not only a clue to general processes and relationships, but also is a way of studying a specific aspect of medical care which is important in itself—how appropriate the drugs in use are, how much concern there is with economy of drug outlay, and so on. Drug therapy as such has become a significant modality placed daily at the disposal of society through prescribing physicians. Whether actual usefulness measures up to the potential is not to be prejudged but there are ways of studying it.

The decision to prescribe a certain medication is not only per se an important aspect of the medical job of the doctor but also reflects a number of broader characteristics of the medical care process. Several types of studies focusing on varying elements of the act of prescribing will be cited here. Such studies could be adapted to different national environments and international comparisons could be developed. Studies of prescribing would add to the understanding of the medical care process within a country, region, or city and would aid in policy formation.

Choice of Names

When the doctor writes a prescription, does he refer to the drug by its proprietary or generic name? His choices as shown in a sampling of his prescriptions reveal the strength of competing influences acting on the doctor's mind. In particular, the effectiveness of promotional efforts by private drug companies is indicated by the frequency of use of proprietary names, which are usually short, thus easily remembered and quickly written. The use of generic names results from a confluence of factors. The generic name is often used when the doctor is prescribing somewhat older drugs which antedated the therapeutic innovations of the last 20 years. When the generic name is used for a newer drug, this may show a sophisticated detachment from the promotional activities of the companies, an effort to keep down costs of drugs by in effect authorizing competitive shopping for a generic equivalent of a "name brand," and willingness to put more time into remembering and writing out the appropriate generic reference. (Behind these choices lie still other influences: public policy on the naming of new drugs, whether advertising must include the generic name, and so on.) One should note here that the penetration of private drug commerce into countries whose health services are predominantly lodged in the public sector makes doctors' loyalties to brand names a live issue in many different national environments, including developing countries which have substantial imports to meet their drug requirements.

Studies to be cited here have been done in England (Forsyth, 1961),[6] in Baltimore (Furstenberg, 1950-1951)[7] and in New York City (Muller, 1963).[13] An official committee in England (the Cohen Committee) recommended in 1954 that "the practitioner should normally prescribe standard preparations." Forsyth studied the prescriptions of 19 family doctors in a northern industrial town and found that 60 per cent of the prescriptions were for proprietary drugs, of which 90 per cent had a cheaper identical substitute (which showed that there really was a choice).*

Dr. Furstenberg studied a 1 per cent sample of over 100,000 prescriptions written by 159 physicians rendering care under the public welfare medical care program of Baltimore, Md. He found that 55 per cent were for proprietary preparations and identified the actions as pointless waste of the program's money since less expensive official preparations (listed in official sources) were quite suitable.

The New York City study conducted

* Other findings by Forsyth are mentioned in other contexts below.