way or deemed to hold equivalent value in a criminal trial. Testimony by a single medical witness often contained heterogeneous elements, which could be considered of differing relevance to a case. It is therefore important to think beyond questions about

⁵ In theory race was also part of these intersections, in terms of its links to precocity discourses. However, the race of witnesses was not noted in the cases under study and therefore the impact of racial difference on the interpretation of medical testimony is not considered in this chapter. Some cases may have included complainants not of pure white British descent, particularly in London, but newspapers never remarked on any complainant's ethnic origin. As extensive links were drawn between race and sex in other contemporary literature, this absence seems to indicate that complainants who reached the trial stage of proceedings were not racially diverse.

⁶ Joel Peter Eigen, *Unconscious Crime: Mental Absence and Criminal Responsibility in Victorian London* (Baltimore; London: Johns Hopkins University Press, 2003), p. 11.

⁷ Alfred Swaine Taylor, *The Principles and Practice of Medical Jurisprudence*, vol. 1 (London: J. & A. Churchill, 1865), p. 38.

the impact of medical testimony in any given court case, which implies that it represented a coherent type of evidence and that its impact is measurable. This chapter seeks to avoid such potentially restrictive questions of impact, by demonstrating the broader importance of understanding how *shared* medical and judicial concerns interacted in the production of influence in the courtroom.

The Decision-Making Body: Judges and Petty Juries

In his *Handbook of Forensic Medicine*, published in the 1860s, Johann Ludwig Casper noted that verdicts in criminal trials did not operate on the basis of ‘strict proof’ but rather on the ‘mental conviction of the judge (or jury), attained by a consideration of all the ascertained facts in their entirety’.⁸ Judges and petty juries played decisive roles in the reception and interpretation of ‘ascertained facts’, of which medical testimony was just one kind.⁹ Despite the centrality of these groups in court, Martin Wiener rightly notes that ‘[l]ittle is yet known even about judges – how they arrived at their opinions, decisions, and sentences, or what they meant by them ... And about juries we know hardly anything’.¹⁰ Any analysis of the factors influencing a trial’s outcome, however speculative, must therefore start with questions about who made decisions and the processes by which they did so. This section considers who judges and juries were and identifies some broad trends in trial verdicts and sentences, to show that they were influenced by forces both within and beyond the courtroom. These conclusions shape the rest of the chapter’s analysis of the place of medical testimony in determining trial outcomes, by showing that the reception of any evidence was not unmediated or separable from broader social concerns.

As already noted in Chapter Five, the property qualifications for a petty juror matched those for a grand juror but petty juries were commonly drawn from a lower social class. Exact records of the jurors involved in the trials under study are rare but surviving Devon jury lists from 1901 and 1903 indicate that, using the same social divisions applied by Douglas Hay for the eighteenth century, all petty jurors were either

⁸ Johann Ludwig Casper, *Handbook of Forensic Medicine*, trans. from 3rd edn by G. W. Balfour, vol. 1 (London: New Sydenham Society, 1861), p. vi.

⁹ Within this chapter, a ‘petty jury’ is often simply referred to as a ‘jury’ because there is no need to distinguish between petty and grand juries in the context of trial outcomes.

¹⁰ Martin J. Wiener, ‘Judges v. Jurors: Courtroom Tensions in Murder Trials and the Law of Criminal Responsibility in Nineteenth-Century England’, *Law and History Review* 17 (1999), 467-506, p. 470.

‘tradesmen and manufacturers’ or ‘farmers and yeomen’.¹¹ The exact proportion of these social groups could shift when the final 12 men were selected. The cases sampled from Devon’s Epiphany 1901 and Michaelmas 1903 Quarter Sessions had 37 farmers/yeomen and 62 tradesmen/manufacturers on the petty jury long-list. The final juror list selected for the 1903 Michaelmas Session, the only session for which it is known, consisted of seven farmers/yeomen and five tradesmen/manufacturers. This sample is small and undoubtedly the exact nature of jurors’ occupations would have varied from place to place and between London and the provinces. However, in combination with the findings of other historians, it is reasonable to conclude that many petty jurors were of the lower-middle or middle classes.¹²

While ‘literacy’ is a wide-ranging concept, it seems likely these jurors would have had a basic level of ability to read and write because of the record-keeping requirements of their jobs. They would have been a part of literate cultures, including reading newspapers, and were no longer the ‘illiterate plebeians’ that the Scottish author Tobias Smollett had written of in the eighteenth century.¹³ This jury literacy is significant in the light of analysis conducted in the previous chapter, which briefly noted the role that newspapers could play in the reinforcement of gendered stereotypes. Newspaper reports of trials for sexual offences were productive as well as receptive. In 1890, H. Lediard wrote an article in *The Lancet* complaining that:

Cases are discussed with freedom prior to judicial proceedings, because each fresh piece of information bearing on the case is inserted in the paper, and the

¹¹ Douglas Hay, ‘The Class Composition of the Palladium of Liberty: Trial Jurors in the Eighteenth Century’ in *Twelve Men Good and True: The Criminal Trial Jury in England, 1200-1800*, ed. J. S. Cockburn and Thomas A. Green (Princeton: Princeton University Press, 1988), 305-57, p. 344; Exeter, DRO, Devon Epiphany Sessions: The Names of the Petty Jurors, 1901, QS/B/1901/Epiphany; Exeter, DRO, Devon Michaelmas Sessions: The Names of the Petty Jurors, 1903, QS/B/1903/Michaelmas.

¹² See the discussion of middle-class jurors in Martin J. Wiener, *Men of Blood: Violence, Manliness, and Criminal Justice in Victorian England* (Cambridge: Cambridge University Press, 2004), p. 38.

¹³ On the issue of ‘illiterate plebeians’ see P. J. R. King, ‘“Illiterate Plebeians, Easily Misled”: Jury Composition, Experience, and Behavior in Essex, 1735-1815’ in *Twelve Men Good and True: The Criminal Trial Jury in England, 1200-1800*, ed. Cockburn and Green, 254-304. Taking farmers as an example, Randal Holme shows that they had high literacy levels as early as the eighteenth century and Nicholas Goddard shows that they had cultures of newspaper reading; Randal Holme, *Literacy: An Introduction* (Edinburgh: Edinburgh University Press, 2004), p. 23; Nicholas Goddard, ‘The Development and Influence of Agricultural Periodicals and Newspapers, 1780-1880’, *Agricultural History Review* 31 (1983), 116-31. On the general expansion of nineteenth-century male literacy, apparently up to 97 per cent by 1900, see Carl F. Kaestle, ‘The History of Literacy and the History of Readers’ in *Perspectives on Literacy*, ed. Eugene R. Kintgen, Barry M. Kroll and Mike Rose (Carbondale, IL: Southern Illinois University Press, 1988), 95-127, p. 108. On the difficulties of defining literacy see Barry Reay, *Microhistories: Demography, Society and Culture in Rural England, 1800-1930* (Cambridge: Cambridge University Press, 1996), pp. 251-52.

public at large read the comments and the startling headings to the paragraph and thus become biased before they are really aware of it.¹⁴

Petty jurors might therefore have been aware of pre-trial reports for the specific trial that they were attending, as mentioned in this quote from *The Lancet*, as well as of more general newspaper reports of sexual crime. The readership of local and national newspapers was varied and it is impossible to assess exactly what jurors had access to. However, many of the newspapers discussed throughout this chapter had a significant circulation amongst the lower-middle and middle classes. In the light of the farming interests of the Devon jury sample, it is significant that a contemporary noted that *Trewman's Exeter Flying Post* 'circulates in every town and village in Devonshire, also generally in Cornwall, Somerset, and Dorset. Advocates especially the agricultural interest'.¹⁵ *The Times*, from which many examples in this chapter are cited, had an average daily circulation of 38,141 at the start of the period which far outstripped its London rivals until the rise of the cheaper and more 'sensationalist' popular presses at the end of the century.¹⁶ Even relatively high circulation figures underestimate the extent to which newspapers were shared, rented and read aloud.¹⁷ Roger Schofield estimates that five-sixths of the London population had regular access to newspapers by the 1840s in consequence of the sharing and circulation of newspapers.¹⁸ Although the price of *The Times* was potentially prohibitive for jurors from the lower end of the middle classes, in the context of criminal reporting distinctions between different newspapers were often limited. As reports of court proceedings published in *The Times* were often not written by a correspondent of *The Times*, they could be a word-for-word match for those in more 'popular' newspapers because newspapers either 'borrowed'

¹⁴ H. A. Lediard, 'Our Criminal Procedure: Scientific Imperfections and Remedy', *The Lancet*, 18 October 1890, 812-14, p. 813.

¹⁵ Charles Mitchell, *The Newspaper Press Directory* (London: C. Mitchell & Co., 1846) cited in British Library Online, '*Trewman's Exeter Flying Post*'.

¹⁶ David Brown, 'Cobden and the Press' in *Rethinking Nineteenth-Century Liberalism: Richard Cobden Bicentenary Essays*, ed. Anthony Howe and Simon Morgan (Aldershot; Burlington, VT: Ashgate, 2006), 80-99, p. 81 n. 5. On the rise of the popular presses see Virginia Berridge, 'Popular Journalism and Working Class Attitudes 1854-1886: A Study of Reynold's Newspaper, Lloyd's Weekly Newspaper and the Weekly Times', unpublished doctoral thesis, University of London (1976).

¹⁷ Charles Upchurch, *Before Wilde: Sex between Men in Britain's Age of Reform* (Berkeley: University of California Press, 2009), p. 134.

¹⁸ Roger S. Schofield, 'Dimensions of Illiteracy in England, 1750-1815' in *Literacy and Social Development in the West: A Reader*, ed. Harvey J. Graff (Cambridge; New York: Cambridge University Press, 1981), 201-13.

from each other or shared a common source.¹⁹ It is therefore possible that the printed media may have served to shape jurors' ideas about sexual crime, thus the courtroom was not cut off from wider society or from the 'real rape' stereotypes perpetuated by the printed media.

Although variation between individuals means that pinpointing the exact personal prejudices of jurors is an unfeasible task, it is possible to highlight some broad contemporary trends in thinking about sexual crime for men of their social position. The court process was inherently gendered in cases of suspected sexual crime, but middle-class males might also have drawn upon wider social currents of thought about class and age. Many late-Victorian and Edwardian anxieties about child protection, respectability, 'dangerous masculinities' and disorder bridged, although never entirely transcended, gender interests.²⁰ The influence of broad social concerns on jury verdicts, rather than just the specific details of a given case, is indicated by some statistical analysis. Figure 6.1 depicts general trends in jury verdicts during the period under study, taken from a complete record of 'true bills' for 678 prisoners from Gloucestershire, Somerset and Devon and for 1193 prisoners from Middlesex.²¹ The cases have been narrowed to those without guilty pleas in order to focus on trials in which juries had to make decisions, which was generally a decision between 'guilty' and 'not guilty' because very few prisoners were classed 'insane'.²² The graph indicates that jury verdicts cannot be separated from wider social forces, with a general although

¹⁹ For example, the same report of one of the Middlesex trials was published in 'A Danger to Society', *Lloyd's Weekly Newspaper*, 24 August 1873, 3, p. 3 and 'Middlesex Sessions', *The Times*, 26 August 1873, 11, p. 11.

