

Medico-legal evaluation of the gynaecological consultation in cases of annulment presenting to the Ecclesiastical Tribunal of the Roman Curia in Malta.

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Abstract

The Ecclesiastical Tribunal of the Roman Curia in Malta appoints gynaecologists as medical experts to certain cases seeking annulment. These cases often essentially revolve around the confirmation or exclusion of virginity but may involve requests for other information. In this article an experienced gynaecologist and a practicing lawyer, evaluate the gynaecologist's role, outline clinical pitfalls and offer relevant advice.

Introduction

The Roman Catholic Church views marriage as a sacramental and indissoluble bond between a man and a woman. It is a contract which for validity requires two participants of opposite gender who are free to marry and who freely and knowingly enter into matrimony. There is also the very essential requisite that they intend to execute the contract through consummation of their marriage. The Catholic Church considers this bond as created through a human contract but ratified by divine grace and hence virtually indissoluble until consummation, after which it attains absolute indissolubility.

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However, a marriage can be **annulled** by the Roman Catholic Church and this is a declaration of invalidity of the marriage at the time that the matrimonial vows were made. In contrast to “divorce”, an “annulled marriage” never existed and it is only so declared when an ecclesiastical tribunal confirms a lack of validity at the time that the marriage was contracted. We are concerned here with those cases seeking annulment from the Metropolitan Tribunal on the basis of non-consummation of the marriage and hence its invalidity.

A crucial point in the proceedings of such cases will be the referral of the female side for gynaecological assessment, the crux being the establishment of the presence or absence of the hymen. Other medical issues may require gynaecological elucidation.

The clinical consultation

Our advice is to handle this case ethically and medically, like all other gynaecological consultations. This will involve detailed history taking with special reference to the gynaecological and sexual elements. Ideally one should have a nurse present unobtrusively in the background but this is not indispensable. During history taking though strongly advised during the physical examination. You are dealing with a patient about whom you know little and with whom you lack the doctor-patient bonding you have with your normal patients. Uppermost in your mind should be the fact that though ecclesiastical, this is still a medico-legal case with the remote but definite possibility that it might railroad into a civil medico-legal case especially if the Tribunal ruling does not favour the patient. The golden rule is not to discover what can go wrong through bitter experience. All documentation must be carefully and legibly annotated and carefully filed away.

It is essential to realize that such a consultation may present a complete paradigm shift. You are facing a patient on whom you will perform a most intimate examination and who unlike your usual patients did not choose you herself. Another major point of difference is

that the patient may be subjecting herself to an examination, the conclusion of which she may dread to hear. The patient may not be a virgin at all but hope to talk her way through an explanation of the use of vaginal tampons or an odd fall or maybe even an act of God in not being born without a hymen.

The gynaecologist must use the short time of the history taking to come across as humane as possible and try his/her best to bond with the patient who may be reserved, embarrassed, fearful, nervous or outright (rarely) antagonistic. Be it body odour, a belligerent attitude, shifty stance or unkempt dress, it is essential not to alienate the patient. If a patient is nervous at history taking she will be doubly so when vulnerably undressed and about to be examined by an unknown doctor whose conclusion may affect her future disastrously and permanently. A woman who presents at the Curia seeking annulment is more than likely desperately seeking a Church release of her disastrous marriage possibly but not necessarily to seek re-union with another partner with the Church's blessing. She is possibly in great awe of you but you may hold one of the keys of her future peace and happiness

Taking a clinical history

The state of virginity may be a life-long chosen vocation for some, but by and large it is nowadays, a rare finding whether the patient is referred by the Roman Curia or not.¹

However one must maintain an open mind at all times and it is crucial to remember that the patient herself may not be precisely clear in her mind as to what virginity truly means and what the gynaecologist will look for. This is a commoner state of affairs than many imagine. We suggest that you explain what you will do and that this may also serve as a gynaecological check-up.

