

Not the time to be defending territory

From Dr B. P. Curwain,
MRPharmS

Just before my recent two-week holiday, I agreed to speak at an open meeting arranged by a large local pharmaceutical committee. Being an enthusiastic and conscientious pharmacist, I spent some time in the sun, thinking about this, making notes and generally preparing what was to be an upbeat and positive presentation on the future for, in particular, community pharmacy.

The day was scheduled for a date soon after my return from leave on 7 October. Imagine my surprise to receive a message as soon as I arrived back in the United Kingdom to say that the LPC in question had decided to cancel the open day at short notice.

The day had been intended to provide a forum where community pharmacists and their representatives could get together with senior local primary care trust personnel (chief executives, directors, pharmacists etc), many of whom had, I understand, accepted invitations to attend.

Its cancellation can only send out negative messages about the willingness of the LPC fully to engage itself with the changing National Health Service. I do understand that community pharmacy is presently faced with an almost bewildering degree of uncertainty. There is the new national contract, LPS, the Office of Fair Trading report on control of entry, the projected upgrading of technicians and associated skill-mix issues, and so on. However, this is not the time to be battenning down the hatches and defending territory. It is a time to be engaging with as many NHS partners as possible and discussing our future with them.

In fact, there are great opportunities for community pharmacy but it is also a time of danger as well as uncertainty. If we do not find a way to offer what the NHS now wants and needs from us, then rest assured that our political masters will find ways of making things happen without us. I would hate to see us lose the invaluable network of community pharmacies that now serves the population, but if we

are not prepared to make the changes required of us, then the technology is there to allow this to happen, aided and abetted by the development of ancillary staff able to conduct dispensing in our absence. As well as central negotiations by the statutory bodies, let us please have plenty of local dialogue as well.

Brian Curwain
Chief Pharmacist
New Forest Primary Care Trust

PRESCRIPTIONS

ETP must offer benefits to patients

From Mr M. Strange

In the report entitled "Driver for ETP may be cost savings rather than patient convenience" (*PJ*, 28 September, p455), Ian Shepherd states that only two of the electronic transmission of prescriptions (ETP) pilots currently taking place offer patients freedom to choose their pharmacy up to the point of dispensing and that the others "required selection of the pharmacy before or as the prescription was written". He also observes that the technology used should not "fundamentally force change to the patient's behaviour", and that patients should not be locked into a particular mechanism.

Any analysis of the current processes shows that the basic mechanism, where a prescription is printed, given to the patient, taken by the patient to the phar-

macy of their choice, and dispensed, has long been supplemented by "prescription collection services". A patient requests that their repeat prescriptions are routinely printed and supplied to the pharmacy of their choice, where they are dispensed and held for the patient to collect. No one suggests that this is patient registration, yet Mr Shepherd raises the prospect that patient registration is integral to some ETP models.

Mr Shepherd seeks to defend patient choice, yet ignores these collection services, that are increasingly popular because they offer benefits to all concerned, including patients. Indeed it is our position that the TransScript model seeks to increase patient choice by removing some of the logistical restrictions of the current collection services, which are inevitably limited by how far pharmacists/pharmacy staff can travel to collect prescriptions. Our approach will allow patients to have their prescriptions sent to any pharmacy convenient to their home, place of work, etc.

Some ETP models continue to require the printing of a token containing the prescription details, which has to be taken by the patient from the general practitioner to the pharmacy, and requires a transaction with a central database to post the prescription details electronically into the pharmacy system (details already available to the pharmacist on the token). We see no efficiency gains in that. At the same time, this will in itself impose changes on patients and indeed, merely lock them into an alternative mechanism.

Although we agree that ETP should not impose major changes on patients, it must offer them discernible benefits, which is why the TransScript model seeks to reduce the number of visits patients make to their surgery and pharmacy, while extending current levels of choice regarding where their medicines are dispensed. Taking a paper token to the pharmacy and waiting (or leaving and returning later) while the pharmacist downloads and dispenses the prescription appears to offer no additional patient benefits.

Martin Strange
Operations Director
TransScript

PATIENT PACKS

Scrap patient packs forthwith

From Mr S. F. Courtney,
MRPharmS

As a frequent visitor to a local zoo, I notice that every cage and enclosure carries a notice exhorting us not to buy over-packaged goods and gives some amazing figures on the global impact of over-packaging. Most of the environmental agencies make similar statements and the subject was raised at some length in the recent earth summit in South Africa.

I suggest that pharmacy, as a responsible profession, should take a lead and make the gesture of scrapping patient packs forthwith. The savings of paper, cardboard, metal foil, labels and the necessity to use much larger bags would be considerable.

All tablets, with a few exceptions, should be supplied in containers of 100, 500 or 1,000 and the patient should be given the exact quantity that the prescriber orders. No more "shall we give 28 or 30?", no more "is it a calendar pack or not?". Smaller bottles, smaller bags, fewer labels, no more snipping and no more boxes of jagged odds and ends and, above all, continuity of brand for the patient.

