

## OFT REPORT

## Summing up?

From Mr R. D. Gillman,  
MRPharmS

Could the financial debate surrounding the Office of Fair Trading report be summed up as follows? Will the savings on prescription and counter medicines be greater every month than the professional allowance? I doubt it.

Roy Gillman  
Sheffield Pharmacy, Hertford

## OFT proposals should be ditched

From Mr S. H. Shivji,  
MRPharmS

If the Minister for Health is still undecided, even after the furore caused by the Office of Fair Trading recommendation to

abolish control of entry regulations, may I suggest he “asks the pharmacists . . . he will be taking good advice” and ditch the proposal. As far as the Director General of Fair Trading goes, I would not have much confidence in Dracula putting forward proposals regarding blood banks.

Shiraz Shivji  
Crawley, West Sussex

## SUPERMARKET PHARMACY

## Don't knock it till you've tried it

From Mrs P. K. Ball, MRPharmS

Hallelujah! Finally, a pharmacist is happy openly to admit the benefits of supermarket pharmacy (*PJ*, 8 February, p184). All I have seen over the past few weeks are letters generally denigrating supermarket pharmacy — as if we are somehow less qualified and less able to provide standard ser-

vices. In the Sainsbury's pharmacy of which I am manager, we are involved in every one of the local primary care trust initiatives, including nicotine replacement therapy on prescription, emergency hormonal contraception and head lice prevention and treatment — thus providing a more comprehensive service than almost all the surrounding local independent pharmacies. In fact, we are the sole provider of such services for 75 per cent of any given weekend trade and every late night trade. We have local prescription collection, oxygen therapy and all the usual services, so why do other pharmacists naturally assume that supermarkets are unable to provide a quality pharmacy service?

Surely, we are all the same “team” no matter which environment we choose to work in? I choose a supermarket because of its flexible hours, modern and clean facilities, range of staff abilities and potential for change, vision and expansion. We are forward-looking, always seeking to improve — not stuck in the past with unfair prejudices based on ignorance and hearsay.

Do not knock it until you have tried it — you may be pleasantly surprised.

P. K. Ball  
Sale, Cheshire

## CPD

## What to call retired pharmacists

From Mr K. J. Jarrett,  
MRPharmS

With regard to mandatory continuing professional development, I cannot see any

problem with the position of retired pharmacists like myself. Ex-servicemen can use their service rank followed by “(Ret.)”, so why not retired pharmacists who choose not to take part in CPD? The use of the suffix would of course be mandatory.

K. Jarrett  
Largs, Ayrshire

## Certificate to practise would solve problems

From Mr N. R. Newberry,  
MRPharmS

Surely, the continuing professional development issues could be resolved quite simply if community, hospital and primary care pharmacists needed a certificate to practise. To obtain or retain the certificate they would have to undertake CPD. Membership of the Society would then be separated from CPD, so academics and retired pharmacists could remain on the register. Everyone on the register remains a pharmacist. The Society might use a term like “practising pharmacist” but the public would not need to know about it — the working pharmacist they spoke to would be suitably qualified. If asked, other pharmacists would say that they are not authorised to practise and the inquirer directed to an appropriate institution. Actually, the other pharmacists would be unlikely to get asked by the general public as they would not be perceived as being “chemists”.

The practising certificate should be paid for by the relevant pharmacist or their employer.

Nigel Newberry  
Bicester, Oxfordshire

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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.

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CPD

## Will Council members be “pretty inactive pharmacists”?

From Mr K. M. Youings,  
MRPharmS

As I await being reclassified as “inactive”, I cannot help but muse that the chief pharmacists for England, Scotland and Wales will be the “chief inactive pharmacists”, and that the earlier controversy over the possible appointment of a non-pharmacist Secretary and Registrar has been resolved — on appointment even if they were pharmacists they become inactive.

Ought there to be a new category for members of Council? Since they spend say six weeks on holiday, four weeks on Council work, presumably a couple of weeks a year visiting branches and another couple of weeks on the numerous other committees on which many sit, “pretty inactive pharmacist” seems appropriate.

It is a pity Gilbert and Sullivan are no longer with us!

K. M. Youings  
Romford, Essex

REPEAT PRESCRIBING

## Illegibility of prescriptions

From Mr P. F. Pavey, MRPharmS

I agree with Walter Fisher (*PJ*, 15 February, p230) about illegibility of computer-printed prescriptions. I have recently contacted the author of a newsletter circulated to practices in our local health authority hoping that this issue might be raised since, besides irritation to ourselves, there are cost and clinical governance issues to be considered.

