compound. The implementation of these rules by the Kefauver-Harris bill of 1962 has done much to correct this difficulty for the prescribing physician.

On too numerous occasions, we have seen patients simultaneously receiving a similar drug in two preparations of different brand name. Meprobamate, for example, can be prescribed by at least 33 different brand names either alone or in combination with a variety of other drugs.[1] Many of these names give no indication of the active ingredients. It is most often when a combination of drugs is prescribed by a single brand name that the physician may lose sight of the various components and prescribe one of the ingredients again in a separate preparation. In addition, the increasing knowledge of the effects of drug interactions makes it imperative for the physician to be acutely aware of all drugs the patient is receiving. We have noticed a similar difficulty particularly when antibiotics have been prescribed by brand name. Following an inadequate therapeutic effect, the patient may be given another brand name antibiotic without the physician realizing the same antibiotic is being given. Although such errors are not frequent, prescribing by generic name would do much to stop these instances of poor therapy. Therefore, we strongly recommend that all drugs be prescribed by generic name. In those instances where the physician feels a specific company's product is best for his patient, the generic name of the drug should be followed by the name of the company whose product he wishes. This appears to us to be a logical solution. After all, if a physician has determined that a specific manufacturer's product is best for his patient, he should at least know the name of the company.

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Dr. GARB. There is much of importance and interest in this article and I will return to it again. At this time, there are two statements that I wish to quote. (They use the term "brand name" to refer to what I have called "private product name." They are using it in the usual fashion.) These doctors say:

> On too numerous occasions, we have seen patients simultaneously receiving a similar drug in two preparations of different brand name.

They go on:

> We have noticed a similar difficulty particularly when antibiotics have been prescribed by brand name. Following an inadequate therapeutic effect, the patient may be given another brand name antibiotic without the physician realizing the same antibiotic is being given. Although such errors are not frequent, prescribing by generic name would do much to stop these instances of poor therapy.

Much of the public discussion of brand versus generic prescribing have assumed that there are only two basic ways to prescribe drugs. Instead, there are three. Let us assume that a physician wishes to prescribe a particular medication.

One way would be to write: meprobamate.

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[1] Apascil, Atraxin, Biobamat, Calmiren, Cirpon, Cyrpon, Ecuanil, Equanil, Equanil LA, Harmonin, Mepantin, Mepavion, Meproleaf, Meprosin, Meprospan, Meprotabs, Miltown, Nervonus, Neuramate, Oasil, Pamaco, Panediol, Perequil, Perquietil, Pertranquil, Placidon, Probamyl, Quanil, Quilate, Sedabamate, Sedasil, Urbil, Viobamate.