continue to have the right and opportunity to make a subsequent attempt at suicide.

We do not suggest that any method of interpreting principles that may be relevant in a volunteer based organisation would be transferable to the clinical domain, but we believe that when in doubt we should err on the side of life. Each situation will be different and will need careful and sensitive assessment (in so far as time and the circumstances permit). Nobody, however, can escape from the fact that death is for ever.

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1 Warsop A. Preventing suicide. *BMJ* 1994;309:1304. (12 November.)

Generic inhalers for asthma

Patients titrate dose against response

EDITOR,—In West Sussex prescribing of inhaled drugs for asthma has changed dramatically during the past four years. Between 1992-3 and 1993-4 alone, prescriptions for corticosteroids, measured in defined daily doses, rose by 31%, while those for bronchodilators fell by 18%. The ratio of defined daily doses of corticosteroids to bronchodilators rose from 0·44 to 0·70. This increase was achieved as a result of a determined effort and superb teamwork by every practice in the county but would not have been possible if changes to generic preparations had not been implemented at the same time.

The proportion of bronchodilators prescribed generically increased from 13·1% in October 1992 to 30% in September 1994 and that of corticosteroids from 4·5% to 24·2% in the same period. No problems resulting from these changes have been reported. It would be surprising if problems were reported because in the treatment of asthma the patient is taught to titrate the dose against his or her own response so minor differences in bioequivalence, if they exist, would be unimportant. The complaint by Mike Pearson and colleagues about the changes to generic inhalers for asthma[1] is particularly puzzling as it is well known that because of the reciprocal arrangements between the manufacturing companies many inhalers prescribed and dispensed with the brand name have in fact been produced by a manufacturer of generic inhalers.

It is essential that doctors prescribe the least expensive effective preparation available if resources are to be redistributed to maximise the benefit to patients.

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1 Pearson M, Lewis R, Watson J, Ayres J, Ibbotson G, Ryan D, *et al.* Generic inhalers for asthma. *BMJ* 1994;309:1440. (26 November.)

Money saved could be spent on patient education

EDITOR,—Mike Pearson and colleagues question the campaign to promote generic prescribing of inhalers for asthma.[1] I wish to draw attention to the cost implications of the continued use of branded products in Lancashire, where 1·4 million people are served by 284 practices.

The table shows the number of beclomethasone 50, 100, 200, and 250 μg inhalers and salbutamol 100 μg inhalers prescribed in Lancashire in the six months to September 1994. Altogether 53% of prescriptions for salbutamol inhalers were for branded products. A shift to 100% generic prescribing would have produced a saving of £102 501 on spending of £353 085. Altogether 76% of prescriptions for beclomethasone inhalers were for branded products, representing a potential saving of £132 050 on spending of £983 323.

Number and cost of prescriptions for salbutamol and beclomethasone inhalers and potential savings in six months to September 1994, Lancashire Family Health Services Authority

	No	Cost (£)
Salbutamol inhalers 100 μg		
Branded	99 649	227 530
Generic	89 949	125 555
Both	189 598	353 085
Potential saving		102 501
Beclomethasone inhalers 50, 100, 200, and 250 μg		
Branded	56 192	806 291
Generic	18 163	177 032
Both	74 355	983 323
Potential saving		132 050

Overspends on prescribing by general practitioners are to be paid for from local health authority budgets. Commissioners of care must therefore consider whether such extra costs can be justified by demonstrable clinical benefit. I know of no evidence that practices that use generic products provide less effective care for patients with asthma than those that use branded products. Compliance with the totality of effective care in asthma[2] is likely to be enhanced more by spending money on patient educators than on expensive delivery systems.

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1 Pearson M, Watson J, Ayres J, Ibbotson G, Ryan D, Flynn D, *et al.* Generic inhalers for asthma. *BMJ* 1994;309:1440. (26 November.)
2 Woodhead M, ed. Guidelines on the management of asthma. *Thorax* 1993;48(suppl):S1-24.

