On generic prescriptions and live surgeries

Indian healthcare is currently engulfed by two major issues.\cite{1,2} One relates to drug prices and the government’s advice to doctors to use generic drug names in their prescriptions. The second relates to live workshops that occur during medical conferences and the perception that these are simply paid advertisements for device manufacturers. Social, and unsocial, media is agog with messages and memes from indignant doctors, offended by this encroachment on their freedom and doubts on their integrity. Unfortunately, people see only the doctor as the public face of this profession and in an environment where every advice is suspected to be financially motivated, he ends up being considered the culprit even if the beneficiary is someone else.

It is a matter of fact that many drug prices in India are heavily marked-up.\cite{3} Drugs are often sold to retailers at a fraction of their marked price (maximum retail price [MRP]) and it is left to the retailers to offer “discounts” to patients at their whim. The mark-up exists because the user (prescribing physician) is not the payer (patient). This is a unique situation, totally unlike other goods where the user is the payer and thus in a position to demand the best price. Once the manufacturer convinces the physician of the quality, he has to entice only the seller, usually with a high profit margin. The payer, patient, plays no role. The situation becomes worse when it comes to in-hospital patients where the hospital not only charges the MRP but adds a “handling cost.” What possibly takes the cake is charging two patients a 300% markup while reusing a single-use device.\cite{4}

As a consumer, one would be appalled with the above facts. Making a profit is a right but exploitation is not. Declaring a charge for a service is perfectly valid but surreptitious up-marking is not. The ideal solution to this problem would be full disclosure of who is making how much profit and letting the patient drive the prices. This is unlikely to happen and, even if it did, a patient is unlikely to be in a position to choose among five brands.

Physicians, then, must make an attempt to empower patients. An important step would be forcing manufacturers to print rational MRPs, minimizing the leeway available to retailers. While promoting their brands, pharmaceutical companies often claim a selling price lower than the MRP if the patient is referred directly to them. This creates captive customers with no choice. Instead, sales representatives should be asked to state only the MRP and be forced to compare with competitors only on the printed price.

While the advice to prescribe drugs with generic names alone may be grounded in good faith, it has the potential of causing harm to patients. Generic drugs are manufactured by dozens to companies and it is an accepted fact that quality varies heavily among manufacturers in India. Generic drugs often cost a fraction of their MRPs and leaving it to the retailer to sell one that gives them maximum profit can be disastrous. However, physicians can empower patients by providing them a choice by writing generic names of drugs in addition to a brand in which they have faith. With the large population of uneducated patients, unscrupulous dealers will still profiteer but at least some patients will make a proactive decision. Further, they will hopefully realize that the physician is not the one who is making the profit.

The second conundrum is of live operative workshops. Such workshops are immensely popular not just with sponsors but also with attendees. Apart from showcasing technology, live surgeries provide an opportunity to learn techniques that are difficult to explain through books. It is also argued that patients benefit from the free devices and availability of expert surgeons.

However, while the stated objective of such workshops is to “teach,” many turn out to be demonstrations of surgeon, device, or institutional capabilities. This change from teaching, with its inherent questioning of indications and acceptance of complications, to demonstrations that brook no fault, adds to surgeon stress and can influence surgical outcomes. It is also an important cause for selection of sub-optimal patients. Despite published papers that attest to safety of live surgeries, the atmosphere in workshops may not be ideal.\cite{5,6} There is pressure on the surgeon to show the “best” surgery, coupled with an unfamiliar environment.

Demonstration is an important method of teaching surgery, and while unedited videos with live discussion may be a good method, it is not popular. If the primary objective is to “teach,” it should be possible to demonstrate surgery without commercial pressures. Selection of the patient, surgeon, procedure, and technology should be based on merit without influence of a sponsor. The presence of a patient advocate within the operating room while surgery is performed in the surgeon’s own institution, along with audit and reporting of outcomes are added steps that help provide patient safety.\cite{7}
Determining the ideal solution to both these problems is not easy. Until we develop a strong system of accountability, we are unlikely to find an efficacious answer. However, an analysis of the cause for uproar should allow us to play a proactive role in finding a solution instead of assuming the role of a victim. The only loser currently is the patient and each one of us runs a risk of playing that role at some point in the future.

**Rajeev Kumar***
Editor, Indian Journal of Urology,
All India Institute of Medical Sciences, New Delhi, India
'E-mail: editor@indianjurol.com

**REFERENCES**

1. Nagarajani R. National Pharmaceutical Pricing Authority Slashes Stent Prices by up to 85%. Available from: http://www.timesofindia.indiatimes.com/india/stent‑prices‑slashed‑by‑up‑to‑85/articleshow/57136127.cms. [Last accessed on 2017 Apr 28].
2. Nagarajani R. Doctors Turn Sales Representatives in Live Surgery Telecasts. Available from: http://www.timesofindia.indiatimes.com/india/doctors‑turn‑sales‑representatives‑in‑live‑surgery‑telecasts/articleshow/58201115.cms. [Last accessed on 2017 Apr 28].
3. 500% Profit Margins on Drugs: Study. Available from: http://www.archive.indianexpress.com/news/500‑profit‑margins‑on‑drugs‑study/978062/. [Last accessed on 2017 Apr 28].
4. 3 Hospitals Recycled One-use Angio Medical Devices, Finds FDA. Available from: http://www.timesofindia.indiatimes.com/city/mumbai/3‑hospitals‑recycled‑one‑use‑angio‑medical‑devices‑finds‑fda/articleshow/58389889.cms. [Last accessed on 2017 Apr 28].
5. Eliyahu S, Roguin A, Kerner A, Boulou M, Lorber A, Halabi M, et al. Patient safety and outcomes from live case demonstrations of interventional cardiology procedures. JACC Cardiovasc Interv 2012;5:215-24.
6. Mullins JK, Borofsky MS, Alal ME, Bhayani S, Kaouk JH, Rogers CG, et al. Live robotic surgery: Are outcomes compromised? Urology 2012;80:602-7.
7. Artibani W, Ficarra V, Challacombe BJ, Abbou CC, Bedke J, Boscolo-Berto R, et al. EAU policy on live surgery events. Eur Urol 2014;66:87-97.

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the publisher is credited and the new creations are licensed under the identical terms.

Financial support and sponsorship: Nil.

Conflicts of interest: There are no conflicts of interest.

© 2017 Indian Journal of Urology | Published by Wolters Kluwer - Medknow