As a spin-off from this initiative all the scissors made redundant could be collected and given to third world countries where I am sure they would be a boon.

Stuart Courtney
Wickham,
Hampshire

ADVICE FOR CORRESPONDENTS

Letters for publication can be posted, faxed, or sent by e-mail to letters@pbarmj.org.uk and should not normally be of more than 400 words. The Journal reserves the right to abridge letters and to edit them for clarity and style. Pharmacist correspondents should supply their membership numbers and a contact telephone number should always be given. Women correspondents should specify a preferred title otherwise "Ms" will be used.

Letters are accepted for publication on the understanding that they have not appeared anywhere, including electronic media, previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform The Journal at the time.

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication will usually be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

Trying to appease race-relations lobby

From Mr D. K. Rayner,
MRPharmS

I echo recent letters from Annie Elliott and Ashok Patel on the Society's census. Several points come to mind — in particular the "ethnic" question appearing in second position in the census — placing it in importance above current work position and area of practice.

Refreshing my mind on the definition of "ethnic" I referred to my dictionary and thesaurus: pertaining to race, originating from a specific racial, linguistic group (connected by common descent, posterity, house, family, tribe or nation). Clearly a wide-ranging definition but one which would include the respected Jewish fraternity (person of Hebrew descent) — absent from census definitions.

I also considered "origin" in the context of "ethnic" and came to the conclusion that one's parents were not capable of being considered an origin except subjectively. Ethnic origins must, therefore, be taken as far back as possible, in any way to qualify as original. In my case, born with totally white hair and blue eyes would indicate a probable Scandinavian origin. Likewise my surname was, until the 14th century, a Christian name, still found as such in Germany in the form Reiner. If I am to state my ethnic origin accurately, it is most likely Scandinavian, but of German descent, down the paternal line.

Similarly my distant cousin, with army parents, was born in Singapore. Six months later and she would have been born in Chester. So much for origins if only taken back one generation.

As others commented at the time of the National Census, crystallised definitions can become arrant nonsense. Clearly, therefore, if the evidence on which our Society is to spend money, time and research is a nonsense, then so will the outcome be a nonsense.

I am totally unconvinced by the utterances of the pharmacy practice research department, that the Society is a quasi public body in terms of the Race Relations Acts.

I checked with my general practitioner daughter and she has never been asked such ethnic origin questions by her own professional bodies, the British Medical Association and the General Medical Council.

There is every indication that the Society is charging with ill-considered momentum down a pathway designed solely to appease the race-relations lobby but where the only likely outcome is more and more evidence-gathering and even greater future political correctness and potential divisiveness.

I too treat this census question with the contempt which it deserves.

David K. Rayner
Bradford

CHF

Confusion over use of digoxin

From Mrs D. Webbe, MRPharmS

With reference to the continuing professional development article "Chronic heart failure" (*PJ*, 7 September, pp325-7), I have been left with some confusion surrounding the use of digoxin in patients with CHF and normal sinus rhythm.

I understand that Mark Kearney, who wrote the above article in collaboration with Helen Williams, was also a co-author of a research letter previously published in *The Lancet*,¹ in which he alerted clinicians on the routine use of digoxin in CHF due to increased mortality associated with its use. This was substantiated by the results of two studies, the UK-HEART and the AIRE study,¹ which both demonstrated that digoxin use was an independent predictor of mortality and adverse prognosis in CHF. The *PJ* article seems, however, to suggest that digoxin may still be considered for patients remaining symptomatic despite optimised doses of diuretics, angiotensin-converting enzyme inhibitors, beta-blockers and spironolactone.

In view of that, please would the author(s) answer the following questions:

1 Is it really worth giving digoxin to multidrug-resistant CHF patients with sinus rhythm (who presumably are

already very ill), given its overall adverse effect on mortality?

2 Before recommending its use with the associated potential hazards in such clinical settings, should we not first look for some evidence-based results?

Daniela Webbe
Benfleet, Essex

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1. Lindsay SJ, Kearney MT, Prescott RJ, Fox KA, Nolan J. Digoxin and mortality in chronic heart failure. UK Heart Investigation. *Lancet* 1999;354:1003.

MARK KEARNEY and HELEN WILLIAMS reply: Thank you for your interest in our article. The two articles that you refer to^{1,2} were retrospective analyses of studies not specifically designed to explore the mortality benefit of digoxin in patients with chronic heart failure. This has been done prospectively in the Digitalis Investigation Group (DIG) study,³ which in over 6,000 patients with chronic heart failure demonstrated a mortality neutral effect of digoxin. The DIG study monitored patients on digoxin closely and articles 1 and 2 serve to illustrate the importance of this.

