aeruginosa has been found repeatedly in these situations.—We are, etc.,

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Respiratory Infection in Early Childhood

SIR,—It is encouraging to see that Dr. P. S. Gardner and his colleagues (11 November, p. 316) and your leader-writer (p. 307) are now advocating the use of blood gas and acid-base measurements in the management of the child with severe respiratory infection. However, it is of little use demonstrating the presence of a major degree of respiratory acidosis unless the facilities for treatment are readily available, and this means intermittent positive-pressure ventilation (I.P.P.V.) through a nasotracheal tube. This point does not seem to be emphasized enough in either of these articles.

I would agree that this type of therapy is easily undertaken only in a hospital with facilities for intensive care, but this should not be taken to imply that I.P.P.V. is an extremely difficult technical exercise. A number of centres in Great Britain have this well established as part of a routine service, and it may not be entirely coincidental that two centres reporting series of I.P.P.V. free of major technical troubles have been those where there has been considerable co-operation between paediatricians and paediatric anaesthetists.¹

The number of children with respiratory infections requiring I.P.P.V. is probably not great, and it is therefore important that experience gained in the operating-theatre in the management of infants with respiratory distress syndrome, apnoeic attacks, or after major surgery, and in older children with status epilepticus, meningitis, tetanus, etc., should be concentrated. This may well mean channelling admissions to larger centres, but it seems unlikely that there will be much progress in further reducing mortality in a number of diseases in children unless this is done.

Surely we have now reached a stage when a children's hospital should find prolonged I.P.P.V. no more unusual or difficult than caring for the more severely ill child with, say, pyloric stenosis or intussusception.—I am, etc.,

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REFERENCES

- ¹ Reid, D. H. S., and Tunstall, M. E., *Anaesthesia*, 1966, 21, 72.
- ² Rees, G. J., Stead, A. L., Bush, G. H., and Jones, R. S., *Brit. med. J.*, 1966, 2, 1611.

Brand Names of Drugs

SIR,—We have read with some concern your editorial attitude (7 October, p. 1) towards the Sainsbury Committee's recommendations that brand names should be abolished for new medicines. In our view too much emphasis has been put on the theoretical advantages of this proposal, while too little weight has been given to the economic and practical considerations.

Firstly, on the economic side, let us assume that a company has developed a useful new product but is required to market it under an

officially approved name. If it were patentable (and often, for a variety of reasons, it is not) the fact that imitators could use the original name would greatly encourage them to obtain a compulsory licence, as they are able to do under section 41 of the Patents Act. Thus the lack of trade-mark protection would swiftly lead to fragmentation of the originator's market, since doctors are unlikely always to specify on their prescriptions the name of the originating company, however great its reputation. The greatly enhanced financial risks involved for the developer would be bound to constitute a severe deterrent to long-term investment in pharmaceutical research in this country. As to export markets, there are many countries where products cannot be sold under brand names unless these have first been registered in the product's country of origin. In any event, the difficulties already explained of establishing a clear lead for the developer's original product in this country would undoubtedly prejudice its export potential.

For the N.H.S., however, the savings from the abolition of brand names would be negligible. There are only a small number of cases where branded products are more expensive than similarly formulated unbranded medicines. It is calculated that savings, if such branded products were eliminated from N.H.S. prescribing, would be something of the order of 0.5% of cost of the pharmaceutical services.

Nor would the abolition of brand names significantly reduce the numbers of differently named preparations on the market. Out of the 2,150 or so branded prescription medicines listed in *Medindex* at the beginning of 1967 there were some 1,780 different formulations each based on different chemical entities. That is, abolishing brand names could reduce the number of differently named preparations only by less than a fifth. Brand duplication is very much the exception, but the fact that it can occur provides for the possibility of competition leading to superior formulations.

In practical terms it is possible that the difficulties of prescribing and dispensing in the absence of brand names have been treated too lightly because there has been too little distinction drawn between the terminology for the chemical *ingredients* and that for the *preparations* which are formulated from one or more such ingredients. For the former, the approved name is unambiguous. For the latter, difficulties would arise from the absence of brand names in at least three ways: firstly, in describing special formulations, such as delayed release capsules, aerosols, or specially flavoured mixtures acceptable to children; secondly, and more particularly, in the case of small but significant variations between such formulations—for example, with capsules designed to release their medicament at different rates; and, thirdly, in identifying specially formulated presentations which were only subtle improvements over the "official" preparations. In theory each could be described in a phrase describing the formulations, coupled with the approved name and that of the manufacturer. In practice this would probably add to the confusion, rather than decrease it. Many of us must have recollections of this type of nomenclature from our time in the Services.

Finally, we do not accept that legislative controls, relying on severe penalties for

improperly formulated medicines, provide the best way of ensuring uniformly high standards of pharmaceutical quality. We believe that the manufacturers' pride in their own products, when marketed under their own brand names, provides a much stronger incentive.

General practitioners are busy men, and the use of brand names can be convenient as well as logical in their prescribing. We believe that the medical profession should give very careful consideration before supporting proposals to abolish brand names for medicines.—I am, etc.,

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Abortion and Conscience

SIR,—Dr. Myre Sim in his letter on abortion and conscience (4 November, p. 297) complains that doctors have no reliable evidence to guide them in their interpretation of the various clauses of the new Abortion Act.

The World Health Organization¹ defines health as follows: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This definition is surely relevant when one is considering whether or not to advise termination of pregnancy.

Dr. Sim quite rightly feels that the doctor who advises a termination of pregnancy should have a clear conscience that the dangers threatening the pregnant woman are real. Should he not feel that the doctor who advises against termination of pregnancy also has a clear conscience that no dangers threaten the patient? It is ironical that his letter should appear but a few pages after an article (p. 271) describing 48 days' intensive hospital treatment of a woman who died from complications of a self-induced abortion.—I am, etc.,

Aland, Finland.

PETER DARBY.

REFERENCE

- ¹ Constitution of the World Health Organization, *Chron. Wld Hlth Org.*, 1947, 1, 29.

Institutional Care of the Mentally Subnormal

SIR,—Professor T. McKeown and Dr. I. Leck (2 September, p. 573) have drawn attention yet again to the shortage of facilities generally for the subnormal. These studies have much to commend them, and their accuracy, especially in relation to the needs of adult patients, is not in doubt. However, should their findings be applied to the needs of patients under 16 years of age any future planning based on them can only have disastrous results. Whatever the authors themselves may have intended, their results will certainly be quoted and used by those intent on reducing costs, and therefore some of their omissions should be mentioned. My remarks here refer only to children.

The singular lack of hospital accommodation at the time of their survey for children in Birmingham is mentioned, and it is suggested that this shortage is overcome by it being "a relatively compact area in which