The patient (who may be elderly and have poorer eyesight than we do) might have to request items from the list printed on the repeat portion of the FP10 — a great risk of errors here. Only last week I had an incident where a patient was expecting beclometasone inhalers but had a prescription issued for beclometasone nasal spray. Both items were on the repeat list.

This type of incident can lead to wastage and delays in getting the correct medication. Inkjet printers and larger type faces are the solution. Let your local surgery know if you believe you have a problem.

Patrick Pavey  
Romsey, Hampshire

COMMUNITY PHARMACY

## What are extended opening hours?

From Mr J. Downing, MRPharmS

John Wilson (*PJ*, 8 February, p184) misses the point. The supermarket in question will undoubtedly review the profit and loss from the pharmacy in question and reduce hours if the graveyard shift is not profitable.

It is often impossible for these outlets to find pharmacist cover for such late hours and often the pharmacies are closed to the public.

His story regarding the customer coming to his pharmacy at 9.15pm when their normal pharmacy had closed at 9pm illustrates the classic conundrum. The public will always want more than it is reasonably possible to provide. He says that his pharmacy is offering extended hours. Is opening until 9pm not extended hours?

Jim Downing  
York

LOCUM PHARMACY

## Still it is only market forces

From Mr M. Duckworth,  
MRPharmS

I read with interest the letter from Stephen Taylor (*PJ*, 8 February, p188) relating to “the money grabbing attitude” in 2002 by locum pharmacists.

Might I suggest that if the large multiples and employer pharmacists did not offer such ludicrous remuneration packages for their employee pharmacists, then perhaps they would not be left with having to fill vacancies with long-term locums. I suggest the current situation has arisen because individual pharmacists are able to command a more real-

istic price for their services through locuming rather than be subject to minimum wage restrictions by “money grabbing employers”. Does Mr Taylor not value the expertise provided by a locum who even at £25 per hour comes much cheaper than plumbers, builders or car mechanics. Still it is only market forces.

No doubt locums will be able to increase their fees further once a large number of pharmacists leave the register due to the Royal Pharmaceutical Society’s continuing professional development requirements. But perhaps this will be counter-balanced by those seeking employment once premises close down because of implementation of the Office of Fair Trading recommendation. I look forward to the future.

Michael Duckworth  
Huddersfield

DISPENSING

## Do not be afraid to ask for help

From Ms H. Neill, MRPharmS

I am sure that Christopher Wragg (*PJ*, 8 February, p188) is well aware that a toddler died as the result of a mistake made during the preparation of a “simple” peppermint water formula. The case occurred as I was beginning my pharmacy degree and has remained firmly rooted in my mind ever since.

It goes without saying that this is the ultimate nightmare scenario for every pharmacist and one that should never be repeated.

Extemporaneous dispensing is taught to undergraduate pharmacy students, but the time available for such teaching is only a small portion of the overall degree. As with any part of one’s education, if teaching is not put into practice, knowledge and skills are inevitably lost. Pharmacists nowadays simply do not encounter requests for extemporaneously dispensed products often enough to develop their competence.

All the more reason therefore that those pharmacists unfamiliar with preparing such products can seek accurate information on how to do so or, preferably, ask special manufacturers to make the item instead. They should certainly not be

made to feel stupid for asking for help.

This logic risks driving some pharmacists into “guesstimating” answers rather than lose dignity from not knowing. Questioning how, what, why and where is a key part of a pharmacist’s development. The day that my pride prevents me from asking a question, no matter how simple, is the day that I will discover I am in the wrong profession.

Helen Neill  
Cardiff

YPG PROJECT

## False impression clarified

From Mr N. J. Wicks,  
MRPharmS

I must write to correct readers (and John Evans) about the current status of the fundraising for the Young Pharmacists Group pharmacy project (*PJ*, 1 February, p158). In his article Mr Evans states that the YPG has been unable to purchase a pharmacy because “it has not been able to acquire an adequate level of financial support”. This is simply not the case. The project has so far had over £100,000 donated or pledged. Although this amount would be sufficient to purchase a pharmacy, we need to give the project the best financial start we can. The fundraising is only just getting into full swing and anyone wishing to know more can go to [www.ypg.info](http://www.ypg.info), from where they can download the project prospectus.

