LOCUM PHARMACY

Supply and demand cannot be the only determinant

From Mr H. P. S. Khara, MRPharmS

As a locum, I would like to say in response to your news feature on how much a locum is worth (*PJ*, 30 November, p773) that the majority of agents and locums have worked hard to relieve the pressures of the fallow year shortfall, and been of invaluable worth to managers, contractors and the public.

Flexibility, variation and independence, rather than financial gain, are probably the main reasons more pharmacists are deciding to work as locums. The experiences gained from working in over 40 different shops this year are incalculable. Employers benefit in that there is no National Insurance to pay, no obligation to pay sick or holiday pay, pension or redundancy pay. For the locum there is a risk of not finding work or being unable to work, having sometimes to travel at short notice. Being a locum is not for everyone, and one must weigh the pros and cons.

That a multiple may introduce a low flat rate irrespective of experience and quality seems insulting. This would penalise all locums, and destroy many good working relationships. Most locums know that tomorrow's booking will rely on their work today and that it is, therefore, a mistake to charge "extortionate" rates.

Supply and demand cannot be the only rate determinant. A locum working a 300+ items/day health centre and dealing with homes and addicts would not expect to be remunerated at the same rate as one dispensing 100 items. If we are valued only by demand, as suggested by flat rates, I think many locums would then be hoping to see an end to contract limitation or to even seek alternative paths. Flexibility in rates does vary greatly, company to company, and multiple to multiple. It can probably be assumed that such action would result in a redistribution of the more experienced locums, and possibly an irreparable loss of goodwill.

The situation is further complicated by the fact that there seems to be a larger than usual number of foreign pharmacists being enticed into the country on short-term contracts. Imported cheap labour is not a new idea. Since an escalation of any such trend would undoubtedly affect the livelihoods of British pharmacists it would be interesting to hear the views of other members. Who knows? This time next year I may have to accept bookings in sunny Madrid.

Harpreet Khara
Coventry

Locums provide considerable savings for employers

From Mr M. L. Hutton, MRPharmS

I read with interest the article on the worth of a locum pharmacist (*PJ*, 30 November, p773). The demands made upon a pharmacist over the years have grown both professionally and commercially with expectations demanded all too often without financial benefit.

The great debate of supervision rolls on — will pharmacists be required on-site eventually, and will a pharmacist be able to supervise numerous pharmacies via a CCTV system? Ridiculous? Or a probability.

Years of study to attain a degree, preregistration year and commitment to continuing education in personal time, meetings, committees and time spent "representing" the profession with the public, voluntary groups, media and fellow professionals are valued at what? One company believes £17 per hour, another £22, to another a determination to "not be held to ransom to pay extortionate rates for locum cover".

Locums are only paid for the work they do. They get no holiday pay, no company pension contributions or employer National Insurance contributions, no sick pay, no company benefits, no staff discount and no bonus payments. These added together make a considerable saving to pharmacies requiring locums' services.

There are pharmacists who carry out locum work in addition to their usual pharmacy employment, which brings "reduced rate" income to their salaries to pay for holidays etc. Some pharmacists travel to the United Kingdom to work because of restrictive conditions of employment or political unrest in their home countries and their pharmaceutical services are provided at reduced rates in order to obtain work permits and employment. These factors can devalue the services of a locum pharmacist whose livelihood depends upon having locum work throughout the year.

A good locum — professional, accountable and reliable — is a valuable asset for any pharmacy and should not be devalued to the detriment of the profession, the locum or National Health Service contracts for provision of pharmaceutical services. What is a pharmacist worth? A lot more than he or she is paid.

Mark Hutton
Lincoln

ADVICE FOR CORRESPONDENTS

Letters for publication can be posted, faxed, or sent by e-mail to letters@pharmj.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.

MULTIPLE PHARMACIES

Time to return community pharmacies to independents?

