by this author used data from a large center for ambulatory care and showed that certain drugs were habitually referred to by trade name, others by generic; that the selection correlated significantly with the length of the names (the proprietary being one-third shorter on the average); and that the generically specified drugs constituted a somewhat older group of drugs. The choice of vendors was considerably wider for the generic group; therefore the use of the generic name kept purchasing choices open for the institution. Vendor monopoly in many (over half) of the drugs in the proprietary group meant that the use of a generic name would not have widened the choices at the point of purchasing by the pharmacy. Name selection has to be considered in conjunction with institutional policy as to competitive bidding and with the actual degree of monopoly for specific drugs if one wishes to evaluate the influence of doctors' choices on the purchasing process.

Stability and Change in Doctors' Selection of Drugs

The outpouring of new drugs in the recent decades of innovation, especially in the United States before the effort to strengthen controls embodied in the 1962 Kefauver-Harris Law, raised questions concerning the stability of physicians' drug selection habits under conditions of rapid change in the drug market. Changes in habits over a period of years and in various places can be studied through existing data. An important source of data is total money values of drug production, trade, and consumption, which are or should be available at national levels. These figures permit comparison of specific products and classes of products in use in different years and in different countries. For example, in the United States data on production tell, or at least strongly suggest, which types of illnesses are self-medicated rather than seen by physicians (through figures on dollar values of "ethical" and "over-the-counter" drugs produced for domestic consumption) and which symptoms and illnesses account for the major share of financial resources devoted to medicaments at different times.[3]

Students of the medical care process may inquire: do doctors' choices have a "chronic" stability based on early habit formation and the medical necessities of a given patient load? If not, how rapidly and under what conditions do they change? Menzel, Katz, and Coleman used survey research methods to make a sociological study of the adoption of a new drug within a medical community.[4] They found the process associated with the interpersonal relations of the physicians, and with a number of their individual attributes, including attachment to medical institutions outside the community, and relative concern with recognition within their profession as compared with the respect of patients and the esteem of the community. Doctors who were more isolated from the local medical community introduced the new drugs later than those who were more socially integrated with their colleagues, and the former were more influenced by detail men and advertising than by doctor-doctor relationships.

The study was carried out among 125 general practitioners, internists, and pediatricians constituting 85 per cent of the practitioners in these fields in four cities in the midwestern United States. The social-professional context in which the study was performed was further elaborated in a later study which treated readiness to try the newer antibiotics of the day (circa 1959) as one of several "dimensions of being modern."[11] (Today widespread apprehension about toxic effects very probably would lead investigators to a different criterion of "modern" attitudes toward introducing new drugs.) These studies carried implica-