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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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Reference

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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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References

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-