Noel Wicks  
Chairman  
Young Pharmacists Group

THE PROFESSION

## Tutors paid less than locums

From Mr D. K. Rayner,  
MRPharmS

I noted with interest the letter from Richard Harris (*PJ*, 15 February, p229) in which he compares the surmised rate per hour for a qualified plumber with that for a locum pharmacist and, with one or two reservations, I cannot but agree with him.

However, I have received from Manchester University a request for local pharmacy tutor volunteers. Apparently 17 areas (listed) are in need of such, commencing 1 April. The job is part-time and entails "half a day per week or 24 hours a month". The salary is stated as circa £4,000 per annum plus travelling expenses. If my arithmetic is correct that equates to £13.88 per hour.

It seems that pharmacy tutors are to be paid less than locum pharmacists and even less than plumbers. No surprise at a shortage then.

**D. K. Rayner**

*Bradford, West Yorkshire*

#### DIABETES

## Covering the options

*From Mrs I. Gummerson,  
MRPharmS*

Neil Caldwell, commenting on "rapid-acting insulin", eg, Humalog (*PJ*, 15 February, p228) stated that the recommended time of administration of a rapid-acting insulin analogue is immediately before a meal (to limit the post-prandial rise in blood glucose). The BNF states "shortly before meals or when necessary shortly after meals, according to requirement". However, I do not know how many people find it necessary to inject rapid-acting analogues after meals although I can think of two possible reasons why they might need to.

First, they might need to inject after a meal of high fat/low carbohydrate content (not generally recommended for people with diabetes), where the food is retained in the stomach for longer and the post-prandial rise in blood glucose is delayed. In this situation, the risk of post-prandial hypoglycaemia would be increased if they inject too early, especially in individuals who have good glycaemic control.

Secondly, people who have slow absorption of food due to delayed gastric emptying caused by autonomic dysfunction (sometimes observed in people who have had type 1 diabetes for many years) might need to inject thus.

So for the rapid-acting analogue insulin perhaps "inject shortly before meals, or as directed" would cover the options?

I would be interested to hear from pharmacists with diabetes who inject after meals and why.

**Irene Gummerson**

*Wakefield,*

*Yorkshire*

*(e-mail irenegumm.wake@virgin.net)*

## Insulin confusion

*From Mr D. M. Wilkes,  
MRPharmS, and others*

We would like to share the following experiences regarding confusion between insulin glargine (Lantus) and insulin lispro (Humalog) that have occurred within Ceredigion.

Insulin glargine is a long-acting insulin analogue launched in Britain by Aventis in August 2002. Lantus insulin cartridges (3ml) are used with the Optipen Pro 1 insulin delivery pen.

Insulin lispro is an insulin analogue of a faster onset and shorter duration than soluble insulin. Humalog insulin cartridges (3ml) are used with the Humapen Ergo insulin delivery pen.

An initial concern has been the fact that Lantus is a clear solution similar to a short-acting insulin, unlike existing long-acting insulins, which are cloudy suspensions. Because of the risk of confusion, all diabetes specialist nurses and pharmacists have been advised to ensure that any patients prescribed Lantus are counselled about this risk.

Incidents have occurred when patients have put the Humalog cartridge into the Optipen Pro 1 in error and, consequently, have administered the wrong insulin. This has occurred because although the Lantus and Humalog cartridges have the name of the insulin and have different colour-coded bands on them, they are the same size and shape and are interchangeable.

Following the first incident, all patients prescribed Lantus in this area were contacted to receive extra counselling. Despite this, another three incidents occurred. Fortunately, no one has suffered any long-lasting side effects. Patients have, however, experienced a loss of diabetic control, with hypoglycaemic episodes at night and raised blood sugar levels during the day. These incidents did not cause them any harm at the time, but other patients may not be as fortunate.

Aventis reported that it has only had one report of this happening and this was in the United States. We believe that the number of incidences is probably a lot higher than this. Either patients in Ceredigion (a sample of 92,000-registered population) are not as careful as the rest of the population or prescribers and nurses are not considering the possibility of this mix up occurring when patients are presenting with poor diabetic control while on Lantus and Humalog.

Local general practitioners and pharmacists have been asked to ensure that all patients receiving both Lantus and Humalog are counselled about the risks of confusing the cartridges.

The specialist diabetic nurse at the local hospital is now recommending that Humalog disposable pens are prescribed for new patients. Existing patients will remain on disposable cartridges. Until the design is changed these patients will still be at risk of administering the wrong insulin. As this is a patient safety/clinical governance issue, should the companies concerned not be pressured into changing the design of their cartridges to remove the risk identified? We would be grateful to hear from other pharmacists or diabetic nurse specialists as to whether they have experienced similar incidents.

