such proposals simply "management decisions." For clinicians as well to put forward or advance administrative policies of this sort and to shelter under the excuse that the problems are unrelated to our ethical code is very saddening.

I agree with Mr Potter that our first and, I would say, our overriding responsibility as clinicians is to the interests of the individual patients who have committed themselves to our care. Doctors who concern themselves in DHSS proposals damaging to the best interests of their, or their colleagues', individual patients should give careful consideration to their ethical position. We alone in NHS management are members of a profession that has a well-defined code of conduct to follow, and if we depart from a strict adherence to our primary duty we place ourselves on a very slippery slope indeed.

CHRISTOPHER HOLBOROW

London W1

Elizabeth Garrett Anderson Hospital

SIR,—An article in the *Sunday Times* (16 October 1977) stated that the Elizabeth Garrett Anderson Hospital is closed and that "the battle is lost." The hospital is not closed. Its outpatient departments are functioning normally. Because of the Health Authority's decision not to repair one of the lifts, surgical inpatients are being temporarily housed in St Mary's Wing by courtesy of the Whittington medical staff. However, all medical inpatients are housed in the Elizabeth Garrett Anderson Hospital itself.

The Secretary of State on 20 September agreed that there is a need for this hospital to be preserved. The question is where that will be. Consultative procedures are now in progress. The Elizabeth Garrett Anderson Action Committee, which represents staff, patients, and voluntary workers, is convinced that the most sensible future for the hospital is in South Camden near main line stations, five tube lines, and bus routes.

May I reassure general practitioners and others that the Elizabeth Garrett Anderson hospital's services continue and will do so for the foreseeable future.

JEAN LAWRIE

Eynsford, Kent

The drug bill

SIR,—I have read Dr J F Lowe's letter (15 October, p 1024) on this subject with interest and sympathy. I, too, had thought of this many years ago. Indeed, I went so far as to obtain a little rubber stamp with the words "Please supply NF equivalent." The prompt result was a personal visit from a senior drug house representative with the open threat to take me to court to restrain me from using a registered proprietary name in order to obtain something else.

As in so much in the NHS I quietly gave up. It was not worth the effort (or cost) to try to assist this extremely, nay, ludicrously, wasteful NHS. Permit NHS drugs to be prescribed free of charge. This really would help the nation's drug bill and would also be acceptable to the socialists.

T RUSSELL

Chalfont St Peter, Bucks

Points from Letters

The four humours

Dr S BREARLEY (Middlesex Hospital) writes: Your new filler series "Words" includes some interesting speculation on the origin of the ancients' theory of the four humours (8 October, p 938). May I draw your attention to another theory,[1] which I find both plausible and elegant?

"Variations in the suspension stability of the blood probably led to the development of the theory of the four humours of the ancient Greeks. When blood is withdrawn from a healthy person it clots quickly and two portions, the clot and the serum, are formed. In the presence of disease, sedimentation of the corpuscles may be so accelerated that some of the corpuscles quickly settle at the bottom of the vessel in which the blood has been collected and, since they are deprived of oxygen, appear very dark. Above this, the corpuscles still containing oxyhaemoglobin, and therefore red, will be found. The rapid sedimentation of the erythrocytes permits some separation of the leucocytes and these, especially when there is a leucocytosis, form, together with fibrin, a well defined grayish-white layer in the uppermost layer of the clot. These three portions of the blood were named respectively 'melancholia' or 'black bile,' 'sanguis' or true blood, and 'phlegma' or 'mucus.' The blood serum itself formed the fourth humour, 'cholera' or 'yellow bile.'"

[1] Wintrobe, M M, *Clinical Haematology*, 6th edn. Philadelphia, Lea and Febiger, 1966.

Dangers of salt as an emetic

Dr N C HYPHER (Slough, Bucks) writes: I am sorry my letter (16 April, p 1033) has given Professor William O Robertson (15 October, p 1022) the impression that I was championing the use of salt as an emetic. I indicated in my letter that I had tried it in 1930 in a patient whose gastric mucosa had become insensitive to the irritant action of salt because of the local anaesthetic effect of methyl salicyl on the pharynx, oesophagus, and stomach. The patient was an adult and not a child. . . . I agree with Professor Robertson that syrup ipecacuanha is the accepted emetic today for use in children. Your leading article (15 October, p 977) indicates that it is not so effective with adults and gastric lavage is recommended.

Low morale in general practice

Dr A J SIMPSON (Penicuik) writes: . . . I work in a general practice of six doctors and am particularly concerned by the extremely low morale of our members. They see their standards of living falling and pressure of work increasing. This is not due to serious illness requiring urgent medical treatment but because the public demand more and more attention for minor ailments. There is also the ever-increasing request for the completion of forms and certificates of all sorts which ultimately require the signature of a doctor. We are totally unimpressed by talks of "sanctions" and "one-day strikes" as these are useless methods of complaint and are degrading to the profession in our eyes and those of our patients. I see only one solution to the problem in general practice and that is for doctors to resign from the NHS. It certainly sounds as if dentists are about to resign anyway and with very good reason too. The resignation of general practitioners has been threatened twice in the past, but conditions are worse than ever now and the Government has blatantly refused to listen to our problems and declares that the profession has not the power to demand attention . . .

Human tick infestation in Britain

Dr J A SLATER (Barley, nr Royston, Herts) writes: In August, while picnicking on the shores of Coniston Water, I painlessly acquired a tick on my arm. It was 3 mm in diameter, black, and had a hard shell. It was embedded in my skin to one-third of its depth. I removed it (with difficulty) by breaking off its body and digging out its head and jaws using a needle.

Following this, I had a 4 cm^2 area of erythema and induration for 16 days. . . . I can find no mention in the literature of human tick infestation occurring in Britain, nor did I see this in rural general practice. I would be most interested to hear the views of any readers who have seen tick infestation in this country.

Local corticosteroids for chronic backache

Dr I H J BOURNE (Experimental Surgery Unit, Hammersmith Hospital, London W12) writes: . . . In my general practice I have injected 115 patients suffering from chronic and recurrent backache with a mixture of triamcinolone and lignocaine into painful tender spots at the sites of their backache. Eighty-seven patients (77·4%) had good and lasting relief from this treatment and were able to stop or to cut considerably their intake of analgesic drugs and dispense with a variety of other treatments. A single-blind controlled trial involving 38 patients showed that the local anaesthetic injected on its own did not give as good results as the mixture (Fisher's exact test, $P = 0{\cdot}03$). A larger, double-blind trial is being planned of patients referred to hospital because of chronic backache. I would be interested to hear from any colleague who has experience of this form of treatment or who is willing to take part in the larger trial.

Disopyramide and warfarin

Dr A R MOORE (Welwyn Garden City) writes: I was interested to read the account of an interaction between disopyramide and warfarin (1 October, p 866). I reported my suspicion of a similar occurrence in a patient attending my anticoagulant clinic to the Committee on Safety of Medicines in November 1976.

Dermatitis from cosmetics

DIANA CAMERON-SHEA (Unicliffe Ltd) writes: Your leading article (24 September, p 782) states that cinnamon caused dermatitis in six patients who reacted to TCP ointment. As the makers of TCP we wish to point out that cinnamon oil was removed from TCP ointment in September 1975 as a result of our own investigations.