

■ COMMUNITY PHARMACY

Out-of-hours cover could lead to working unreasonable hours

From Dr I. Ab I. Davies, MRPharmS

I read with interest the leading article (*PJ*, 28 February, p234) suggesting that the new general medical services contract offers opportunities for pharmacists to contribute to out-of-hours care. Indeed, the pharmacy strategy for Northern Ireland (*PJ*, 14 February, p180) suggests that "late opening of pharmacies might be a better option than 24-hour emergency on-call cover".

Most pharmacies with a single pharmacist or proprietor are open from 9am to 6pm, six days a week. Full cover for the six days would constitute a 54-hour week. The availability of a locum for one day a week would still involve the pharmacist in a 45-hour week. Extending the opening hours to offer out-of-hours care would increase the working time of pharmacists well beyond that which would be considered reasonable. Few of these pharmacies, I would suggest, could afford the luxury of employing a second pharmacist full time or even part time.

Why are GPs opting out? Perhaps they have come to realise that 24-hour cover is not only unreasonable but also potentially dangerous, especially when they are called out at frequent intervals outside normal surgery hours.

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E-mail
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Letters to the editor

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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.

Employees' time should be valued

From Mr A. Matalia,
MRPharmS

I read Mike Jones's letter (*PJ*, 13 March, p318) with interest. He values his time at £70 per hour. Since I have not worked in community pharmacy for a number of years, I, too, would be inclined to value my time at a similar figure.

I have noted that many pharmacy owners also value their time at similar rates, but wonder why they value the time of their professional colleagues (eg, locums or employees) at only 25 per cent of this figure, and thereby give their ultimate paymasters (the Government) the ammunition to argue that pharmacists are only worth this amount. This seems to be reflected in NHS remuneration.

The day employers value their employees at £70 per hour will be the day they can justify a substantial increase in the global sum and pharmacy can be legitimately viewed as a profession.

Sadly, this seems a "chicken and egg" situation. Only the employer can take the initiative.

A. Matalia
Coventry

OTC products should be supplied in child resistant containers

From Mr L. Kumwenda, MRPharmS

As part of risk management, I think regulatory authorities should re-visit the issue of child resistant containers, with a view to extending the requirement to most over-the-counter products.

Currently, manufacturers are not required to supply certain OTC medicines in child resistant containers. I am particularly concerned with OTC medicines that contain sedative antihistamines, decongestants, opium tincture, methyl salicylate and senna, to name a few.

It is obvious that pharmacists' efforts to minimise risk by supplying prescription medicines

in child resistant containers is negated by OTC products being supplied in ordinary containers.

If accidentally swallowed, medicines pose a health risk irrespective of whether they are in the prescription-only, pharmacy or general sale list category.

Luso Kumwenda
Swansea

■ OBESITY

The role of syrup in medicines should be examined

From Mr H. R. Patel, FRPharmS

From all recent accounts in the media, obesity is a growing problem. Is it time, therefore, to reduce or eliminate the use of syrup in medicines and in particular for chronic therapy like methadone treatment? For someone on, say, 100ml of methadone a day, the amount of sugar consumed must easily exceed or make up a substantial part of the total daily energy needs. If we are going to tackle obesity in the population, the role of syrup in medicines must also be examined since it could be contributing to the problem.

Hemant Patel
Brentwood, Essex

■ PRESCRIPTION FRAUD

Significant fall in prescription fraud

From Mr W. M. Darling, FRPharmS

Figures released recently illustrate the significant achievements the NHS has seen in tackling prescription fraud. Between 1999 and 2003 prescription fraud fell by

60 per cent from £117m to £47m. This means that in 2003 there was an additional £70m being spent on patient care and not lining fraudsters' pockets.

We are aware that there is still work to do and that £47m is still being lost but we are confident that with the continued support of the profession and the commitment of the Royal Pharmaceutical Society, the Pharmaceutical Services Negotiating Committee and the National Pharmaceutical Association, we will reduce prescription fraud to the absolute minimum.