From Mr B. J. Hewitt, MRPharmS

Pharmacists, not just locums, have generally been exploited by multiple pharmacies for far too long. Only in recent months has this imbalance started to shift. As a profession, we have worked longer and longer hours, missed lunch on a daily basis, and suffered dark, back room working environments for poor financial reward. I believe that, in a time when bricklayers can earn up to £70,000 a year, a pharmacist is worth £30 an hour as a locum, with pay increases equivalent to those employed by multiples. If multiples claim this is impossible, then they should make it their business to look at why their income via the National Health Service is limited, and why no one is prepared to work as managers in their stores. If they cannot find pharmacists to open their stores at rates they are prepared to pay, they should give up their dispensing contracts to pharmacists who want the opportunity to run their own business.

The Journal itself suggested that we should not work for less than £19 an hour (*PJ*, 1 June, p750) yet Lloydspharmacy publicly states it will pay no more than £17 an hour. I would not work for either of these two ridiculously poor rates. It is a fact small villages on the edge of the city have been left with no pharmaceutical service, despite local pharmacists being available. We can only hope that the Office of Fair Trading report will come some way in addressing this appalling situation. It is also evident due to the increasing complaints by the general public to their primary care trusts that pharmacy's image is thus being tarnished.

The general public want and need pharmacists they can trust and continuity of care. Multiples cannot offer this. Perhaps they should consider returning pharmacy to individual pharmacists, selling off stores as franchises to individual pharmacists or groups of pharmacists. If a pharmacist has ownership of his premises more care will be taken with presentation, patient care, working conditions and, importantly, support staff morale. Pharmacy may then evolve from

the loner's job it is at present, to having more pharmacists per store, allowing the planned extended roles to be fulfilled.

Ben Hewitt
Nottingham

PUBLIC HEALTH

A way for pharmacists to demonstrate their usefulness

From Mr H. Patel, FRPharmS

Given the high levels of premature death, chronic disease and disability in the United Kingdom compared with many other European countries, and the major health inequalities, it is essential that a highly effective, modern public health delivery system is in place. Such a system must include community pharmacy because six million people visit a community pharmacy every day.

"Shifting the balance of power" made it crystal clear that public health will be present throughout the delivery system. Primary care trusts will have major public health responsibilities and staff to address health and inequalities in the populations they serve and to deliver preventive services. Further statements to clarify the intent of the Government indicate that public health involvement will be expected from all providers of services where "NHS and social service money flows". In fact, this statement is still too narrow as work on community development and education reforms is demonstrating.

So it comes as no surprise to receive a letter from a Government agency promoting Warm Front grants to low-income householders asking community pharmacists' help to promote the scheme. It says: "As you know, on average 80 per cent of all prescriptions are issued to non-paying recipients. Furthermore, the majority of free prescriptions are issued to clients in receipt of benefits that qualify them for a Government Warm Front grant. For eligible householders aged 60 or over the grant could be as high as £2,500, other eligible householders could receive a grant of either £700 or £ 1,500. Pharmacists are therefore ideally placed to identify householders who qualify for a grant that could have a significant impact on the health of that household."

The supporting data claim that:

- Britain has an excess winter mortality rate of 30,000 deaths per year, on average
- For every 1C drop in temperature in winter there is an associated increase of 8,000 deaths
- Cold homes are linked to mortality, especially due to bronchitis, heart attacks and strokes. Even deaths from duodenal ulcers and genitourinary disease increase. Cold increases home accidents, can worsen the pain of arthritis, can exacerbate asthma, resulting in wheeze and affects a number of groups with specialist disease conditions

To help prevent this, pharmacists are asked to put a Warm Front leaflet in bags containing exempt dispensed medicines and to hand out leaflets to target customers.

I hope that community pharmacists everywhere will put "community concern" in their thinking at this time of year and demonstrate the use and influence of an extensive community pharmacy network. Perhaps then, with the Office of Fair Trading inquiry results looming, more people outside the profession will be inclined to support the network at a time of need. It is not the so-called "modernisation" of the Royal Pharmaceutical Society or lack of adventure at the Pharmaceutical Services Negotiating Committee or high level policy at the Department of Health that will demonstrate the usefulness of community pharmacy, but pharmacists themselves by their actions.

