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Original Communication

Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs)

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Abstract

Background: A Sexual Assault Referral Centre (SARC) is a model of service developed in the UK to provide immediate medical care, forensic and after care services for the victims of serious sexual assault. National guidelines recommend female medical staff for victims of serious sexual assault, although there has been few studies specifically undertaken to ask victims themselves about their choice of gender of staff in a SARC.
Objective: To collect feedback from victims about their preferences for staff gender within SARCs as a means of informing recruitment policy.
Methods: Three SARCs participated in the study; two in London and one in Manchester. Clients over the age of 16 years (with no vulnerability) were asked to complete a questionnaire about their preference for gender of staff providing forensic examination and care.
Results: Most victims (76.8%, male and female) preferred SARC staff to be female. Almost 100% of victims would continue with the examination if carried out by a female doctor, whereas 43.5% of victims said they would not if the doctor were male.
Conclusion: SARCs should continue to consider female staff as the primary gender of staff providing services, as part of their recruitment policy, within the realms of employment law.
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1. Introduction

A Sexual Assault Referral Centre (SARC) is a 'one stop' location where victims of sexual assault can receive a forensic medical examination to assist with police investigations and aftercare support such as counselling.[1] The medical needs of victims may include treatment of minor injuries, medical assessment and prevention of sexually transmitted infections including HIV, emergency contraception and psychosocial support. Victims attending most SARCs are given the choice to have a forensic examination with or without reporting to the police, typically if the incident occurred less than seven days ago. Some SARCs are only

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open to police-referrals. A forensic medical examination, including taking intimate samples, is crucial if assailants are to be prosecuted and convicted. Sensitive, non-judgemental, professional and sympathetic care during and after the examination is essential in enabling the victim to gain control as part of the recovery process. Access to services may be hindered if SARC staff members lack the appropriate knowledge, skills and attitudes.

Previous studies suggest that both female and male victims prefer female staff caring for them following sexual assault,[2–4] whilst some female victims have experienced forensic examination by a male doctor as unsympathetic, judgemental and humiliating.[5] There may also be cultural issues biasing personal preferences, e.g., for some women examination by a male doctor could be against their religion and traditional values.[4] In addition, because the perpetrators/assailants are mostly male, victims do not want to be intimately examined by a male doctor soon after the event.[5]

The National Service Guidelines for SARCs and elsewhere recommended that forensic medical staff should be female[1,6] in large part as an attempt to improve the poor conviction rate for rapes reported to the police (5.6% in England and Wales[7]). This has led to the justification and substantiation of a female only recruitment policy in the Manchester and London based SARCs. However, limited specific research has been done to ask victims of sexual assault about their preference of staff gender. This study was, therefore, carried out to explore the views of both male and female victims.

2. Method

The research was carried out from April to September 2005 in three SARCs: The Haven – Camberwell; The Haven – Paddington (both of the latter in London); and St. Mary's Centre (Manchester). Ethical approval was obtained from South Manchester Research Ethics Committee and the relevant departments of the individual NHS Trusts. Clients attending a SARC for a forensic medical examination were invited to participate in the study. The forensic physician or crisis worker would explain the study in full, obtain consent and give the information pack, including a questionnaire for completion either on site or to be taken away for completion at their convenience (prepaid envelopes were enclosed in the packs to encourage return of the questionnaires). In order to maximise recruitment, for those who were initially unsure about participation, the study was also discussed with victims at follow-up visits. Frequency and non-parametric statistics were calculated.

The total number of clients at the three sites during the study was 1125, of whom 859 were eligible to participate in the study. From these, 177 completed questionnaires were returned, giving a response rate of 20.6%. Most respondents were recruited by the Haven at Paddington (108, 61.0%), followed by the Haven at Camberwell (38, 21.5%) and St. Mary's at Manchester (31, 17.5%). There were 168 (94.9%) female respondents and 9 (5.1%) male. Most respondents who gave their age (132, 75%) were between 18 and 34 years, see Table 1 for details. A majority of respondents who cited their ethnicity (103, 58.5%) defined this as 'White British', see Table 2 for details.

Table 1
Age groups of respondents, excluding unknowns ($n = 176$)

Age	n	%
16–17	14	8.0
18–24	71	40.3
25–34	61	34.7
35–44	20	11.4
45–54	8	4.5
55+	2	1.2

Table 2
Ethnicity of respondents, excluding unknowns ($n = 176$)

Ethnic group	n	%
White British	103	58.5
White Other	28	15.9
Mixed White Black Caribbean	1	.6
Mixed White Asian	3	1.7
Mixed Other	5	2.8
Asian Indian	1	.6
Asian Pakistani	4	2.3
Asian Bangladeshi	2	1.1
Asian Other	7	4.0
Black Caribbean	10	5.7
Black African	5	2.8
Black Other	5	2.8
Other Ethnic Group	2	1.1

3. Results

3.1. What would victims prefer?

Overall, 138 of the respondents (78.4%) indicated a preference for female forensic physicians, and 132 (74.6%) for female crisis workers. These figures were roughly the same for female respondents, since the number of male respondents was so small. A majority of males expressed no preference for forensic physician gender, although a third would have preferred a female. This difference between the two participant groups was sufficiently large to be statistically significant ($p < 0.05$) in a Pearson Chi Square Test ($p = 0.00$, two-tailed). Conversely, over half of males expressed a greater preference for female crisis workers, reflecting their female counterparts. No-one expressed an active preference for a male crisis worker and only one respondent, a male, expressed a preference for a male forensic physician. The rest claimed to have no preference for the gender of the service provider. See Table 3 for details.