Bill Darling

Chairman, NHS Counter Fraud and Security Management Service

ADR REPORTING

Do not forget about the yellow card scheme

From Mr A. R. Cox, MRPharmS, and others

The National Patient Safety Agency has recently announced its reporting scheme. We would like to use this opportunity to remind pharmacists of another reporting scheme that has been in place for nearly 40 years: the yellow card scheme. Hospital pharmacists were accepted as reporters in 1997 and community pharmacists were invited to participate in 1999, after successful trials of both groups. Pharmacists should report any suspected reaction, no matter how trivial, to the following groups of agents:

1. Drugs and vaccines that are being closely monitored (indicated by a black triangle in the British National Formulary)
2. Any drug used in a child
3. Any herbal preparation

For established products, any suspected serious reactions should be reported. Serious reactions include those that are fatal, life-threatening, disabling, incapacitating or which result in admission to hospital or prolong hospital stay or are medically significant. Congenital abnormalities following drug use are also classified as serious.

Adverse drug reactions arising as a result of error should also be reported using the yellow card scheme. Such reports have informed important decisions about the licensing of medicines and drug safety messages provided to health care professionals. For

example, *Current Problems in Pharmacovigilance* described how the Committee on Safety of Medicines (CSM) had received 74 reports of seizures associated with bupropion (Zyban). In half of these reports, individuals had a past history of seizure or other risk factors that clearly contraindicated the use of bupropion.¹ In the same issue, *Current Problems* gave guidance on the prescribing of alfacalcidol drops in children following 13 reports of accidental overdose which had resulted in hypercalcaemia or nephrocalcinosis.²

One of the founding principles of the yellow card scheme was that reports could be made, and would be treated, in strict confidence. This important principle continues to be upheld by the CSM, so reporters may be reassured that they can report in confidence. The future success and capability of the yellow card scheme to perform its valuable public health role depends on the continued participation of reporters.

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References

1. Committee on Safety of Medicines. Zyban — safety reminder. *Current Problems in Pharmacovigilance* 2001;27:5.
2. Committee on Safety of Medicines. Accidental overdose with alfacalcidol (One-Alpha drops). *Current Problems in Pharmacovigilance* 2001;27:3.

CAREERS SUPPLEMENT

Is industrial pharmacy a peripheral activity?

From Dr I. M. Walker, MRPharmS

Beverley Parkin's reply (*PJ*, 6 March, p282) to Robin Harman and Julian Gilbert regarding the pharmacy supplement published with *The Independent* on 21 February does not seem satisfactorily to address the issues that they raised.

Scant reference was made in the supplement to the opportunities that are available for pharmacists within the pharmaceutical

industry: two brief references in the main text and one in the advertorial. In contrast, the focus of the supplement was essentially exclusively directed towards community and hospital pharmacy, as exemplified by the highlighted panels giving career perspectives from both a community and a hospital pharmacist.

Ms Parkin states that the "the decision on content and focus of the publication was, as is usual, for the editor to make". Did the Royal Pharmaceutical Society have any input into and control over the balance of the supplement? If the answer is "yes", then it has failed to ensure a balanced presentation of the career opportunities available to pharmacists. If the answer is "no", is it likely that any other professional body would similarly relinquish control over how it presents itself to an audience of 200,000 readers of *The Independent*?

It should be of concern to all pharmacists that it is possible that the Royal Pharmaceutical Society not only concurs with the focus and content of the supplement but also has a vision for the future of pharmacy and pharmacists that is centred around community and hospital pharmacy, and in which

industrial pharmacy is considered a peripheral activity.

Ian Walker

Ely,
Cambridgeshire

BEVERLEY PARKIN, director of public affairs and communications, Royal Pharmaceutical Society: The Royal Pharmaceutical Society, of course, promotes pharmacy as a career across all the fields of work in which pharmacists practise. The answer to Ian Walker's question is that the Society had input into, but not control over, the content of *The Independent* careers supplement. In briefing *The Independent*'s editorial team, we talked to them about the full range of careers that are open to pharmacists, as is evident from the copy in the publication. That the editor chose to run only more detailed profiles of a community and a hospital pharmacist was his decision, and is likely to have been influenced by the limitation of editorial space. I agree that it would have been interesting also to see profiles of pharmacists working in industry, primary care, teaching, management and, indeed, all the many areas where pharmacists work.

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