Hemant Patel
Secretary
North-East London Local Pharmaceutical Committee

EDUCATION

Factors to be considered

From Dr D. N. John, MRPharmS

In his interesting paper on the subject of educational achievements (*PJ*, 23 November, p750) Dr Philip Rowe quite rightly acknowledges the limitations associated with data from a single cohort. Further, there are other factors that might explain, at least in part, possible differences between the two groups of students.

One factor that one may expect to contribute to the final degree mark is the "A"-level score on entry into the scheme. For example, did students who self-selected to undertake the sandwich course at Liverpool John Moores University have higher "A"-level scores than those who selected the standard linear four-year course?

Dai John
Head of Clinical Pharmacy, Law, Ethics and Practice
Welsh School of Pharmacy, Cardiff University

Dr PHILIP ROWE replies: Some marker of prior ability was required to detect any possible biased intake into the two different forms of the programme. In the published analysis, I used achievement within the MPharm programme itself up to the point where the sandwich and linear students separated. "A"-level scores would be an alternative marker, but would be one further stage removed from final graduation results. The marker used was, I believe, the most current available.

That of course does not absolutely prove that it was the best. It would certainly be interesting to investigate "A"-level scores as an alternative marker.

RURAL PHARMACISTS

There was no cohesive force

From Mr A. G. M. Madge, MRPharmS

The announcement that the Rural Pharmacists Association is to be wound up (*PJ*, 2 November, p635) brings back to me, as co-founder with John Davies, many memories.

When it was founded, there was a need for such a group. Rural Pharmacists were isolated with no cohesive force serving rural areas. This was the era of dispensing doctors, who were disadvantageous to rural colleagues. John and I served and, I trust, helped our rural colleagues at that period of pharmaceutical history.

Mervyn Madge
Plymouth, Devon

CPD

A Society of dispensing pharmacists?

From Mr B. W. Knox, MRPharmS

I agree with Susan Macdonald (*PJ*, 16 November p712). I pay my Royal Pharmaceutical Society retention fee but, although I use my knowledge of pharmacy daily in my work, it is not necessary for me to be a member. There must be many other pharmacists in a similar position to myself. If, or when, we all resign, we will be left with a Society of National Health Service dispensing pharmacists.

Is that what is wanted? Is that a good thing for the future of pharmacy? Should the Society be no longer seen as one which embraces all aspects of pharmacy? Does the Society care about this issue? Or is it going to sleepwalk into rejecting anyone who does not dispense? How about an answer on this issue.

Brian W. Knox
Harrogate

Dr ROBERT DEWDNEY, head, education division, Royal Pharmaceutical Society, replies: A number of correspondents who have expressed concerns about participation in continuing professional development have made the assumption that CPD must focus on practice in community or hospital pharmacy. This is not the case. For any pharmacist participating in CPD, the focus should be on the work that they do. For community pharmacists, the majority of their CPD would relate to community pharmacy practice. For industrial pharmacists, CPD would focus on their work in industry, eg, production, formulation, quality assurance, etc. We know from the CPD pilots that for most pharmacist, CPD will bring little change in the nature and extent of their learning activities. The major change is keeping records of CPD. In the pilots, most pharmacists spent about 30 minutes each month on record keeping.

The detailed requirements for pharmacists' participation in CPD are not yet defined. Assuredly though, it is not the intention of the Society that introduction of CPD will lead to committed pharmacists relinquishing their membership.

ZYPREXIA

Supply problems

From Mr J. R. Briggs

I was surprised to see Lilly's two-page advertisement for Zyprexa in *The Pharmaceutical Journal* of 9 November. Since the introduction of Lilly's supply chain management scheme in March 2000, we have encountered frequent shortages of Zyprexa because the company has continuously refused to supply us with sufficient quantity to meet demand. This came to a head at the end of September this year when we had a shortfall of nearly 200 packs of Zyprexa Velotabs 10mg. Since the inception of the scheme we have received numerous complaints from pharmacists and GPs about our inability to supply this product.

Often we have had to supply either parallel-imported products or borrowed stock and in September Lilly was sending free packs of Zyprexa direct to doctors to get around the problem.

