

should not be totally restrictive, but rather a guide to the majority of prescribing to be done by the participants and it is important that all the participants feel that they have contributed to the contents of the formulary. I believe that all drugs in the formulary should be in their generic form, and this should include combination preparations if the names are not too cumbersome. Where a formulary drawn up by others is used I believe that the participants should make such modifications as to make them feel it is to some extent their own work.

This leads me on to the discussion of the use of generic prescribing (June *Journal*, pp.293-295). I believe that this is in some sense scientific and helps to place drugs into their categories as well as saving costs. If more doctors prescribe in this way it will enable the pharmacist to keep the generic formulations as the main stock. My pharmacist adviser tells me that the bulk of his return comes from the fixed returns on prescriptions, and very little from the 'on cost' element. The drug companies who develop worthwhile new drugs will make good profits, so too will the efficient producers of generic drugs; only those who produce 'me too' formulations of no particular merit will suffer deserved decline in profit.

I think we should also learn from the Israeli example as set out in Dr Cohen's letter (June *Journal*, p.300). House doctors in our hospitals should be given simple generic lists from which they could prescribe on their own initiative, having to refer to senior doctors for the more complicated and expensive drugs. While undergoing vocational training in general practice, trainers and trainees together should prepare their own lists for the trainees to use. This sets a sensible pattern for self-regulation and careful generic prescribing for the future. This is the way for the profession to avoid government interference. In many cases self-regulation already happens; if it becomes universal we have nothing to fear.

DAVID A. GREGORY

13 Claremont Street
Spital Tongues
Newcastle upon Tyne NE2 4AH

Sir,
Until recently I was a keen devotee of 'generic' prescribing. It was clearly a 'good thing', and it gave me a sense of superiority over the fusty old general practitioner who couldn't spell dextropropoxyphene. However, a friend who is a drug company representative then told me that the Government is able to regulate directly the amount of profit that a phar-

maceutical company makes in this country. The fact that the pharmaceutical industry has recently cut its advertising budget drastically in response to a Government 'clawback' suggests that he is right. If the Secretary of State for Social Services should suddenly need to raise £100 million from the industry it seems that he can do so directly without the need for a limited list. Of course, if too much is taken back, the drug companies may get annoyed and close down their research and manufacturing units in this country, but this is a political problem and not the concern of the general practitioner.

'Proprietary prescribing' means that the patient will always receive a product of the same external appearance and bioavailability, from a company with reputable quality control. The placebo effect is important; what are our hypertensive patients to think when they receive a different colour and shape of tablet every month? The good general practitioner will decide whether a prescription is necessary and, if it is, he will decide what pharmaceutical agent or agents are required. If he should choose a compound preparation he will have good reasons for his choice, but once the choice has been made, there is no merit in using the generic name for its own sake.

I think that we should prescribe what is best for our patients, and let the Government haggle over the total cost with the pharmaceutical industry.

MICHAEL LEUTY

3 Lime Avenue
Thongsbridge
Huddersfield HD7 2SS

Antibiotics in urine specimens

Sir,

Many urine specimens received from general practice patients contain antibiotics.^{1,3} Does the presence of antibiotics make the diagnosis of urinary tract infection more difficult and therefore are these specimens 'nonsense urines'? We have identified the antibiotics that are present in urine specimens received from patients of general practitioners in the Leeds area using a simple microbiological method, as described in a previous publication.² Patients may take antibiotics that have been left over from previous prescriptions or be taking antibiotics for the treatment of unrelated conditions such as upper respiratory tract or skin infections, or have provided a specimen after antibiotic therapy has already commenced. Some antibiotics, notably trimethoprim, may be present in significant concentrations in the urine for several days after completion of therapy and reduced renal function, particularly in the elderly, may delay the clearance of an antibiotic otherwise rapidly excreted in the urine, making it difficult to collect an antibiotic-free post-treatment specimen. Antibiotics, such as erythromycin, that are not routinely prescribed for urinary infections may still inhibit the growth of *Escherichia coli* sufficiently to obscure laboratory diagnosis.

All urine specimens received in December/January 1984/85 (limited to 1000 specimens) from general practice patients were tested for the presence of antibiotics, which were then identified.²

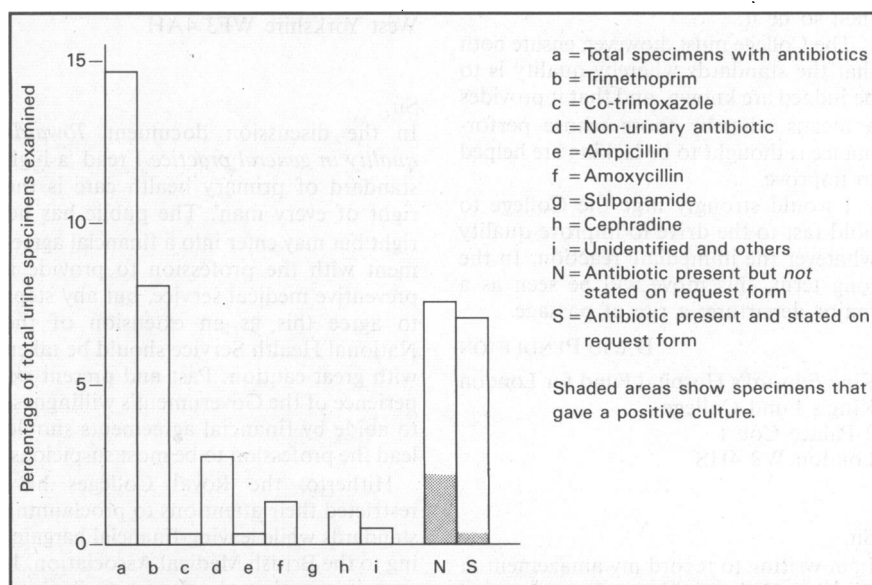


Figure 1. Percentage of total urine specimens examined containing antibiotics. Those samples containing antibiotics where antibiotics were and were not stated on the request form are also shown as a percentage of the total urine specimens examined (n = 1000 specimens).