

Rational Drug use and Essential Drug Concepts

Akbar Waheed

Rational drug therapy is defined as “administration of the right drug indicated for the disease, in right dose through an appropriate route for a right duration” following are the reasons for irrational use of drugs:^{1,2,3,4,5,6}

- Lack of information about drugs
- faulty training of medical graduates
- Absence of role models
- Lack of diagnostic facilities
- Demand from patient – prompt and quick
- Patient load
- Promotional activities of drug companies
- Exaggerated claims by drug companies
- Lack of patient doctor communication
- Ineffective rules and regulations

There are so many hazards of irrational use of drugs, some of these hazards are given below:^{7,8,9}

- Ineffective and unsafe treatment
- Over treatment
- Under treatment
- Prolongation of ailment
- Loss of patient doctor confidence

Following are examples of some common types of irrational uses:

Type I Drug	Type II Drug used for same ⁸
Chlorpheniramine Paisa = 00.05	Terfenadine Rs = 08.00
Nalidixic Acid Rs = 02.32	Norfloxacin Rs = 11.00
Bandrofluzaide Paisa = 00.12	Indapamide Rs = 03.00
Cimetidin Rs = 06.05	Ranitidine Rs = 10.50
Aspirin Paisa = 00.05	Piroxicam Rs = 03.75
Diazepam Paisa = 00.20	Bromazepam Rs = 02.07

Some general principles for rational prescribing are^{6,7,8,10}

- Need for drug therapy

Correspondence:

Prof. Akbar Waheed

HOD Pharmacology

Islamic International Medical College

Riphah International University, Islamabad

E-mail: akbar.waheed@riphah.edu.pk

Received: Sept 18, 2016; Accepted: Sept 20, 2016

- Choice of drug:
 - Efficacy of drug
 - Safety of drug
- Cost effectiveness
- Mono drug therapy
- Drug combinations (only if essential e.g chemotherapy of cancer T.B. etc)
- Dose of the drug (optimum doses should be used)
- Dosage form/route of administration (parenteral route should only be used when required and in emergencies)
- Duration of therapy (not so long and not too short)
- Patient's compliance

Following are some suggestion for developing national strategies for promoting rational use of drugs.^{11,12,13,14}

- EBM guidelines to be developed
- Essential drug lists / treatment of choice should be published by MoH.
- Auditing of prescription by drug and therapeutic committees of MoH.
- Subject should be taught at UG level at medical colleges
- Continuing medical education (CME) for doctors.
- Public education through family physicians / PMDC/medical institutes.
- Avoidance of perverse financial incentives by drug marketing companies.
- Appropriate and strict drug regulations by MoH.

Doctor's participation should be a pre requisite for changes in behaviour of irrational Prescribing and the objectives should be:

- To identify factors which hinder rational drug therapy
- To foster the concept of essential drugs in order to reduce the cost of health care delivery
- To tailor prescribing to the needs of individual patients
- They should know the advantages of an essential drug list, such as cost effectiveness control, management, purchase, storage and distribution
- Factor responsible for irrational therapy with

reference to patients such as his socioeconomic status, social taboos and beliefs, simultaneous treatment form different systems of medicine.

- Prescribing irrational drug combinations & formulation by physicians.

There is a need to find remedial measures to overcome irrationality at various levels that what is the reason for the popularity of certain drugs or combined products which are irrational & expensive, & to find out/suggest measures to curb their unethical promotion. Remedial measures suggested include:^{14,15}

- Patient education.
- Improvement in diagnostic facilities.
- Making essential drugs readily available at all times.
- Continued medical educations of physicians/ monitoring and feedback from prescription data
- Training at undergraduate and graduate level

The public should be educated about the harmful effects of drugs, especially of self-medication. Patient education is the responsibility of the prescriber/members of health team. Patient should be explained about the drug prescribed, dose, and duration of therapy, possible side effects, implications of missing dose/ or discontinuation of therapy.¹⁶ Emphasis is needed on preventive aspects of health rather than curatives one.

Some reasons for use of irrational drugs include:¹⁴

- Easy availability without prescription
- Ignorance of harmful effects.
- Misleading advertisements.
- Attractive incentives for marketing / prescribing.

Advertisement for a drug influence young doctor a lot, some prescribers will look to advertisements for science on which to base their choice and marketers will provide it. The most important step in preserving the profession's integrity is to explain at undergraduate/postgraduate levels how marketing works.

Doctors themselves can be taught to look at advertisement critically.^{4,5}

Conclusion:

The profession needs to be alert not subverted.

REFERENCES

1. Barnett A, Creese AL, Ayivor ECK. The economics of pharmaceutical policies in Ghana. *Int J Health Serv.* 1980; 10: 479-99.
2. Victora CG, Facchini LA, Grassi Filho M. Drug usage in Southern Brazilian Hospitals. *Trop Doctor.* 1982; 12: 231-5.
3. Hogerzeil HV. The use of essential drugs in rural Ghana. *Int J Health Serv.* 1986; 16: 425-39.
4. Isenalumhe AE, Oviawe O. Polypharmacy: Its cost burden and barrier to medical care in a drug oriented health care system. *Int J Health Serv* 1988; 18: 335-42.
5. Angunawela II, Tomson GB. Drug prescribing patterns: a study of four institutions in Sri Lanka. *Int J Clin Pharmac Ther Tox.* 1988; 26: 69-74.
6. Goodburn E, Mattosinho S, Monge P, Waterston T. Cost benefit of self prescribing. *Lancet.* 1989; 2: 281.
7. Weedle PB, Poston JW, Parish PA. Drug prescribing in residential homes for elderly people in the United Kingdom. *DICP.* 1990; 24: 533-36.
8. Maitai CK, Watkins WM. A survey of outpatient prescriptions prescribed in Kenyatta national hospital. *East Afr Med J.* 1980; 58: 641-5.
9. Chennabuthni CS, Brown DJ. Prescribing patterns in Seychelles. *Trop doctor.* 1982; 12: 228-30.
10. Palombo FB, Knapp DA, Brandon BM, Knapp DE, Solomon DK, Klein IS, Shah RK. Detecting prescribing problems through drug usage review: a case study. *AM H Hosp Pharm.* 1977; 34: 152.
11. Maki DG, Schuna AA. A study of antimicrobial misuse in a university hospital. *AM J Med Soc.* 1978; 275: 271-82.
12. Oviawe O, Okonokhua I, Isenalumhe A. Prescriber performance in a pediatric general practice clinic of a university teaching hospital. *W Afr J Med* 1989; 8: 130-4.
13. Parkinson R, Wait C, Welland C, Vost DA. Cost analysis of minor ailments in rural Swaziland. *Trop doctor.* 1983; 13: 38-40.
14. Speight ANP. Cost effectiveness and drug therapy. *Trop Doctor.* 1975; 5: 89-92.
15. Yudkin JS. The economics of pharmaceutical supply in Tanzania. *Int J Health Serv.* 1980; 10: 455-77.
16. Glucksberg H, Singer J. The multinational drug companies in Zaire: their adverse effect on cost and availability of essential drugs. *Int J Health Serv.* 1982; 12: 381-7.