Your questions should be simple, clear and to the point, always tactful and discrete. In spite of her vulnerability the patient will often open up with her conjugal problems. It is neither a time for cracking of jokes to quicken friendship nor for much talking but rather for listening and writing down the essentials. A quiet reassuring and serene atmosphere may manage to relax the patient nicely and likely to lead to a relaxed patient at examination excepting in the presence of cases like vaginismus. The latter may be hinted at in the sexual history when the patient may simply refer to symptoms of dyspareunia. However if for some reason or other, the patient senses cold detachment or even indifference she may be sub-consciously less co-operative at the point of physical examination.

It is important not to miss systemic complaints and the examination carries the usual responsibility of a consultation (in fact you are free to charge a normal fee

for it). Unrelated pathology such thyroid dysfunction, hyper-prolactinaemia, liver problems as well as psychiatric problems have all surfaced at these consultations and some of these may have directly or indirectly contributed to the original marital dysfunction.

Of importance and to be duly noted are any points related to sexual activity which may arise in answer to direct questioning or volunteered by the patient. One patient for example spontaneously stressed her husband's perennial avoidance of vaginal penetration in favour of anal intercourse. Even perversions may leave the patient *virgo intacta*. Only God in His wisdom knows the vagaries of mankind – be overtly shocked a nothing but maintain a stoic exterior. Things may be poured out with great pain, things which happen behind closed doors where one person may be at the complete mercy of her lawfully wedded husband. At times one will be moved by great compassion hearing about a husband who one wonders if he is human recalling John Locke's [John Locke was an English empiricist philosopher (1632-1704). This saying is often attributed to James Joyce, the Irish writer who only echoed Locke] words "The actions of men are the best interpreters of their thoughts." At other times you wonder if the patient's husband is a saint. You listen with empathy, you write quietly but maintain frequent eye contact and you pass, no judgement.

One way of de-stressing the tense patient is to explain that besides fulfilling the request of the Metropolitan Tribunal the examination also serves as a check-up, thus introducing the element of 'medical care'. This bringing down the examination to an almost ordinary visit often increases the patient's general receptivity and co-operation. At this juncture the odd patient, (pardon the pun), might explain to you, in all naivety that only recently she had a check-up and a pap smear. Inevitably one is left wondering whether the patient is not a *virgo inacta* and thinks she is, whether she was indeed a *virgo* till some over-enthusiastic gynaecologist forced a speculum in to perform a smear test or was perhaps a smear test performed using a virginal speculum – to what end one wonders.

During history taking one may also ask about the use of tampons. A positive reply does not augur well for the presence of an undamaged hymen. One particular patient stated rather proudly that she had had a regular full gynaecological assessment every year for the last ten years including smear testing, but she was still a virgin as she had never had intercourse !

Another patient explained to me that she had experienced pain with intercourse for a good many years – a mystifying statement backed by a patulous vagina on physical examination. This points to one fact alone – that some patients have a pathetic ignorance of the scope of the gynaecological examination in this specific instance.

Others do not know what virginity means and others still know nothing about everything.

History may reveal other strange facts likely not to be believed if heard outside the consulting room. Conjugal sexual ignorance can be astounding with the normal coitus thought to involve the male genitals and various parts of the female ranging from the anus up to the umbilicus. Both husband and wife may be unbelievably devoid of knowledge of coitus with insertion being effected in many places save the right one —not as a fetish or perversion but in the honest belief that this is what should be done. Whereas lack of knowledge of coitus and birth in a substantial number of women is a known and well published phenomenon,² absent coitus from lack of knowledge is not. The same phenomenon has also rarely presented with infertility to the medical author of this paper

It is helpful to form a good idea of the patient's sexual history both before and within marriage. Some patients will clam up and open up slowly whereas others may need slowing down if notes are to be taken legibly. Voluminous talking about sex does not equate with sexual activity but the patient may have much to complain about whether the cause of her problems lies with her or her husband. One should delve into the details of the subject and tactfully ask about orgasm, pain or discomfort during any sexual activity, vaginismus. Some patients may not even understand your drift while others may have run the gauntlet of much medical investigations and state their condition themselves such as vaginismus. It is best to omit the use of jargon with these patients even if they attempt to use it themselves as it may well be that they do not know precisely the meaning of what they are casually quoting, sometimes to impress. If they reveal that they have already been through the mill of medical investigations it is always useful to get as detail of conclusions as they can deliver. It should not be accepted blindly for patients at times reach conclusions which were never given to them by medical practitioners but having an idea of what went on may help e.g. a laparoscopy was done and endometriosis diagnosed.

