

performed well, but there are a number of variations of technique to be mastered, including the careful paring away of the callus which so often covers and surrounds viral warts, especially on the feet. Occasionally it might be necessary to curette or excise part of the tissue which has been frozen, and there is always the possibility of the unexpected need to decide to take a cryobiopsy. In my opinion, therefore, the general practitioner who undertakes any form of surgery (and I deliberately do not use the term 'minor'), including cryosurgery, must have developed some surgical skill from previous experience of carrying out surgical procedures. In addition there is a need for training with this, as with any other new technique to be used on our patients.

I have been pleased to welcome more than 200 doctors (and a number of chiropodists) to my cryosurgery sessions; of these, over 40 have bought the necessary equipment to treat their patients with liquid nitrogen cryosurgery. Many of them have kept in touch with me and have declared their great satisfaction with their results.

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References

1. Williams KL, Haq IU, Elem B. Cryodestruction of haemorrhoids. *Br Med J* 1973; 1: 666-669.
2. Hopkins P. Cryosurgery by the general practitioner. *Practitioner* 1983; 227: 1861-1873.

Sir,

I have read the excellent article about cutaneous warts by Drs Keefe and Dick. But why use sledge hammers to crack nuts and why all the complex buck-passing? Armed with a few drops of local anaesthetic and a sterile sharp curette the general practitioner can treat most warts immediately. It will actually cost him less time and trouble than the telephone calls, letters and so on involved in referral to a specially trained nurse and it will save the patient much time and some stress.

Surely we should try, even in these scientifically wonderful days, to keep the treatment of simple things simple?

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AIDS and chastity

Sir,

I disagree with Andrew Brown's com-

parative vision of the acquired immune deficiency syndrome (AIDS) as a preventable calamity similar to world war two (Letters, February *Journal*, p.81). He is disappointed that doctors of our 'post-Christian western medicine' offer only platitudes instead of recommending chastity as the principle way to avoid human immunodeficiency virus (HIV) infection. Unfortunately he misses the point that perhaps for the first time in history human sexuality is being discussed frankly and realistically by doctors and the public alike. AIDS has led to a greater understanding of the complexities of both heterosexual and homosexual lifestyles and will thus enable us as doctors to give the very best advice to patients on how to avoid infection with HIV. Exhorting our patients to be chaste is to ignore the fallibility of human nature, whatever religion is espoused and, by failing to address the reality of their lives, we may actually place them at greater risk.

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Timing and purpose of the MRCGP examination

Sir,

I would like to respond to Dr Bahrami's criticism (March *Journal*, p.126) of my article (January *Journal*, p.30) in which I acknowledged that 'modified essay questions with appropriate feedback are a useful learning tool, and some factual knowledge is obviously essential'.

An examination of established general practitioners who have some responsibility for the policies and organization of the practice in which they work is more likely to be associated with good practice than one in which the candidates have no influence in such areas. At no stage did I state or imply that the examination should be a one-off commitment to continuing education. Too often it is regarded as the last hurdle to be jumped over. The whole thrust of the article was that a career structure should be created with membership and fellowship by assessment.

I would also like to see other packages of continuing education with appropriate assessments incorporated into such a system, but this lay beyond the remit of the original article.

Finally I hoped that the statement that 'the MRCGP has been developed into the most well-researched postgraduate examination in our profession' went some way to acknowledging its excellence.

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Torture of prisoners in Turkey

Sir,

Readers may be aware of the current campaign organized by Amnesty International highlighting the torture and ill-treatment of prisoners in Turkey. Despite the fact that Turkey signed and ratified the United Nations Convention against Torture and the European Convention for the Prevention of Torture in 1988, Amnesty International believes that torture continues to be a widespread and systematic practice in Turkey.

The Turkish Medical Association has taken a strong position against torture, and has taken steps to prevent doctors being involved in or participating in any form of torture or maltreatment of prisoners, or to be present during executions. The Association has drafted a statute of ethics in the medical profession, article 16 of which presents a clear position on the medical care of prisoners, torture and the death penalty. Doctors are asked by Amnesty International to write to the Association to show their support of this stance: Turkish Medical Association, Turk Tabipleri Birliği, GMK Bulvarı 21/12, Demirtepe - Ankara, Turkey.

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Survey of GPs' work in the third world

Sir,

In the past many general practitioners spent time working overseas before entering practice. With increasing competition for practice vacancies I suspect young doctors may be deterred from taking this career 'side-step'. To provide them with more information I am carrying out a survey of general practitioners who have worked in the third world and then become principals after 1 January 1984.

I would be grateful if any readers who have done this and who would be willing to complete a questionnaire would write to me.

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