²⁰ On 'respectability' see Shani D'Cruze, *Crimes of Outrage: Sex, Violence and Victorian Working Women* (London: UCL Press, 1998), p. 18. On 'dangerous' masculinity, see Wiener, *Men of Blood*, p. 38; and David Taylor, *Hooligans, Harlots, and Hangmen* (Santa Barbara, CA: Praeger, 2010), pp. 2, 58, 118-21. Issues related to the offender's dangerous masculinity are implicit in this thesis's discussion of anxieties about working-class disorder and about the importance of 'respectability' and character in influencing trial outcomes, but are not extensively engaged with for two main reasons: firstly, these discussions shed little light on the main research questions posed by this thesis because they centred on class and gender rather than age; secondly, in the context of sexual crime such ideas were discussed far less explicitly than anxieties about female behaviour. 'Rape myths' often turned on models of female victimhood rather than models of masculinity.

²¹ The statistics are calculated from Calendars of Prisoners as follows: Exeter, Devon Record Office (DRO), Calendars of Prisoners, 1850-1914, Q/S/32/192-5853; Gloucester, Gloucestershire Archives, Calendars of Prisoners, 1850-1914, Q/SGc/1850-1914; London, London Metropolitan Archives (LMA), Calendars of Prisoners, 1850-53, MJ/CP/A/031-069; London, LMA, Calendars of Prisoners, 1855-92, MJ/CP/B/001-043; London, LMA, Calendars of Prisoners, 1889-1905, MXS/B/03/001; London, LMA, Calendars of Prisoners, 1906-15, MXS/B/03/002; Taunton, Somerset Record Office (SRO), Calendars of Prisoners, 1850-1882, Q/SCS/1-330; Taunton, SRO, Calendars of Prisoners, 1882-1914, A/CJA/1/1-16.

²² Only eight insanity verdicts were reached during the period, across both regions.

uneven downward trend in conviction rates in cases of suspected sexual crime. Despite this drop, conviction rates were high at between 48 and 82 per cent for five-year periods within the overall period 1850-1914. The mean average conviction rate for the two locations combined was 67 per cent. It seems that, at least to some extent, the pre-trial selection of cases that fulfilled a jury's expectations of 'real rape' criteria was successful as a majority of cases that reached a jury secured convictions.

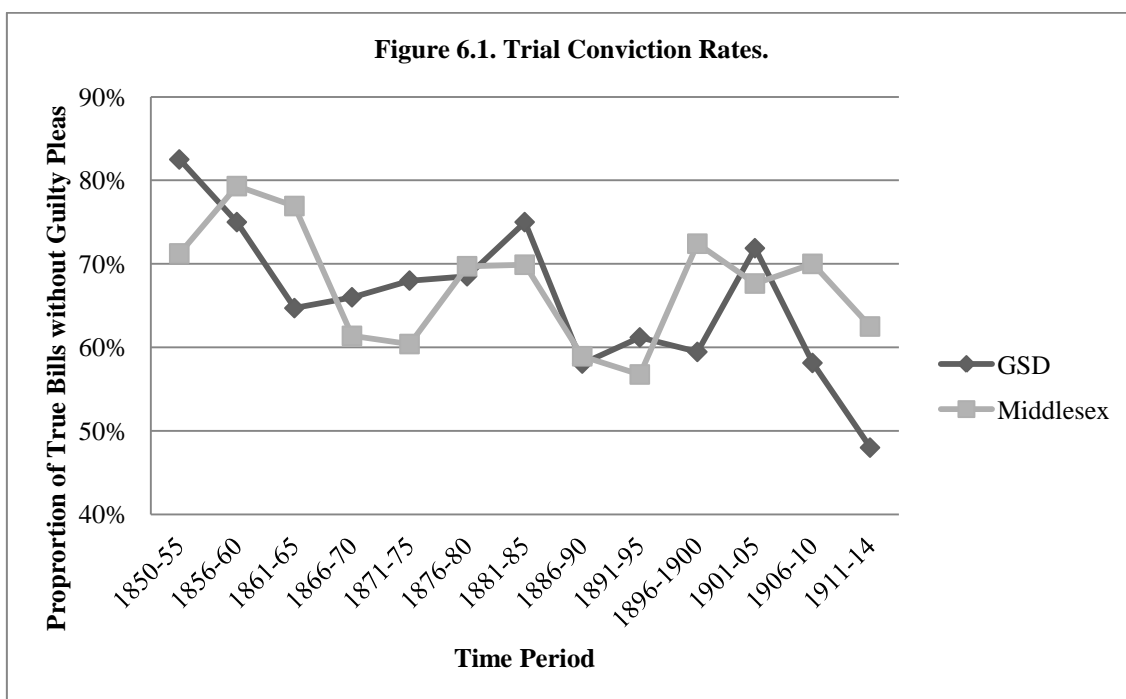


Figure 6.1 shows similar patterns for Middlesex and the provincial counties, indicating that conviction rates were linked to broad trends in contemporary thought rather than being localised. The maximum disparity between provincial and urban conviction rates was 15 per cent, in the period 1911-14, and in Figure 6.1 the regions demonstrate similar peaks and troughs at key periods. The dip in conviction rates in the 1890s also corresponds to the findings of Louise Jackson at the Old Bailey, which she attributes to judges and juries 'running out of sympathy for girl victims' in the 1890s.²³ The graph indicates that trends in the 1890s were not only a post-1880s 'backlash' but also part of a long-term downward trend in conviction rates. This overall trend may be attributable to the gradually rising age of consent during the period, which came with associated anxieties about blackmail and false claims. Such concerns were particularly evident

²³ Louise Jackson, *Child Sexual Abuse in Victorian England* (London: Routledge, 2000), p. 106.

after the 1885 CLAA. On 10 May 1894, the *Standard* newspaper printed an anonymous letter stating that:

Raising the age of consent to sixteen was undoubtedly a mistake. Young girls between the ages of fourteen and sixteen have now, it is feared, in an immense number of cases, become sources of income to depraved parents by practising the system of blackmailing. Respectable and innocent lads are led away by designing girls, and induced to break the law.²⁴

These anxieties were by no means created by the 1885 legislation, but it exacerbated existing fears by removing consent as a defence in many cases.

Figures 6.2 and 6.3 demonstrate how anxieties about blackmail and false claims manifested themselves in trial outcomes, by comparing verdicts in 100 cases tried prior to the 1885 Criminal Law Amendment Act (CLAA) with 72 cases after the CLAA came into action on 14 August 1885. The graphs depict alleged sexual crimes against females by males under the age of 18, who were considered to be most vulnerable to seduction and blackmail by precocious girls just a few years younger than themselves.²⁵ Such an approach takes into consideration contemporary anxieties about age and gender *difference*, rather than just age and gender. The two graphs together demonstrate a clear shift in trial verdicts after 1885. There was no significant rise in acquittals after 1885, but juries increasingly convicted prisoners on the lesser charge of common assault in cases involving complainants over the age of 13. Such sympathy for young prisoners did not extend to cases in which crimes were committed against girls under the age of 13. These trends indicate that jurors drew upon wider contemporary concerns about precocity and the dangers surrounding girls at and above the age of puberty, which were shared with medical witnesses but not necessarily created by them.

²⁴ 'The Criminal Law Amendment Act', *Standard*, 10 May 1894, 6, p. 6. For similar comments see 'Common Sense', *The Times*, 3 November 1887, 13, p. 13.

²⁵ Chapter Two of this thesis showed that Charles Roberts highlighted concerns about blackmail relating to the fact that girls of fifteen, protected by the 1885 CLAA, 'have attained to the physical maturity of boys of from seventeen to nineteen years of age'. Limiting the sample to cases involving prisoners under the age of 18 therefore seems a suitable means to consider links between age difference and blackmail concerns. Charles Roberts, 'The Physical Maturity of Women', *The Lancet*, 25 July 1885, 149-50, p. 149.

Figure 6.2. Verdicts in Cases with Prisoners under the Age of 18, before the 1885 Criminal Law Amendment Act

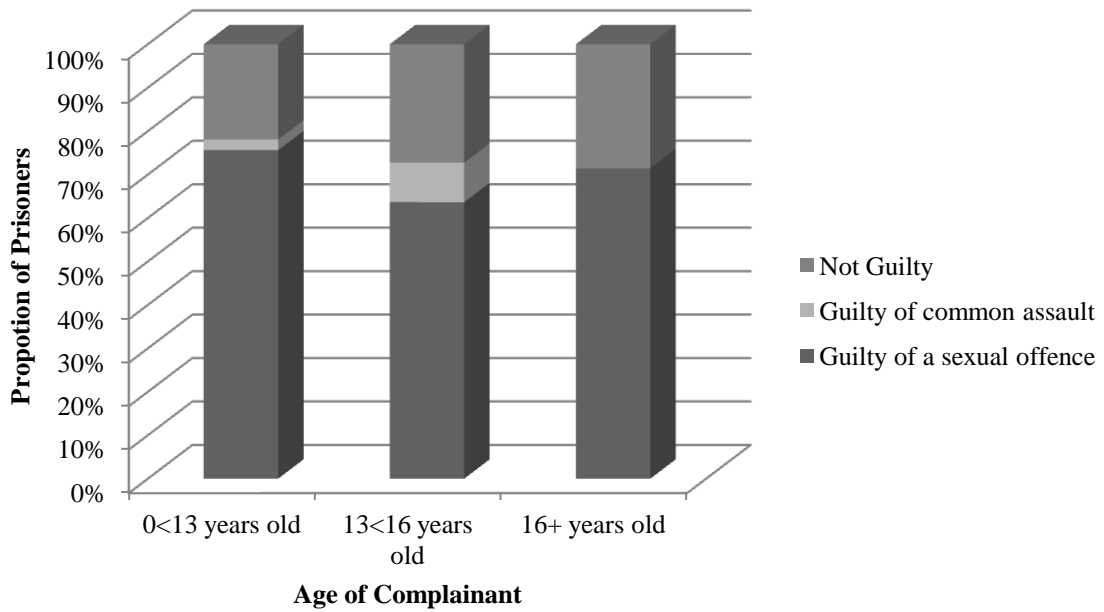
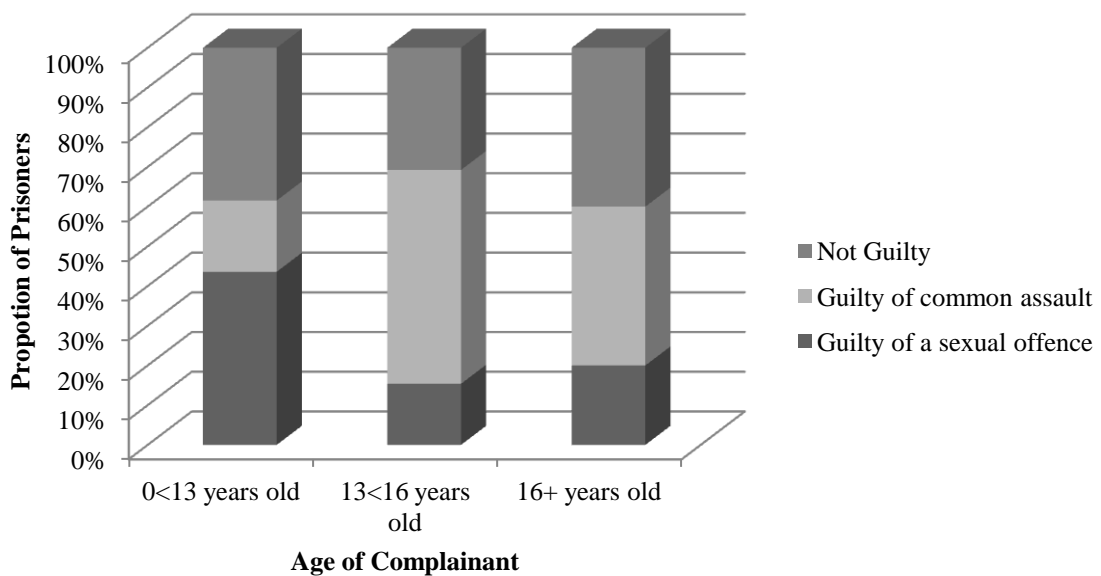


