Branded versus generic drug use in chronic disease management in Hong Kong

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To the Editor—The study by Lee et al[1] increases our understanding of people's knowledge and acceptance of generic drugs. Several points warrant further discussion.

Public doctors, unlike those in the private sector, generally have little knowledge of the drug source. A choice of brands is rare. For example, the Clinical Management System of the Hospital Authority commonly uses the original brand name as an alias for a drug because these are better remembered. The final drug dispensed will depend on stock availability. On-screen support at the prescribing page may better inform doctors. Since the patient pays only according to the duration of use, it is not justifiable to routinely ask the patient's consent when selecting a generic versus a branded medicine.

Relatively poor public knowledge about generic drugs might not be due to lower local literacy as Lee et al suggest.[1] The adult literacy (primary education and above) rate in Hong Kong is quite good: 96% in 2015 and 2016.[2] This is similar to that in the current study (96.4%).[1] Japan implemented a generic drug policy in 2002. Patients pay less and their doctors and pharmacists are given financial incentives to use generic drugs. Hence, unsurprisingly, Japanese are more knowledgeable about generic drugs. A choice of branded and generic drugs has been explicit on the prescription since 2006.[3,4] In contrast, Hong Kong has no policy or public information. On the consumer webpages of the Drug Office of the Department of Health, under "General Knowledge on the Use of Medicines", generic drugs are not mentioned.[5] The public would benefit from official views.

Health literacy on drugs can be improved by official healthcare programmes and by encouraging the public to read medical news, drug labels and to search official websites. Nevertheless individual counselling by healthcare professionals is essential. There are barriers for both healthcare professionals and patients but they should nonetheless become familiar with both the trade and generic names of prescribed drugs. A patient's proficiency in English may be an advantage because most doctors know the English names of drugs but are not routinely taught the Chinese names. The Cantonese or Putonghua pronunciations are particularly challenging. The two local medical schools play a pivotal role in preparing new doctors in this regard.

Author contributions

The author had full access to the data, contributed to the study, approved the final version for publication, and takes responsibility for its accuracy and integrity.

Conflicts of interest

The author has disclosed no conflicts of interest.

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Authors' reply

To the Editor—In our recently published study, we evaluated the understanding of generic substitution among healthcare professionals (HCPs) and members of the general public in Hong Kong. Our findings showed that the knowledge and perception of generic substitution among the general public and HCPs remain low. We thank Dr Poon for his comments and respond to each point raised.

Public versus private health care system

We agree and acknowledge the point raised by Dr Poon about the awareness of HCPs in the Hospital

Authority (HA) compared with private physicians who run their own clinic about drug source. Kumar et al[1] have shown that most physicians at private hospitals in Malaysia have a negative perception of generic drugs with consequent limited use in the private sector. Public physicians have limited knowledge about or influence on the final drug dispensed. The drug formulary in each HA hospital is developed and overseen by various internal committees including the drug management committee (DMC), drug advisory committee (DAC), and drug formulary committee (DFC).[2] The role of the DMC is to oversee the overall drug management of the HA whereas that of the DAC is to review new drugs and new indications for the HA drug formulary. Finally, the DFC reviews the existing drug lists to remove obsolete drugs and evaluate the indications for special drugs when necessary.[2] The members of these three committees may include the chairman of the cluster service and the chief pharmacist of the HA, the Chief Nursing Manager, and two academics in healthcare-related disciplines from local universities.[1] They are responsible for the centralised decision process for the drug formulary. We agree that we should better inform our HCPs about the choice of drugs available in the HA. In addition, we advise patients whether the drugs they are taking are a generic or branded product by appropriate labelling. Patients should be reminded to record any potential adverse drug reactions (ADRs)/side-effects or alert their physician if they feel unwell if any of their medications are switched.

Understandably, routinely obtaining patient consent could be challenging in the public sector, given the current workload of the HA and the funding of the healthcare system. Nonetheless with advances in technology and a higher level of education and awareness of the general public, it is not surprising that patients are increasingly aware of their health conditions and may be confused by generic substitution. To avoid any potential conflict among patients and HCPs, public and professional education to enable an understanding of drug quality as well as bioavailability and bioequivalence should not be delayed.

Education of the general public and professionals

Undeniably, the adult literacy rate in Hong Kong has been improving but this may not apply to the existing elderly population. More than one-fifth of the current elderly did not attend primary school according to a report published in 2016.[3] It may therefore be difficult for them to fully understand the concept of generic substitution and the need to alert HCPs about any potential ADRs. Our findings are in line with other published studies. In Malaysia, less than one-third of Malaysian consumers were aware of generic medicines.[4] In India, over 60% of patients did not know the difference between branded and generic drugs.[5]

It was clearly emphasised by Dr Poon the need to train future doctors and other HCPs in health literacy on drugs as well as their trade and generic names. In the local pharmacy curriculum, we generally use generic names. We usually include the trade names in the supplementary information. Similar to Hong Kong, Australian pharmacology students may lack an in-depth understanding of generic medicines and need further teaching about the quality and safety of generic medicines versus branded products.[6] In Ireland, general practitioners showed a lack of knowledge and problems with perception of generic medicines.[7]

Conclusions

The knowledge and perception of generic medicines remains low in many countries including Hong Kong. Prescribing behaviour with regard to generic drugs may vary between different sectors (public vs private) of the healthcare system. Education of both the general public and HCPs as well as HCP trainees is crucial to enable a better understanding of generic versus branded drug use.

Author contributions

Concept and design: VWY Lee.
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Interpretation of data and drafting the manuscript: FWT Cheng.
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Ketamine analogues multiplying in Hong Kong

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To the Editor—New psychoactive substances are increasingly seen in Hong Kong. We have previously reported an outbreak affecting 52 patients involving a ketamine analogue, 2-oxo-PCE, which is much more potent than ketamine and caused more severe clinical adverse effects.[1,2] We report the recent identification of two other ketamine analogues, 2-fluoro-deschloroketamine [2-(2-fluorophenyl)-2-methylamino-cyclohexanone] and deschloro-ketamine (2-phenyl-2-methylamino-cyclohexanone), in urine samples of two unrelated ketamine abusers.

The 2-fluoro-deschloroketamine was first synthesised in 2014 as a ketamine derivative.[3] To date, there have been no case reports of its abuse or poisoning in the scientific literature. Deschloroketamine was first described in 1962 and its recreational use was first reported in 2015.[4] Both drugs belong to the arylcyclohexylamine class which is known to possess antagonist activity at the N-methyl-d-aspartate receptor.[5] User reports on internet forums showed that 2-fluoro-deschloroketamine has a similar potency as ketamine, whereas deschloroketamine is more potent than ketamine. These two drugs are not detected by common urine toxicology screening methods.

Frontline clinicians should be aware of patients with suspected ketamine abuse but with negative urine immunoassay and toxicology results. In point of fact, the kind of new psychoactive substances greatly outnumbers traditional drugs of abuse nowadays.[4] Poisoned patients or drug abusers may present with unfamiliar clinical toxidromes. Traditional toxicology analyses usually cannot determine the true nature of such new psychoactive substances. Analysis of these substances is available in our laboratory and can be requested by clinicians in Hong Kong.

Author contributions

C Li, MHY Tang, YK Chong, and TWL Mak drafted the manuscript. All authors contributed substantially to the concept or design or the study, acquisition of data, analysis or interpretation of the data, and critical revision of the manuscript for important intellectual content. All authors had full access to the data, contributed to the study, approved the final version for publication, and take responsibility for its accuracy and integrity.

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