Psychological factors

The gynaecologist faces a patient who may be harbouring myriad complex psychological permutations. One assumes that the patient is in front of you hoping that you will find an intact hymen which is another step forward in the long haul of obtaining an annulment. Yet rarely one may meet a patient who consciously or subconsciously does not desire an annulment. Such a woman who knowingly or not, fears the idea of the loss of her marriage, especially but not necessarily if the cause lies with her persona, might tell untruthfully that she has had coitus. In one such case witnessed in

Glasgow by the medical author of this paper, a woman maintained that she had had regular intercourse within marriage and then was found to have an intact hymen and a severe case of vaginismus. She may not have read Baudrillard's hypothesis [Jean Baudrillard a French sociologist and philosopher (27 July 1929 – 6 March 2007) whose work is frequently associated with postmodernism and specifically post-structuralism.] but she certainly had a sub-conscious that could speak! In such cases one must also bear in mind the possibility of psychological or even psychiatric disturbances.³

Very rarely a patient may ask you openly to certify (falsely) their virginity to which one may react by throwing the patient out or recommendably explain that the Metropolitan Tribunal is not bound to rely on this single gynaecological assessment. And lest she gets the wrong idea one must add that the suggestion is not only wrong but could endanger your medical registration. In view of this danger we believe that the gynaecologist should avoid undertaking such an examination in relatives or close acquaintances. He/she may also make a note to the effect that the patient is neither close a friend nor a blood declaration in the official report although this is not a requirement.

While taking a patient's history it is our advice to be liberal with empathy but very stringent with sympathy. The former is a positive cognitive attribute which by 'feeling with' the patient involves an understanding of the patient's perspectives as a separate individual.⁴ It implies both a capability to understand the patient as well as a clinical capability to communicate this understanding to the patient, thus building or strengthening the clinical bond. On the other hand, sympathy is defined as a relationship or an affinity between a person in which whatever affects one correspondingly affects the other.⁵ To an immature patient sympathy may consciously or subconsciously imply support to the point of favouring her case – if long term it may also give subliminal symptoms which may be dangerous to the doctor-patient relationship. To a mature person, open sympathy may translate as patronisation. Empathy, a laudatory quality, is very much entwined with the aspect of the practising the humane art and science of medicine and is fast being lost in a busy world. Sympathy is what the patient should get, along with a hug when she relates her problems to her best friend over a cup of tea.

The gynaecological examination

A gynaecological assessment on a stranger who was sent to you for assessment may present an extremely delicate scenario. Combined with what is at stake the situation demands even more tact. Borrowing from numerous studies on cervical screening where "embarrassment and fear of pain during examination

have been reported as potential barriers to such screening.⁶⁻⁸ It is of the utmost importance to conduct a detailed examination in optimal psychological circumstances.

As in all examinations of this nature, over-familiarity must be shunned and ideally an assisting nurse should be present, although this may not be habitual in the private sector. An explanation of what is being performed is useful to keep the patient calm as well as distracted while it enforces the clinical nature of an intimate examination. As in history taking, unexpected pathology may always be detected.

Occasionally one finds an anomaly of the lower genital tract whether directly affecting the vagina and of importance to the examination in question or less directly important such as the anomalous opening of the urethra or anus. The vagina may be absent (along with an absent uterus) or alternatively one may find two vaginas, one of which may be functional⁹ and the other, non functional and still with its intact hymen. A hemivagina, a septated vagina or even male genitalia, rudimentary or not may be present. We speak here of astronomically rare conditions for example the incidence of congenital absence of vagina (and uterus) is unknown but is believed to be in the region of 1 in 4,000 to 5,000 female births.¹⁰ Conscious of the difficulty of proving the statement, it is the medical author's opinion that however rare these anomalies are, the patient in question stands a higher than average chance of suffering from them. The findings must be explained in layman's terms and in view of the potential of harm to health, further investigations of the genital tract as well as the renal system should be emphasized. These can be arranged through the patient's family doctor or gynaecologist (unlikely to have one). We recommend prudence in taking over the case for long term management although at the end of the day the patient's choice of gynaecologist is final. The question of how much of this information is to be forward to the original non-medical referring choice is discussed elsewhere.

