have just got married, taken on mortgages, or started families. Anxiety is mounting and morale is low. Many more schemes need to be organised, with new SHO posts created to cope with this very urgent situation.

SASHA BELLAMY

London SE12

Violation of human rights against Chilean doctors

SIR,—It was encouraging to see in the *BMJ* (27 June, p 2139) a letter from Professor S Hirsch and others expressing concern about the arrest and detention in Chile of Professor Pedro Castillo, Dr Manuel Almeyda, and Dr Patricio Arroyo. The following declaration in support of their Chilean colleagues has been sent to the Government of Chile by 12 senior members of the staff of the Royal Postgraduate Medical School.

"We the undersigned physicians in the UK want to express our urgent concern about the detention of the Chilean physicians Dr Manuel Almeyda, Dr Patricio Arroyo, and Professor Pedro Castillo, and demand from the Government of Chile their immediate release if no charges are proved against them that they have broken the laws common in any civilised society.

"We demand a declaration from the Government of Chile that the human rights of the detainees will be respected and that their lives are not at risk.—Dr A W G Goolden, Dr E C Gordon-Smith, Professor V Dubowitz, Dr M Impallomeni, Dr C Pallis, Professor J H Humphrey, Dr P Lewis, Dr D M Krikler, Dr K Mashiter, Dr K Fotherby, Dr P I Reed, Professor D K Peters."

A JADRESIC
Chairman,
Association Chilean Academics in Exile

Royal Postgraduate Medical School,
Hammersmith Hospital,
London W12 0HS

Doctors and torture

SIR,—I was very sorry not to be called at the ARM to speak to motion 501 on torture ["That this Meeting unequivocally condemns the usage of medical personnel in enforcement of inhuman laws and degrading measures"].

It was my intention to pledge the total support of the prison medical officers of England and Wales for this motion and to record, in public, their absolute opposition to the misuse of psychiatry and other medical practice to the furtherance of political ends.

P A TRAFFORD

HM Prison,
Bristol BS7 8PS

Private practice and general practice

SIR,—The personal view contributed by Dr V P Smith (21 March, p 983) refers to private medicine and private specialist practice as if they were one and the same. They are not, and to use the terms interchangeably is to confuse the issue.

Britain has the worst of both worlds, for private general practice is actively discriminated against by the simple ploy of making private patients pay the full market price for drugs. This means that the majority of patients with hypertension, diabetes, rheumatoid arthritis, etc, who require regular drug therapy and who are looked after by competent general practitioners, cannot afford to attend as private patients as the drug bills would be crippling financially. Private specialist practice is a different matter. An operation is usually a "one-off" situation, and medical patients may later return to their NHS general practitioner for renewal of a drug prescription. In my experience in Australia the problems which Dr Smith describes did not arise, as the patient had to be referred by a general practitioner to be able to claim a rebate for specialist fees.

Dr Smith also mentions that vocational training is producing an age of strong primary care. The candidates for the MRCGP examination will have spent a year as a trainee in general practice, but the rest of their training (eight years) will have been hospital based and biased. My impression is that this vocational training produces general practitioners who unwillingly accept responsibility and therefore refer patients for specialist opinion and care far too readily, as they are unused to making decisions without the back-up of hospital investigative resources.

I would suggest that the vocational training schemes, with minor modifications, would be ideal for trainee specialists as they might then gain some insight into the workings of general practice.

B G WALL

Blackpool, Lancs

Occupational health should not accept tobacco industry sponsorship

SIR,—Your leading article (4 July, p 4) seriously criticised the Institute of Occupational Health for accepting money from the tobacco industry. Since it is already evident that some readers have thought that you were referring to us, we hasten to correct any such impression. We have enough financial problems of our own without being saddled with this one.

CORBETT MCDONALD

TUC Centenary Institute of
Occupational Health,
London School of Hygiene
and Tropical Medicine,
London WC1E 7HT

*** We apologise for not making it clear that the institute to which our leading article referred is the new Institute of Occupational Health in Birmingham (see news item, 30 May, p 1802).—ED, *BMJ*.

Points

Simple computerised repeat prescription control system

Dr A G ELEY (Derby DE3 4DY) writes: I read with interest the article by Dr David Meldrum (13 June, p 1933) on the use of computers for repeat prescribing. . . . The newer Commodore machines (4000, 8000 series) have eliminated the problem of garbage collection, and in my practice my own Commodore computer has been running for 14 months without any problems of any kind. . . .

Metastases in the liver

JANET PUTMAN (Department of Medical Biochemistry, University Hospital of Wales, Cardiff CF4 4XW) writes: In your leading article on metastases in the liver (27 June, p 2078) you rightly point out the difficulties with biochemical tests and the importance of understanding their limitations. Although serum acid phosphatase determination is of value in prostatic disease I am not aware that this enzyme is helpful in other malignancies when one is looking for liver secondaries. To suggest combining tests for liver enzymes with acid phosphatase determination to enhance the biochemical assessment is misleading. The reference given to support this statement[1] refers to alkaline phosphatase. Specificity for the presence of hepatic metastases was increased by combining tests for aspartate transaminase and alanine transaminase with alkaline phosphatase determination.

[1] Cederqvist C, Nielsen J. *Acta Chir Scand* 1972;**138** 604-8.

"Caucasian"

Dr J G B RUSSELL (Department of Radiology, Manchester Royal Infirmary, Manchester M13 9WL) writes: May I refer to the letters (2 May, p 1480; 27 June, p 2136) objecting to the term Caucasian to describe those with an ethnic origin of white European? I should like to point out a further important reason why this term should not be used. The race which erupted across Europe around 1500 BC from the region around the Caucasian mountains also spread into India and the Indian races therefore could equally well claim the name Caucasian. There is a fascinating similarity in many fields between the Celts and the Indians. There are similarities of their early religion, laws, language, and customs indicating this common origin.[1] Interestingly, among these similarities of behaviour which have persisted is the use of the fast to death as a social weapon. . . .

[1] Dillon M, Chadwick N. *The Celtic realms*. London: Weidenfeld and Nicolson, 1967:1.

Not obvious?

Dr VERNON HOCHULI (Medway Hospital, Gillingham, Kent ME7 5NY) writes: . . . I have in six months as a casualty officer come across four elderly confused patients who had been given rectal suppositories for constipation by their general practitioners. They had inserted the suppositories without first removing them from the plastic or tinfoil coverings. They claimed that they had not been told to remove the outer coverings. I realise that they were confused but I wonder if what seems obvious to one person is as obvious to another person. . . .

Correction

Antacids for duodenal ulcer

In the letter by Dr J R Murray (4 July, p 61) there was an error in the last line of paragraph 2, where 430 g should have read 430 mg.