On the general question of drug costs, we would first point out that this is by far the smallest portion of the health care bill and it has declined in recent years, both as to the prices of the drugs themselves and the proportion they represent of the total costs of an illness. Prescription drugs now account for only 9.8¢ of the health care dollar, according to the Department of Commerce, compared with 11.7¢ a decade ago.

The Department of Labor reported in September that the price of prescription drugs on its Consumer Price Index has dropped 11.2% since the 1957–59 base period. We believe these trends, registered in a period when the prices of virtually all other commodities have been going up, raise serious questions as to the validity of the argument over drug costs as a pretext for requiring generic prescribing for any segment of the population, especially when such a program is advanced as a government economy measure.

We are in complete accord with the position taken by the American Medical Association on several occasions that physicians should supplement their medical judgment with cost considerations when prescribing for their patients. But this cannot mean that price is to be established as the paramount consideration in the selection of a medicine, over safety, and effectiveness. As physicians, we are professionally and ethically concerned that our patients receive only the highest quality products made by manufacturers who value highly their names and reputations and are known to, and trusted by, the prescribers.

The pressure for economy in prescriptions, as in many consumerist arguments, makes use only of the fact that fit a tendentious hypothesis. It is indeed a fact that some medications are available at a lower cost in identical form without a brand name. It is also a fact that, to some patients, it would make little, if any, difference what brand of a particular medication were prescribed. In these instances, the physician may wish to specify the least costly variety, provided quality is not sacrificed.

But the minor advantages of prescribing generic drugs stop at that point and the disadvantages begin. Health care personnel, knowledgeable in pharmaceutical manufacture and dispensing, are fully aware of the dangers of using non-brand-name drugs. And this danger does exist. We know of no hospital that requires generic prescribing of its staff members, including military hospitals about which so much has been said before the Subcommittee.

One of our professional colleagues, Doctor Durward Hall, Congressman from Missouri, has informed you of the rigid standards enforced by the military in the procurement of drugs, and the meticulous care exercised to assure the purchase of only quality products. We assume it has been established to the Subcommittee's satisfaction that the formularies of military hospitals are stocked with products of proven quality. Even beyond this, there is not a physician practicing in one of those institutions who does not possess complete discretion to prescribe precisely the medicine he deems best for a particular patient. His peers have not limited him to the formulary, stocked as it may be with products obtained under the most stringent requirements. If the medicine he prescribes is not on the shelves it will be specially purchased.

There must be a reason for this. There is. It lies at the heart of the generic prescribing issue.

From the physician's point of view, brand name drugs often have important and vital properties, in addition to the active chemical ingredients, that make them especially valuable in the treatment of certain patients. The carefully controlled and precisely stated characteristics of the drug are significant information that the prescribing physician relies on when he specifies the drug for his patient. The patient's response to a prescribed drug can be scientifically evaluated because the physician knows exactly what it was that he prescribed. If the doctor is forced to prescribe a generic drug, he may lose an important element of control over the treatment of his patient.

Where there are successive refills for long term treatment, the physician would again be deprived of control over his patient's treatment unless each new supply had the same variables—coating, solubility, disintegration time, base, etc. We submit that this is impossible when the medicine comes from several different manufacturers with different methods and standards of quality control. Under these conditions, there could be variations in therapeutic response which might mislead the physician in his diagnosis or alter the patient's progress. This hazard can be avoided if each refill comes from the same manufacturer who is known and trusted by the prescribing physician.