3.2. What if there was no choice?

When asked if they would still have a forensic medical examination if they had to see a female forensic physician,

Table 3
Respondent preferences for gender of SARC staff

Staff type	Preference	Respondents					
		All ($n = 176$)		Female ($n = 168$)		Male ($n = 9$)	
		n	% of all	n	% of F	n	% of M
Forensic physician	Female	138	78.4	135	80.8	3	33.3
	Male	1	0.6	0	0.0	1	11.1
	Either	37	20.9	32	19.0	5	55.6
Crisis worker	Female	132	74.6	127	75.6	5	55.6
	Male	0	0.0	0	0.0	0	0.0
	Either	45	25.4	41	24.4	4	44.4

Table 4
If a victim could not choose the gender of the forensic physician, would she/he still have the examination? (excluding unknowns)

Forensic physician gender	Have exam	Respondents					
		All		Female		Male	
		n	%	n	%	n	%
Female	Yes	172	99.4	164	99.4	8	100.0
	No	1	0.6	1	0.6	0	0.0
	Known	173	100.0	165	100.0	8	100.0
Male	Yes	99	57.6	92	56.4	7	77.8
	No	73	42.4	71	43.6	2	22.2
	Known	172	100.0	163	100.0	9	100.0

Table 5
If a victim could not choose the gender of the crisis worker, would she/he still have the examination? (excluding unknowns)

Crisis worker gender	Attend SARC	Respondents					
		All		Female		Male	
		n	%	n	%	n	%
Female	Yes	174	99.4	165	99.4	9	100.0
	No	1	0.6	1	0.6	0	0.0
	Known	175	100.0	166	100.0	9	100.0
Male	Yes	118	68.2	111	67.7	7	77.8
	No	55	31.8	53	32.3	2	22.2
	Known	173	100.0	164	100.0	9	100.0

all but one of those who answered (a male) would still have had the examination. However, nearly half (71/163, 43.6%) of females and nearly a quarter (2/9, 22.2%) of males who responded would not have had an examination if they had to see a male doctor. See Table 4 for details. A McNemar Test found this difference in acceptance for male and female doctors was statistically significant ($p = 0.00$, two-tailed).

When asked if they would still attend a SARC even if they had to see a female crisis worker, all but one of the respondents who answered (a female) said that they would still attend. However, nearly a third (53/164, 32.3%) of female respondents and nearly a quarter (2/9, 22.2%) of males said that they would not attend a SARC if they had to have a male crisis worker. See Table 5 and Chart 1 for details. A McNemar Test found this difference in acceptance for male and female crisis workers was statistically significant ($p = 0.00$, two-tailed).

3.3. Ethnicity

Two-tailed Pearson Chi Square Tests and Fisher Exact Tests found no statistically significant differences ($p > 0.05$) between the responses of the different ethnic groups in the sample. Categories were combined to take into account the larger number of White British participants and the smaller numbers from different ethnic background. The Pearson Test was conducted using the categories of White, Mixed, Asian, Black and Other, whilst the Fisher Exact used simply White and non-White.

3.4. How strongly respondents felt about staff gender

About half of all respondents who answered this question (89/164, 54.3%) felt strongly about the issue of staff gender. See Table 6 for details. The difference between the answers of female and male respondents did not prove to be statistically significant in a Fisher Exact Test ($p > 0.05$).

Respondents were invited to add any other comments to the questionnaire sheet that they felt wee important. Most of these were compliments to how the staff had helped them through a difficult process. Only two respondents offered a

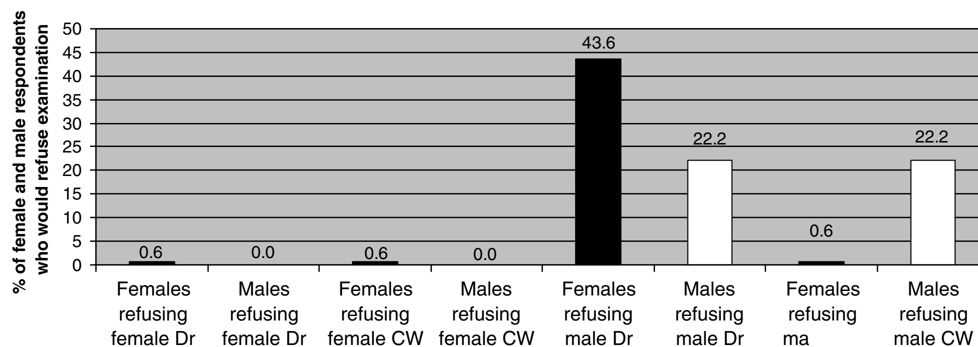

Chart 1. Respondents who would refuse forensic medical examination, percentages excluding unknowns.