We still advocate the use of digoxin in patients with chronic heart failure in sinus rhythm. However, as evidence for the use of beta-adrenoceptor blockade and spironolactone in addition to angiotensin-converting enzyme inhibitors emerges, digoxin naturally falls down the therapeutic hierarchy for patients with chronic heart failure. Despite this, in symptomatic patients on maximal therapy we support the use of digoxin with careful monitoring of renal function and plasma digoxin levels.

The DIG study demonstrated improvements in morbidity which are important to the quality of patients' lives, a very important point in patients with a prognosis worse than some soft tissue tumours.⁴

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1. Lindsay SJ, Kearney MT, Prescott RJ, Fox KA, Nolan J. Digoxin and mortality in chronic heart failure. UK Heart Investigation. *Lancet* 1999;354:1003.
2. Spargias KS, Hall AS, Ball

SG. Safety concerns about digoxin after acute myocardial infarction. *Lancet*. 1999; 354:391-2.

3. The Digitalis Investigation Group. The effect of digoxin on mortality and morbidity in patients with heart failure. *N Eng J Med* 1997;336: 525-33.

4. Stewart S, MacIntyre K, Hole DJ, Capewell S, McMurray JJ. More "malignant" than cancer? Five-year survival following a first admission for heart failure. *Eur J Heart Fail*. 2001;3: 315-22.

MODERNISATION

Disappointed by lack of consultation

From Ms E. Doran, on behalf of the executive of the British Pharmaceutical Students' Association

Since many of the United Kingdom's 8,000 pharmacy students return to university this month, we believe the time is right to comment on the ongoing modernisation debate. As the branch of the Society that represents pharmacy students, we are certain that changes proposed now will affect our members for the whole of their working lives.

The British Pharmaceutical Students' Association continues to support the dual role of the Society and we appreciate that, as it stands, the Society is close to the Government's vision of a health care professional body. It is important that this fact is not lost in the midst of the debate.

We do not believe that anyone in the profession should be against substantial lay input with regards to public safety, however, we are disappointed by the apparent lack of meaningful consultation with the wider membership. The BPSA will support any sensible model which upholds the interests of its members, the public and the profession as a whole. We believe this means a proposal that includes the fundamental principles of:

1 Maintaining both regulatory and representational roles, but if necessary having the ability to oppose Government policies that affect non-regulatory issues

- 1 Accountability to members for the services and functions provided
- 1 An increased lay input into the governing of the profession, but at a lesser proportion than that proposed by the modernisation steering group

We look forward to the membership deciding on which proposal they support and which they believe will genuinely take pharmacy forwards.

Elizabeth Doran
Public Relations Officer
British Pharmaceutical Students'
Association

ANTIBIOTICS

Volume for reconstitution should be clear

From Mr C. P. Caplan,
MRPharmS

Back in the early 1970s I campaigned with various manufacturers to make more clear the volume of purified water to be

added to the various powdered antibiotic suspensions.

The late Stan Hazard, our local representative from Abbott Laboratories, persuaded his bosses of the importance of helping pharmacists by displaying, in clear, large print, the volume of water to be added — congratulations to Abbott for continuing this excellent service to pharmacists.

It is a shame there are those who do not see the importance of assisting pharmacists at the point of reconstitution of these medicines. Volumes vary significantly, as we all know, yet the size of the labelling appears to be getting smaller — or is it my age?

One of your reports from the British Pharmaceutical Conference (*PJ*, 28 September, p447) had the headline “Patient safety is our *raison d'être*”, and quoted Dr Jim Smith, chief pharmacist in England, as saying: “discrepancies happen far too frequently

and we must minimise them”. So how about it then?

C. Caplan
Leeds

SOCIOLOGY

Not relevant to pharmacy

From Mr J. H. Morgan,
MRPharmS

I have just read the article “The social context of pharmacy” (*PJ*, 21 September, pp395–7). I consider myself to be reasonably intelligent, but I found it to be completely incomprehensible and of no relevance to pharmacy in general. These types of articles are the main reason that the average pharmacist never reads the *PJ*. The language would only be understandable to someone with a degree in sociology (an irrelevant science at the best of times). I would be interested to know what they were trying to convey.

J. H. Morgan
Cardiff

E-MAIL

E-mail correspondents are asked to give a postal address or membership number.

Front cover more suitable for Saga

From Ms L. M. Godfrey,
MRPharmS

We were told some time ago that the cover of the *PJ* would in future project a new “professional” image to reflect the nature of the Society. The covers lately are more suitable for Saga. The latest one (28 September) would be a good advertisement for a family holiday with Kuoni. Am I missing the point?

Lois Godfrey
London N8

Although we attempt to produce covers of a high quality, to claim that this is what we do every week would leave us with egg on our faces. The covers do aim, however, to reflect what is happening in the profession, ie, they are news driven, and the latest one was to mark the British Pharmaceutical Conference this year “The generation game: creating a healthy future”. — EDITOR.