*Part of the author's responsibility is to advise on prescribing and encourage the use of generic medicines.

Report on Australian surgeons

EDITOR,—Simon Chapman's glowing account of the Baume inquiry into Australia's surgical workforce is tinged with his political views.[1] Professor Baume's central conclusion—that the cause of surgical waiting lists in Australia is a shortage of surgeons, which in turn is due to excessive control over surgical training by the Royal Australasian College of Surgeons—has been rejected not only by the college but also by the Australian Medical Association and the specialist surgical societies. His suggestion that, if numbers of surgeons cannot be increased rapidly, incompletely trained people should be allowed to substitute for surgeons is widely regarded as being silly.

The Baume report has been criticised not only for inaccuracies (for example, overestimating the population of Australia in 2001 by three million) but also because it ignores facts, preferring instead views based on Professor Baume's "suspicion" or anonymous submissions by disgruntled groups or individuals. Surgeons presented Professor Baume with evidence that cutbacks in public hospitals related to the budget were the cause of long waiting lists and indicated that, if they were allowed to work to full capacity, their waiting lists would disappear rapidly. This evidence was largely ignored in the conclusions of the report.

Professor Baume's conclusion that hospital bottlenecks in Australia are due to a shortage of surgeons, who, he said, are relucant to work in public hospitals, is an untruth that has left surgeons gasping. In general surgery there are virtually no unfilled consultant vacancies in urban Australia, where waiting lists are longest. When such a vacancy was advertised recently at Westmead Hospital (a teaching hospital of the university in which Chapman works) almost 100 people applied.

Chapman says that Professor Baume drew attention to the "fantastic incomes" of surgeons. This phrase does not appear in the report, and the fantasy is therefore Chapman's. Fantasy, however, is an appropriate word, as Professor Baume pointed out that the quoted figures for doctors' incomes may be inaccurate and that the amounts represent gross income, from which practice expenses (ranging from 50% to 90%) need to be deducted. Australian surgeons' net incomes are, in fact, modest compared with those of other professional groups.

Chapman, a colleague of Professor Baume, describes him as "a creative egg cracker in medicopolitical cake baking." This assessment of Professor Baume is not shared universally by Australian doctors. The late Professor Fred Hollows, who encountered Professor Baume when the latter was minister for aboriginal affairs, was extremely critical of him,[2] and many Australian surgeons support his view.

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1 Chapman S. Australian surgeons savaged by cutting report. *BMJ* 1994;309:1254. (12 November.)
2 Hollows F, Corris P. *Fred Hollows—an autobiography.* Kerr: Sydney, 1992.

Treatment of low back pain

EDITOR,—Kwame McKenzie's news item about the Clinical Standards Advisory Group's report on the treatment of low back pain omits to state that general practitioners should have direct access to osteopaths as well as to chiropractors and physiotherapists.[1] Osteopaths should be part of the forthcoming and much needed "revolution."

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1 McKenzie K. Back treatment needs revolution, says report. *BMJ* 1994;309:1602. (17 December.)

Primary care and general practice

EDITOR,—In their editorial on the primary health care team Pauline Pearson and Kevin Jones fail to ask one fundamental question: does "primary care" exist?[1] Increasingly, primary care is used as a synonym for general practice. For an example of this, one need look no further than Kathryn L Evans's review of sinusitis, in which she writes that "most uncomplicated acute sinusitis is managed in Britain in primary care."[2] This is one of hundreds of examples that appear in journals every week and are heard in common speech. This use is misleading.

Many people in primary care professions have no direct or regular links with general practice and yet offer community based health interventions with open access. These people include opticians, dentists, chiropodists, shop pharmacists, osteopaths, school nurses, and child guidance professionals. As Pearson and Jones point out, other primary care workers who do work with general practitioners, such as district nurses and health