Figure 6.3. Verdicts in Cases with Prisoners under the Age of 18, after the 1885 Criminal Law Amendment Act



Petty juries were influenced by broad class- and age-based anxieties about issues such as blackmail, although they may have been acting under the direction of a judge rather than on the basis of personal concerns. The *Bristol Daily Mercury* reported that in one Somerset case from 1907, ‘[i]t was held that there was no evidence of corroboration, and the Court directed the jury to return a verdict of not guilty, and the prisoner was

discharged'.²⁶ Similar statements about the jury's decision 'under the direction of [the judge]' or 'by direction of his lordship' were made throughout the regions and period under study.²⁷ Such judicial roles are directly relevant to questions about the impact of medical testimony in court. Tony Ward and Tal Golan have both noted how judges could 'guide the jury in its assessment of the scientific witnesses and their evidence' in order to prevent a 'trial by experts'.²⁸ However, not all juries necessarily followed a judge's direction. Sally Lloyd-Bostock and Cheryl Thomas note that 'throughout the centuries of their existence, English juries have been known to acquit in the face of both overwhelming evidence of guilt and a judicial direction for conviction'.²⁹ Scholars in a range of contexts including coroners' courts and murder trials have also shown that eighteenth- and nineteenth-century jurists sometimes convicted or acquitted 'against the evidence'.³⁰ While bearing in mind that not all juries responded to a judge's direction in the same way, the prevalence and importance of directed verdicts in the period under study should not be underestimated. Interactions between judges and juries were variable, but few of the verdicts discussed in this section were unmediated judgements.

The judge's role in court awaits some explanation beyond the issue of directing verdicts. In the provinces the judge was officially a 'chairman' of a bench of justices or magistrates, whereas the Middlesex Sessions' magistrates were presided over by a 'chairman' with an 'Assistant Judge'.³¹ These judges wielded great discretionary power as they were the only members of the court who were elected, salaried and required 'the personal qualification of some legal knowledge, reasonable experience, [and] an acquaintance with forms and technical proceedings'.³² In Middlesex a chairman and Assistant Judge also required legal qualifications, but county Quarter Sessions were

²⁶ 'Somerset Quarter Sessions', *Bristol Daily Mercury*, 11 April 1907, 6, p. 6.

²⁷ 'Devon Midsummer Sessions', *Trewman's Exeter Flying Post*, 8 July 1868, 3, p. 3; 'Middlesex Sessions', *Lloyd's Weekly Newspaper*, 29 August 1886, 4, p. 4.

²⁸ Tony Ward, 'Law, Common Sense and the Authority of Science: Expert Witnesses and Criminal Insanity in England, ca. 1840-1940', *Social & Legal Studies* 6 (1997), 343-62, p. 344; Tal Golan, *Laws of Men and Laws of Nature: The History of Scientific Expert Testimony in England and America* (Cambridge, MA; London: Harvard University Press, 2004), p. 138.

²⁹ Sally Lloyd-Bostock and Cheryl Thomas, 'Decline of the "Little Parliament": Judges and Jury Reform in England and Wales', *Law and Contemporary Problems* 62 (1999), 7-40, p. 37.

³⁰ Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon Press, 1987), p. 29; Wiener, 'Judges v. Jurors', pp. 472-80.

³¹ The term 'judge' encompasses the roles of chairman and Assistant Judge throughout the thesis, as the practical distinctions between the roles in the cases under study were sufficiently minor to consider them together as one type of position within the judicial system.

³² Richard Burn, Joseph Chitty and Thomas Chitty, *The Justice of the Peace and Parish Officer*, vol. 5 (London: S. Sweet; A. Maxwell, 1837), p. 592.

overlooked in the 1835 legislation that made a legal requirement similarly obligatory for borough Quarter Sessions.³³ Despite these distinctions in qualification, in both regions the judge was generally a person of great experience in the courts and ‘a gentleman of great integrity’.³⁴ There was therefore a notable class distinction between complainants and judges, even more so than between complainants and petty jurors. Again, this has relevance for rest of the chapter’s analysis which addresses how anxieties about working-class sexual development and behaviour were drawn upon to guide trial outcomes.

In the event of a prisoner being found guilty a sentence was determined by a chairman consulting with his ‘brother justices’, as no trial went ahead without a minimum of two justices present.³⁵ Fewer people decided upon a sentence than a verdict, which meant that theoretically the sentencing process was more open to being swayed by the personal convictions of a court chairman and his colleagues. This theory is corroborated to an extent by the fact that the Middlesex Sessions’ chairman from 1889 until 1908, Mr Littler, was apparently ‘renowned in the contemporary press for his stiff sentencing practices’.³⁶ Andrew Ashworth notes that judicial discretion during sentencing was restricted in the early-nineteenth century because ‘[t]here were maximum and minimum sentences for many offences, and several statutes provided a multiplicity of different offences with different graded maxima’.³⁷ In the period and statutes under study, some of these restrictions were still in place. Few of the crimes had minimum sentences, except if a judge opted to impose penal servitude. However, after common law charges such as indecent assault and common assault were consolidated in the 1861 Offences against the Person Act, most sexual crimes were attached to a maximum sentence of two years imprisonment with or without hard labour. Any conviction on a reduced

³³ Equivalent legislation regarding the legal qualifications of judges was introduced for Middlesex in 1844; David Bentley, *English Criminal Justice in the Nineteenth Century* (London: Hambledon Press, 1998), pp. 77-78.

³⁴ British Parliamentary Papers (BPP), Eight Report of her Majesty’s Commissioners for Revising and Consolidating the Criminal Law, 1845, p. 266.

³⁵ Charles Knight, ‘Quarter Sessions’, *The Penny Magazine of the Society for the Diffusion of Useful Knowledge*, 31 January 1839, p. 40.

³⁶ C. E. A. Bedwell, ‘Littler, Sir Ralph Daniel Makinson (1835–1908)’, rev. Eric Metcalfe, *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004) <<http://www.oxforddnb.com/view/article/34557>> (accessed 23 July 2012).

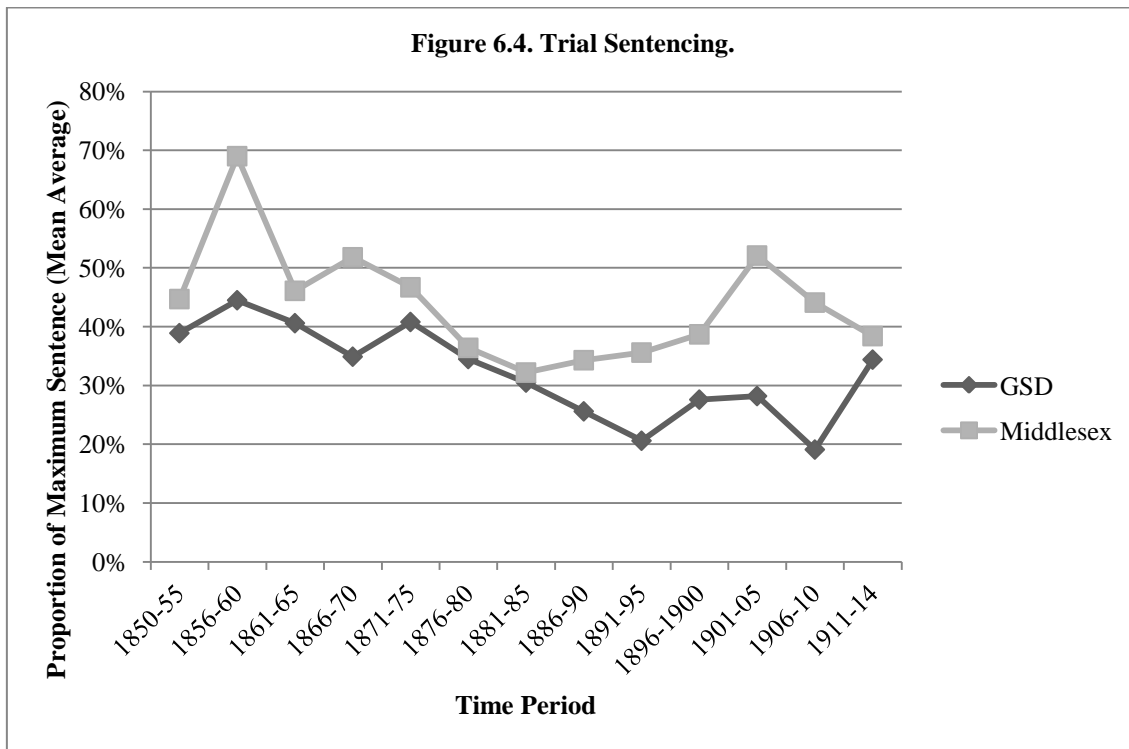
³⁷ Andrew Ashworth, *Sentencing and Criminal Justice*, 5th edn (Cambridge; New York: Cambridge University Press, 2010 [1992]), p. 52.

charge of common assault had a maximum sentence of one year.³⁸ Judges were therefore somewhat limited in the sentences that they could impose. Newspapers also often reported cases in which judges expressed a desire to sentence a prisoner to ‘flogging’ but were unable to do so.³⁹ However, judges still had great discretion within legal parameters and could allow prisoners to leave the court with little more than a fine. They also had the right to take into consideration character testimonials when making their decisions.

Figure 6.4 depicts the proportion of the maximum sentence that judges handed down to prisoners in Middlesex and Gloucestershire, Somerset and Devon over time. Sentences fell during the period under study but, unlike verdicts, there were some differences between rural and urban sentencing patterns. The general decline in sentences over time indicates that judges, like jurors, may have been drawing on wider trends in social thought about sexual crime. As with verdicts, it is possible to identify a slight lowering of sentences in the 1890s which rose again around 1900 in both regions. However, the lack of clarity in these patterns and the presence of greater regional differences than in verdict trends must also be acknowledged and are difficult to explain beyond the fact that judges had a significant degree of discretion. Within these broad patterns were sentencing extremes as low as a single day’s imprisonment (0.03 per cent) and up to 24 months imprisonment with hard labour (100 per cent) in both regions under study. These sentencing choices could skew the averages heavily and may have been either due to the personal choices of a particular judge, or to the type of testimony given in court. Rural judges also generally handed down lower sentences than their urban counterparts, which could be explained by differences in legal training or by a more localised legal system in which judges knew and had more sympathy for prisoners. As already noted, the Middlesex Sessions had a chairman who apparently favoured heavy sentencing between 1889 and 1908, which may have influenced the rise in average sentences in Middlesex and the disparity between the two regions under study at this time.

³⁸ Young offender legislation also allowed for prisoners under the age of 16 to be sent to reformatory school for between two and five years, although this power was rarely used in the cases under study.

³⁹ For example, in 1870 a Middlesex judge apparently ‘said he was sorry that the law did not allow him to give a more severe sentence than the one he was about to pass for the horrible manner in which he had treated a child of such a tender age, for he had committed a most atrocious outrage upon her. He wished that he had the power to order him to be flogged’; ‘Law and Police’, *Reynolds's Newspaper*, 18 September 1870, 8, p. 8.



