Letter to the Editor

Rational Use of Medicines – Snakes and Ladders?

According to WHO, rational use of medicines (RUM) requires that 'patients receive medications appropriate to their clinical needs in doses that meet their own requirements for an adequate period of time and at the lowest cost to them and their community'.

Teaching about RUM: Problem-based learning (PBL) in pharmacology and therapeutics helps students to develop critical reasoning skills essential for clinical practice.[1] The learning objectives of practical sessions in pharmacology are to: make students specify the therapeutic objective for a particular condition; choose between drug and non-drug treatments; select an appropriate drug; write a correct prescription; counsel patients, and arrange follow-up. The objectives of sessions on assessing promotional materials are: Critical analyses of promotional materials; Sensitization regarding misleading information, and Keeping up to date with appropriate and objective information.[2] During these sessions students are taught about: Rational use of drugs in general; Concept of essential drugs; Sources of information on drugs; Common examples of irrational drug use; Patient compliance and ways to improve it, and Critical analysis of journal articles.

Class activities are frequently conducted on: analysis of prescriptions using WHO/International Network for Rational Use of Drugs indicators, critical analysis of drug advertisements based on WHO Ethical Criteria for Medicinal Drug Promotion; communicating drug and non-drug information to patients, and analysing the rationality of prescriptions. Solving clinical problems; selection of drugs and prescription-writing and delivering drug-related and non-drug information to a patient, are considered important transferable skills in pharmacology.[3]

Initiatives to promote RUM: A number of steps have been initiated in the Manipal Teaching Hospital (MTH), Pokhara, Nepal to promote RUM. Establishment of a Drug Information Centre (DIC) is a step towards promoting RUM and evidence-based practice of medicine in our hospital. All medicines have to be approved by the hospital's Drug and Therapeutics Committee (DTC) before they can be introduced in the hospital pharmacy, and no medicines are dispensed without prescription.

The DIC receives queries from different clinical departments in the hospital. It has so far answered around 450 queries in its 18 months of operation. However, medical representatives (MRs) continue to be the source of drug information. Through the drug information bulletin and regular interactions with clinicians we are sensitizing them to the limitations of commercial sources of drug information. Changing the

established behaviour of practising doctors is difficult and may require time.

Promotional activities of the pharmaceutical industry

MRs have free, unrestricted access to prescribers and many doctors, medical officers and interns carry bags, pens, note pads and other paraphernalia gifted by the pharmaceutical industry. Companies organize parties and get-togethers, and Continuing Medical Education programmes for doctors are often accompanied with lavish cocktail dinners. Recently the DTC decided to ban the use of fixed-dose combination (FDC) of ampicillin and cloxacillin in the hospital. But this move has been opposed by some doctors on the basis of information obtained from an MR!

Pharmaceutical companies even organize sports events between teams comprising consultants, medical officers and interns of the area. On the other hand, organizations in Western countries (no free lunches, healthy skepticism etc.) are working towards disentanglement of prescribers from the pharmaceutical industry. Therefore, we feel that organizations with a similar agenda are required in Nepal.

Lacunae observed

Prescribing by brand names is common. The reason for this is supposedly the non-availability of generic drugs. Use of brand names by teachers even during lectures is another indicator of the insidious influence of drug companies. The most notable example is furosemide which seems to have been completely displaced by the name of one of its brands, Lasix. Similar is the case with povidone iodine (Betadine). Phenergan, a brand of promethazine is an example where the brand name is very commonly used, and many doctors seem to have forgotten the generic name.

Another notable incident was finding a writing pad in the DIC with the proprietary name of a drug. When enquired, the answer was "It should not have been there." (Steps have been taken to ensure that promotional materials or materials with brand names of drugs are not displayed in the DIC).