Many of our customers do not have a second wholesaler because the Government clawback has made it uneconomical to have a second threshold to meet.

I am not recommending that health workers should use other manufacturers' products. I am simply saying that we continue to have problems with our quarterly allocation of products from Eli Lilly and, until such time as it can give us an undertaking that all orders will be met in full, we consider that problems of supply may be experienced.

Jonathan Briggs
Managing Director
East Anglian Pharmaceutical

DERICA RICE, general manager, Lilly, replies: Lilly can confirm that it has a supply chain management system in place across its European operations for some of its products. The objective is to improve the efficiency and cost-effectiveness of Lilly's manufacturing and distribution system and ensure continued, uninterrupted supply of our products to patients. We can also confirm that Zyprexa is indeed a product within this system.

We would like to add that we are unaware of any instance where a patient who needed Zyprexa has been denied treatment. We are confident that the allocations provided to wholesalers in our system will provide sufficient product for the local market.

FOOD-DRUG INTERACTIONS

Grapefruit or grapefruit juice?

From Dr B. O. Hughes, MRPharmS

In your continuing professional development series (*PJ*, 19 October, p571) Pamela Mason highlights the interactions between grapefruit juice and drugs such as dihydropyridine, calcium channel blockers and terfenadine, but your illustration shows half grapefruits with a caption "Grapefruit may interact with many medicines". I understood the interaction to be only with processed grapefruit juice. Could you clarify the matter?

Bryn Hughes
New Malden, Surrey

Dr PAMELA MASON replies: The interaction is possible with any grapefruit juice, whether processed or freshly squeezed. The culprit ingredients appear to be the flavonoids, specifically naringin, concentrations of which may range from 100–800µg/L in any grapefruit juice and have been reported to be 100–500µg/L in commercial grapefruit juice preparations.[1]

Reference

1. Fuhr U. Drug interactions with grapefruit juice. Drug Safety 1998;18:251–72.

Clarification, please

From Mr C. E. Richman, MRPharmS

Having read your continuing professional development article regarding drug and nutrient interactions (*PJ*, 26 October, p609), I believe that there were some notable omissions and also reference to one proposed interaction which I have been unable to validate.

I would be interested to know the mechanism or reference for the interaction of verapamil and calcium. There is no indication of interaction in the British National Formulary and one case report of oral calcium supplements in the 1996 edition of 'Drug interactions' by Ivan Stockley (p452). This reference discusses an isolated report of a potential interaction with calcium adipate and calciferol and verapamil, in a patient with diffuse osteoporosis and long standing atrial fibrillation. The commentary suggests that the general importance of this case is unclear.

Notable exceptions in the article's table for calcium are the 4-quinolone group, tetracyclines and thyroxine, all of which are established or well-reported interactions.

I would be grateful to know of any references which further supports the table and would make the general suggestion that such tables be clearly referenced in order to improve the value of such work and to supplement the CPD cycle.

Colin Richman
Stockholm, Sweden

Dr PAMELA MASON replies: I agree that the importance of the verapamil and calcium interaction is unclear. A general reference to support the article's table is: Utermohlen V. Diet, nutrition and drug interactions. In: Shils ME, Olson JA, Shihe M, Ross CA (editors). Modern nutrition in health and disease. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 1998. pp1619–43.

With regard to the omissions Mr Richman mentions, tetracyclines, quinolones and penicillamine appear in the table in relation to mineral supplements. Calcium is included in these.

DRUG TARIFF

Should nurses prescribe generically?

From Dr R. J. Schmidt, MRPharmS

May I have an explanation for a change that has appeared in the November 2002 Drug Tariff? The change is all the more surprising because it was not announced in the "advanced notice" section in the preface to the October 2002 tariff.