Decisions about trial verdicts and sentences were often based on discretion, rather than on any clear-cut legal guidelines. Although the background of every juror and judge in the provinces and Middlesex is not available, this section has indicated that individual discretion could be important in shaping the outcome of judicial proceedings. By extension, it seems likely that there was a personal element to the reception of medical testimony in court. However, analysis of trends at a micro-level is not always possible or even useful. While the personal aspects of decision making must be acknowledged, there is also analytical value in examining criminal trial outcomes more broadly. As this analysis has shown, trial outcomes were also influenced by general societal trends and by the changing legal options available. Judges and juries interpreted witness testimony through the class-, age- and gender-based frameworks of thought available to them. As this chapter will go on to show, many of the same contemporary concerns informed the reception and use of testimony put forward by medical witnesses in court.

The Sexual Body: Genital Signs and Chastity

This section pays attention to the impact of medical testimony about genital violence on trial verdicts and sentences, but in doing so identifies the difficulties and inherent restrictiveness of such an approach. By demonstrating the variable reception of medical

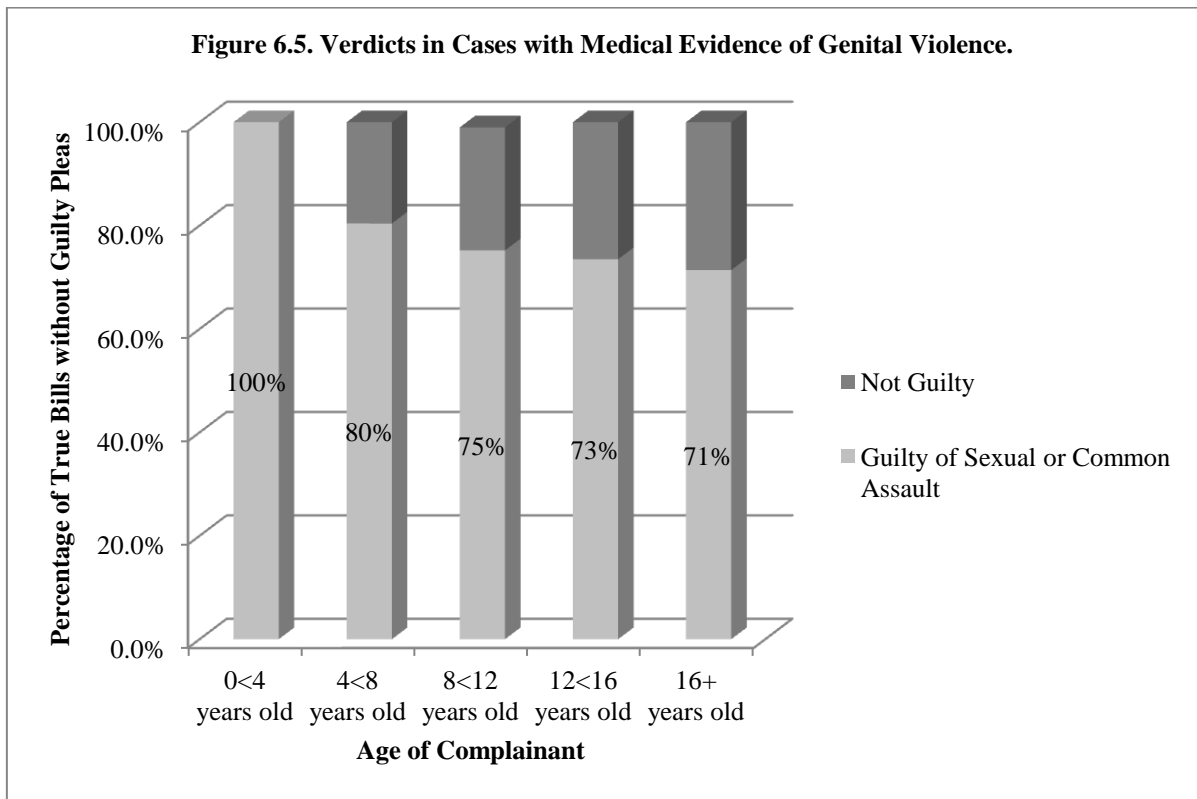
testimony on genital violence, this analysis emphasises the importance of moving beyond understanding medical influence on trial outcomes as part of a simple cause-and-effect relationship. It then moves on to consider links between the subjects of genital violence and (un)chastity, taking a broader perspective by situating medical testimony and its influence in wider frameworks of thought. It considers the role of evidence about (un)chastity and character from both medical and lay witnesses, thereby showing that there is value in moving beyond the question of impact to consider the common middle-class concerns about age, gender and class that shaped both the nature and reception of the testimony given in court.

Basic statistical correlations between trial verdicts and medical testimony on genital violence raise more questions than they answer. As the average conviction rate for the two regions under study was 67 per cent, it is ostensibly significant that prisoners were convicted in 78 per cent of cases in which medical practitioners found marks of genital violence on females or males.⁴⁰ However, this correlation should not be overstated as there was a similarly high conviction rate of 72 per cent in cases in which lay people testified to finding marks of genital violence. It was therefore seemingly the subject matter rather than medical ‘expertise’ that guided this statistical correlation between testimony and verdict. Complicating matters further, prisoners were also convicted in 68 per cent of cases in which medical testimony on genital signs was uncertain, and 72 per cent of cases in which *no* marks of genital violence were found. Many of the latter cases were apparently convicted on the basis of evidence on subjects other than genital violence, such as the testimony of direct witnesses. Simple statistical correlations evidently are not a reliable means to evaluate the impact of a given form of testimony on trial outcomes.

More revealing patterns can be identified by further breaking down these statistics into how the age of a complainant influenced the jury reception of medical testimony on genital violence. Figure 6.5 demonstrates that juries were more likely to convict in line with medical testimony on genital violence in cases with the youngest complainants, with the conviction rate dropping gradually from 100 per cent in cases with complainants under the age of four to 71 per cent in cases with complainants over the age of 16. Although the youngest and oldest age groups were the smallest samples,

⁴⁰ These statistics refer to ‘true bills’ without guilty pleas.

these trends are significant.⁴¹ The graph clearly depicts how the correlation between medical testimony on genital violence and jury verdicts diminished gradually as complainants grew older. Rigid legal frameworks that treated childhood as a two-tier division, under the felony and misdemeanour clauses of sexual consent legislation, were followed as little by jurors as they were by medical practitioners.



The trends depicted in Figure 6.5 must be interpreted in the light of more general links between a complainant's age and jury verdicts, for *all* cases in which a complainant's age is known. Overall, for the same five age groups depicted in Figure 6.1 from youngest to oldest, the average conviction rates were 79 per cent, 69 per cent, 73 per cent, 64 per cent and 63 per cent respectively.⁴² These figures indicate that the age-based reception of medical testimony about genital violence was in line with generally

⁴¹ These statistics are calculated from cases with medical testimony on the subject of genital violence, or the absence thereof, in which a complainant's age was known as follows: 0<4 years old: 9; 4<8 years old: 59; 8<12 years old: 122; 12<16 years old: 44; 16+ years old: 8. This graph does not exclude boys, but it should be remembered that males were the subjects of only three per cent of medical examinations and so the majority of this evidence relates to females.

⁴² These statistics are calculated from 'true bills' without guilty pleas in which a complainant's age was known, as follows: 0<4 years old: 11 guilty, 3 not guilty; 4<8 years old: 148 guilty, 64 not guilty, 1 insane; 8<12 years old: 409 guilty, 151 not guilty, 1 insane; 12<16 years old: 199 guilty, 110 not guilty, 1 insane; 16+ years old: 90 guilty, 51 not guilty, 1 insane.

higher conviction rates in cases involving younger girls and boys. However, average conviction rates were even higher within such general trends when cases also had corroborative evidence of genital violence. It is possible that the increasingly uncertain tone of medical testimony on genital signs in older complainants, as outlined in Chapter Five, served to reinforce existing age-based trends in trial verdicts. The age of complainants thus shaped both the nature and reception of medical testimony about signs of genital violence, to an extent that was arguably more than mere coincidence. These shared age-based trends were the result of some commonality between the concerns of medical practitioners and jurors, rather than just the impact of one on the other. Although the medical frameworks used to interpret genital violence were often physiological, Chapter Five showed that they also connected with broader social and moral concerns about age and blackmail which were shared by lower-middle-class and middle-class jurors.

Statistics cannot be understood without being situated alongside qualitative analysis of the same issues, which is possible through analysis of newspaper reports. The following reports are mostly drawn from Middlesex due to source availability, as there was a proliferation of London daily newspapers and extensive attention was given to the Middlesex Sessions by prominent papers like *The Times*. The connection between medical testimony on genital violence and trial verdicts was sometimes extremely clear. For example, in 1870 *The Times* stated that in a Middlesex case of attempted carnal knowledge on a seven-year-old girl ‘[t]here was corroborative evidence by an inmate of the house and by the doctor, and the jury found a verdict of *Guilty*’.⁴³ In the pre-trial statement for this case, the surgeon had testified that ‘the parts were considerably swollen as though violence had been used towards the child’.⁴⁴ Medical testimony on genital injury was similarly influential in cases involving boys. When a Middlesex surgeon found that a 15-year-old boy had ‘considerable inflammation’ and ‘laceration’ around the anus but that ‘penetration had not been made’, *The Times* reported that ‘[t]he evidence of the medical man strongly corroborated the story of the boy, and there was

⁴³ ‘Middlesex Sessions’, *The Times*, 15 March 1870, 11, p. 11.

⁴⁴ London, LMA, Pre-Trial Statements, Thomas Austin tried at the Middlesex Sessions on 14 March 1870 for attempted carnal knowledge, MJ/SP/E/1870/005.

other confirmatory evidence in the case. The jury found the prisoner *Guilty*.⁴⁵ In both of these cases the medical testimony on genital violence was noted as an influence on trial outcomes, albeit only alongside other corroborative evidence. Medical testimony could also contribute to acquittals, as in a case from the Devon Quarter Sessions in which *Trewman's Exeter Flying Post* noted that '[t]he hearing of a charge of assaulting his daughter, aged 14, brought against Michael O'Brien, merchant sailor of Stonehouse, resulted in an acquittal, a doctor stating that there was no corroboration of the girl's story'.⁴⁶ *The Times* of 5 February 1852 reported on a Middlesex case in which 'the surgeon who examined [the complainant, aged 14] showed that the offence had not been attempted. The jury *acquitted* the prisoner'.⁴⁷ In both of these cases medical witnesses had testified to finding an absence of any genital injury. However, medical testimony never operated alone and in the latter case the acquittal was also partly because the girl's evidence 'differed from what she had previously given'.⁴⁸

Other newspaper reports indicate that some juries used medical testimony about genital injury to guide decisions about the charge under which a prisoner should be convicted, as they were often given the option of convicting on a lesser charge than the initial indictment. *The Times* reported that in another Middlesex case:

Henry Margetson ... was indicted for having, on the night of Saturday, the 23rd of last month, assaulted with intent a girl of the age of 13 years ... The medical evidence did not support the more serious charge, and the jury found the prisoner *Guilty* on the count for indecent assault.⁴⁹

Again, this report broadly corresponded to the pre-trial statement in which the surgeon had testified that 'I could find no marks of violence on the child at all ... The Hymen is perfect still'.⁵⁰ This medical testimony as to an *absence* of marks of violence was seemingly used by the jury to decide to downgrade the charge, while a witness to the girl screaming and running away from the prisoner was used to determine the prisoner's guilt. However, the impact of medical testimony on jurors' decisions about charges was

⁴⁵ London, LMA, Pre-Trial Statements, Justus Dickhart tried at the Middlesex Sessions on 7 June 1864 for indecent assault on a male, MJ/SP/E/1864/011; 'Middlesex Sessions', *The Times*, 8 June 1864, 13, p. 13.

