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

confidentiality and inform the police if he suspects the patient of a crime, in order to protect the public interest.^{2,3} Since illegal immigration and overstaying are criminal offences any citizens, including doctors, may give full information to the Home Office, etc. Thus it is also legal for the DHSS to give the Home Office full details of an illegal immigrant in order to assist with arrest and deportation.

So Miss Joan Legood, the clerk of St Bartholomew's Hospital, appears to have acted correctly in the case mentioned by Mr Martin Birnstingl (26 January, p 256) and detailed in the leading article on the front page of the *Guardian*.⁴ The patient was a woman of Turkish-Cypriot origin. Miss Legood became suspicious that the girl might not be eligible for NHS treatment and telephoned the DHSS, which obtained the following information from the Home Office. "Arrived UK 1974, was given extensions for temporary stay until September 1975, was then told to return to Cyprus, appealed against decision, but appeal dismissed and was told to embark on 7 August 1979." Thus the girl was an overstayer and therefore a criminal and not entitled to NHS care. The *Guardian* reported Miss Legood as saying, "It was likely that the patient would soon be arrested and deported from the country since her father had already been sent back to Cyprus in this way."

Mr Birnstingl was so horrified that he contacted the girl and warned her not to attend his clinic, since he feared she might be arrested on the spot. Mr Birnstingl writes, "I cannot see why the DHSS should need to approach the Home Office at all over these people" and "Dr Vaughan's doubts about a patient's immigrant status are neither here nor there in the context of the medical ethic." I would argue that it certainly is Dr Vaughan's business. Mr Birnstingl seems obsessed with confidentiality; would he inform the police if a patient admitted to murder? Would he break confidentiality for any other crimes?

At the Hospital for Tropical Diseases I have seen many illegal immigrants and overstayers, both black and white, who have entered the UK pretending to be tourists or students with the intention of obtaining free medical care or permanent immigration, or both. Owing to our often weak laws, often weakly enforced, there are a large number of illegal immigrants in the UK,⁵ who often receive helpful advice, both oral and written, from immigrant organisations and others. One book contains detailed advice on how illegal immigrants can outwit the Home Office.⁶ Terrorists have entered the UK illegally and committed murder.⁷ There may be 50 000 illegal immigrants from Iran⁸; some have brought in heroin, and the proportion of Iranian heroin in the UK has greatly increased.^{9,10} Would Mr Birnstingl break confidentiality to report a heroin pusher?

Most countries, both rich and poor, have much stricter immigration laws than does the UK. For example, Burma in 1968 examined the documents of all people in certain areas and detected a high proportion of illegal immigrants.¹¹ All people attending for NHS care should have details of their birth certificate or passports recorded.¹² Foreigners whose passports are stamped with a visa for six months or less are not entitled to free NHS care, unless a genuine emergency develops after entry to the United Kingdom. The UK should imitate Burma and intensify the campaign, involving all citizens, for the detection and deportation of illegal immi-

grants and overstayers in order to reduce crime, disease, and Government spending. Illegal immigrants and overstayers should be allowed only one civil right, and that is deportation.

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Inner city GPs

SIR,—Dr J A Jewell is right to draw our attention to the plight of young doctors waiting to enter practice in East London (9 February, p 407).

When we started the East London vocational training scheme in 1977 we hoped to attract young doctors to work in the area. There has been no shortage of highly motivated and very well qualified applicants. Most of them have been living in East London for some years and have every intention of continuing to do so. The difficulty is to find them suitable permanent employment as they finish their three-year course.

The first four trainees to complete the course finish at the end of this month. One is joining a practice in Tower Hamlets and one a practice in Newham. Three other trainees have also been appointed as partners in practices involved with the course. Of the first four to complete the course all are keen to stay but only two have been successfully placed in our own area. This is a start but we are by no means complacent.

As general practitioners we are independent contractors, which would be the difficulty if Dr Jewell's excellent proposals were to be adopted. We cannot be told when to retire or where to practise—a two-edged sword. Appointment of additional salaried doctors would be a solution but it would cause difficulties under the present regulations.

Single-handed vacancies in East London now appear regularly in the *BMJ*; there are two in the current issue. Three-year vocational trainees are advised not to apply, as only applicants with two years' experience following traineeship will be considered by the Medical Practices Committee. The three-year course is designed so that successful trainees will have sufficient knowledge and experience of practice management to run a practice when they complete the course. I do not expect any favours on their behalf, but I would ask that they be allowed to compete in the open market for single-handed vacancies.

Any new development plans should include provision of accommodation suitable for group or health centre practice even though present doctors may not be willing to use them. It is practicable to use such buildings for residential purposes until required for medical practice.

The situation will, one hopes, improve.

Meanwhile there is one exciting prospect. The new town at Beckton, where there is a type D initial practice vacancy that was advertised this week, will be needing seven further doctors over the next few years.

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Women and general practice

SIR,—Dr Julie Shepherd is right to be concerned if there is any suggestion that women are to be excluded from general practice (26 January, p 257). However, she is wrong in her assumption that no part-time training places are available or that the training is inflexible.

A trainee in general practice can work half time or any proportion between half and full time. Training in hospital posts may also be part time and the responsibility rests with the regional health authority. The posts in either general practice or hospital need to be set up individually and hence are not normally advertised, and doctors should contact their regional adviser in general practice. In this region we have a substantial number of women training part time and from 1 February have a woman general practitioner appointed at the regional health authority to supervise all those intended for general practice.

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Removing patients from GP lists

SIR,—A popular misinterpretation of the allocation procedure for general practitioners is long overdue for correction.

Until recently it was widely held that an assigned patient could not be removed for three months unless by a successful formal appeal. A few weeks ago I challenged this view by removing such a patient "by return." Surprisingly, my action was referred to the DHSS for a ruling and the controversy was thereby emphasised, but the predictable delay would have totally defeated the purpose and I objected. The immediate response confirmed the right to remove the patient after the usual eight-day statutory period but added the little-known rider that the patient could be reinstated at once, and so on. However, in the interest of the patient this prerogative was rarely exercised by the family practitioner committee, which exhorted tolerance for the rest of the quarter pending discussion with the local medical committee.

Amendment of the regulations seems mandatory.

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Centralisation of services

SIR,—The London Health Planning Consortium was set up by the DHSS with terms of reference concerned with services in