(The editorial referred to follows:)

[From the American Journal of Hospital Pharmacy, vol. 24, March 1967]

THE AMA AND GENERIC PRESCRIBING

(By George P. Provost)

The House of Delegates of the American Medical Association, at its meeting in Las Vegas, November 28–30, 1966, reaffirmed AMA's policy that physicans should be free to use either generic or brand names in prescribing and encouraged physicians to supplement medical judgment with cost considerations in making this choice. The action was taken as a result of a recommendation by the AMA Board of Trustees, whose report stated:

"The issue of cost is not simply a matter of prescribing drugs generically as opposed to brand name prescribing. Often there will be substantial variations in the cost of the same drug marketed under different brand names by a number of reputable manufacturers. However, generic prescribing alone will not assure that the least costly brand will be dispensed or that the savings will be passed on to the patient. Nor will generic prescribing alone assure the physician that his patient is receiving the product of a manufacturer in whom he has confidence . . .

"The attending physician should not delegate this choice—that is, he should not prescribe generically—unless he is convinced that he can rely upon the quality and purity of the drug that will be dispensed to his patient. If this is not the case, then the physician himself should designate the source of supply by prescribing by brand name or by adding the name of his choice of supplier to the generic name of the drug . . . .

"If medical considerations lead the physician to the conclusion that he can safely delegate the choice of supplier to a pharmacist, a hospital formulary committee or some other third party, he does not abrogate his responsibility to protect the economic as well as the medical interests of his patient . . . Thus, in choosing to prescribe generically, the physician should be assured that whoever actually make the choice of supplier can and will take into account not only the medical needs of his patient but will protect the patient's economic interests as well."

Unfortunately, but perhaps not entirely unrealistically, AMA's position is based largely on distrust or lack of confidence or understanding in the ability of the pharmacist. The selection of a brand of a drug is, after all, more of a pharmaceutical than a medical judgment. Drugs become *pharmaceuticals* after they are put into dosage forms. Physicians are trained in *drug therapy* but not in the area of *pharmaceuticals.*

The hospital pharmacist and the physician practicing in the hospital can take comfort in the fact that the Pharmacy and Therapeutics Committee, referred to as the hospital formulary committee in the AMA report, can "take into account . . . the medical needs" of the patient and "protect the patient's economic interests as well." This is one of the main reasons for its existence. Indeed, the AMA has endorsed the hospital formulary system by its approval of the Statement of Guiding Principles on the Operation of the Hospital Formulary System. According to the Statement, "The pharmacist, with the advice and guidance of the Pharmacy and Therapeutics Committee, shall be responsible for specifications as to quality, quantity and source of supply of all drugs, chemicals, biologicals and pharmaceutical preparations . . . ." The document concludes, "A hospital formulary system . . . is considered to be important in drug therapy in hospitals. In the interest of better patient care, its adoption by hospital medical staffs is recommended."

Hospital pharmacists operating under the formulary system are well aware that they have assumed full responsibility for the pharmaceutical quality of their products, those they purchase in finished form as well as those they finish in their pharmacies. If hospital pharmacists are not better prepared and more capable of assuming this responsibility than are physicians or nurses, there is little reason for having a pharmacist in a hospital.