⁴⁶ 'Devon Quarter Sessions', *Trewman's Exeter Flying Post*, 21 October 1905, p. 7.

⁴⁷ 'Middlesex Sessions', *The Times*, 5 February 1852, 7, p. 7.

⁴⁸ 'Middlesex Sessions', *The Times*, 5 February 1852, 7, p. 7.

⁴⁹ 'Middlesex Sessions', *The Times*, 16 November 1875, 9, p. 9.

⁵⁰ London, LMA, Pre-Trial Statements, Henry Margetson tried at the Middlesex Sessions on 15 November 1875 for indecent assault, MJ/SP/E/1875/022.

more problematic than it first appears. When a Middlesex prisoner was accused of carnal knowledge of an 11-year-old girl, *The Times* noted that:

[T]he evidence of the child and of the divisional surgeon of Police who had attended her, coupled with the prisoner's own statements, clearly established most abominable conduct on his part towards the child; but it did not appear that he had completed the offence. The jury found him *Guilty* of the attempt.⁵¹

Despite this claim that the prisoner had not 'completed the offence', the surgeon Thomas Jackman's pre-trial statement in this case included testimony that '[i]n my opinion penetration has to some extent taken place, from the fact of the vagina being larger than natural'.⁵² Jackman's testimony indicated that the prisoner had 'completed the offence' in law by partially penetrating the complainant, even if full penetration had not occurred, and thus corroborated the girl's claim that 'I am sure his person went into mine'.⁵³ There are three possible explanations for this discrepancy: the newspaper misreported the case; the judge did not direct the jury as to the fact that *partial* penetration constituted proof of 'carnal knowledge' by the court, which would have been a deliberate choice in the light of Middlesex judges' legal training; or the jury chose to wilfully ignore medical testimony in the light of other evidence, such as the girl's failure to complain after the first offence and the prisoner's testimony that she was a consenting party.⁵⁴ The latter two possibilities indicate that judges or juries drew on wider frameworks of moral thought in order to interpret the medical testimony on genital violence that they received.

Medical evidence about genital violence also had some influence on judges' sentencing of prisoners. Judges regularly handed down higher sentences when a medical witness testified to finding that a young female victim had contracted venereal disease, which was perceived as contributing to the moral and physical 'ruin' of an innocent girl. As *The Lancet* observed in 1884, 'heavy sentences ... are always inflicted when disease is

⁵¹ 'Middlesex Sessions', *The Times*, 21 October 1874, 11, p. 11.

⁵² London, LMA, Pre-Trial Statements, William Paget tried at the Middlesex Sessions on 20 October 1874 for carnal knowledge, MJ/SP/E/1874/022.

⁵³ LMA, Pre-Trial Statements, William Paget.

⁵⁴ This list includes the possibility that a judge may have *omitted* certain information when directing a jury but does not include the possibility of misdirection, because the latter would likely have been noted in newspapers, medical literature and/or an appeal. The possibility that this judge directed the jury that proof of ejaculation was required to 'complete the offence', as a form of clear misdirection, can therefore be deemed sufficiently unlikely to be excluded from the main list of possibilities. A legally-trained judge would have been aware that the old law about proof of emission had been revoked almost 50 years earlier in 1828, from which time onwards proof of penetration only was required. However, in the absence of clear direction from a judge it is possible that a *jury* may have drawn on such older ideas about the definition of rape.

communicated'.⁵⁵ These claims are borne out by the Middlesex cases, although reports of the impact of such testimony in the south-west counties either were rare or do not survive. After medical testimony that a 10-year-old girl had acquired syphilis from an assault, a Middlesex judge stated that '[t]he pollution of a child of tender years was a crime the atrocity of which no language could describe'.⁵⁶ Although this judge referred to 'pollution' of both mind and body, the presence of venereal disease was part of his decision to hand out the maximum sentence of two years imprisonment with hard labour. In another case in which the prisoner was also given the maximum sentence, a medical witness testified that a girl of only two years old was suffering from gonorrhoea and London's *Morning Post* noted the 'most distressing consequences' of the assault when reporting the sentence.⁵⁷ When four girls under 10 years old were apparently assaulted in October 1851, the *Morning Post* reported that '[t]he worst feature in the case was, that up to the present time, the girls are suffering from the effects of the misconduct of the prisoner'.⁵⁸ This case involved evidence from a medical witness that the girls had gonorrhoea, which seems likely to have been the 'effects' to which the paper referred. However, in this case the judge considered the 'weak intellect' of the prisoner as a mitigating factor and passed a sentence of nine months imprisonment. There were evidently no automatic connections between trial outcomes and medical 'expertise' in the courtroom, as medical testimony was always situated against other evidence. However, medical practitioners and judges alike drew upon age-based and gendered concepts of 'pollution' in emphasising the seriousness of venereal disease as a consequence of sexual crime.

To this point the analysis has focused on direct links between trial outcomes and medical testimony on genital violence, but has demonstrated some of the limitations of such an approach. Situating medical evidence in broader frameworks of thought is potentially more fruitful than posing the ultimately impossible question of 'how important' their evidence was. On this basis, the analysis will now turn to the more

⁵⁵ 'Liverpool (From Our Own Correspondent)', *The Lancet*, 24 May 1884, 963, p. 963.

⁵⁶ London, LMA, Pre-Trial Statements, Robert White tried at the Middlesex Sessions on 22 January 1867 for carnal knowledge, MJ/SP/E/1867/002; 'Middlesex Sessions', *The Times*, 23 January 1867, 9, p. 9.

⁵⁷ London, LMA, Pre-Trial Statements, George James tried at the Middlesex Sessions on 17 February 1858 for indecent assault, MJ/SP/E/1858/004; 'Middlesex Sessions', *Morning Post*, 18 February 1858, 7, p. 7.

⁵⁸ London, LMA, Pre-Trial Statements, Joseph Willis Ford tried at the Middlesex Sessions on 20 October 1851 for assault with intent, MJ/SP/E/1851/022; 'Middlesex Sessions', *Morning Post*, 22 October 1851, 7, p. 7.

specific subject of links between genital signs and chastity, particularly the chastity of pubescent and post-pubescent girls.⁵⁹ This subject provides an example of how the reception and use of medical testimony was connected to broader societal anxieties. As noted in the previous chapter, many trials involving medical evidence of a complainant's unchastity were dismissed at early stages so there is not a large pool of evidence from which to consider jury verdicts in such cases. However, in one case that was seemingly passed forward for trial on the basis of other testimony, a surgeon examined a 16-year-old complainant and found that '[i]ntercourse has been had with her, if it had been this morning it was not the first time'.⁶⁰ A number of local London papers, including the *Daily News* and *Morning Post*, printed the same account of this Middlesex trial. They noted that:

Mr Tothill, surgeon, of 8, Charles-street, St. James's-square, stated that he was called in to examine the prosecutrix on the morning in question. This gentleman's evidence tended to throw considerable discredit on the girl's account of the assault, and to show that she had told more falsehoods than one in the matter. Mr Ribton addressed the jury at length, very earnestly, on the prisoner's behalf, and the Assistant-Judge having summed up, the jury returned a verdict of acquittal.⁶¹

The newspapers indicated that this acquittal was partly the result of Tothill's medico-moral testimony, which demonstrated that the complainant was previously unchaste and had told 'falsehoods'. Its importance did not necessarily lie in the influence of an 'expert' witness but in its subject matter which tapped into broader class-, age- and gender-based concerns about the sexual behaviour of pubescent girls. This medical testimony also tied in with other evidence in the case that did not fit with models of victimhood, such as the girl's failure to call for assistance.

Juries demonstrated some agency in the reception and use of witness testimony. In a case of alleged indecent assault from Middlesex in 1865, in relation to a nine-year-old female complainant, a police surgeon testified that:

I feel confident that the laceration of the hymen must have been occasioned by the introduction of some foreign body: it might have been occasioned by the

⁵⁹ Male chastity was only discussed in court in the context of male-male sex and, as already noted, the only case with evidence of prior male unchastity from homosexual intercourse was dismissed at the pre-trial stage.

⁶⁰ London, LMA, Pre-Trial Statements, Charles Bruno tried at the Middlesex Sessions on 1 May 1854 for indecent assault, MJ/SP/E/1854/015.

⁶¹ 'Middlesex Sessions – Yesterday', *Daily News*, 3 May 1854, 6, p. 6. The same account can be found in 'Middlesex Sessions', *Morning Post*, 3 May 1854, 7, p. 7.

introduction of a man's finger ... ([cross-examined] by Mr Young) Coughing would not cause the rupture – it might have been done by a child's finger.⁶²

His testimony, under cross-examination, that the girl's lacerated hymen 'might have been done by a child's finger' raised questions about the value of the corroborative evidence. This line of defence questioning about whether the girl touched herself implied that she may have done so either out of curiosity or indecently, although the issue of masturbation was not explicitly addressed. This case was rare because, although the previous chapter showed that cross-examination on the subject of young children touching their genitals was not unusual, cases in which a medical practitioner *refuted* the possibility were more likely to reach trial. In this particular case the medical witness acknowledged the possibility that the child's injury was either deliberately or unintentionally self-inflicted. However, the possibility was seemingly given barely a second thought by the jury who 'immediately' convicted the prisoner despite there being no witnesses to the alleged assault.⁶³ This decision contrasts with the case cited above in which medical evidence about the unchastity of a 16-year-old girl was a factor in the prisoner's acquittal. The two cases differed in many respects, not least because medical testimony about the girl's unchastity was more explicit in the first case. However, there is also a possibility that medical evidence was selectively received and interpreted in the light of these complainants' different ages. The second complainant's youth may have influenced the petty jury to reject any notion that her genital injury was self-inflicted. Such claims are inherently speculative but, particularly as the above analysis demonstrated the age-based nature of trial verdicts, there were seemingly some overlaps between medical and wider societal ideas about the greater likelihood of unchastity at and above the age of puberty.

For the purposes of this chapter's subject matter and overall argument, the significance of the issue of chastity lies in its links with a range of social concerns beyond the purely medical. Newspaper reports and trial verdicts indicate that the sexual innocence of post-pubescent women was regularly questioned in both regions under study, often in the absence of medical testimony. One Devon jury acquitted a prisoner without hearing the case for the defence in an indecent assault case, because the 'young woman ... admitted

⁶² London, LMA, Pre-Trial Statements, William Boddington tried at the Middlesex Sessions on 24 August 1865 for indecent assault, MJ/SP/E/1865/016.

⁶³ 'Middlesex Sessions', *Standard*, 25 August 1865, 7, p. 7.

in cross-examination that she was the mother of two illegitimate children'.⁶⁴ In another Devon case involving a 20-year-old complainant, a local newspaper reported that the jury convicted the prisoner only on the minor charge of common assault because 'it transpired that the prosecutrix when 16 years of age was delivered of a child ... the girl was not a modest girl'.⁶⁵ Although these cases did not include medical testimony, the notion that a 16-year-old girl should show 'modesty' had clear points of comparison with medical literature about the expected development of modesty at puberty.⁶⁶ Such similarities indicate the presence of common frameworks of thought rather than the impact of medicine on the judiciary or *vice versa*. Ideas surrounding the potential for girls to be unchaste at and after the age of puberty also did not necessarily correspond to the legal age of sexual consent. Instead, they related to broader contemporary concerns about the intersections between class, age, gender and sexual promiscuity.

