or branded, approved substance which he has in stock and he is paid on the basis of the lowest-cost one listed in the CDI. It must be an approved interchange. He may be able, by co-operative purchasing, to supply a branded, approved product at the low-cost price. It is recognised that not all generics are suitable for interchange; for example, 24 brands of chlordiazepoxide are available in Ontario, but only seven are listed for interchange.

There is an obligation to provide a prescribing and dispensing guide in order better to standardise pharmaceutical health care. This is the reason for the *BNF* and a CDI would supplement this. In preparing the CDI everything is taken into account, such as therapeutic value, the critical nature of the drug, relevant dosage, raw materials, formulation, compounding procedures, production control to maintain quality, safety, bioavailability, and therapeutic efficacy. Good manufacturers of generic drugs are willing to comply with bioavailability data, making it available to the CDI. It is in their interests to do so.

The Parcost CDI contains about 700 popular used products grouped in therapeutic classes and arranged to illustrate interchangeability. The prescription label would bear the identity of drug manufacturer and strength. This would help the medical profession to identify the product dispensed since patients might describe an "interchange" drug which differs in appearance from that expected. There are listed products in a non-interchangeable category, such as anticoagulants and some digoxin products considered critical in their therapeutic reactions. The contraceptive pill is another non-interchange drug because of differences in side effects. Freedom for doctors to order "no interchange" should always be available, but it would be reasonable to ask the prescriber to justify his or her action.

Parcost could save 25% of the drug bill, especially if coupled with limiting supply to a maximum of 28 days or less if short-term use is indicated. Saving on the drug costs in this way would be preferable to a drug benefit scheme, which limits the number of products available to be prescribed. Serious consideration of the virtues of Parcost and limitation of brand promotional expenses is a must—keep our excellent NHS viable.

FREDERICK J REYNOLDS

Birmingham 29

SIR,—Sir Henry Yellowlees has set out well the arguments in favour of more economical prescribing by general practitioners (15 March, p 797) but has failed to grasp the nettle of escalating costs caused by a profusion of new and usually expensive drugs being produced to gain shares in profitable areas. Beta-blockers and anti-inflammatory agents appear to be the current examples.

It seems that a new drug only has to pass the Committee on Safety of Medicines to become immediately acceptable on prescription. No consideration is given to the actual need for that product, or to whether there is already an adequate range available. It is inherently wrong for the DHSS to make new drugs immediately prescribable and then send regional medical officers round asking general practitioners not to use them.

Most GPs work from their own well-tried list of 200-300 preparations, and yet there are several thousand available on NHS prescription. Clearly we must allow for individual clinical freedom of choice, but equally clearly we cannot continue to expand unnecessarily the list of products available to patients largely free of charge.

Many countries operate with success a two-tier system whereby patients pay for those items not on the official list; this more than anything would enable vast economies to be made, and might encourage the drug companies to make more valid and more responsible contributions than some of them do at present.

PATRICK J HOYTE

Clitheroe, Lancs

Not fully trained?

SIR,—At a recent meeting of our trainers' group in Birmingham great concern was expressed over the increasing difficulty of our trainees in obtaining a post as a principal in practice after completing the traineeship. As trainers, we regard the placing of our trainees as a very definite part of our role, and some would even question the morality of taking on a trainee for a year if there is no post available as a principal at the end of the training.

The Medical Practices Committee, with its purely numerical approach, must take some blame for this state of affairs. We also find it strange that this committee will not approve a qualified doctor, having become vocationally trained, for succeeding to an FPC vacancy for a single-handed practitioner—we know of several such cases. When large amounts of money have been spent on vocational training in general practice, it seems contradictory then to say that a doctor able to qualify for a vocational training allowance is not fit to be a single-handed principal, and therefore by implication is not fully trained.

We feel that this situation is rapidly worsening, and with the now legal requirement for vocational training applying from next February many of our trainees are asking what on earth it is all for.

D W WALL
Course organiser and convener,
South Birmingham Trainers Group

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Anglo-French contrasts in medical practice

SIR,—It is fascinating to read in the *BMJ* of 26 April (p 1109) that the French GPs, practising residual medicine single handed for long hours without benefit of notes, ancillary staff, or other post-RCGP goodies, are found to be satisfied or very satisfied with their work, informal and approachable, and not considering emigration; while British GPs practising new-deal, whole-person medicine tend to be dissatisfied and considering emigration and to cover our surgeries with admonitory notices.

Is not the explanation simply that French GPs are paid for what they do and so they do not mind doing anything the patients want, while we are paid by capitation and use all these devices to try to limit our contact with our patients. Furthermore, we find that the satisfaction of doing what we define as worthwhile family medicine in ideal situations does not come up to that of simply pleasing our patients by doing what they want where and when they want it.

E W M CHANNING

Health Centre, Bideford, Devon

Review Body award

SIR,—As I wrote to Dr Vaughan last year, the Review Body is an expensive and unnecessary quango and I have never been convinced that anything it has said has been of real benefit. This last figure suggested by them demonstrates this only too well. The percentage could have been reached with hardly any basic thought given the 10% outstanding and the cost of living, but the real point is that for most working men the take home pay is what matters—that is, their pay after tax and national insurance.

It is an unavoidable fact that 30% given to us in 1981-2 represents an infinitely larger take home pay than 30% given to us under the restrictive tax system of the last Government, and I would have thought that this matter should have been considered by the Review Body and that they should have had the courage to say so. As courage has never been an attribute of the Review Body, one is possibly not surprised. Certainly we shall overall get more benefit from our rise in regard to the taxation problem, bearing in mind that if people have to be taxed to some degree the richer must pay more than the nurses getting their 14%, and there must be added pressure on the resources of the Health Service. Obviously from the point of view of people of my age, with only one full year to go before retirement, proper pay is long overdue; but it would seem to me that in subsequent years the tax question should be thought about.

My own feeling is that future pay rises should be dealt with easily between the Minister, the Chairman of Council of the British Medical Association, and the Chairman of the Hospital Consultants Association.

A F RUSHFORTH

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SIR,—The partners of this practice have met and discussed our recent pay award. In view of the economic difficulties facing the country at the present time, we feel that the level of the award is difficult to defend.

As a practice we personally would be willing to accept a delay of one year in the implementation of the top 5% of the award. We would be interested to hear the views of other general practitioners.

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Correction

Volkmann's ischaemic contracture

We regret that a printing error occurred in the letter by Mr J Emerson (19 April, p 1088). The last sentence of the second paragraph should read: "Furthermore, when intraneural blood flow is restored oedema can be seen in the epineurial space after three to four hours' ischaemia, and in the endoneurial space after eight hours' ischaemia."