Ever since the Nurse Prescribers Formulary appeared in the Drug Tariff in 1994 [now Section XVIIB9(i)], there have appeared the following words at the head of the list of medicinal preparations: "These preparations will only be prescribable as listed." This instruction appears also in the British National Formulary where the Nurse Prescribers Formulary is reproduced together with details of NPF preparations, but with slightly different wording: "Although brand names have sometimes been included for identification purposes the non-proprietary names shown on the list should be used for prescribing purposes." Taken together, these instructions in the tariff and BNF clearly indicate that nurses should prescribe generically (except where no generic name exists) and that pharmacists should not dispense prescriptions written by nurse prescribers unless the prescribed preparation was written "as listed" in the tariff. Indeed, it is my recollection from the earliest days of nurse prescribing that nurses were to be obliged to write prescriptions generically and this would show the way for GPs who were at that time also being urged to move to generic prescribing.

I understand that the NPF is a "white list" and that it may therefore be unlawful to do other than prescribe the preparations in the NPF "as listed". Because the NPF is a white list, the Department of Health risks opening a can of worms by relaxing the requirement to prescribe preparations "as listed".

Putting common sense aside for a moment, what would be the legal position if a pharmacist received a nurse's prescription for Senokot tablets? According to my understanding, Schedule 10 of the NHS (General Medical Services) Regulations 1992 as amended (ie, the "black list") relates only to prescriptions written by GPs. This is why the NPF had to be made a "white list". So a prescription written by a nurse for Senokot tablets or Laxoberal elixir or Dulcolax tablets should now be reimbursable as a result of this recent change made in the November 2002 tariff.

Over the past eight years or so, generic prescribing by GPs has burgeoned and this in turn has helped to bring down the cost of medicines to the NHS (and hence benefited taxpayers). So why has the DoH now replaced "These preparations will only be prescribable as listed" with the words "Nurses are recommended to prescribe generically, except where this would not be clinically

appropriate or where there is no approved generic name"? Has there been a change in policy? Is generic prescribing being relaxed? Perhaps the DoH could give an example of a preparation in the NPF for which there is published clinical evidence of non-bioequivalence between a proprietary preparation and another that might be dispensed against a generically-written nurse prescription. Why has this change been rushed through without even an advance warning notice being published in the October 2002 Drug Tariff?

Richard Schmidt
Barnoldswick,
Lancashire

Dr GORDON GEDDES, head of information and technical services, Pharmaceutical Services Negotiating Committee, states: In the view of the PSNC, the changes to the wording at the head of the list in Part XVIIB(i) do not affect the processing of prescriptions written by nurse prescribers. The facility whereby nurses may prescribe proprietary preparations as long as the non-proprietary description appears in the Nurse Prescribers' Formulary has two precedents.

Although contrary to the spirit of the Dental Practitioners' Formulary, orders on dental forms for proprietary preparations with a generic description in the formulary have been passed for payment. Since this is not detrimental to community pharmacy, the PSNC has never challenged this interpretation. Another example is the prescribing of certain appliances, eg, elastic hosiery, by brand name although only a compatible generic description appears in Part IXA of the Drug Tariff. Hence it is understandable that the NPF has been similarly interpreted.

On the above basis, I agree with Dr Schmidt that, were a nurse to order a scheduled drug such as Senokot tablets, then because senna tablets are included in the NPF, the prescription should be passed for payment because of the way the regulations are worded. Since this interpretation is as yet untested, the PSNC recommends that any such prescriptions are returned to the prescriber.

Please note that the Nurse Prescribers' Extended Formulary allows the prescribing by suitably trained nurses of all licensed P and GSL medicines prescribable on the NHS except Controlled Drugs and presentations and pack sizes that are not to be prescribed under the NHS (p522 of the November Drug Tariff).

COMMUNITY PHARMACY

The death of community pharmacy as we know it?

From Mr M. Stein, MRPharmS

A community pharmacist encounters a stranger and the following conversation ensues:

Good morning. How can I help?

Hi. How are you?

Fine thanks. No worries.

You haven't heard then?

Heard what?

They've started pharmacist-free dispensaries in hospitals.

You're joking!

No. King George Hospital, part of Barking, Havering and Redbridge Trust. The pharmacist visits the ward with the consultants, gives his professional input and the prescriptions and orders are sent to the hospital dispensary. Technicians dispense and checkers check. They are all trained, of course.

