difficulties with methodological rigour and interpreting the clinical findings for a primary care context, the results of randomised controlled trials may be of questionable validity.¹ Systematic reviews and meta-analyses may offer ways to address the problems of methodological quality, but such reviews cover only limited topics and may themselves lack rigour. Nor will there ever be evidence from randomised controlled trials, systematic reviews, and meta-analyses to support all but a minority of the many interventions of everyday primary care.

Koki Tsuruoka and colleagues highlight our concerns about the use of appropriate end points of treatment in randomised controlled trials. Like them, we used a pragmatic method of defining end points. All antihypertensive drugs were allocated to group (i) even though a reduction in mortality and morbidity has been established with only relatively few drugs.² Furthermore, Tsuruoka and colleagues' study raises issues about generalising results to countries where health systems and clinical practice may be very different.

Meakin and colleagues iterate our concern about the diagnostic label recorded in patients' notes and draw attention to the exclusion of patients who were referred or investigated. We too were concerned about the use of the first recorded problem as a primary diagnosis. Our methodology related interventions to diagnostic labels. We deliberately excluded patients sent for investigation and referral because investigations may modify diagnostic labels and referral may modify either diagnostic labels or the treatment plan. In our paper we insisted that the results should not be generalised. Interestingly, however, if the referral and investigation group is added back into the sample the proportion of drug interventions (72%) compares favourably with that reported by Fry,³ given the small sample size.

The main point of our study was not merely to estimate the proportion of evidence based interventions in general practice but to debate the appropriateness of methods used to assess evidence based practice. We consider it misjudged to compare percentages of evidence based interventions in different disciplines. It is now appropriate, however, to shift the debate to exploring alternative paradigms of evidence based care and consider how we can ensure that the increasing body of research evidence is made accessible to all practitioners.

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Over the counter drugs

Both doctors and pharmacists should prescribe better

EDITOR,—The prescribing of antibiotics is a complex issue. There is increasing agreement that this class of drugs is overprescribed and that the development of antibiotic resistance is a major clinical problem, particularly in hospitals.¹ In general practice a concern is the prescribing of antibiotics for patients with a sore throat. Given that microbial cultures are difficult to undertake, however, some prescribers recommend the use of antibiotics under well defined conditions.²

Judith Hollis-Triantafillou's comments highlight the same problems in the context of over the

counter prescribing of antibiotics by pharmacists.³ There is a danger, though, in concluding from her article that restricting antibiotics to prescription only would solve the problem. This is not the case, as prescribing records in Britain show. The answer is more likely to lie in making both medical and pharmaceutical practice evidence based, but this may not be easy.⁴ The pharmaceutical industry, pharmacists, and doctors have vested interests. To suggest, as Hollis-Triantafillou seems to, that any one group is more altruistic than another is perhaps disingenuous. If prescribing decisions were more transparent and evidence based all parties, not least our patients, would benefit.

Hollis-Triantafillou also conveys her exasperation at having her cheap expectorant replaced by a more expensive, unidentified alternative remedy by the pharmacist. Perhaps the pharmacist was right, given that evidence for the efficacy of expectorants is so sparse.⁵

In writing this riposte, we are not trying to be defensive on behalf of pharmacists but wish to point out that there is poor prescribing by both doctors and pharmacists. The prescribing of depot cortisone in lieu of antihistamines for a minor allergy, described by Hollis-Triantafillou, is perhaps an example. However, there is no easy solution. The answer perhaps lies in re-examining methods of persuading both doctors and pharmacists to be better prescribers, reducing patients' expectations, toning down over-enthusiastic advice by some pharmaceutical manufacturers, and providing more evidence based updated guidelines and advice (as is being done through initiatives such as the Cochrane Collaboration).

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Working party will see whether antimicrobials should be available

EDITOR,—The series of articles on the availability of over the counter drugs that were previously available only on prescription¹ is important in

view of the increasing number of drugs licensed in this way. The British Society for Antimicrobial Chemotherapy has taken a keen interest in the fact that people now have easier access to antimicrobials because, unlike any other class of drugs, antimicrobials have an ecological dimension. While formal proof of a causal link between use of antimicrobials and antimicrobial resistance of microbes remains elusive,² many professionals concerned with infection are convinced about the connection—as is Judith Hollis-Triantafillou.³

In response to the possible availability of antimicrobials over the counter, the society has set up a working party with the remit of producing recommendations on the desirability or otherwise of such a change and on the conditions under which it might occur. As joint convenors of the working party we would be interested to hear from any readers who have opinions on this matter.

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GPs' rate of recommending over the counter drugs varies

EDITOR,—In recent years the number and range of drugs available over the counter has increased dramatically. Limited evidence suggests that the general public may respond to this by increasing self treatment.^{1 2} Much less evidence exists, however, about how doctors are responding to the new scenario created by the deregulation of many medicines. It has been suggested that doctors ought at least to start making more systematic inquiries about patients' prior use of over the counter drugs.³

In a preliminary study of general practitioners' current practice we selected six general practitioners working in practices in the west midlands, which contrasted in terms of their location (rural, suburban, or inner city) and fundholding status. At the end of 3030 consecutive consultations (505 each) the general practitioners recorded whether the patient had used over the counter drugs before the consultation, whether they had recommended an over the counter drug, and whether they had issued a prescription (table 1). They also collected data

Table 1—Frequency with which patients admitted to prior use of over the counter (OTC) drugs and general practitioners recommended OTC drugs or issued prescriptions. Figures are numbers (percentages) of consultations*

Practice	Consultations for which data were returned (n=505)	Patient admitted to prior use of OTC drug	OTC drug recommended	Prescription issued	Prescription issued and OTC drug recommended
1	444 (87.9)	50/258 (19.4)	10/444 (2.3)	315/406 (77.6)	5/406 (1.2)
2	463 (91.7)	130/375 (34.7)	118/463 (25.5)	113/369 (30.6)	106/369 (28.7)
3	464 (91.9)	179/448 (40.0)	80/464 (17.2)	247/445 (55.5)	44/445 (9.9)
4	496 (98.2)	208/495 (42.0)	186/496 (37.5)	387/495 (78.2)	147/495 (29.7)
5	459 (90.9)	77/449 (17.1)	35/459 (7.6)	268/449 (59.7)	16/449 (3.6)
6	477 (94.5)	13/473 (2.7)	15/477 (3.1)	250/453 (55.2)	6/453 (1.3)
Total	2803 (92.5)	657/2498 (26.3)	444/2803 (15.8)	1580/2617 (60.4)	324/2617 (12.4)

*Some responses were missing.