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Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing.* Failure to comply with this may lead to delay in publication.

Generic prescribing

Sir,

Your editorial on prescribing (April *Journal,* p.146) is a thoughtful contribution to the current debate. I think, however, that you minimize some of the problems associated with generic prescribing.

Take the issue of bioequivalence. We are all now well-aware of the difference between proprietary Lanoxin (Wellcome) and generic digoxin, but this problem only came to light after several patients had suffered. Since you wrote your editorial, but before the April issue was published, Hayward and Fentiman[1] reported that Nolvadex (the ICI brand of tamoxifen) abolished breast pain in six women, but that this pain recurred when generic tamoxifen was used. They questioned whether some of the new generics of tamoxifen may be less effective in the treatment of breast cancer, and this important drawback, if it exists, will not become apparent for many years. If we prescribe generic drugs this is a risk that we run, but, in this example, at least, it is not a risk that saves the NHS money. Nolvadex costs the same as the drug tariff price of tamoxifen. A generic prescription, which will result in your patient receiving any of the 20-plus varieties of generic tamoxifen, will increase the profit of the generic manufacturer, perhaps an overseas based company, but the pharmacist will be reimbursed as if the branded drug had been prescribed.

When there is a substantial difference between the price of a generic drug and its branded equivalent the prescription of the former will not necessarily save the NHS money. The amount of profit pharmaceutical companies make out of the NHS is limited by a complex formula. If they suffer diminished profits on the sale of one drug, owing to generic competition, they are free to negotiate an increase in the profit on other drugs to make up the difference, provided the global limit is not exceeded. There is a balance to be struck between preventing excess profits from the NHS on one hand and nourishing a valuable exporting industry on the other. This is the responsibility of government, not the profession.

Our responsibility is to ensure that a drug is only prescribed if it is necessary and to prescribe the cheapest type of drug for a particular job. Many of us still prescribe too freely and know too little about the comparative cost of drugs that are equally effective.

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1. Hayward JL, Fentiman IS. Generic prescribing. *Br Med J* 1986; **292:** 762.

Prescription charges

Sir,

Stephen Birch (April *Journal,* p.154) seems to be displeased at the reduced consumption of prescribed drugs in those patients who have to pay prescription charges. As a general practitioner I feel pleased at seeing data showing low consumption of drugs.

Current public attitudes vary regarding drug therapy. Many subscribe to the idea of a 'pill for every ill'. *Homo sapiens* has become, according to Professor Abraham Goldberg, *Homo pharmakiens.* Current medical opinion emphasizes a more rational and 'leaner' prescribing policy in view of potential adverse drug effects and costs and the Government's 'limited list', although unfavourably received by the profession, has been accepted in principle.[1]

I believe that individuals should assume more responsibility in the self-care of self-limiting illnesses. The alarming increase in the consumption of prescriptions by those who receive free prescriptions is probably due to reduced self-care. Indeed some who are entitled to free prescriptions openly demand their rights for drugs for almost every complaint. Some claim they cannot afford to purchase remedies from the chemist, while continuing to purchase tobacco and other products known to be harmful to their health. Some expect, and indeed try to pressure the doctor, to prescribe minor analgesics, cough suppressants and rubefacients, and at times doctors do succumb to these demands.

Doctors and some patients feel that drugs are overused[2] and the NHS is feeling the burden of the increasing pharmaceutical bill. As a taxpayer I certainly do not feel happy about subsidising the drug treatment of every simple cold, sneeze, cough, minor sprain and ache in the nation.

One important way to more rational prescribing is for the doctor to learn to say 'no',[3] and, while maintaining rapport with the patient, to advise more appropriate therapeutic strategies, for example stopping smoking to reduce a cough, losing weight to help relieve an arthritic pain, increasing dietary consumption of fibre instead of using prescribed laxatives. I feel it is important to combine this advice with an imposition of a small financial responsibility for prescriptions. Birch's data has proven that a prescription charge helps to reduce the consumption of prescription drugs.

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1. Reilly A, Taylor R, Webster J. General practitioners' attitudes towards the limited list. *J R Coll Gen Pract* 1986; **36:** 151-152.
2. Lervy B, Clayton S. Drug prescribing; some patients' views. *J R Coll Gen Pract* 1986; **36:** 169-170.
3. Fensterheim H, Baer J. *Don't say yes when you want to say no.* New York: Dell Publishing, 1979.

Assessment of teaching practices and trainers by trainees

The paper by Drs Charlewood and Airlie (February *Journal,* pp. 69) seems to ignore the bias that can be introduced when self-interest overrides objective assessment. With the poor state of the job-market few trainees would take the risk of antagonizing their trainer (whose medical connec-

tions or favourable reference may be crucial in obtaining a partnership) by giving a low score or writing unpleasantly honest comments about the trainer and his practice. Even though trainers do not receive the scores and comments until some months after a trainee has left, the trainee is still likely to be seeking a permanent position.

