# BRITISH MEDICAL JOURNAL

SATURDAY 22 FEBRUARY 1975


## LEADING ARTICLES



## PAPERS AND ORIGINALS



## MEDICAL PRACTICE








NO. 5955 BRITISH MEDICAL JOURNAL 1975 VOLUME 1 413-472 ASTM CODEN: BMJOAE 1 (5955) 413-472 (1975)

BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR. SECOND CLASS POSTAGE PAID AT NEW YORK N.Y. WEEKLY 70p

# CORRESPONDENCE



*Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are now being received that the omission of some is inevitable. Letters should be signed personally by all their authors.*

## Shortage of Organs for Transplantation

SIR,—I wonder if some guidance can be given by your readers as to the most profitable use one can make of one's body after death. My wife and I have both donated our bodies for dissection in the anatomical department of Glasgow University after death, which seemed to us the most necessary use to which they could be put. However, with all this publicity about kidney and other organ transplants I wonder whether this is the best. I presume that kidney transplants from elderly persons are not particularly desirable, in which case our present intention would be the best. Is there any guidance to acceptable age? So far as corneae are concerned there does not seem to be any disadvantage, but perhaps the reverse, in using elderly corneae so long as they are transparent. The reason for this is probably that the donated cornea simply becomes a skeleton into which the recipient's cells thereafter grow. Further, the avascularity of the cornea eliminates any problem from aging vessels.

By the way, it is stated in the report from the British Transplantation Society (1 February, p. 251) that the cornea remains viable for at least 12 hours. As I understand it this should be qualified by saying that it must be removed before the development of rigor mortis, and this, of course, depends on the ambient temperature. If the body is promptly removed to a mortuary and, preferably, refrigerated the period may be longer but if retained in a warm room then the viable period may be much shorter.—I am, etc.,

W. O. G. TAYLOR

Heathfield Hospital,
Ayr

## Victims of Rape

SIR,—To obtain a fair trial for alleged rape there is much to be said for examination of the victim in a gynaecological department. In my very small experience of examining victims I had no hesitation in examining the patients under anaesthesia. For example, in Germany in 1944 two nuns were subjected to multiple rape by British troops. Examination included the removal of the entire lining of the endometrium against the possibility of conception. The advantage of this routine is that the assailant is given a trial without the inevitable bias of having impregnated his victim—whether or not a pregnancy is terminated.

A verdict of guilty of rape (especially if the victim is a child) is a grave decision for a jury—indeed, the prisoner may suffer violence at the hands of fellow prisoners. The evidence must obviously be collected with great care and by an experienced doctor. Your leading article (25 January, p. 171) does well to warn us that counsel for the defence can be ruthless even with professional witnesses.—I am, etc.,

HUGH CAMERON MCLAREN

Birmingham Maternity Hospital,
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SIR,—The issue of rape tends to be dealt with somewhat scantily at all levels of medical education, and your leading article (25 January, p. 171) was therefore to be welcomed. While I recognize the difficulties under which a writer on this subject must inevitably struggle—for example, the fact that there has been virtually no research into the sociology of rape in Britain—there are several disturbing opinions stated in the article. Firstly, the view that "some women . . . seem to have invited" rape. There is a widespread myth that women frequently "provoke" such attacks and then "cry rape" in unjustified circumstances. The proportion of such false claims has recently been estimated by a police spokesman as 3-4% of all cases. This tallies with the few large-scale studies of rape carried out in the United States.[1] Secondly, beating of the victim is described as a "relatively uncommon" occurrence. It is, of course, far more common than malicious claims of rape—again the only proper research is from the U.S.A. and indicates that force is used in all but 14% of rapes and that the physical beating can be described as "brutal" in 21% of cases.

From my experience of working in a rape crisis centre in the U.S.A. I would like to emphasize the need for assessment of potential psychological damage to the victim in all cases. Some of the first calls which rape crisis centres receive when they become operational are from women raped 20 years previously who have never had any counselling help but who exhibit proved psychosexual difficulties. The question of where to refer a rape victim for counselling is indeed difficult; perhaps doctors with psychosexual training might see this as a way of extending their present valuable work.

You also ask whether there may be a large hidden reservoir of cases at present unrecognized. The social stigma of rape (for example, the implications, already discussed, of provocation by the woman) makes this very likely; indeed the Federal Bureau of Investigation recognizes that only about 20% of American cases are reported to the police. Since writing and speaking on this subject in this country I have been overwhelmed with letters and referrals from women who have been raped. The majority have not reported their rape to the police and express horror at the court proceedings as one reason for non-reporting. Many had never visited a doctor and some victims had never told their families or husbands of the attack.