The question of sentencing was also interwoven with anxieties about chastity and age. Because prisoners were most likely to be convicted when girls were proven *not* to have been previously unchaste, judges commonly emphasised the importance of punishing prisoners for 'ruining' girls. These connections were made most prominently in the context of sexual crimes against girls aged 10 or below, for whom precocious puberty and any form of prior unchastity was considered particularly unlikely. When a prisoner was found guilty of an indecent assault on a nine-year-old girl in 1874, *The Times* reported that 'the Judge sentenced the prisoner to be imprisoned and kept to hard labour for nine calendar months, remarking that it was a most abominable case, and that the child was probably ruined for life'.⁶⁷ Chastity of mind as well as body was taken into consideration, as demonstrated by two indecent assault charges in Middlesex on girls aged nine and 10 in which Serjeant Cox presided as judge. Cox 'remarked on the terrible effects which might flow from corrupting the mind of so young a child, and sentenced him to six months imprisonment with hard labour' in one case and, in the other, 'said that the contamination of the mind of a young girl was a serious offence, and sentenced the prisoner to be kept at hard labour for three months'.⁶⁸ Although the latter case was apparently mitigated by the prisoner's previous good character, evidently

⁶⁴ 'Devon Sessions', *Trewman's Exeter Flying Post*, 18 October 1902, 3, p. 3.

⁶⁵ 'Devon Quarter Sessions', *Trewman's Exeter Flying Post*, 23 October 1897, unpaginated.

⁶⁶ See Chapter Two for a more detailed discussion of the development of 'modesty' in girls and the 'will' in boys at puberty, both of which were apparently necessary for controlling and hiding sexual urges.

⁶⁷ 'Middlesex Sessions', *The Times*, 19 June 1874, 11, p. 11.

⁶⁸ 'Middlesex Sessions', *The Times*, 25 January 1877, 11, p. 11.

the sexual purity of young girls was considered an aggravating factor during sentencing. That the same judge made these comments twice indicates that there may have been some personal element to such concerns, although they seem to have been broadly representative of judicial practice. These comments about ‘contamination’ and ‘ruin’ were related to broad anxieties about youth and pollution, as discussed in Chapter One. These age-based concerns had many points of comparison with medical literature and medical witness testimony, but did not originate from the medical profession.

A complainant’s chastity, and by extension her character, was seemingly a consideration for judges and juries alike irrespective of whether evidence came from a lay witness or from medical testimony. On this issue, medical roles were negotiated on the basis of *general* rather than *scientific* anxieties. The importance placed on the issue of female chastity was also related to a trend, seen in criminal trials for a range of offences, for a complainant’s perceived ‘respectability’ to be situated against that of the accused. However, comments about ‘respectability’ must be considered a bit more closely. As Alison Phipps notes:

Arguments in this area tend to be ahistorical and atheoretical, focusing on how individual sexual reputations are measured against stereotypical constructions of feminine behaviour, with little attention paid to where such stereotypes come from and in whose interests they operate. A key problem is that respectability is seen as a paradigmatically feminine characteristic rather than as a concept marked by both gender and social class.⁶⁹

Phipps is convincing in her argument that historians should examine the reasons for societal stereotypes, rather than simply identifying their existence. Such an approach is by no means straightforward. It is difficult to locate the origin of ‘rape myths’ or models of respectable female victimhood because these stereotypes had such long roots. However, this is not to say that context had no role in shaping the finer details of such long-term ideas. The nature and reception of witness testimony about a complainant’s character may have been shaped by specific middle-class anxieties of the Victorian and Edwardian periods, such as a general fear of disorderly working-class sexualities and a heightened concern about blackmail after the 1885 CLAA. A complainant’s unchastity was problematic in the light of long-held ‘rape myths’ and concerns about respectability, but it also had particular importance at a time when medical practitioners

⁶⁹ Alison Phipps, ‘Rape and Respectability: Ideas about Sexual Violence and Social Class’, *Sociology* 43 (2009), 667-83, p. 675.

and jurors were on heightened alert for false claims. Phipps's comments on the importance of recognising respectability as a 'concept shaped by gender and social class' also requires the addition of age, in the light of arguments made throughout this thesis about the importance of puberty as a life stage. The issues of puberty, chastity, sexual maturity and the perceived propensity of women to lie were inextricably bound together within and beyond medical thought.

This analysis has indicated that medical evidence on genital violence had some influence in court, but was considered in combination with other forms of testimony. However, it has also highlighted the limitations of focusing on the question of impact in isolation from the other societal and legal issues that shaped the reception of medical testimony. Listing newspaper reports about verdicts or sentences and comparing them with medical testimony is inherently restrictive. It is arguably more helpful to take the lack of uniformity in the reception of medical testimony as a starting point for analysis rather than a conclusion in its own right. The limitations of analysis about cause-and-effect relationships can only be overcome by posing new questions, for example about the lenses through which medical evidence was received and understood rather than the degree of its impact. The reasons why certain types of medical testimony were given greater roles in determining trial outcomes must also be examined rather than simply described. This section has shown that links between the subjects of genital violence and (un)chastity provides one such means to examine these connections. The analysis relates back to a contemporary medical text cited in Chapter Five, which observed that '[w]hether the victim is chaste or otherwise has no bearing on the legal aspect of the case, although it may influence the minds of the jury'.⁷⁰ It has shown that medical evidence about genital signs of unchastity, or at least the little of this testimony which was not dismissed before trial, was relevant to wider social anxieties rather than being simply a question of the impact of 'expert' testimony. It is therefore possible to look beyond the subject of impact to identify shared frameworks of thought that shaped both the nature of medical testimony on genital signs and the ways in which it was received and interpreted at trial. These conclusions lead in to the chapter's final section on the subject of consent, which was interwoven with the issue of chastity but was a sufficiently complex issue to be considered in its own right. It shows that different

⁷⁰ C. Graham Grant, *Practical Forensic Medicine: A Police-Surgeon's Emergency Guide*, 2nd edn (London: H. K. Lewis, 1911 [1907]), p. 43.

societal concerns and definitions of consent shaped medical roles in court, thus develops and consolidates the conclusions drawn in this section.

The Resisting Body: Bodily Signs and Consent

Consent was a vaguely defined but important legal issue which did not always turn on evidence of physical resistance. This section shows that, in terms of the simple question of impact on trial outcomes, medical testimony on marks of resistance was more influential than other forms of medical evidence. However, the impact of medical evidence must be situated within the wider frameworks of thought that have been emphasised throughout this chapter. Ideas about consent and resistance were framed by moral concerns about character, such as the notion that working-class females and unchaste women were more likely to have consented. Judges and juries also had great discretion to decide how the full 'will' of a woman could be proved. The following analysis indicates that the importance of medical testimony on resistance was due to a tendency for jurors, although not always judges, to conceptualise consent in terms of a physical struggle. Medical witnesses did not necessarily construct this definition of consent, but were positively received when their testimony supported and fitted within it. Again, medical witnesses' role in determining trial outcomes was shaped by the subject matter of their testimony rather than by any inherent sense of 'expert' authority.

As noted in the previous chapter, medical witnesses focused on the subject of bodily resistance even though they recognised that consent was a multifaceted concept. Reports of trials from both regions indicate that juries also drew connections between physical resistance and consent, even in cases involving the youngest complainants. Although the subject of consent commonly excluded children, it was legally relevant in indecent assault cases involving male or female complainants of any age before 1880 and over the age of 13 after 1880. In 1857 *The Times* reported on a case of alleged indecent assault against an eight-year-old girl in which 'as it appeared the child did not resist [the prisoner] was acquitted on the point of law as to consent'.⁷¹ Carolyn Conley notes similar cases in her work on crime in Victorian Kent, in which she argues that juries often conceptualised consent in terms of physical resistance rather than as a matter linked to 'consent of will', fear or influence. She notes that juries focused on physical

⁷¹ 'Middlesex Sessions', *The Times*, 11 February 1857, 12, p. 12.

resistance in incest cases despite the apparent mitigation of the unequal father-daughter power relationship, citing two cases in which prisoners were acquitted because their teenage daughters showed ‘insufficient resistance’ to an alleged assault.⁷² Notably, in these cases resistance was deemed ‘insufficient’ rather than entirely absent.

The apparent tendency for juries to focus on consent as a physical struggle, sometimes irrespective of a complainant’s age or relationship to the prisoner, meant that verdicts in Middlesex and the south-west counties generally corresponded to medical findings about bodily violence and resistance. Although the limitations of statistical analysis have already been noted, it may be significant that correlations between medical testimony on bodily violence and trial outcomes were far clearer than between testimony on genital violence and trial outcomes. For all ‘true bills’ without guilty pleas, juries convicted in 70 per cent of cases in which medical witnesses found marks of violence or resistance on a complainant’s body and only 57 per cent of cases in which medical practitioners explicitly noted the absence of such marks. Because juries were often directed on the subject of consent, it is possible that they felt obliged to adhere to the official law on the matter even in cases involving young girls and boys. This possibility is supported by the case cited above involving an eight-year-old complainant, which was explicitly described as being dismissed on a ‘point of law’. It is further borne out by a Middlesex case involving an alleged indecent assault on a nine-year-old boy in 1857, in which a prisoner was also acquitted on the basis of the boy’s apparent consent. In this case, according to newspapers, the verdict was passed ‘with regret’ after the ‘Assistant-Judge left the case to the jury upon the question of consent’.⁷³

Although there was no clear-cut or consistent hierarchy of factors that influenced trial outcomes, medical evidence on questions of physical resistance could seemingly outweigh testimony on the subject of (un)chastity. These two subjects were not entirely separable, as Francis Ogston noted in his medical jurisprudence textbook that ‘the previous character of the woman who has charged a man with the commission of a rape on her is allowed considerable weight in law in determining the assent or non-assent’.⁷⁴

⁷² Carolyn A. Conley, *The Unwritten Law: Criminal Justice in Victorian Kent* (Oxford: Oxford University Press, 1991), p. 121.

⁷³ ‘Middlesex Sessions’, *Lloyd's Weekly Newspaper*, 17 May 1857, 4, p. 4.

⁷⁴ Francis Ogston, *Lectures on Medical Jurisprudence* (London: J. & A. Churchill, 1878), p. 119.

However, some medical witnesses found signs of both resistance and unchastity in their examinations and in such instances weight had to be given to one or the other. In a Middlesex case from 1885 a surgeon testified to his examination of a servant girl, whose age was not specified but was likely to have been between 15 and 20 like many servant girls of the time.⁷⁵ He stated that:

I don't think the violence as detailed in evidence in this case would hardly cause the rupture of the hymen. In my opinion the girl's hymen had been ruptured before Sunday the 11th ... (cross-examined) Hearing the girl say that she had been sleeping with a young man for a week ... I am not surprised to find the hymen ruptured.⁷⁶

Alongside these observations on the girl's apparent prior unchastity, he commented that he found that 'the girl stooped slightly and walked slightly lame ... there were bruises on the left thigh and just below the knee and the left breast was bruised'.⁷⁷ London's *Standard* newspaper focused only on the latter testimony when it reported that 'the medical evidence proved that she had been subjected to much violence ... The Jury returned a verdict of Guilty against both Prisoners'.⁷⁸ In this case the girl's bruises, which were taken as marks of resistance, outweighed her apparent lack of respectability or modesty. This pattern can be explained by the fact that a complainant's chastity was officially irrelevant in law whereas her consent was central. Both were highly moralised issues, but consent had a more formal place in the judicial sphere. The verdict can also partly be explained by the fact that the girl testified that she previously 'slept with a young man but he didn't touch me' and the man in question was called to testify that 'I never had connexion with her'.⁷⁹ Her reputation was thus saved by witnesses other than the medical 'expert', whose evidence instead became of value in demonstrating her resistance to the alleged indecent assault. While moral matters were a crucial part of the court script, medical testimony was seemingly drawn on by juries as and when it was subject to requirements rather than being a 'dominant discourse'.

