Should Physicians be Encouraged to use Generic Names and to Prescribe Generic Drugs?

While using the brand names seems like a trivial issue at the outset, using these names is inherently problematic. Cardiovascular drugs remain the most commonly prescribed drugs by the physicians. The junior doctors are likely to introject practices of their seniors and consequently to reciprocate from the experiences learnt from their preceptors. Using the brand names seems like a trivial issue at the outset, using these names is inherently problematic. Cardiovascular disease represents the most common cause of morbidity and mortality across the globe, and cardiovascular drugs remain the most commonly prescribed drugs by the physicians. The junior doctors are likely to introject practices of their seniors and consequently to reciprocate from the experiences learnt from their preceptors. A recent study showed that the residents at all levels are likely to prescribe the expensive statin medications even when the generic versions are visible. There is also some evidence that junior physicians have higher cost profiles than physicians with greater experience. In 2008, Kesselheim et al showed that despite paucity of evidence that brand drugs are superior to the generic formulations, editorialists frequently raise concerns regarding the efficacy of generic drugs and advocate against the interchangeability. Moreover, the generic names are often difficult to pronounce, especially for the patients which might be a limitation. However, it should be a reasonable expectation from the physicians who have undergone years of training at the medical school and then the residency training to be able to use the generic names of the medications. Herein, we present several arguments to facilitate prescription of the generic drugs.

First, after a specific duration, the drug is also available in the generic formulation. These generic forms are more cost-effective than their branded counter parts. The health care costs of US (2.6 trillion dollars in 2009) are expected to surpass 4.6 trillion dollars by 2020. The policy makers and education experts have increasingly recognized the importance of cost-effectiveness in an era where the health care costs are increasing, and the rate of increase has surpassed the rate of economic growth. The choosing widely campaign has suggested a number of measures that can potentially help curtail some of the costs. American College of Graduate Medical Education included the cost-effectiveness as training milestone in 2012. The Institute of Medicine has also endorsed the recommendations and has emphasized on the need of reducing the health care costs while transitioning to pay for performance model.

Prescribing the generic formulations may ameliorate some costs conferred by the health care. For instance, in 2009, the branded statin medications also accounted for 5.8 billion dollars in terms of costs. Despite this, the residents continue to prescribe the branded versions of the drug. It is logical to extrapolate that the physicians who use the brand names of the drugs are more likely to prescribe them in their clinical practice, which may be associated with increased costs. Second, there is no evidence that the efficacy of branded drugs is superior compared with the generic formulations. A number of clinical trials such as the Comparative Dose Efficacy Study of Atorvastatin Versus Simvasatatin, Pravastatin, Lovastatin, and Fluvastatin in Patients With Hypercholesterolemia (CURVES) and the Measuring Effective Reductions in Cholesterol Using Rosuvastatin therapy (MERCURY) study have shown that the efficacy of the drugs including those with the narrow therapeutic index is similar. This is because generic drugs are approved after the demonstration of bioequivalence, which is demonstrated by showing that the active ingredient of the drug reaches similar plasma concentrations in similar time.

Third, the adherence of the generic drugs may be superior compared with the branded versions. Studies have shown that adherence is associated with improved outcomes and decreased hospitalizations. Similar efficacy, improved adherence and cost-effectiveness means that there is little if any justification for prescribing the branded versions. In a rigorous propensity-matched comparison of 90,111 patients...
on generic versus branded statins, Gagne JJ evaluated the composite clinical end points (defined as aggregate of all-cause mortality and hospitalization for stroke or acute coronary syndrome) between generic versus branded statin formulations. They found an 8% decrease in the risk of the clinical outcomes with the use of generic statin drugs (hazard ratio 0.92, 95% CI 0.86 to 0.99).10

The implementation of pharmacy benefit plans in many health care settings where the generic drugs are automatically substituted is a step in the right direction and needs to be implemented universally.

Finally, in the philosophical sense, we as clinicians are servants of humanity, and our primary role is to ensure the interests of our patients and not of the pharmaceutical industry. Academic institutions should realize that there trainees who are the future practitioners are likely to practice what they have been preached. A study suggested that the post graduate year I (PGY1) residents prescribe brand name statins in a manner that reflects their attending physicians, whereas the senior residents prescribe higher cost drugs regardless of the attending practices.11 This suggests that there is a need to educate across the board. Restricting ourselves to the medical names can also help limit the conflicts of interests the physicians have with the industry. We suggest that the residents as well as the attending physicians should be encouraged to use the medical names of the drugs in the rounds, in medical records, and in discussions with the patients.

Disclosures

The authors have no conflicts of interest to disclose.

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