If genuine vaginismus is encountered one must accept that the patient cannot consciously relax enough even to allow inspection of the vulva, never mind that of the hymen if there is one. This does not automatically preclude previous coitus with a resultant hymenorrhexis for the vaginismus may be the result of sexual violence or even rape in or out of marriage. In such cases we recommend a formal examination under light general anaesthesia or sedation in an operating theatre. Using simple sedation may not suffice and if this is used we still recommend that it is administered by an anaesthetist

In cases of vaginismus one should obtain a further detailed history and ask direct questions. One patient answered such a specific question about possible sexual abuse in childhood with an immediate, very frank and

surprising story of how an uncle used to abuse her as a child - a fact she had revealed to no one including a very patient husband.

With regard to the examination of the hymen, one must assess how much of the vaginal orifice it covers. Although normally only *part* of the orifice is occluded, rarely it may cover the *whole* vaginal orifice and although an imperforate hymen as a rule presents in adolescence, at least one case of presentation in an early married woman has been noted (Pers comm.. Mr. Charles Brown F.R.C.O.G., Consultant Gynaecologist, Southern General Hospital, Glasgow, Scotland.) Inspection alone may be insufficient to conclude that a hymen is intact¹¹ and here one may gently feel the circumferential resistant edge of the hymeneal orifice using the tip of the small finger. One should also make a note of the *shape* of the hymeneal orifice as well its approximate size. Damage through examination must be guarded against and an attending nurse may vouchsafe such taken care if possible future accusations were to arise. The hymeneal details need to be reported on and although photographic representation is obviously unethical a good diagram would be definitely in order.

If the hymen is absent, one may further gather a good indication of the frequency of the practiced coitus from the state of the vagina. Thus a broken hymen and a vagina which hardly admits a normal finger may be justified by the insertion of a just a tampon. Incidentally one must express no personal opinions to the patient on his findings including the controversial aspect as to whether a hymeneal cleft has been caused by the insertion of a tampon. In the Tribunal court such an explanation would prove to be uphill all the way but it is up to the Tribunal to give the corresponding weight. Any degree of vaginal wall laxness equates with frequent insertion of some object or other and coitus may not be excluded - it is in fact the most likely cause. An over lax and even patulous vagina is obviously even more significant and may be even consonant with childbirth. Be not surprised that these varying degrees of "virginity" may have been heralded by seemingly honest protestations of definite virginity in the course of history taking. The mind may play tricks but the hymen unfortunately is to sexual function what the black box is to an aeroplane. Furthermore, as comedian Groucho Marx once stated "I can say I'm suffering from a severe case of utter self delusion but you can say that I'm plain lying! We're both right". Extremely rarely one may find a hymen which has been displaced eccentrically during coitus and never torn - anatomically a *virgo intacta*, though practically having had consummate sexual intercourse. In examining the hymen one is hardly likely to encounter an imperforate hymen although medicine is the biggest exponent of the truism that one should never say never. An obviously torn hymen with the hymeneal

remnants known as carunculae myrtiformes should be clear to see. In the adult woman, consensual intercourse (as contrasted to rape) often tears the hymen centrally and spreading into an indeterminate tear.¹² Some hymeneal variations may cause confusion such as cribriform opening may be misinterpreted as an imperforate hymen until the fine openings are detected. A septated hymeneal opening may also be initially confusing. One must also be conscious that in extremely rare occasions (0.03%) a hymen may be congenitally absent⁹, though in such cases there will not be the tell-tale ridge left after a hymen is normally torn during coitus.

One may also very rarely encounter strange hymeneal orifices two examples being represented here in Figures 4 and 5 namely the sub-septate which is reminiscent of the uvula of the throat and the fimbriated type. One must be careful in trying to diagnose in-betweens by which we mean a situation where the hymen is present and seemingly intact but is beginning to show the early signs of rupture such as the insertion of a smallish finger. The hymen first shows early signs of strain or partial early rupture between the 3 and 9 o'clock positions i.e. the posterior half where one may see irregular edges (Stage I). These may progress to an irregularity of the normal regular orifice and may be due say to masturbatory activity.

