taken in women under 35 who have had three or more pregnancies. The statistics illustrate the recent success of opportunistic screening in young health conscious women with support from the medical profession.

Secondly, the importance of cervical cytological screening in the under 35s has been supported by the Dundee and Angus population study.[1] The large reduction observed in both incidence of and mortality from invasive cervical carcinoma in the 35-54 age group was probably accounted for by the high pick up rate and treatment of CIN 3 in women under the age of 35, as it has been estimated that women with invasive cancer are from 5 to 16 years older than those with the preinvasive stage. Importantly, up to 80% of young women in this population responded to opportunistic screening.

Thirdly, following DHSS recommendations, district health authorities are currently appointing programme managers in cervical cytology. Most of those appointed will probably be administrators who by necessity will follow DHSS dictates. Currently, these include the computerisation of cervical cytology call and recall based on population registers with special emphasis on women over 35. This policy will certainly detect missed cases of invasive cervical carcinoma and be viewed as politically successful. However, we must wait with interest to see whether the incidence or mortality from invasive cervical cancer will fall in the long term.

As a corollary, however, limited NHS finance implies that such a policy could interfere with the increasingly successful screening of those under 35. The prevention and cure of preinvasive disease during the reproductive years must surely be as important as the treatment of overinvasive disease in older women with its substantial mortality.[2] Because of financial restraint, the NHS seems to be in danger of shortly inflicting a mother-daughter conflict as to which generation is screened and treated for cervical carcinoma.

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1 Duguid HLD, Duncan ID, Currie J. Screening for cervical intraepithelial neoplasia in Dundee and Angus 1962-81 and its relation with invasive cervical cancer. *Lancet* 1985;ii:1053-6.
2 Slater D, Duke E. Cervical smear policy. *Lancet* 1985;ii:1305.

Ventilation or dignified death for patients with high tetraplegia

SIR,—In reply to Dr J F Searle's question about our two patients with injuries at the C2-3 level (18 January, p 204) both the caring relatives and the patients themselves stated that they were glad that the decision to ventilate had been taken. Both patients are now at home with positive pressure ventilation at night. During the day one uses electrophrenic respiration and the other breathes solely using accessory muscles. In a recent study in the USA 28 out of 30 respiratory dependent patients with high tetraplegia stated that they were glad to be alive (G G Whiteneck *et al*, unpublished observations). Therefore complications should be treated even when it is clear that spontaneous ventilation will remain inadequate.

There is no evidence to indicate the effectiveness of general intensive care units in the UK in successfully discharging home ventilator dependent patients with damaged spinal cords or in weaning the others. The USA experience indicates that successful early weaning of patients with high tetraplegia or the early discharge home of ventilator dependent patients is achieved much more often by dedicated model spinal cord injury centres than by general intensive care centres. Spinal cord injury centres have developed skill in managing the particular psychological, physical, and emotional problems of spinal cord damaged patients. Peer support by other patients is a vital ingredient of successful rehabilitation and this cannot be provided by general intensive care units.

Donovan *et al* have shown that early transfer of spinal cord damaged patients to a spinal injuries centre is associated with reduction in early and late complications.[1] Early transfer to a spinal injuries centre undertaking ventilatory care should therefore be the rule unless specifically contraindicated on medical grounds. In such cases, comprehensive treatment in a general intensive care unit is required, and Dr Searle is to be congratulated on providing such a service in Exeter.

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1 Donovan WH, Carter RE, Bedbrook GM, Young JS, Griffiths ER. Incidence of medical complications in spinal cord injury: patients in specialist compared to non-specialist centres. *Paraplegia* 1984;22:282-90.

Doctors and torture

SIR,—The letter from Dr Gary Butler (1 February, p 340) in response to Dr John Havard's excellent leader accuses him of having distorted the political situation in Chile. Dr Butler maintains that one of the main reasons for the military coup in 1973 was the denial to many Chileans of the basic human rights of peace, food, and employment. I find it amazing that anyone, particularly someone who has been to Chile, could have such a misconception of the destruction of democracy and the imposition of terror.