As an ex-trainee of the Northumbria vocational training scheme I was aware that several of my colleagues felt that trainers could identify an individual ex-trainee from trainees' comments on the anonymous questionnaires and therefore it would not have been surprising if trainees played safe and marked generously.

The other factor that supports my doubts about the validity of this method of assessment is that there was no significant change in the scores between the first and second 18-month periods. If the intention of this exercise was to improve the standards of trainers and their practices, then it failed either because no improvement occurred or because the method of assessment was not objective enough to detect improvement.

PHILIPPA WOOD

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Sir,
Dr Wood's letter criticizes our method of assessment of teaching practices on the grounds of possible bias from self-interest. This risk is one that we are well aware of and we would accept Dr Wood's comments without reservation.

Trainees may refrain from unpleasant criticism of their trainers for a variety of reasons including the one stated by Dr Woods. Another common reason is that trainees and trainers like each other, and trainees' comments suggest that this is often the case. However, as we pointed out, trainees do sometimes make unflattering comments and give scores to match so that at least some are not motivated by self-interest.

Many trainers feel confident that they can identify the individual trainee whose comments are fed back to them but surprisingly they are often wrong when this is put to the test. In any case it is one thing to suspect an identity and another thing to prove it.

Furthermore, although there have been no significant changes in the scores of the Northumbria teaching practices as a whole there have been some very significant changes in individual practices — even to the extent of a change in the identity of the trainer.

Clearly our method has both advantages and limitations, and as we suggested it should be supplemented by other methods of assessment and feedback. Our method is, however, simple, cheap, easy to administer and a useful educational exercise.

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Sir,
The paper by Drs Charlewood and Airlie is interesting but not very helpful. The criteria used for assessment are no doubt characteristics of 'good doctors' but the talents required by trainers and training practices are different in my opinion.

While it is helpful for me as a trainee to be attached to a practice with good relationships between all staff, good premises and organization and a high standard of medicine, what matters most to me is much less tangible and to do with broadening my horizons as a person and as a doctor.

I would suggest adding to the criteria of a good trainer the following:
1. Does he/she encourage me to think broadly about health issues and challenge established dogma?
2. Does he/she identify my weaknesses and help me to develop my talents?
3. Does he/she give me time and space to criticize and comment on the practice in particular and medicine in general?
4. Does he/she listen to me?
5. Does he/she introduce me to new ideas and to a variety of paramedical people to allow me to understand the complexity of health problems?

We live in times of rapid change and yesterday's concepts of ideal health care do not answer today's needs. We need doctors to be inspired, questioning and humble, to develop the ability to challenge and improve our health care system while taking note of what is said by many others. It should be a priority of trainers to promote such abilities in trainees and they should be judged according to how well they fulfil this task.

I have one year as a trainee — one very very valuable year. At the end I have to ask of my trainers, 'Yes, they are good doctors — but did they make me think?'.

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Deputizing services

Sir,
Why is Dr Smith so concerned about 30% of training practices using deputizing services? (Letters, March *Journal*, p.131). It is generally considered that out-of-hours work comprises less than 2% of the total workload in general practice. A well-run deputizing service will provide a service at least as good as an average rota.

If Dr Smith is concerned about continuity of care he should turn to the paper by Roland and colleagues (March *Journal*, p.102), where he will find that group practices, even those with personal lists, could do no better than a continuity score of 1.0 in 30% of cases (that is 30% of patients saw the same doctor at every consultation). As a single-handed practitioner I would be upset if I did not have a continuity score of 1.0 in 80% of cases!

Surely the answer to the problem of continuity of care is in the formation of consortia of single-handed doctors sharing premises and facilities rather than group practices or partnerships.

It is irritating for colleagues to be continually sniping at deputizing services in different ways often without any consideration of the great value that good services of this type provide for patients in need and for the relief of over-worked doctors.

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Personal lists

Sir,
Like your correspondents in the March edition of the *Journal* (p.133), I had read the leading article on personal lists by Dr Tant (November 1985 *Journal*, p.507). My only criticism at the time was that he had been too tactful in not emphasizing the dilution of personal care that must occur in combined list group practices.

The advantages to patients of being able to 'shop around' for an appropriate doctor for each ailment are more apparent than real. An articulate fraction of our patients will always have the ability to choose appropriate medical care and in a good personal list system patients should have the right to change their doctor without rancour. Those of our patients who really do need continuity of care (the inadequate, the mentally handicapped, the feckless, the eccentric and the unlikeable) are least likely to be able to choose which doctor they should consult about certain problems and in a combined list practice will probably be seen by whichever part-