Table 6
Did clients feel strongly about staff gender at SARCs?

Feel strongly	Respondents					
	All		Female		Male	
	n	%	*n*	%	*n*	%
Yes	89	54.3	87	56.1	2	22.2
No	75	45.7	68	43.9	7	77.8
Known	164	100.0	155	100.0	9	100.0

comment directly on the issue of gender: ‘an individual’s attitude is important regardless of their gender’; and ‘female victims should see female forensic physicians and counsellors as it is more comforting and easier to talk’.

4. Discussion

The main finding of this study is that most SARC clients want to see female staff, and so concurs with the conclusions of Chambers and Millar,[2] Temkin[3] and Kelly et al.[4] Most of the sexual assault victims who took part in the study wanted female staff to provide their care, with almost all of the rest saying they were happy to see either male or female staff. Only one respondent, a male, expressed an active preference to be seen by a male forensic physician and no-one preferred to see a male crisis worker. Most female respondents would prefer to see a female forensic physician and a majority of male respondents said they had no preference for either gender. It is possible that the emotional trauma and expectation of a high level of service may have contributed to the ‘no preference’ responses made by some respondents. For example, a client willing to undertake the examination may want it over quickly and so tolerate whatever is involved to achieve that. Such tolerance is different to a genuine lack of preference.

Many, especially female, respondents said they would refuse to attend a SARC at all or have a forensic medical examination there if they had no choice other than to see a male forensic physician or crisis worker. This is reflected in the similar numbers of female respondents who said that the gender of SARC staff members was something they felt strongly about. About a quarter of male respondents were prepared to see both male forensic physicians and crisis workers, but female respondents were less prepared to see male forensic physicians than they were crisis workers. Similarly, fewer male than female respondents felt strongly about the issue.

These gender differences most likely reflect the intimate nature of the medical examination, which can involve genital examination, including internal inspection and taking of swabs. But, as these results show, a large number of male respondents did express throughout the questionnaire an aversion to being seen by male staff at a SARC, offering qualified support for Bradley’s[5] assertion. The fact that they have just been assaulted by a man, as well as issues of masculinity, are often cited by SARC staff as important reasons in making that choice. Whilst the male sample size for this study was in line with the client gender profiles of such services (5–10%[8]), the number of male respondents was small and may have had a negative bearing on some of the statistical tests. It is possible that the same female respondent who answered negatively to the prospect of having to see a female doctor or crisis worker misunderstood the questions, which could otherwise appear as an anomalous response.

The participating SARCs serve multicultural, metropolitan areas and the sample group for this study was ethnically diverse. However, the absence of statistically significant differences between the ethnic groups in the study should be qualified. Not only were the number of respondents from some ethnic minorities small, but they also represented a self-selected sample. It is possible that cultural barriers to disclosing an assault and accessing services may mean that those who do come to SARCs have different views to those who stay away.

Having only male team members available could force a third of women to refuse to accept forensic medical services, having a considerable detrimental effect on the already poor conviction rates. Were a male forensic physician or crisis worker to be scheduled to fulfil a shift, then a female back-up would be necessary in the strong likelihood that the first choice male would be refused. This would have considerable resource implications. It also suggests difficulties in engaging women to report rapes to the police in areas that do not have SARCs or other ‘female-first’ policies.

Responsibility for the provision of forensic physicians lies with the police, with some forces sub-contracting/outsourcing to independent companies. There are difficulties nationwide in recruiting female forensic physicians for sexual offences work. Therefore, the responsibility of ensuring that victims are seen by female staff for forensic medical examination belongs to the police. This will have significance for the police with respect to the attainment of national targets for reporting of sexual assault offences. Choice of gender under the statutory requirements of the Gender Equality Duty,[9] which came into force in April 2007, should be addressed within the workforce strategy of a SARC.

The presence of female staff in a SARC is appropriate for a sexual assault referral service and the findings from this study support the need for national policy and guidance to further recommend the recruitment of female staff in SARCs. In the current climate where resources are limited, employers need to ensure employees are appropriately trained to established standards, professional with their attitude towards sexual assault issues and victims, no matter what gender they are and provide choice of gender of staff, where there is an explicit request for one. Crucially, as was noted by one of the respondents, the training and education of all staff, whether male or female, must include treating victims with dignity, sensitivity and without prejudice.

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