In these situations a very accurate and detailed description must be given. Also one should not omit to gently ask specific questions directed at the patient.

The possibility of hymenoplasty must also be borne in mind and this may be combined by a vaginal "rejuvenation" operation by which the vagina is also tightened. Any patient is a candidate for this operation but it seems to be especially common among women from the Middle East and Latin America. Hymenoplasty may be performed either by gathering together the ridges of the torn hymen and approximating them or else by the insertion of a very delicate and artificial silicone based implant which tears on pressure. Very careful inspection should reveal tell-tale signs which are subtle but present

nonetheless. However if truth be told laser hymenoplasty may leave hardly any tell-tale signs and here minimal scarring might be detected by the trained eye on microscopic visualisation. If a genuine doubt exists, play by honesty being the best honesty and document your findings and your doubts.

Having conducted the gynaecological assessment, it is only fair to expect questions about your findings. The way these are handled depends on the gynaecologist's attitude. As a rule we believe that should respect the patient's right to information about herself and the medical author has in the great majority of cases adhered to this sacrosanct fact. However if all truth be told, being but flesh and blood facing a very litigious patient, with a full clinic waiting outside and with a pounding headache after a morning's major list, he has, very rarely explained gently that the facts of his report will be fully explained to her by her lawyer. Not giving information is acceptable since the information would be given later – telling the patient one thing and writing another is beyond contempt. If the state of *virgo intacta* is confirmed the gynaecologist is acting *ultra vires* by raising even the least hope of a positive decision on the case by the Tribunal will decide. Such involvement is unnecessary and dangerous.

Drawing up a report

In drawing up the report, the gynaecologist must be succinct, clear-precise and ideally give diagrammatic representations. The answers posed by the Tribunal must be answered clearly and unambiguously and if this is not possible this must be clearly stated with the supporting reasons.. If possible the report should clearly answer the key question as to whether the hymen is present or not. If this is asked which is the normal state of affairs. Any conjectures must be clearly stated as such and these should be backed by reference to the latest publications wherever possible. At the end of the day the Tribunal is asking your expertise and your report should answer more questions than it raises.

Fig. 1: Pictorial representation of the different types of openings found in the hymen.¹⁴

