thyrotoxicosis⁸—strong evidence for the presence of liver enzyme induction in hyperthyroidism. Although isoenzyme studies of alkaline phosphatase⁹ have shown that at least some of the rise in thyrotoxicosis is of bony origin and is thought to reflect an increased osteoblastic activity, there is direct evidence of liver enzyme induction by thyroxine in animals.^{10 11}

Thus the commonest type of liver abnormality in the thyrotoxic patient appears to be a functional and thus reversible phenomenon unrelated to structural liver damage, the practical importance of which should be to avoid unnecessarily invasive procedures in the investigation of these patients.

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Methylcellulose paint as possible cause of heart failure?

SIR,—Methylcellulose enjoys an immense worldwide use as a food additive, a pharmaceutical, and an industrial aid. Because it is not absorbed from the gut or through the skin it has essentially no toxicity. It has zero vapour pressure and the heavy, water-soluble dust does not reach the alveoli. Finally, it has next to no solubility in organic solvents such as amylacetate. Drs P L Weissberg and I D Green offer no evidence of its existence in the paint blamed for induction of an acute toxic myocarditis (3 November, p 1113) and there is no technical reason to suppose it was there.

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Hazard of nitrous oxide cryosurgery

SIR,—As I was responsible for introducing nitrous oxide for cryosurgery in this country,^{1 2} I was concerned to read Minerva's note on its hazards (2 February, p 337). I suggested its substitution for carbon dioxide because it is a better refrigerant and is almost universally available in operating theatres, and its acute toxicity is much lower. A reversion to carbon dioxide would therefore be no solution to the pollution problem and the other advantages would be lost.

So far as I know, no cryosurgical equipment emits more than about 15 litres of nitrous oxide a minute, so that the hazard is no more than two and a half times that from an anaesthetic—and, of course, usually lasts for a much shorter time. However, the same arguments that have been used to justify the requirement for control of anaesthetic pollution must apply and either passive or active extraction can be used. Passive extraction is much easier for cryosurgery than for anaes-

thesia because there is plenty of driving pressure, so that small tubes can be used over long distances if necessary. Devices that do not emit the gas from a single tube should be either banned or modified and, of course, not used in unventilated rooms.

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In defence of clinical freedom

SIR,—I write to comment on the letter by Dr Mark R Baker, "In defence of clinical freedom" (26 January, p 255). While it is possible that "clinical freedom" has been responsible for the alleged benefits of active and energetic modern hospital geriatric service practice, the corollary is surely that clinical freedom was also responsible for the previous level of activity which Dr Baker feels has with advantage been superseded.

Could it not also be true that "the greater demands on community health services and personal social services have been absorbed less well" because of the tendency to discharge patients more quickly? If clinical freedom is always a virtue it should also be recognised that those who spend public money in other fields are certainly not permitted such licence.

It surely cannot be desirable that some elderly patients should run a "substantial" risk of not being able to manage in the community. In the practice of geriatric medicine it may be more obvious that co-operation with other medical and non-medical services is important, but I believe this to be true in all clinical practice. "Clinical" freedom means precisely that: the freedom of a medical practitioner to take "clinical" decisions. It does not mean that one can take all decisions affecting a patient's admission, length of stay, discharge, and subsequent support services without considering the likely effect on other human and material resources.

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Cutting the drug bill

SIR,—In 1977 you kindly printed a letter by two of us (ML and AKS) drawing attention to the considerable savings that could be made in general practice by the use of generic prescribing rather than using trade names (7 May 1977, p 1218). At that time we assessed over a period of four weeks the savings that were made by prescribing nine commonly used drugs by generic rather than the familiar trade name. Since 1977 we have continued to prescribe generically wherever possible, with virtually complete acceptance and we believe without therapeutic detriment.

Recently there has been considerable national publicity concerning the cost of the drug bill in the NHS and obvious economies that are open to GPs.¹ In the light of this publicity we have reviewed the savings produced in our practice over a four-week period in January 1980. We chose 12 commonly prescribed drugs which we have been prescribing generically for the past three years and made a note of every one prescribed, whether initially or in a repeat prescription.

The drugs chosen were diazepam (Valium), nitrazepam (Mogadon), indomethacin (Indocid), methyl dopa (Aldomet), frusemide (Lasix), phenylbutazone (Butazolidin), amitriptyline (Tryptizol), imipramine (Tofranil), chlorpropamide (Diabinese), ampicillin (Penbritin), oxytetracycline (Imperacin), penicillin V (VCIK).

At the end of the four-week period we costed the alternatives and found we had made an approximate saving of £270. This is in a three-man teaching practice of 6000 patients, and represents annual savings of £3500. If this example was followed by our GP colleagues over the whole country the savings to the NHS would be in the region of £24m a year. In times of stringent financial constraints when hospital and community services throughout the country are being subjected to cut-backs which may well have an adverse effect on patient care, we feel that economy in GP prescribing is well worth pursuing. We know that we should all be aware of interaction of drugs, of incompatibility and adverse reactions. We should also be aware of comparative cost.

We would like to see the DHSS take a far more active advisory role in this matter. The GP and receptionist's bible is *MIMS*. This is an excellent up-to-date publication but has to be read very thoroughly to extract comparative costs. The *British National Formulary* is also an excellent book, but is unfortunately infrequently consulted. Perhaps we should have a British National Health formulary produced by the DHSS and kept up to date. This would give prescribing information and comparative cost of generic and trade preparations. Clinical freedom must obviously be cherished and this applied to freedom of prescribing. However, freedom must be accompanied by responsibility and accountability. We believe that, unfortunately, at the moment in general practice there is an element of irresponsibility, perhaps owing to ignorance and laziness. Perhaps we should have DHSS "reps" competing with the pharmaceutical industry in trying to "sell" GPs the idea of prescribing economy. At the moment regional medical officers are concerned only with those doctors whose prescribing costs are above the average, but this is having little impact because the average prescribing costs are unnecessarily high. The Secretary for Social Services recently remarked in Parliament that we are now in an era where patients expect "a pill for every ill." GPs are very aware of this and many are taking a more active role in health education. A few well-chosen words will often be of more therapeutic value and certainly do much less harm than many prescribed pills, and if drugs are indicated perhaps we as GPs can ensure that unnecessary extravagance is avoided.

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¹ *Daily Telegraph* (leading article) 27 November 1979, and subsequent correspondence.

Illegal immigration and medical confidentiality

SIR,—Under the Immigration Act of 1971 illegal immigration and overstaying are criminal offences.¹ A doctor may break