

## **Choice of medicines - positive choice versus negative choice**

When we are in the presence of a large number of objects and when we want to make a selective sorting, which method we have to adopt? How is it necessary to proceed if 10 000 objects of similar forms, colors going from the white to the black, with numerous nuances of grey, are mixed from the start of operation? Some hundreds objects are white or almost white. Some hundreds objects are black or almost black.

We can eliminate the black and dark gray objects at first, then the more and more clear objects. It is a negative sorting, either we can select positively the white and almost white objects in limited number.

If it is about medicines, the negative selective sorting of dangerous medicine, of which the benefit/risk is openly negative, must be operated by the bodies of pharmacovigilance.

Occasionally the review Prescrire publishes a list of medicines which should necessarily be removed from the market. This procedure of exclusion is laborious. It induces challenges and reluctances. It is not feasible on a large-scale of thousands of medicines the dangerousness of which is lesser, but the utility of which is debatable, or which are indisputably useless.

The positive selective sorting was used to build a list of essential medicine (EM) because it is the much simpler, and less expensive operation and that it introduces the parsimonious concept in the prescriptions. To choose hundred medicines from some thousands requires a collective clinical experience which can be reached by expert and independent clinicians, capable of participating in a consensual approach step by step. This consensus does not mean the unanimity on every element of the list. That is why such list must be completed by a complementary list where each has to find one or several medicines which he absolutely wants to prescribe. That is also why you should not impose this list, but incite doctors to prescribe with them rather. With no administrative constraint of any kind. Naturally the same list must be able to be declined in the form of lists containing the same number of medicines, but suited to every specialty, to every category of practice. We can conceive for example that the cardiologists need, with a certain frequency, about ten medicines rarely prescribed by the general practitioners and that they do not need, or by exception, about ten medicines represented on the common list of EM.

To conclude, let us say that the choice of a positive operation of selection leading to the promotion of a restricted list of EM is easier and not too time consuming. It is capable of structuring a progressive consensus towards optimized prescriptions. This reduction may stand out as a simpler practice, freed of the confusion created and maintained by uncountable drugs, more necessary for the incredible profitability of financial investments than for the best health of the patients.

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