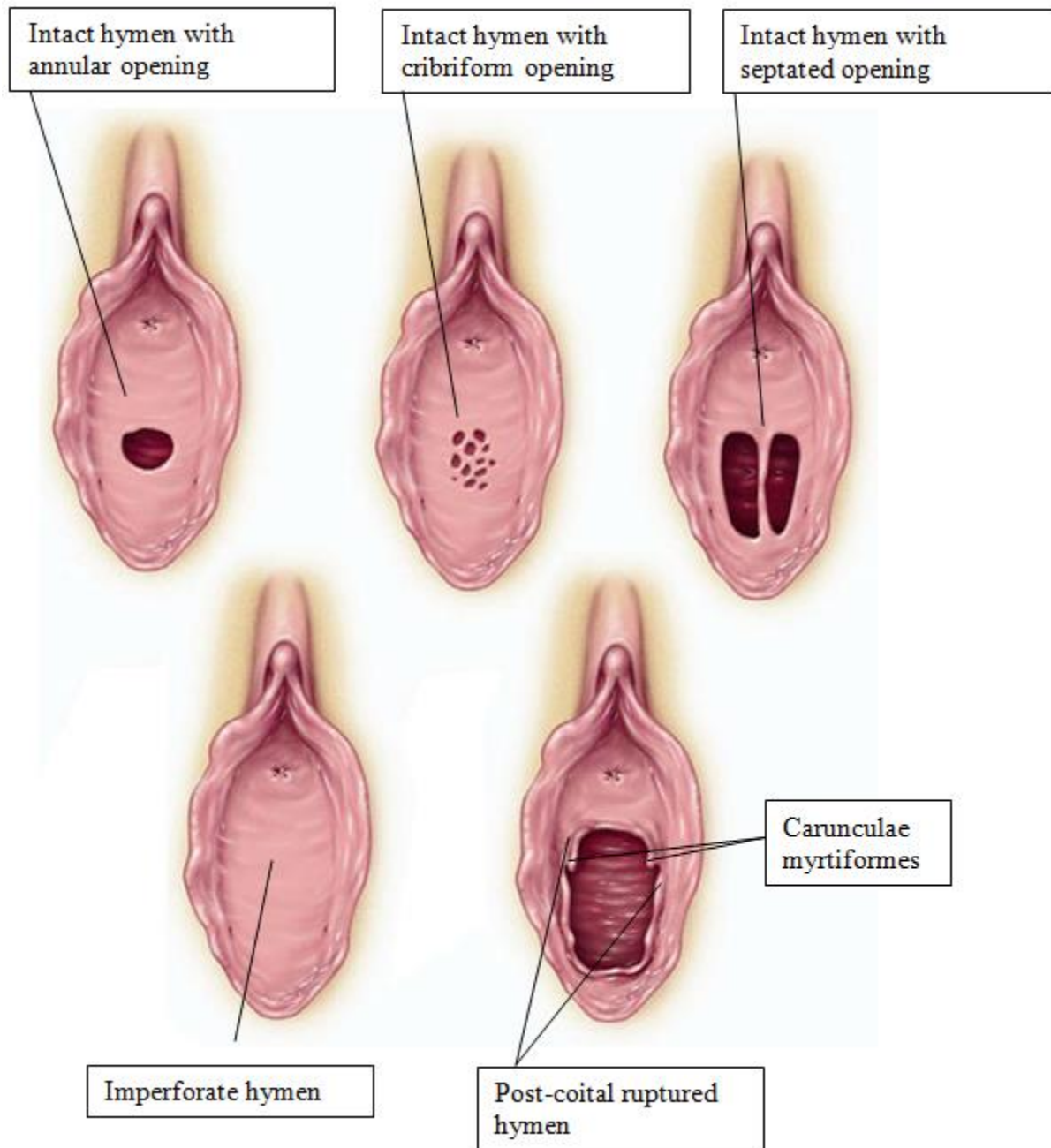


Fig. 2: HYMENOPLASTY¹⁵

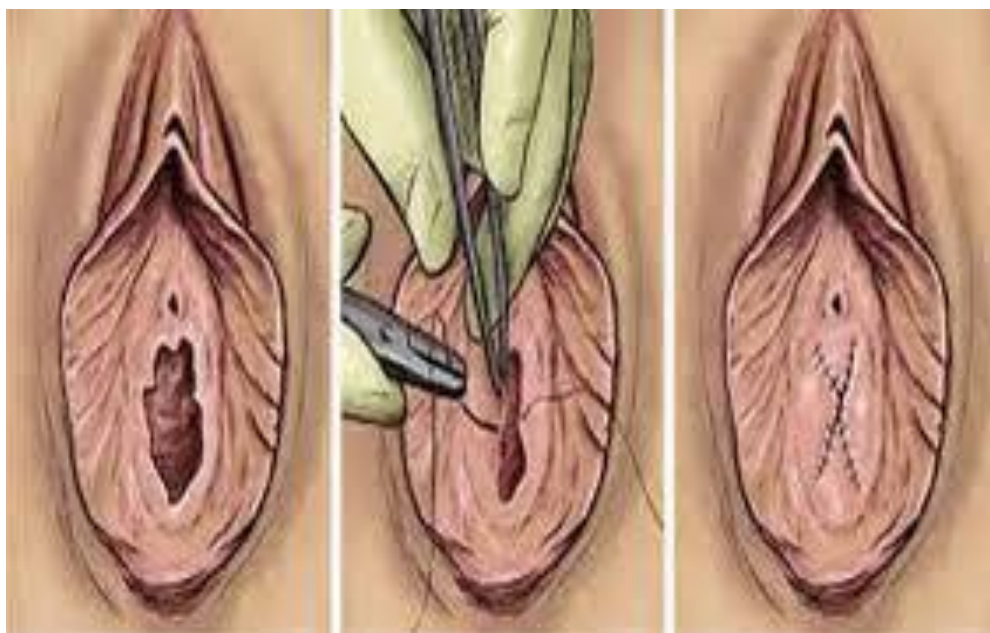


Fig.3 A rather poor example of a surgically reconstituted hymen.¹⁶



Fig 4: The very rare intact sub-septate hymen¹⁷

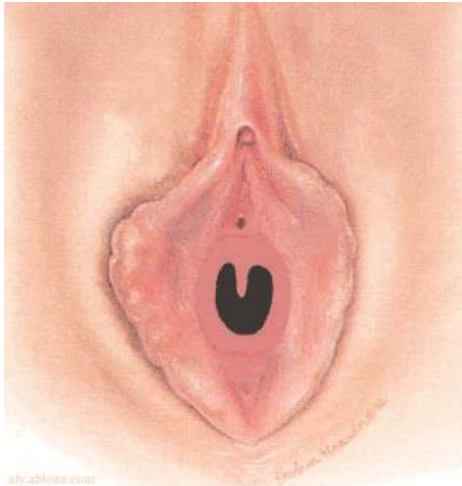


Fig 5: The very rare intact fimbriated hymen¹⁷

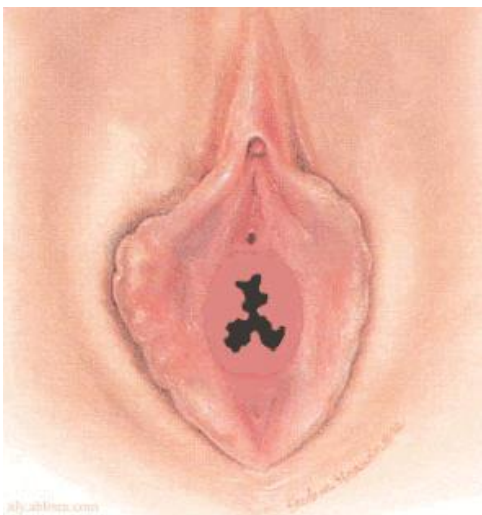


Fig 6: Stage I of hymeneal tearing : Irregularity between 3 and 9 o'clock¹⁷

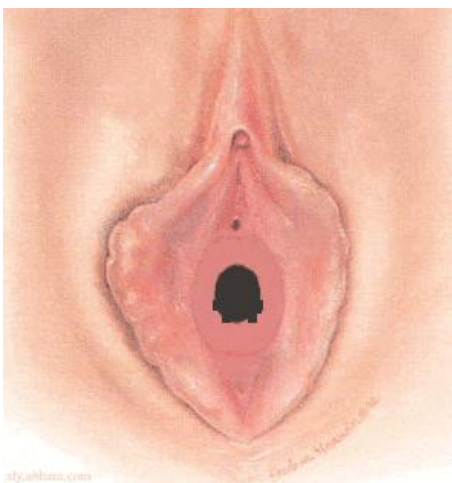
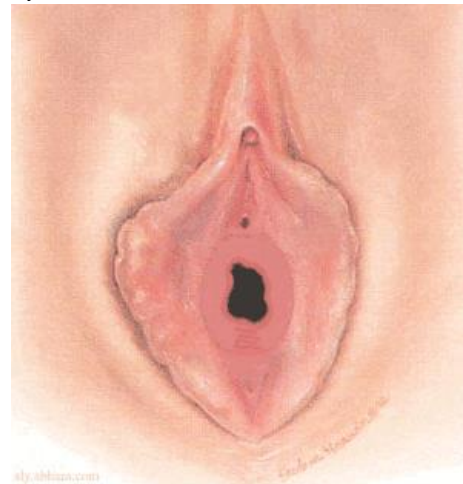


Fig. 7: Stage II of hymeneal tearing: Annular irregularity¹⁷



Conclusion

The gynaecologist give a complete gynaecological examination as in an ordinary consultation in addition to bearing in mind the information requested by the Metropolitan Tribunal. The gynaecologist must retain his professional reserve which is not devoid of empathy so as not to alienate the patient. His words must be carefully chosen –comforting a patient distressed by the finding of a ruptured hymen with words such as “Your hymen is ruptured but that does not prove intercourse” must be avoided. Whatever you say may be echoed by the patient’s lawyer in the Tribunal. Remember that while you are bound by professional secrecy, your patient is not.