I visited Chile in 1977 on behalf of the International Union of Students and I have since come into contact with many of those from Chile who are now living in the British Isles. Immediately after the coup in 1973, 1200 doctors were dismissed from the health service, which had been largely based on the British model. According to the report of the Chicago Commission of Inquiry into the Status of Human Rights in Chile, one in four doctors was dismissed, suspended, or expelled or left the country. More than 200 doctors have been imprisoned for long periods without being charged and between 50 and 100 have been killed or have "disappeared."

What is important now, with the people of Chile demanding the return of democracy, is support for those doctors forced into exile who now wish to return. Many distinguished Chilean doctors are prohibited from entering their own country. I hope that the BMA will actively support those who wish to return to live and work in Chile. Only when human rights are restored should an active medical exchange programme be contemplated.

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SIR,—Dr Gary Butler calls, with good reason, for the condemnation of many activities of the political regime in Chile (1 February, p 340). In its last published report on worldwide human rights Amnesty International speaks of Chile's "long-standing pattern of human rights violations including the detention of prisoners of conscience and the torture of detainees." Dr Butler's scepticism, however, about Dr John Havard's leading article (11 January, p 76), with its strong criticism of the regime, demands that the record on human rights abuses against doctors in Chile be put straight. Chilean doctors are active in working for democracy and human rights. Some recent cases (only the latest in a long series of abuses including torture, exile, and death) indicate the kind of pressure put on doctors who work with human rights organisations or refuse to collude with repression

Juan Restelli Portuguez, GP, member of the National Commission Against Torture and president of the Chilean Commission for Human Rights in Africa, had his car firebombed in February 1984 and in December 1984 was detained by the secret police and banished without charge or trial for 87 days to Portezuelo, 1535 miles south of his home.

Ricardo Godoy, regional secretary of the Collegio Medico (Chilean Medical Association) in Africa, was also sent into internal exile for 90 days without charges or reasons being given.

Pablo Venegas Cancino, psychiatrist, was arrested by plainclothes police in November 1984 and released without charge three days later, having reportedly been tortured.

Mario Insunza and Fanny Pollarolo are psychiatrists who work with torture victims. Their homes were raided last August. Dr Pollarolo was banished arbitrarily twice during the year and was arrested addressing a women's rally at Christmas.

Dr Pedro Castillo (Chilean Commission for Human Rights) was sent into internal exile. Dr Paz Rojas was arrested during a peaceful march. Dr Patricio Arroyo was refused the right to work in the state system. Ricardo Vacarezza, haematologist, was effectively expelled by not having his contract renewed.

Carmen Andrea Hales is a 28 year old psychologist who was working with young drug addicts for a church foundation. She was twice kidnapped, interrogated, and beaten during 1985 by armed groups believed to be closely linked with official security forces. She now lives in self imposed exile in the USA.

Dr Havard's appeal for international support for the Collegio Medico in its efforts to defend medical ethics can only be reinforced by the evidence of victimisation of the health professionals named above.

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SIR,—I was glad to see Dr John Havard's leading article about doctors and torture in Chile. The article was a vivid reminder of the continuing atrocities in Chile and of the persisting lack of effective action by some international organisations who claim to be opposed to torture. However, having gone to Chile for my student elective in 1980 I disagree with Dr Havard's suggestion that more visits by doctors and medical students would help to expose the oppression in Chile.

My view of the regimen in Chile was clouded by the overwhelming hospitality which I received from pro-Pinochet doctors who were naturally keen to improve Chile's image abroad. It would seem that Dr Gary Butler had the same experience during his student elective. People opposed to the Pinochet regimen were wary of talking to me and I learnt little more than I knew already of the brutality of that government.

Many doctors would want to support Chileans who are opposed to the widespread torture in their country. Unfortunately, the publicity and support which can be generated by attending such events as the conference recently organised by the Collegio are very different from the effect that an isolated medical student or junior doctor might have by visiting Chile. Such individuals may only be adding to the list of foreign visitors which will be used by the government as evidence of international acceptance of its regime.

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