**Don Wilkes**

*Pharmaceutical Adviser  
Ceredigion Local Health Group,  
Lampeter,  
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**Rachel Russell**

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**Shirley Oliver**

*Diabetic Specialist Nurse  
Bronglais General Hospital,  
Aberystwyth, Ceredigion*

#### THE SOCIETY

## Registration suggestion is outrageous

*From Mr M. P. Smith,  
MRPharmS*

The latest consultation document from the Royal Pharmaceutical Society, on mandatory continuing professional development (*PJ*, 8 February) proposes to

alter the status of some requirements for registration. The Society cites the General Medical Council, the General Dental Council and the Nursing and Midwifery Council to support its proposals. It admits the Society is not just a regulatory body, as these three are. What is it then?

The problem with trying to please the government of the day is that that such a body is transient. What will happen to the Society when the Government or policy changes?

The Industrial Pharmacists Group believes one of the Society's functions is "to maintain the honour and safeguard and promote the interests of the members in the exercise of the profession of pharmacy" (the words are from the Society's Charter). Nowhere is it mentioned that a pharmacist needs to work in the National Health Service or, indeed, in pharmacy at all. The Society's latest suggestion, that the Register may have to be divided into different branches of practice and that some pharmacists may not be allowed to use that description, is outrageous and contrary to the definition of a profession. Keeping knowledge up to date is something all professionals do, from interest alone. Practising a profession, in one branch only, constantly, from the day of admission to that profession is becoming less common as part of the changes in society generally. People change jobs, take extended breaks from work or change their area of expertise.

The Industrial Pharmacists Group believes the Society should celebrate the diversity of the profession, indeed publicise it more widely and encourage the public to consult pharmacists as the first encounter with health matters. That way the Society would be doing what the Government wants but on its own terms.

**Mel Smith**

*Chairman  
Industrial Pharmacists Group  
Royal Pharmaceutical Society*

#### PJ ONLINE

The *Pharmaceutical Journal's* website, *PJ Online*, can be found on the internet at [www.pjonline.com](http://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.

## Arnica trial not big enough

From Mr K. R. Nathwani,  
MRPharmS

I would like to comment about the findings of the researchers from Exeter University with regards to their trial of homeopathic arnica (*PJ*, 8 February, p180). I would like to question their understanding of homeopathic philosophy and to remind those with no experience of homeopathy that:

- Homeopathy treats the whole person — it is a holistic science which treats by the laws of similars, ie, what causes also cures
- Every individual is different, some patients may respond to arnica, others may respond to hypericum or calendula or staphisagria depending on their individual symptom picture. In homeopathy you cannot treat everybody with the same remedy (as allopaths do), treatment is based on individual prescription
- Arnica is an excellent remedy where the symptom picture characterises: sore, lame bruised feeling, after traumatic injuries, fears touch, indifference, nervous — cannot bear pain, wants to be left alone (It is doubtful that all patients on the trial fit this category.)
- The potency is questionable, homeopathic remedies are not designed to be prophylactic and should not be prescribed allopathically. Some patients may have responded better to perhaps a 200C dose or even a 1M dose depending on the intensity of the symptoms
- Homeopathic remedies should only be repeated under the guidance of a qualified homeopath, since these remedies should only be taken where symptoms agree, otherwise you could “prove” the remedy, ie, cause aggravations, or even the symptoms that the remedy is trying to cure.
- Homeopathy is therefore designed to treat on all levels of the person, ie, mental, emotional and physical, by stimulating the body's own healing processes.

The trial was not sufficiently large to justify the researchers' statement on arnica, nor are they in any position to state that arnica is a waste of money (often cheaper and more effective than ibuprofen). In my practice I have had excellent response with homeopathic remedies, especially arnica, when prescribed according to homeopathic principles, which have remained sound and solid for over two centuries.

Any one involved in conducting a homeopathic trial should consult a qualified practitioner before making unfounded claims and criticisms of homeopathy.

**Kamal Nathwani**  
*Sanjivani Homeopathic Pharmacy Hertford*

## Arnica can be of benefit at appropriate dose

From Mr A. G. Simmons,  
MRPharmS

As a practising homeopath, I question whether the study into the effects of arnica after hand surgery (*PJ*, 8 February, p180) has added significantly to our knowledge. It appears that the investigators have overlooked two major homeopathic principles, namely those of individualising treatment to the patient's symptoms and the minimum dose.

