branded for desertion or evasion of the draft, but amnesty has not been able to verify these figures. At least one victim was displayed on Iraqi television shortly after the operation.

It is reported that those subjected to punitive amputation are being forced to pay for the anaesthetic used during the operation. This is in keeping with the Iraqi government's known policy over executions: it has been a longstanding and well documented practice for the Iraqi authorities to demand payment from families for the bullets used to execute their relatives.

It is a matter of concern that such barbaric measures should have been introduced, but most disturbing to any doctor must be the fact that doctors are being coerced into this regime in direct conflict with all medical ethical principles. Reports that one Iraqi doctor has been executed and several others have been imprisoned for refusing to obey the decrees while another has been shot dead by infuriated relatives of a victim show graphically that Iraqi practitioners are caught in a lethal trap in which they are being savagely penalised whether they obey the decrees or refuse.

Do we have to stand by helplessly while our medical colleagues are abused? It is not easy to devise strategies that might help them, apart from letting them know of our concern. Saddam Hussein seems impervious to international appeals to his humanity. The Iraqi Medical Association, even if it had any independence, could not intervene without endangering its officers. Perhaps the most potent source of pressure might be Islamic organisations, such as the Arab Medical Association, rather than Western ones. I welcome suggestions, especially from Iraqi or other Middle Eastern doctors living outside Iraq.

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1 Court C. Doctors in Iraq face amputation dilemma. *BMJ* 1994;309:760. (24 September.)
2 Butt G. Iraqi doctors face climate of fear. *BMJ* 1994;309:898. (8 October.)

Practice gazette in Leicestershire

EDITOR,—We agree with M C Record and colleagues that, although practice annual reports are important internal documents, better sources of data exist for many activities involving other sectors.[1] We also agree with most of the authors' respondents that comparative data are useful for practices.

In Leicestershire we recently started to produce and circulate a practice gazette that draws on family health services authority data (though not the annual report), prescribing analysis and cost (PACT) data, and routinely collected data from hospital admission and disease registers. Each practice is provided with information about its activity compared with that of all other practices in the authority and those in the same locality. The steering group for this project includes representatives from the health authority and family health services authority, the local medical committee, and the university department of general practice. To date we have produced two editions. These have included data on employed and attached nurses, claims for provision of contraceptives and for night visits, turnover rate, cervical cytology coverage, and rates of inadequate smears. The latest edition featured diabetes and included data on prevalence, rates of annual review (drawn from returns concerning the management of chronic diseases from the practice and from the country-wide register), admission rates, and prescribing for this condition.

Much cynicism exists in general practice about the value of collecting data, to which the requirements of health promotion payments and the annual report contribute. Others have noted the problems of quality control and lack of comparability among sources.[2] By using selective data in this way we aim to tackle these problems and to support practices in planning quality services to improve the health of their population. In future we hope to encourage effective dissemination and use of consultation and morbidity data collected within practices, exploiting recent advances in software interrogation.

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1 Record MC, Spencer JA, Jones RH, Jones KP. General practitioners' views about the statutory annual practice report. *BMJ* 1994;309:849-52. (1 October.)
2 Haste FM. Value of data provided for health promotion programmes. *BMJ* 1994;309:359-40. (8 October.)

Privatisation of NHS prescribing

EDITOR,—Stephen Head is correct in highlighting the effects of an increase in private prescriptions.[1] The spurious effect of reducing the prescribing of generic and low cost drugs will both increase average costs and decrease total prescriptions shown by prescribing analysis and cost (PACT) data. It will also remove the base for calculation of the incidence of adverse drug reactions.

Currently the Prescription Pricing Authority's data can be used for the base denominator of all prescriptions written for a drug. In future the incidence of adverse drug reactions will be calculated on the basis of a reduced number of prescriptions as private ones will not be included. The apparent rise in incidence will be misleading. Perhaps a solution to this and the other issues raised would be to use the NHS prescription pad for all prescriptions and to tick the ones that have been dispensed privately. This would retain the total data on prescribing and dispensing for epidemiological studies, calculations of the incidence of adverse drug reactions, and assessment of rational prescribing and general trends. Financial analysis could be done on the NHS component only. Practice computing systems would not supply these data as they record prescriptions written, not those dispensed.

A similar situation is happening in NHS dentistry: the dental health and treatment of the nation can be more accurately assessed by market research studies than from public records.

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1 Head S. Privatisation of NHS prescribing. *BMJ* 1994;309:957. (9 October.)

Sir Winston Churchill

Unsubstantiated personal attack

EDITOR,—I could scarcely credit that such a deeply offensive personal attack on my late grandfather, Sir Winston Churchill, could be granted space in the *BMJ*.[1] I am indebted to a reader, who described this vicious personal attack as "beneath contempt," for drawing it to my attention.

Ian Robertson, who describes himself as a senior scientist at the Medical Research Council's Applied Psychology Unit in Cambridge, is a charlatan and a liar when he claims that the prime minister "often had to be carried dead drunk from the War Rooms." He preposterously goes on to state: "On the other hand, maybe that's not so comforting when one remembers the hundreds of thousands of German civilians he burned alive in the firestorms of Dresden and elsewhere, during air raids of questionable military value. . . . How many deaths have been caused by mentally unbalanced national leaders?"

I challenge Robertson to produce evidence for his statement. Certainly neither the late Sir John Colville, nor any other of my grandfather's private secretaries who lived and worked in close proximity to him throughout the war, ever saw him the worse for drink. Possibly Robertson is so ignorant of the subject on which he purports to pontificate that he is unaware that the strategic bombing policy drawn up by the chiefs of staff, both British and American, was fully endorsed by the entire wartime national government, including its Labour and Liberal members.

Is Robertson now going to tell us that President Roosevelt was, likewise, regularly carried out "dead drunk" from the White House?

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1 Robertson I. Drunk in charge. *BMJ* 1994;309:1237. (5 November.)

Never the worse for drink

EDITOR,—I have just read the outrageous attack on the late Sir Winston Churchill and am appalled that it should have appeared in what is generally regarded as a respectable publication.[1] I joined Sir Winston's secretarial staff in 1932 and remained with his family until his death in 1965. In all those years, except for illness or holidays, I saw him almost daily and had a unique opportunity to watch his moods—sometimes sad, sometimes exuberant, but never the worse for drink.

Robertson obviously bases his theory on scandalous hearsay. He would do well to study his subject a great deal more carefully before again writing such an ignorant and libellous attack—particularly on someone who is no longer here to defend himself.

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1 Robertson I. Drunk in charge. *BMJ* 1994;309:1237. (5 November.)

**We apologise to Mr Churchill and others for the offence we have caused, and on p 1519 Ian Robertson offers his apologies. We received letters from three other correspondents offended by the article.

The Medical Research Council wants us to make clear that the views expressed by Ian Robertson in his column are personal ones unconnected with his employment with the council and do not reflect the views of the council.—EDITOR

Correction

Surgical removal of third molars

An error occurred in this letter by Russell Hopkins (12 November, p 1301). The second sentence of the second paragraph should begin: "Take, for example, a patient who presents with an acute or chronic pericoronitis [not peritonitis]."