What about the final check? It's something I've always relied on and thought it was the most important check for the pharmacist to carry out.

Nope! You obviously didn't read the letter in the *PJ* where a spokesman from the legal department said that the pharmacist only had to carry out the professional check. To which he means, I suppose, drug suitability, dose, interactions and side effects profile. All the other checks can be carried out by trained technicians.

So will community pharmacies still have to have pharmacists on the premises?

Well, if you carry the hospital scenario to its logical conclusion, the answer must be no. General practitioners could employ, say, one or two pharmacists per practice to give their professional input and carry out the professional check. Then the prescription can be e-mailed or sent to a local pharmacy for dispensing by technicians and checking by checkers.

I suppose the big boys will save lots of money not having to employ pharmacists.

Yes, to begin with. But obviously the Government will reduce the dispensing fee since pharmacists' salaries will be taken out of the equation. It will have the last laugh.

But what about the sale of P items? Surely pharmacists will still be able to sell them?

No problem! As many as possible will be transferred to GSL (small packs will help here) and the manufacturers will employ a pharmacist to give his professional input at the formulation stage. They will also produce protocols for the sale of P medicines and it will be fairly straightforward for the checkers at the pharmacy to follow it with the customer.

So, if community pharmacy will not need pharmacists, what will happen to us?

Good question!

But surely the Society wouldn't and couldn't let that happen!

Well you know how busy they all are deciding what their future role should be, finding out the ethnicity of their members and deciding how many lay members should be on the Council — you know — the sorts of things they bother themselves with and what they are good at. Any way, they've never really helped you have they? Of course the inspectors might have some time on their hands. Those signs that used to be on medicines counters that said "only when the pharmacist is present" will be a thing of the past. Must dash, nice talking to you. Sorry it's a bit depressing.

Bye. Didn't catch your name. Hey! Don't forget your scythe!

Malcolm Stein
Hatfield, Hertfordshire

THE PROFESSION

Commercial interests must not encroach on professionalism

From Mr J. Williams, MRPharmS

If we want those in authority to recognise our profession then we must get the Royal Pharmaceutical Society to control what we practise, and take it out of the hands of the multiples who are destroying whatever professional credibility we have left.

In this age of independence and self-medication that is promoted by Government and business alike, what the general public and authority at local and Government level want is a profession able to guide and advise them through the myriad of expensive concoctions that are advertised as being beneficial to mind and body, rather than the quasi-professional shopkeepers they now see promoting any and every quack remedy that shows good profit. We cannot be recognised as true health care professionals or command respect while seen selling "tablets for healthy eyes" or "tablets for a healthy mind".

We cannot be seen to be practising professionally while we allow the sale of potent medicines over a shop counter with a cursory nod of the head. We cannot protect the nation's health while we sell herbal preparations of dubious quality and unproven efficacy. We cannot elevate our professional status while we promote the latest specious potion at inflated prices. The fact is we cannot be seen to be trusted.

We will not be accepted as a major player in public health until we stop putting commercial inducements before professional judgements. This is where our Society should and must be our strength. Whatever good is held in the balance by the efforts of the National Pharmaceutical Association is outweighed at present by the commercial objectives of the pharmacy chains.

We have had the Jenkin judgment and the Dickson case. In the light of recent comments by some of our past officials, perhaps we might be lucky the third time with a "Patel professional protocol" enshrined in law. Whatever it is, we must stop this insidious commercial encroachment into what should be seen as our professional role in modern society.

John Williams
Aylesbury, Buckinghamshire

PJ ONLINE

***The Pharmaceutical Journal*'s website, *PJ Online*, can be found on the internet at** www.pjonline.com.

At the site, pharmacists can take advantage of a daily news services and can view the contents of the current weekly issue.

The site also contains a searchable archive of *PJ* material and a searchable database of current job advertisements.

Correction

The response to the letter from Brian Knox "A society of dispensing pharmacists?" (p811) was from Dr Peter Wilson, the Royal Pharmaceutical Society's consultant on continuing professional development, not Dr Robert Dewdney.