In my experience, arnica can be of significant benefit after surgery, but only if it is the remedy indicated by the patient's symptoms. Also, within this study, the doses used and the frequency they were repeated are, in my opinion, inappropriate.

**Andrew Simmons**  
*Pharmacy Department, Airedale General Hospital*

## Would not use arnica for pain relief

From Mr D. B. Needleman,  
MRPharmS

I should like to point out a number of things about the “study” of arnica reported in *The Journal* (8 February, p180).

The Research Council for Complementary Medicine has commented extensively regard-

ing the poor quality and the flawed nature of this research and as they are far more experienced in this field than I, I can only state their opinion.

As a pharmacist and a homeopath of many years standing I can only say that I was disappointed in the research and the media coverage. No mention has been made of the inappropriateness of the remedy to the condition it was used to address. I, along with many hundreds of my colleagues, would not use arnica for pain relief. We would most likely have used hypericum or possibly ruta graveolens, so the study was based on a false assumption. I would also like to point out that we would not use arnica in this way before and after an operation because the dosage is inappropriate.

I run the Homeopathic Helpline and since 1996 have answered more than 60,000 queries, many of which dealt with the use of remedies before and after surgery. Not once have I recommended the use of arnica before an operation — only after to aid healing and not for the relief of pain.

It is a great sadness to me that the only professor of complementary medicine at any United Kingdom university seems to make a career out of conducting research that is designed to detract from the benefits of complementary therapies.

It saddens me more that no homeopath appears to have been consulted before, during or after this study in order to verify the use of the arnica in this way. We also do not know the source, storage or handling that related to the arnica used, which may have an impact on any results.

To end I would also like to state that homeopaths often treat carpal tunnel syndrome and thereby obviate the need for surgery.

**David Needleman**  
*Director Alliance of Registered Homeopaths*

Professor EDZARD ERNST, director, complementary medicine, Peninsula Medical School, Exeter, replies: Of course, homeopathy usually requires individualised prescription according to the “like cures like” principle and we were, of course, well aware of this. In a study of homeopathy for childhood asthma to be published shortly in *Thorax*, we conscientiously followed this concept. Arnica for trauma is,

however, quite a different matter. Most homeopaths use it for “acute” rather than “constitutional” prescribing regardless of the law of similars. Most if not all textbooks recommend it in that way and arnica is sold for self-medication in United Kingdom pharmacies following the concepts tested in our study. Thus we thought it important to design our study in the way we did.

The argument regarding the treatment schedule/dose might be valid. It could be that a modified dose is effective. To minimise the risk of a false negative result, we used two different potencies. The doses we ended up using were chosen after considerable thought and consultation with several trained homeopaths (I am one myself). To be absolutely sure, one would need to test all doses/treatment schedules possible and several thousand combinations are conceivable — too many for our modest research budget.

Mr Nathwani comments that the study was “not sufficiently large”. His letter continues reporting anecdotes from clinical practice. This is an almost farcical contradiction where the largest trial of arnica so far (ours) is deemed not big enough but single cases suffice as evidence in favour of arnica.

Mr Needleman argues that arnica is not a painkiller. True — that is why we used swelling and bruising as other primary outcome measures. The claim that we do research “designed to detract from the benefits of complementary therapies” is simply ridiculous. In this study, the plastic surgeon was a strong believer in arnica and we bent over backwards to design a fair and rigorous trial.

With all this intense and often ill-informed criticism of our arnica study in the professional and lay press, I often wonder: would the critics have found our methodology equally flawed if the result had been positive? Does nobody seriously consider the possibility that homeopathic arnica simply does not work? This, I fear, is what both the trial and the systematic review of previous placebo-controlled studies<sup>1</sup> imply.

### REFERENCES

1. Ernst E, Pittler MH. Efficacy of homeopathic arnica. A systematic review of placebo-controlled clinical trials. *Arch Surg* 1998;133: 1187–90.

## Putting children first

From Professor H. McNulty,  
FRPharmS

In their Broad Spectrum article (*Pf*, 14 December 2002, p843) Chi-Loon Cheung and colleagues draw attention in an emotive way to the risks of and need for safer paediatric medicines. The authors' aims are laudable but they appear not to understand the Medicines Act or the legal rights and responsibilities of pharmacists and prescribers in devising some unrealistic solutions.