⁷⁵ Yaffra Claire Draznin notes that, in 1870-1900, half of servants were under the age of 20; Yaffra Claire Draznin, *Victorian London's Middle-Class Housewife: What She Did All Day* (Westport, CT; London: Greenwood Press, 2001), p. 75. For the period 1851-75, Geoffrey Best similarly notes that one in three girls aged 15 to 20 were domestic servants; Geoffrey Best, *Mid-Victorian Britain, 1851-75* (London: Fontana, 1979), p. 124. Ginger S. Frost cites the same figure for the 1890s; Ginger S. Frost, *Victorian Childhoods* (Westport, CT: Praeger, 2009), p. 64.

⁷⁶ London, LMA, Pre-Trial Statements, Louis and Mary Keavy tried at the Middlesex Sessions on 13 November 1885 for indecent assault, MJ/SP/E/1885/053.

⁷⁷ LMA, Pre-Trial Statements, Louis and Mary Keavy.

⁷⁸ 'Middlesex Sessions', *Standard*, 14 November 1885, 2, p. 2.

⁷⁹ LMA, Pre-Trial Statements, Louis and Mary Keavy.

The previous chapter noted that medical witnesses believed that ‘insensibility’ could justify a lack of resistance, but it was not a purely scientific issue. Medical and lay testimony on insensibility was seemingly received in similar ways. Undoubtedly medical testimony could contribute to a jury’s perception of whether a female or, less commonly, male complainant was ‘insensible’ to justify their apparent lack of physical resistance. In the case discussed in Chapter Five, in which a medical witness was guided by counsel towards indicating that a drug might have caused a prosecutrix’s insensibility, the prisoner was found guilty. In another Middlesex case involving an 11-year-old male complainant, the medical witness testified that ‘[h]e was tossing about on the bed much excited. I thought him drunk but found no perfume of drink in his breath. He made a statement to me. He said he became insensible’.⁸⁰ *Reynold’s Newspaper* reported that the prisoner:

[W]as indicted for attempting feloniously to assault a boy eleven years of age, after administering to him chloroform, or some other noxious drug. Medical evidence having been heard, the jury found the prisoner “Guilty,” under the third count of the indictment, of an indecent assault.⁸¹

This report indicated a connection between the jury’s verdict and the medical testimony, which corroborated the boy’s claim to have been drugged by describing him as appearing drunk without any signs of alcohol intake. Arguably it was the issue of insensibility that was of primary importance in such cases, rather than the fact that evidence of insensibility came from a medical practitioner. Although a scientific basis for moral issues was given weight in court, medical testimony was drawn upon when it fitted with jurors’ existing ideas about a ‘real rape’ rather than shaping what the criteria of a ‘real rape’ were. When other witnesses and complainants referred to insensibility to justify a lack of resistance, newspaper reports indicate that their testimony was given as much weight as similar evidence from medical practitioners. For example, in a Devon case of suspected indecent assault on a young adult female, the local newspaper reported that ‘[a]fter serving the prosecutrix in a very brutal manner – so much so that she was insensible when found – the prisoner left her, and made his way off ... The prisoner was found guilty’.⁸² In this cases proof of insensibility came not from a

⁸⁰ London, LMA, Pre-Trial Statements, Stephen Casaya tried at the Middlesex Sessions on 25 October 1870 for indecent assault on a male, MJ/SP/E/1870/023.

⁸¹ ‘Middlesex Sessions’, *Reynolds’s Newspaper*, 30 October 1870, 6, p. 6.

⁸² ‘Devon Epiphany Sessions’, *Trewman’s Exeter Flying Post*, 15 January 1857, 3, p. 3.

medical practitioner, but from the witness who found the girl on the floor after the alleged assault.⁸³

The subjects of resistance and consent seemingly played a significant role in jurors' decisions, in part because of their legal relevance. Medical practitioners helped to guide such decisions, which was possible because their conceptualisation of consent as largely (although not entirely) a physical struggle corresponded to that of jurors. In the light of conclusions drawn in Chapter Five, such overlaps between medical practitioners' and jurors' definitions of consent were unlikely to have been entirely coincidental. Cases were more likely to reach trial when medical practitioners found signs of physical violence, which may have shaped petty jurors' conceptualisations of consent and reinforced stereotypes about physically violent 'real rape'. However, such definitions of consent were not consistent throughout the courtroom. This section will now go on to demonstrate that judges took a broader view of the meaning of consent and, in consequence, did not draw upon medical testimony to the same extent.

It is difficult to assess the definition of consent used during sentencing, as few cases reached the sentencing stage in which any form of consent had been proven. However, it is possible to identify some points of distinction between the definitions of consent used by judges and juries by considering the limited evidence available from pre-trial statements in combination with other sources. It is particularly useful to examine some case law decisions that included judges' directions to juries on points of consent. Such evidence aids an understanding of the definition of consent that was used at the highest levels of the legal profession, by judges with legal training and experience. Some case law decisions corresponded to medical notions of resistance as a purely physical act, as in an 1865 case law decision that:

[O]n a charge of rape, the jury should be satisfied, not merely that the act was in some degree against the will of the woman; but that she was, by physical violence or terror, fairly overcome, and forced against her will, she resisting as much as she could, so as to make the prisoner see and know that she was really resisting to the utmost.⁸⁴

⁸³ Exeter, DRO, Pre-Trial Statements, William Ponsford tried at the Devon Quarter Sessions on 7 January 1857 for assault with intent, QS/B/1857/Epiphany.

⁸⁴ Regina v Rudland (1865) 4 F and F 495.

The issue of ‘resisting to the utmost’ is particularly noteworthy, as it relates to the notion that a female could feign a struggle without truly resisting. As Joanna Bourke notes, the idea that ‘no’ can mean ‘yes’ in certain circumstances has prevailed for hundreds of years.⁸⁵

Although the above case law decision emphasised the physical aspects of consent, other decisions highlighted the ways in which non-resistance could be mitigated by the complainant being a relative or person in a position of authority such as a schoolmaster.⁸⁶ In such cases, ‘mere submission’ was clearly distinguished from consent. It was reported in one case law decision that Justice Brett stated that:

In cases of criminal assault by a father upon his daughter I have more than once, with the concurrence of Willes, J., told the jury that in the case of a young child and an adult they must consider whether there has been mere submission on the part of the child, known to be merely so by the adult, or whether there has really been consent.⁸⁷

According to Steve Hedley in the *Oxford Dictionary of National Biography*, Brett was a ‘commanding figure’, a Conservative and a ‘common-law traditionalist, he thought highly of juries, which he directed genially but forcefully’.⁸⁸ As a high-profile judge, it seems likely that his decision on this matter would have been influential upon other judges of the time. Even though there was undoubtedly a personal element to such direction, his views were shared by Justice Willes who was also a ‘commanding’ judge of the time. Thomas Dixon notes that Willes was ‘known for his prodigious intellect, for showing mercy in criminal cases, and for his tendency to be moved to tears’.⁸⁹ That a judge known ‘for showing mercy’ encouraged a jury to distinguish between consent and ‘submission’ in cases of father-daughter incest indicates that these cases were viewed with particular severity. In an 1870 Central Criminal Court trial for carnal knowledge of a girl above the age of 10 and below the age of 12, Justice Lush similarly directed the jury that:

On the second count [of indecent assault] you cannot convict if there has been consent, as an assault excludes consent. But consent means consent of will, and

⁸⁵ See the section entitled “‘no’ means ‘yes’” in Joanna Bourke, *Rape: A History from 1860 to the Present Day* (London: Virago, 2007), pp. 67-76.

⁸⁶ *Regina v McGavaran* (1852) CCLC 6.

⁸⁷ *The Queen v Lock* (1872) LR 2 CCR 10.

⁸⁸ Steve Hedley, ‘Brett, William Baliol, first Viscount Esher (1815–1899)’, *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004) <<http://www.oxforddnb.com/view/article/3350>> (accessed 23 July 2012).

⁸⁹ Thomas Dixon, ‘The Tears of Mr Justice Willes’, *Journal of Victorian Culture* 17 (2012), 1-23, p. 2.

if the child submitted under the influence of terror, or because she felt herself in the power of the man, her father, there was no real consent.⁹⁰

Although such examples are drawn from case law, they indicate that judges drew upon a more multifaceted definition of consent than juries. They also indicate that juries demonstrated some autonomy in defining consent, which did not necessarily correspond to the legal definition or to judicial direction.

Case law records indicate that judges may have conceptualised consent as more than a physical struggle, a conclusion which is somewhat corroborated by the decisions made by judges in the Middlesex and south-west Quarter Sessions cases. Judges passed heavier sentences in cases of ‘carnal knowledge’ that involved incest irrespective of the degree of resistance that a complainant had demonstrated. Prisoners who committed incestuous assaults on young female family members were given some of the highest sentences: the mean average sentence for direct blood relatives was 84 per cent of the maximum by law, and the same statistic for an uncle or a relative by marriage was 70 per cent of the maximum sentence for law. *The Times* reported a Middlesex case from 1875 in which:

James Seagrave, 58, was indicted for attempting to ravish and for assaulting with intent his step-daughter, a girl under the age of 13 years ... Mr. Edlin said it was as gross an outrage, considering the position the prisoner occupied towards the child, as had ever come before him, and sentenced him to two years’ imprisonment, with hard labour.⁹¹

These responses to incest cases may have been due to broader anxieties about the ‘unnatural’ nature of incestuous relationships between blood- and step-relations, rather than to ideas about consent. However, the impact of incestuous relations on sentences also tied in with the case law decisions outlined above in which familial relationships were noted to cause ‘mere submission’. These models of consent differed from the emphasis on pure physicality found in much medical testimony and in jury verdicts, although judges seemingly drew upon a multifaceted conceptualisation of consent rather than completely rejecting its physical aspects.

Some judicial discretion was also used in relation to the subjects of age and consent, as in a Somerset case from 1884 in which ‘three lads from 12 to 15 years of age’ were

⁹⁰ Regina v Woodhurst (1870) CCLC 12.

⁹¹ ‘Middlesex Sessions’, *The Times*, 28 August 1875, 9, p. 9.

convicted of a common assault on a servant girl aged 16 years old.⁹² The judge passed a sentence of only 14 days imprisonment out of a possible maximum of 12 months. Although the possibility of this girl's consent was theoretically removed by the 'assault' verdict, this sentence implies that some responsibility may have been placed upon her. She was older than the prisoners and, according to a local newspaper, 'the defence was that a girl was a consenting party'.⁹³ The notion that the victim was implicitly blamed for her encouragement in this case, even if it did not constitute consent in law, seems increasingly likely when other cases are considered. In another Somerset case from the same year a 'lad' confessed to an indecent assault in his testimony but was given a reduced charge of common assault and a sentence of only a month, possibly because the complainant was 23 years old and '[t]he defence was that the girl began joking with the prisoner'.⁹⁴ The fact that these two cases came from the same court in the same year indicates that these decisions might have been influenced by the individual preferences of its judge. However, they also related to broader ideas about females needing to demonstrate that they resisted to the 'utmost' of their ability. The multifaceted definition of consent used by judges was also flexible, and took into consideration issues such as perceived encouragement. Post-pubescent women could be blamed for encouraging an assault if 'no' did not really mean 'no', or if they had been overfriendly with a prisoner. This issue relates to observations made in the first section of this chapter about the importance of age *difference* between prisoners and complainants, rather than just the age of complainants, in the light of contemporary concerns that a young man might be led astray by a precocious young woman.

