Dispensing substitution: avoid the impression of therapeutic chaos

Effective treatment is not only pharmacological but also behavioural in its actions. People value the familiar so switching brands of medicines without explanation can adversely affect adherence as patients lose confidence in their treatment.

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There are many arguments in favour of generic prescribing. They may have prompted the Department of Health to consult on the related topic of generic substitution in primary care last year. After this consultation the DoH decided to abandon its plans (P1, 15 October 2010, p457). Yet it raised important questions about dispensing substitutions.

No responsible healthcare professional would normally fail to subscribe to the principles of generic supply where it is clear that a pharmacologically and pharmaceutically identical product is available. Self-evidently, we should provide the cheapest option available. Or should we?

When we select between other more or less identical choices — whether foods in the supermarket or flights for our holidays — it would also be logical always to choose the cheapest. However, we know from a myriad of sources that we do not do this. The cheapest option is not always the one freely chosen.

It is part of human nature not only to be illogical, but to prefer familiarity, and to stick with known patterns. Remember the outcry when Coca-Cola tried to change the shape of its bottle, or (for the more chronologically challenged) when Smiths took the bag of salt out of its crisps?

Some hypothetical examples

Let us look at examples of how this applies to pharmacy.

A raised cholesterol level prompts a patient’s GP to prescribe simvastatin. The local community pharmacy is able to maximise its profit by dispensing simvastatin from company A. Treatment goes well and after a month the patient returns with an identical prescription. But due to the pressures of Category M, the pharmacy now supplies simvastatin from company B.

On returning home the patient discovers a different style of packaging. The generic name of the drug is much less prominent, and the tablets themselves are different in colour and shape. Understandably he is perplexed. He therefore stops taking his medicine for several weeks until he returns to the pharmacy. Although the two products were bioequivalent in the regulatory sense, they failed in their equivalence for the patient.

Secondly, consider a schoolteacher with ulcerative colitis who has taken mesalazine for many years. She knows her normal pack (mesalazine A), its trade name and the size and shape of the tablets. She presents with a generic prescription for mesalazine 400mg at her local pharmacy. It dispenses mesalazine B. The patient objects, but accepts it when faced with the alternative of an inconvenient trip to another pharmacy (which might yield the same result).

Unfortunately, two weeks after starting mesalazine B the colitis relapses for the first time in two years and hospital treatment is needed. Her interpretation of this event is to blame the change in therapy. Biologically it is more likely that this was a spontaneous relapse unrelated to the drug change, but the patient’s confidence in her medication and in her pharmacist has been shaken. The idea of going back onto mesalazine B is unacceptable to her. She feels uncertain, confused and less motivated to continue with maintenance treatment.

These are situations that many pharmacists have experienced. It is now the case in some hospitals that only certain brands of medicines are stocked (despite sometimes being more expensive) to aid patient adherence and to reduce dispensing errors. Perhaps such policies should be considered in the community?

More than bioequivalence

In both scenarios the problems have little to do with issues of pharmacological and pharmaceutical bioequivalence, but a great deal to do with patient concerns related to presentation consistency. People value the security of the familiar. Our current approaches to generic prescribing and associated dispensing introduce opportunities for this to be lost and for adherence to suffer accordingly.

The argument for generic prescribing is clear if there are no hidden costs from using one alternative against another. There is also a case for the different but related practice of generic substitution, ie, the dispensing of a lower cost generic in place of a prescribed brand, as and when the products concerned are genuinely identical. However, difficulties can occur if the options are not perceived to be identical by the recipient.

Effective treatment is not only pharmacological but also behavioural in its actions. Substitution of pharmacologically and pharmaceutically identical products may not be considered a neutral event by patients, particularly if they have not been informed of the switch. There is some evidence that switching treatments without a patient’s consent can reduce adherence.1 This can reduce confidence in the prescriber and prescription, as can formulation changes that are not fully explained.3

Pharmacists are almost always the final arbiters of specific dispensing substitutions. At a minimum they are obliged to provide appropriate information and explanations addressing any concerns, and facilitate informed consent and optimal adherence. At best they should arguably be primarily concerned with the overall well-being of the person being treated rather than the narrowly defined technical appropriateness of the pill being given.

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References

