editorials

Comment on Hyperbole: Statement of the Drug Research Board

At the risk of being repetitious, we feel obliged to return to a theme explored repeatedly in past issues of THE JOURNAL.[1-4] This situation reminds me (R.H.M.) of an experience that occurred during my army years. I was attending the Army Command and General Staff College at Fort Leavenworth. On the first day in our nervously chattering class of Military Map Reading, in strode an impressive full colonel: elegant, beribboned, and ramrod erect. He stared sternly at the large group. Then he spoke in measured words, "Gentlemen, I am Colonel Jones, your instructor in map reading. I wish to state at the outset of this course, that at all times, I reserve the right to use the terms *north* and *south* interchangeably!"

This ice-breaking introduction is reminiscent of the ambiguous, mad-hatterish resolution of the Drug Research Board of the National Research Council (NB: the final paragraph):

WHEREAS, The patient's welfare should be the ultimate goal of statutes and regulations concerning drug product selection, which in operational terms means the best product for the lowest cost, and

WHEREAS, The physician must have the ultimate responsibility and authority in drug product selection, since he has the fullest knowledge of the patient's needs and responses with attendant obligation to be held accountable for his selection of particular drug products, and

WHEREAS, The pharmacist may in some situations, have greater knowledge of drug products than other health professionals, including knowledge of both quality and costs, and

WHEREAS, It is appropriate that decisions with regard to the choice of drug products be made by the health professional possessing the greatest amount of information involved in the particular selection in question, with the attendant accountability, therefore be it

Resolved, *That the physician, having selected the chemical entity to be used for therapy, (a) should be required to delegate to the pharmacist, or (b) explicitly retain to himself, selection of the particular drug product to be dispensed and received by the patient.*

(Letters (*a*) and (*b*) and italics are added to lend some semblance of organization to this statement.)

One interpretation of part (*b*) could be that a physician who wants a prescription filled as he has written it would, in effect, be required to specify a second time, "Yes, I really meant what I wrote."

Part (*a*) means the reverse: a pharmacist can choose any brand or generically labeled substitute at his own discretion!

Rather than repeat the tiresome hyperbole that is embraced by the notion that a pharmacist should be granted such latitude, we shall list the minimum requirements that must be met before a physician could properly delegate his responsibility for product selection.

First, the physician would have to know exactly in which pharmacy the prescription would be filled—a tall order in any fair-sized city. Otherwise, if more than one brand of a product is marketed, he would be authorizing *any pharmacist anywhere to decide what the patient should receive.* The chaos that such a practice could wreak is illustrated concretely in "The Plea of a Jacksonville Druggist."[1]

If we assume the rare circumstance in which the physician does know where the prescription is destined to be filled, he would need intimate knowledge of that pharmacy. He would be obliged to know (1) what brands (or "generic equivalents") are being stocked currently; (2) that convincing evidence exists that all the different products are indeed equivalent therapeutically; (3) the cost of the drugs (is one product cheaper than the other?); (4) how he can be assured, if all the foregoing is known, that the most economical one will indeed be dispensed; and finally (5) *whether any saving will be passed on to the patient.*

In the event that a substitution is made, will the patient be confused by receiving a drug with an unfamiliar name on the label or with an unfamiliar appearance and think that he has been given the wrong drug? Will he wonder who is really managing his treatment?

If these crucial questions can be answered, all the rhetoric about "substitution" will be meaningless. The physician simply will prescribe the most economical therapeutic equivalent product in the pharmacy.

But felicitous theory is a long way from practical reality.

If the physician does not have the necessary information about the product available in a pharmacy that his patient may patronize, we might pose one additional rhetorical question (to illustrate another dimension of the need to know the destination of the prescription): does the pharmacist have the financial assets to bear his share of the malpractice judgment, if he happens to cause harm to a patient through an improper substitution? (One may assess a toxic reaction, but how does one measure lack of efficacy in an individual patient?)

Thus the remarkable, through-the-looking-glass resolu-

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