This section has highlighted some of the difficulties of assessing how the issue of consent shaped trial outcomes. The subject was undoubtedly central to many trials in both legal and moral terms, particularly those involving female complainants, but its definition was not clear cut. As judges and jurors drew upon slightly different understandings of consent, the significance that they placed on medical testimony about bodily resistance was not consistent. Consent was conceptualised as a multifaceted issue by judges but more often as a physical matter by jurors, therefore the latter group were particularly receptive to medical evidence on bodily violence. Although judges' and

⁹² 'Somerset Quarter Sessions', *The Bristol Mercury and Daily Post*, 4 January 1884, 6, p. 6.

⁹³ 'Somerset Quarter Sessions', *The Bristol Mercury and Daily Post*, 4 January 1884, 6, p. 6.

⁹⁴ 'Somerset Midsummer Session: Assault', *The Bristol Mercury and Daily Post*, 3 July 1884, 3, p. 3.

juries' conceptualisations of consent might have merged in cases with directed verdicts, it is evidently important not to underestimate the discretion that juries carried in the judicial process. The influence of medical testimony on the subject of resistance was thus variable, depending on the definition on consent held by members of the court. Medical testimony was received and interpreted in light of judges' and jurors' pre-existing ideas, rather than carrying inherent authority. However, medical testimony may also have served to reinforce jurors' conceptualisations of consent as a matter of bodily violence.

Conclusions

This chapter has shown that, in line with conclusions drawn throughout the thesis, medical roles in determining trial outcomes could be important but were not automatic. Relationships between medical testimony and trial outcomes were complex and did not operate as a simple matter of cause-and-effect. These conclusions build on those of other scholars, such as Willemijn Ruberg's study of nineteenth-century North Holland in which she found that 'doctors' opinions were important but not overriding' and Louise Jackson's findings in a sample from late-Victorian Middlesex that 'juries often, but not uniformly, convicted in line with the medical evidence'.⁹⁵ This chapter has shown that these claims are broadly accurate, but has also demonstrated the value of going beyond questions of impact to consider how medicine and the law drew upon *shared* cultures and knowledge.

The chapter has argued that the common concerns of medical witnesses, judges and jurors were not merely coincidental. To some extent they were the result of adversarial and pre-trial processes that shaped the nature of the cases that reached trial, as outlined in the previous chapter, thereby ensuring that they fulfilled the perceived criteria for a 'real rape'. However, they were also influenced by broader prevailing currents of opinion. The triad of age, class and gender fundamentally shaped both the subject matter of evidence that reached trial and the ways in which such testimony was received and interpreted. These conclusions do not seek to undermine or ignore the heterogeneity

⁹⁵ W. G. Ruberg, "'Mother Knows Best": The Transmission of Knowledge of the Female Body and Venereal Diseases in Nineteenth-Century Dutch Rape Cases' in *The Transmission of Health Practices (c. 1500 to 2000)*, ed. Martin Dinges and Robert Juette (Stuttgart: Franz Steiner Verlag, 2001), 35-47, p. 43; Louise Jackson, 'Child Sexual Abuse and the Law: London 1870-1914', unpublished doctoral thesis, Roehampton Institute (1997), p. 177.

of court processes and the agency of individuals within them, particularly as this thesis has emphasised the role of 'discretion' within criminal trials throughout. However, bearing in mind individual agency should not prevent historians from recognising that broad trends in social thought did exist and could have a practical effect on criminal trials. The trends identified in this chapter conclude the thesis by connecting back to its first chapter, in which it was argued that medical ideas about age, sexual behaviour and sexual development carried most 'social currency' when they coincided with broader shifts in social thought. The place of medicine in judicial contexts can only be understood in the light of these broader trends, which defined not only the nature of medical testimony but also its social and legal relevance.

Conclusion

On 1 April 1905, *The Lancet* published a letter by the medical practitioner C. Bell Taylor of Nottingham, which observed that '[m]edicine is not an exact science and never will be and the man who comes into court to expound scientific truth to the laity is expounding something that does not exist'.¹ This thesis has supported and built on his claim that Victorian and Edwardian forensic medicine was 'not an exact science', with particular attention to the contexts of sexual consent legislation and trials for sexual crime. It has shown that ambiguities in scientific thought allowed members of the public and of the judicial, legal and parliamentary professions to seize upon the aspects of physiology that supported their own positions on the subject of sexual crime. Medical practitioners and medical writers actively encouraged this ambiguity, as they also drew upon physiology selectively to promote specific agendas on sexual consent legislation. In addition to showing that medicine was not an 'exact science' in relation to the subjects of sexual consent and sexual crime, this thesis has raised questions about the degree to which it was a 'science' at all in such contexts. That scientific rhetoric was often utilised by others in the parliamentary and judicial spheres indicates that it was deemed to carry some form of influence. However, its perceived value often lay in the provision of scientific validation for existing *moral* concerns, rather than in any inherent authority or 'expertise' carried by medical practitioners. The science of physiology often touched upon issues at the boundaries between medicine and morality, such as chastity and consent, or at least was deemed most useful by the legal and judicial professions when it did so. Physiology in itself thus was neither an 'exact science' nor cut off from wider contemporary concerns.

These comments link to the thesis's first main contribution to knowledge, as demonstrated throughout and across its six chapters, that medical practitioners carried no inherent authority as 'experts' in Victorian and Edwardian law-making and judicial processes. Medical theories and medical practitioners were commonly used in processes of law-making and in criminal trials, but in an unsystematic way across the locations and periods under study. The medical practitioners who shaped age-of-consent legislation and who testified in criminal trials were rarely 'elites', but rather were

¹ C. Bell Taylor, 'The Medical Man as Expert Witness', *The Lancet*, 1 April 1905, 887-88, p. 887.

general practitioners without specialist knowledge of sexual crime or forensic medicine. Medical practitioners also often had little control over how their ideas were drawn upon by others, for example in Parliament, and whether they were called upon to testify in parliamentary committees or trials. Medical authority was thus not automatic, but medical practitioners also were not entirely subservient to the legal profession. They demonstrated agency in negotiating space for their ideas in a range of legal spheres, including the parliamentary and the judicial. Overall the thesis has argued that it is restrictive to consider which of the professions was dominant in any given context and that it is more productive to examine the networks by which medico-legal knowledge was produced. Such networks were shaped by broader societal concerns rather than being only a matter of knowledge flowing 'between' medicine and the law in a mono- or bi-directional fashion. This approach recognises that medical authority resulted not from deference to medical 'expertise' but from the way that medical practitioners, Members of Parliament, members of the judiciary and the middle-class public drew upon and consolidated *shared* non-scientific concerns of the period under study.

It is problematic to claim that any particular societal concern was universally the 'most' or 'least' important. However, the thesis has identified some issues that were repeatedly drawn upon with respect to the nature of medical evidence and its use in law-making or criminal prosecutions. It has shown that precocious and pubescent working-class girls were the focus of contemporary middle-class anxieties about sex, both outside and within Parliament and the courts. Such concerns were shared by medical practitioners and key legal decision-makers, who were generally from higher social classes than the complainants in sexual offence trials or the intended beneficiaries of age-of-consent legislation. Such shared class-based anxieties were also interwoven with the issues of age, gender and race. The concept of precocity was used to highlight the apparent innocence of 'normal' children and the superiority of western European races, in which sexual development was deemed to occur later. Other shared medico-legal concerns that touched upon the issues of age, class and gender related to long-term 'rape myths', such as the notion that girls at or above the age of puberty who resisted 'to the utmost' could not be raped.² The gendered nature of these concerns was due to moral anxieties about 'fallen' girls, which were deemed less relevant to boys. Although societal concerns about 'waste' and national strength were drawn upon by medical practitioners in

² Regina v Rudland (1865) 4 F and F 495.

relation to the sexual behaviour of males, these ideas mainly resonated with eugenicists rather than with the ‘coalition of forces’ that promoted age-of-consent legislation. In the courtroom, the majority of cases and an even greater proportion of medical testimony related to female complainants. There was thus no consistent hierarchy of shared concerns that framed medical ideas or medico-legal relations, as they varied between individuals and contexts. However, the thesis has shown that medical authority was established at the boundaries of medical, social and legal knowledge rather than being a form of objective knowledge imposed ‘from above’.

This study has paid most attention to the influence of age-based concerns on the nature and reception of medical ideas about sexual consent and sexual crime. While not understating the importance of issues such as gender and class, the thesis has focused on age as a category of analysis in order to fill a gap in existing historiography. In taking this approach, it has presented another original argument by demonstrating that ‘children’ and ‘adults’ were not deemed to be homogeneous categories. Law-making processes required the delineation of some ‘hard and fast’ lines between the two, which medical practitioners often adhered to in the parliamentary sphere.³ However, in the courtroom both medical and judicial professions treated such boundaries with a degree of discretion. Many of the shared concerns outlined above related to working-class females at the age of puberty or to precocious girls, who reached puberty early, thus were situated at the boundary between girlhood and womanhood. Because puberty was deemed to be a variable and lengthy development period rather than a turning point, the interpretation of bodily signs by medical witnesses often shifted gradually with the age of a complainant rather than adhering to the two-tier legal system. Jurors’ decisions followed similar patterns in cases both with and without medical testimony. Their apparent receptiveness to such medical testimony therefore was not the result of ‘expert’ authority, but rather was because it had relevance to broader age-based anxieties about the greater propensity of older girls to lie or to be unchaste. Such conclusions are significant for three main reasons: firstly, they indicate that the analytical category of age can provide a new historical perspective on the subject of sexual crime, which has been primarily examined from a gendered perspective to this point; secondly, they corroborate claims made above about shared pools of medico-legal knowledge and the

³ H. R. P. Gamon, *The London Police Court Today & Tomorrow* (London: J. M. Dent & Co., 1907), p. 197.

inseparability of physiology from broader moral, social and legal concerns; finally, they show that separating histories of ‘rape’ and ‘child sexual abuse’ is partly an artificial division. Although these two types of crime were undoubtedly distinct, studying them in this way encourages separate historical analyses of crimes against ‘children’ and ‘adults’. Such an approach overlooks how girls who bridged these two age groups were a particular focus of contemporary medical, social and legal anxieties.

The various chapters of this thesis have shown that, from medical theory to the criminal law to judicial practice, no aspect of medical thought or the legal process was entirely cut off from broader contemporary concerns. Although the thesis has focused on sexual crime these conclusions have broader implications for histories of forensic medicine in general. The thesis has proposed an alternative conceptual framework for understanding medico-legal relations, which focuses not on linear processes of knowledge exchange but on networks of knowledge production and pools of shared knowledge. This approach removes questions about the degree of medical or legal influence in any given context, an approach which misleadingly implies that either profession had some measurable or innate authority. The thesis also has relevance beyond medical or legal history, as it has provided a practical response to Sally Shuttleworth’s question: ‘[i]s it now time to add age ... to the triumvirate of class, gender and race?’⁴ It has shown that adding age to a critical analysis is a productive process, not only in terms of finding new answers but also in terms of creating new questions to ask.

⁴ Sally Shuttleworth, ‘Victorian Childhood’, *Journal of Victorian Culture* 9 (2004), 107-13, p. 107.

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