We also recommend diagrams or illustrations to clarify your findings and statements. Remember you are making a medical or anatomical statement to venerable members of the Curia who are experts in Church law but not medically qualified.

Illustrations are further especially important in cases of anatomical anomalies where visual assistance is invaluable.

It is not incorrect to draw the Tribunal attention’s to new medical approaches and thinking e.g Goodman-Smith et al’s article¹³ on the loss of virinity and the use of tampon’s. However it is incorrect to tie the Tribunal’s hands, medically speaking by being over assertive—where indeed one may never be. Thus a statement such as “There is absolutely no doubt that in view of the intact hymen, definitely no penetration has ever taken place.....” It would be folly indeed to swear what some body could have or could not have done. Especially if you bear in mind that it is well recorded both from antiquity as well as contemporary times that a hymen may be elastic enough to allow coitus and rarely even childbirth, remain unruptured and return to more or less its normal state after. Although it should not worry you in the least, remember that a second or even a third

opinion may be easily resorted to by the Tribunal. You are not asked to confirm your findings under oath as per civil court but mentally you should be prepared to.

We also believe that the patient ought to know and understand the doctor's brief as set by the Metropolitan Tribunal and this should be made amply clear by the ecclesiastically approved lawyer of the patient. Legally your professional secrecy is lifted and you can communicate a specific amount of information you detect to a third party called the Metropolitan Tribunal. The patient agrees to this implicitly when she visits your consulting rooms. Our advice is to have a consent form stating that you will be passing on certain information to the Tribunal and have the patient sign it in front of a witness such as a nurse or a receptionist. One may take this as legal nit-picking but the situation is a potentially legally loaded one. Hopefully no one will ever put it to the test of a civil court.

Further potential medico-legal nightmares exist when incidental pathology is discovered. How much should the gynaecologist divulge to the Tribunal? Naturally if say a hymeneal or a vaginal anomaly is detected these would fall under the pertinent information owed to the Tribunal. If further facts are discovered and these facts do not bear directly on the information requested and implicitly agreed to by the patient. One may simply ask the patient if she agrees with putting all down in the report. If she agrees and the information is passed on then almost certainly the gynaecologist will never hear anymore of the matter. However take the case of the gynaecologist discovering say pelvic damage from a sexually transmitted disease like *chlamydia trachomatis* or *neisseria gonorrhoea*, the patient allows the information to be passed on and later this information somehow or other proves harmful to her case or reputation. The patient decides to seek legal redress and compensation in the civil court but the gynaecologist is not too worried for after all the patient had agreed. But the plaintiff's lawyer hits the doctor hard on two points:

- I. Was there written consent?
- II. If there is (and worse still if there is not), how informed was this consent?

Now technically such incidentally found pathology could even help the patient e.g. finding thyroid dysfunction which might explain the patient's general and sexual attitudes. Yet in Medicine one hardly ever receives thanks – but when things go wrong, it's different. The plaintiff's lawyer can easily make the point that without knowing the facts of the case before the Metropolitan Tribunal, the gynaecologist did not have a chance in blazes of knowing how the revealed information would be incorporated in the great legal machinery of the Court. Hence even if he did go for a signed informed consent, the information he/she imparted was flawed.

Hence our advice is to bear in mind the primary ethical obligations of professional doctor-patient secrecy. Anything not implicitly agreed to by the patient's attendance for your consultation must be well described and the patient allowed to decide on its transmission to the Tribunal. The gynaecologist must explain the implications of these abnormalities as known to him but also stress he is no position to predict whether this information would affect her case and how it may affect it. Furthermore prudence demands that a special consent form – planned, drawn and printed beforehand – is used in this situation and signed again in front of a witness. The gynaecologist must bear in mind that the autonomy of free exercise of professional judgement always be used primarily in the care and treatment of patients (Principle 1 of the World Medical Association Declaration of Madrid on Professional Autonomy and Self-Regulation. Adopted by the 39th World Medical Assembly, Madrid, Spain, October 1987 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005.) However since care has become a double edged sword, the gynaecologist in this situation must also safeguard his/her medico-legal position.

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