The Medicines Act was introduced in 1968 after the thalidomide tragedy had highlighted gaps in controls relating to the manufacture, marketing and supply of medicines. In 1968, many medicines were dispensed in the pharmacy, rather than manufactured and thus could not be licensed. The Act (section 10) allows for pharmacists in pharmacies to make and dispense medicines without the need for a licence (market authorisation). In reality many manufactured products issued from pharmacies are unlicensed medi-

cines at the point of use because both relabelling and repackaging are licensable activities.

The Act gives pharmacists the role of controlling the sale and supply of medicines not on the general sale list. Therefore, we should ensure there are safe systems and procedures for supplying quality medicines under pharmacist supervision and for safe and secure handling of medicines in institutions we may supply.

The term market authorisation implies exactly what it is. The Medicines Act restricts marketing, manufacture, dealing and promotion, but not the prescribing of products, beyond who may do this and how. Few of us will see a product licence/market authorisation; the data sheet/summary of product characteristics (SPC), which must be compatible with the licence/authorisation is the nearest we will get. Many SPCs, however, are written defensively with long lists of side effects, etc. There are other problems with the authors' ideas since:

- SPCs of the same products made by different manufacturers may not be identical
- Provision of SPCs is only a legal requirement when a product is actively marketed so not all SPCs are readily accessible. They are sent to prescribers and not necessarily to pharmacists
- Generic products may not have SPCs and may not be licenced for new doses, new uses, etc. If they were licenced how much would these products then cost?
- SPCs may be changed without notice to pharmacists

The Medicines Act was not intended to do the things the authors propose and it gives us unique roles and responsibilities that should not be put at risk by ill-informed debate, especially when there are few, if any, reported cases of patients being adversely affected from unlicensed use of medicines approved by pharmacists. Tony Nunn has written more eloquently on using unlicensed and off label medicines<sup>1</sup> and has made more practical suggestions for dealing with this issue. He states: "There is little evidence for increased risk from unlicensed use of medicines."

Nevertheless improvements in licensing or marketed products and more research in children are needed and will help reduce risks. The Neonatal and

Paediatric Pharmacists Group (NPPG) has progressed matters with the Royal College of Paediatrics and Child Health (RCPCH), developing a joint formulary 'Medicines for Children'<sup>2</sup> and jointly tackling the problems with the Medicines Control Agency and European Medicines Evaluation Agency. The NPPG and RCPCH have issued joint guidance to trusts, accepting unlicensed use is necessary and suggesting that drug and therapeutics committees should approve new unlicensed uses and require outcome data from clinicians on usage.<sup>1</sup>

Paediatric pharmacists and prescribers are thus likely to be better placed than some others in dealing with unlicensed products or in the use of licensed products outside the terms of the licence. Sensible solutions have been suggested to manage similar risks in psychiatry<sup>3</sup> and there are problems in other patient groups where SPCs offer little advice, such as the pregnant and those needing palliative care.

The law allows doctors to prescribe whatever is needed for their patients' treatment, licenced or not, even thalidomide. Provided that a pharmacist approves the prescription and supplies the product for the individual patient and systems such as those suggested by Nunn operate, then the potential risks should be minimised. Doctors and health authorities should be told this and must not be led to believe, as it seems from the article they are believing, that they must only use licensed products or treat licensed indications. Implementing this policy would certainly damage far more patients and undermine our roles. Doctors and health authorities should also be reminded that we are experts on medicines and it is our duty not to dispense or supply a product that would put patients, prescribers or authorities at risk, be it unlicensed or not.

**Howard McNulty**

Visiting Professor  
Department of Pharmaceutical  
Sciences  
University of Strathclyde

### REFERENCES

1. Nunn T. Pharmacy Management 2002;18:64.
2. Medicines for children. London: RCPCH Publications Ltd; 1999.
3. Brown BT. Pharmacy Management 2003;19:18.

### BSHP

The British Society for the History of Pharmacy, founded in 1967, aims to promote historical research related to pharmacy and to publish research work and other items of interest in its quarterly journal, the *Pharmaceutical Historian*. The society holds meetings and an annual conference and organises visits to places of pharmaceutical interest. Further information is available from the society's website ([www.bsphp.org](http://www.bsphp.org)).

Membership of the society is open to individuals for an annual subscription of £20. Non-pharmacist members are welcome. Special subscription rates are available for overseas and corporate membership.

All inquiries concerning membership, subscriptions or the society's activities should be addressed to the British Society for the History of Pharmacy, 840 Melton Road, Thurmas-ton, Leicester LE4 8BN (tel 0116 264 0083; fax 0116 264 0141; e-mail [bsphp@association-hq.org.uk](mailto:bsphp@association-hq.org.uk)).