Limiting brands in the hospital pharmacy

The DTC has decided that a maximum of three brands of each product will be available in the hospital pharmacy and if the prescriber prescribes a brand not stocked in the pharmacy, it will be substituted by the brand available. For about 50% of medicines only one brand is available in the pharmacy. Two to three brands are kept for about 35% and 15% of medicines respectively. More than one brand is kept for life-saving medicines and frequently-used medicines. For a drug to be marketed in Nepal, it has to be registered with the Department of Drug Administration (DDA). Nepal is a small market for medicines and all registered medicines may not be available at all times. Furthermore, due to frequent road blockades and the uncertain political situation, supply of medicines may be stopped at any time. It is for these reasons that the pharmacy stocks more than one brand of a particular medicine.

The hospital DTC

The hospital DTC invites the different departments to suggest a maximum of three brands of a particular medicine which they would like to recommend for inclusion in the pharmacy. The list is approved by the DTC before the recommended medicines can be included. The DTC comprises a Member

Secretary (Chief of Pharmaceutical Services), heads of all clinical departments, the Medical Superintendent and the Chief Executive Officer (CEO). The decision-making process is democratic.

Physicians' lack of understanding

It is often very difficult to question the rationality or attitudes of prescribers. When asked about reasons for preferring a particular brand, a medical officer said, "The representative of this company visits us often and gives pens and writing pads, while the other representative rarely turns up. So why to prescribe the brand, whose representative never turns up?"

In many cases there is a lack of understanding of the physician's responsibility in prescribing towards the patient. From the academic session beginning in July 2005 we plan to introduce sessions on the economic aspects of prescribing. We will concentrate on how the cost of medicines prescribed will influence the decision of the patient whether or not to buy the medicine, as well as influence the compliance with treatment in poor developing countries. We are trying to include sessions on "doctor-patient relationship" and "ethical issues" into the curriculum.

A few successes

There have been some successes in getting the rational use of medicines practised in our institution. The DTC has removed the FDC of ampicillin and cloxacillin and products containing phenylpropanolamine from the hospital pharmacy. It is also implementing the practice of prescribing by generic name in the hospital. Auditing of prescriptions is carried out and feedback is provided to prescribers through the DTC, as well as personally. Some of the measures taken have also been highlighted in a recent article.[4]

Inappropriate prescribing habits lead to ineffective and unsafe treatment which may cause distress and harm to the patient and lead to higher costs. Such practices make prescribers vulnerable to patient pressure, unethical behaviour of colleagues and high-powered salesmanship of drug companies. Fresh graduates might emulate them later, thereby creating a vicious circle.[5] Learning proper prescribing habits and developing critical appraisal skills as medical students will be vital in ensuring the proper use of medicines in future practice.

Giri BR, Shankar PR

Affiliations:

Mr Bishnu Rath Giri
(Third year medical student)
Member, Patient Assessment Committee,
Poor Patients Fund,
Manipal College of Medical Sciences.
Pokhara, Nepal.
Dr P.Ravi Shankar, MD
Assistant Professor
Department of Pharmacology,
Manipal College of Medical Sciences.
Pokhara, Nepal.

Address for correspondence:

Dr P.Ravi Shankar
Department of Pharmacology
Manipal College of Medical Sciences
P.O.Box 155
Deep Heights
Pokhara, Nepal.
Phone: 00977-61-523600
Fax: 00977-61-522160
E-mail: pathiyilravi@gmail.com

References

1. Spencer JA, Jordan RK. Learner centred approaches in medical education. Br Med J 1999; 31:1280-1283.
2. Kathmandu University. Curriculum for Bachelor of Medicine and Bachelor of Surgery (MBBS). Part One- Basic Medical Sciences. Third Version, Dhulikhel, Nepal, 2001. Pages 136-139.
3. Shankar PR, Mishra P, Shenoy N, Partha P. Importance of transferable skills in pharmacology. Pharmacy Education 2003; 3:97-101.
4. Mishra P. Rational drug use- A growing concept in Western Nepal. HAI News 2004; 31: 15.
5. Department of Essential Drugs and Medicines Policy. Guide to good prescribing –A practical manual. Why you need this book. WHO/DAP/94.11 Pages 1-3.