

Prescribing again

Sir,

Patients may not share the current enthusiasm among doctors for practice formularies. It is sensible to have a restricted formulary so that clinicians can become familiar with fewer drugs. A formulary other than a national list is difficult since patients move from area to area and they also attend hospitals where drug treatment may be initiated. I report on a study which highlights the difficulty of persuading some patients to change their medication voluntarily.

Hypnotic drug prescribing was studied in my practice as part of a study on the treatment of insomnia,¹ three years before the introduction of the Government's limited list. This study had revealed the size of the practice population regularly taking hypnotic drugs and had shown the large variety of hypnotics used. Some of these drugs were far from ideal and despite direct intervention during the study, we had little success in our attempts to stop or modify patients' medication. The study was repeated three months after the introduction of the limited list of drugs. The practice population of hypnotic drug takers had changed little, but the number of different hypnotics had decreased from eight to the three drugs on the limited list.

This showed that while it had proved difficult to persuade patients to change their hypnotics voluntarily, the imposition of the limited list was accepted by them. This was perhaps disappointing since altering a drug should surely be based on clinical not political grounds.

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Reference

1. Ellis P. *Hypnotics in the treatment of insomnia*. Upjohn Essay Prize in Therapeutics, 1982.

Sir,

I do not agree with Dr Marriott (*July Journal*, p. 351) that the introduction of the limited list seems to have caused few problems. Several problems have arisen in my practice, the main one owing not strictly speaking to the limited list but to generic prescribing.

There are a significant number of patients who find that the substitution of nitrazepam for Mogadon (Roche) is unacceptable. In the main they find nitrazepam stronger, sometimes to the point that they

are drowsy during the day. Also a significant number of people find coproxamol not the same as Distalgesic (Dista). Although the quantities of the active constituents are the same, they are perhaps made up or absorbed differently. It would certainly be interesting to know if any other doctors have found the same. I have not noticed any other significant problems with generic substitution.

With regard to the limited list itself, I have written to my Member of Parliament on several occasions and each time one of the ministers responsible has replied saying that the advisory committee is sure that all patients' clinical needs would be taken care of. I am sorry to say that I do not agree with this. There are a number of areas where drugs for which there is a need have not been allowed. The mucolytics we know about as there has been considerable publicity in the press; this is supposed to be under consideration but is taking a long time to resolve. Another example is xylometazoline. I do not know if the committee asked an ear, nose and throat surgeon but I think if they had they would have been told that the spray (which is not now prescribable) is a more effective preparation than the drops (which are prescribable) and both preparations are very cheap.

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Sir,

As a strong advocate of generic prescribing, I must say that having attended the conference on prescribing on 13 September I was disappointed that the Department of Health and Social Security were unable to answer the worry about product liability with generic prescriptions expressed by the General Medical Services Committee representatives.

It seems clear to me that all companies that sell to the DHSS or to pharmacists must accept product liability or their drugs should not be approved for sale.

In the case of generic scripts issued by doctors, and supplied by pharmacists the prescription should be endorsed with the name of the company from whom it was purchased. In the case of imports from East European countries, if there was doubt about acceptance of liability by those companies it should be the responsibility of the regulating body to accept this.

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Frequent attenders, workload and optimum list size

Sir,

Dr Westhead (*July Journal*, pp. 337-340) is mistaken when, in an otherwise excellent article, he says that there had been only two 'controlled' studies of frequent attenders before his. My study anticipates much of his method and conclusions by almost 20 years.²⁻⁹ The main difference between the studies is that Dr Westhead identified his frequent attenders retrospectively while I used prospective methods. Westhead's criterion for classification was based on his own practice figures while mine was based on the reported results of contemporary studies. The subclassifications used in the studies also differ. Westhead identifies a particular group of patients from his practice records and then compares them with a standard group matched by age and sex, applying the psychological and sociological tests that he selected to each group after identification. In contrast, I identified a sample of patients by random selection of surgery attenders and applied his psychological and sociological tests as part of the admission interview. These subjects were followed up and every contact with them, made in the year following immediately after admission to the study, was recorded. They were allocated to the appropriate attendance category from this research record.

Both Westhead and myself used the Eysenk personality questionnaire and came to the conclusion that frequent attenders have higher scores on the 'N' (neuroticism) scale than the 'standard' patients. We both argue that the neurotic personality indicated by the questionnaire is a characteristic which identifies a particular reaction and behaviour pattern which should not be confused with a pathological situation. However, Westhead's frequent attenders had lower 'E' (extraversion) scores, and from this he argued that frequent attenders were also more introverted than 'standard' patients.

The general health questionnaire had not been developed when I was working on this subject but Westhead's finding that his frequent attenders scored high on this questionnaire confirms my clinical observation that a higher proportion of such patients had frank neuroses. I also employed an intelligence test and found that frequent attenders on the whole scored badly. There was evidence that the patients' intelligence status modified their attendance patterns. We both agree on the importance of marital breakdown as a social factor associated with frequent