

CONCORDANCE

Training in communication skills needed

From Mrs S. Steel, MRPharmS,
and Miss A.-M. McCooley,
MRPharmS

The activity of medication review has risen to prominence with the inclusion of specific targets in the National Service Framework for Older People. Medication reviews need to be evidence-based and patient-centred. Any change in treatment that is required should be achieved through the process of concordance, reaching an agreement with the patient that reflects their beliefs and wishes.

During a recent pharmacist-led medication review clinic in a general practitioner's surgery we encountered some difficulty in putting concordance into practice.

An anxious, 75-year-old woman with asthma and heart failure presented at the clinic for a medication review. She took diazepam regularly for anxiety and expressed some confusion about her asthma treatment.

After reviewing her prescribing records it appeared to us that she had been under-ordering furosemide. To achieve concordance I (Anne-Marie McCooley) thought that an explanation about heart failure and its treatment was necessary and, recognising that she was extremely anxious, I attempted to introduce the topic gently. I asked her whether she had heard the term "heart failure" before going on to say that it was a silly term as it sounded rather drastic and that all it meant was that the heart perhaps was not working as efficiently as it once did. The furosemide, therefore, worked as a water tablet, reducing the fluid carried around the body and so reducing the pressure on the heart. It was, however, important that she take it regularly. The patient seemed to be happy with this explanation and the discussion returned to her confusion over her asthma therapy.

The following day the patient telephoned the surgery to tell me that she had been to see her GP that morning and told the GP that I had said that she had heart failure and that she was so worried about it, she had not slept the previous night. In discussing my experience with the GP, I was relieved to be reassured

that I had not done anything untoward and that this woman's anxiety is difficult to avoid.

Reflecting on this experience with colleagues, we identified specific learning needs about communicating with patients. However, finding development activities to improve skills in this area is proving difficult.

The National Prescribing Centre has identified clear competencies for nurse prescribers and for potential pharmacist prescribers that includes communication with patients, and training programmes are being designed to support achievement and maintenance of competency for new prescribers.

In stark contrast, many more health care professionals are likely to be involved in undertaking medication review and, although many of the competencies required are the same as those for prescribing, few training programmes exist.

Up to now, much education and training for pharmacists working in primary care has been focused on managing the rapid growth in prescribing spending rather than focusing on the clinical needs of individual patients and helping them get the most out of their medicines. If the NHS is serious about achieving medication review targets and putting concordance for taking medicines into practice, then a dramatic shift in the focus of continuing professional development activity is required for all health care professionals who communicate with patients about medicines.

Sharon Steel
Anne-Marie McCooley
Pharmaceutical Resource Network

REMUNERATION

Your chance to make suggestions

From Mr S. R. Axon,
FRPharmS

However we may dislike some of the aspects of reimbursement (*PJ*, 4 October, p448) this can never justify dishonesty and if we are to throw accusations of dishonesty at the Department of Health we really should be sure of our grounds.

Individual reimbursement would be an improvement for those on the wrong side of the averaging system but would be both difficult and expensive, if not impossible, to administer and therefore the averaging that is currently used may be the only practical approach. Any averaging system, whether it applies to reimbursement or discount must, by definition, rely on swings and roundabouts, neither of which should involve dishonesty.

With all the new roles that we are so anxious to provide perhaps we are in danger of forgetting the answer to Adrian Korsner's specific question as to why our profession has been put into such a position. Averaging and the swings and roundabouts relate back to the chemist's terms of service, are aimed at avoiding "cherry picking" and thereby ensuring the reasonably prompt supply of medicines to patients.

The good news is that until 31 October we all have an opportunity to make suggestions

as to how the system might be improved by responding to the generic medicines consultation at www.doh.gov.uk/generics/generic_medicinesconsultation2003.htm.

Will we take it or leave it to others and complain ever after?

Stephen Axon
Amersham,
Buckinghamshire

SPECIALS

Taxpayers are not getting value for money

From Mrs M. A. Chapman,
MRPharmS

I am concerned about laboratories charging excessive prices to make up relatively simple products.

For example, a few days ago, 400g 25 per cent salicylic acid in white soft paraffin resulted in a total invoice charge of £157.03. The laboratory, Craig & Hayward Ltd, Pangbourne, were able to supply the next day. On receipt of the faxed invoice I queried the high charge and was told that the pharmacy would usually be granted a professional fee by way of a £21 credit.

Are doctors aware of the cost of such items to the National Health Service and their own budgets? I do not think the NHS, ie, the taxpayer, is getting value for money.

Maureen Chapman
Wirral,
Merseyside

MATT HAYWARD, director, Craig & Hayward Ltd, replies: "Special" non-licensed products are made for an individual specific order. They are manufactured in Medicines and Health products Regulatory Agency approved laboratories with specially trained staff working in a controlled environment with specialised equipment (not on the back bench of a dispensary). These products are often produced and delivered for next day delivery to enable prompt supply to a patient.

I do not believe the price of the "special" non-licensed product is excessive considering the time and facilities required to produce it, the quality control required for all ingredients, the prompt delivery service and VAT.

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ARTIFICIAL SALIVA

Additions to dental formulary

From Miss C. J. Randall,
MRPharmS

In *The Pharmaceutical Journal* of 26 August 2000 (p288) the supply problem with Luborant artificial saliva spray was highlighted. Luborant remains unavailable. However, from 1 September 2003 dentists have been allowed to prescribe any of the following artificial saliva preparations; AS Saliva Orthana, Glandosane, Biotene Oralbalance, BioXtra, Saliveze, Salivix for NHS patients on FP10D prescriptions. The PPA have confirmed that:

- Dental prescriptions for "artificial saliva, DPF" can be filled with any of the above six products
- Dentists can also prescribe the artificial saliva products using the brand names
- Dentists do not have to annotate their prescriptions with "ACBS", the PPA will pass for payment prescrip-

tions that have not been annotated

In addition "rofecoxib tablets, DPF" have been added to the list of products approved for dental prescribing.

Cristine Randall
Senior Medicines Information
Pharmacist
North West Medicines Information
Centre, Liverpool

VACCINES

Two separate vaccines for addiction

From Dr E. O. Gregg

Your news item (*PJ*, 13 September, p316) discussed a potential new vaccine under development at Xenova, which "aims to prevent the relapse of recovering cocaine addicts and smokers". Intriguing as this sounds, I doubt whether a panacea for addiction is in development. Perhaps your reporter has mistaken two separate vaccines that are

being developed by Xenova and others, currently in early stage clinical trials. Other groups are still working to improve the affinity of the antibodies produced.¹

The concept of vaccination or the use of antibody therapy to overcome addiction is worth considering in some depth. It would appear that anti-cocaine and anti-nicotine vaccines are capable of reducing the circulating concentrations of the free molecules² and it seems likely that this reduces their concentration at central locations.³ The question over whether this action would prevent or overcome addiction remains. With widely available legal products (tobacco) or illicit substance (cocaine), surely the user will simply increase the dose to achieve the desired end-point?

Numerous other questions surround this area, including: the intended population group for therapy (before or after addiction is established); the specificity of the response; the duration of the immunity produced; and the safety of the vaccine itself. Despite progress and continuing work, it remains to be established whether nicotine maintenance therapy or partial nicotine withdrawal (vac-

cines) is the more effective in promoting smoking cessation.

Evan Gregg
Towcester, Northamptonshire

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