

STATINS

Is it a huge con?

From Mr F. M. Hickey,
MRPharmS

Having spent a little time studying and reflecting on the availability of over-the-counter statins I believe now that my prejudices have been confirmed and that this is a huge con. By my estimate, carefully worked out on the back of an envelope, it should cost somewhere between £50,000 and £100,000 of patients' own money to prevent one coronary event (probably a myocardial infarction) after five years of treatment in the group highlighted.

So, if we take a town with 1,000 men and women in the category of moderate risk of a first major coronary event in the next 10 years, what will happen to them if they do nothing about it?

If they do nothing, 937 will be fine, but 63 will have had a heart attack (or might even have died) after five years. However, once you have had a heart attack you are considered at higher risk of something else going wrong, so your GP will prescribe an effective dose of a statin (more than 10mg simvastatin daily). If everyone who might benefit opts for self-treatment and pays the full, non-discounted price of OTC simvastatin (£12.99 per 28 days), then perhaps 48 rather than 63 will have a heart attack or die after five years, so 15 nasty cardiac surprises will have been avoided.¹

This will have taken £844,000 of disposable income from the community (approximately £844 per patient), assuming that they have all lasted the course. Let us say that the cost to the NHS of an acute MI is £2,000 and involves eight days in hospital, so for the town's residents investing £845,000 of their own (post-tax) money, central government might be hoping to save £30,000 and free 120 days of bed occupancy over the same five-year period (loosely based on the NHS Reference Costs 2003 and National Tariff 2004, published by the Department of Health, available at www.dh.gov.uk). Had the NHS funded this initiative the Treasury would collect a certain amount from prescription charges, but that would not come near to the cost of prescribing, dispensing and monitoring treatment.

Alternatively, you might argue that it will cost just over £56,000 of patients' own money to prevent

one cardiac event. Non-compliance will be important (boredom will be a major factor) and I think it is not unreasonable to suggest that the success rate will be as little as half that being promoted, hence an upper estimate of £100,000 per event avoided (probably a myocardial infarction) is, I think, not unreasonable. (Central government financial savings and the impact on hospitals will also be reduced by non-compliance.)

What about the alternatives? Exercise more, eat less and better. This will either cost nothing or save you money and is likely to result in an even smaller proportion of our group suffering a heart attack.

Give up the fags! A 20-a-day smoker will spend about £1,650 a year on cigarettes, so that is £8,250 over five years.² Perhaps 30 to 40 per cent of my target population are smokers, so this population group might be spending £2.5m to £3.3m on their collective habit over the five years. Patients will feel better, and be less likely to suffer a whole barrel load of ill-health nasties. They will also be able to enjoy a health-giving moderate intake of alcohol in a bar in Dublin, in a country where legislators have had the courage to implement a real public health initiative.

The down side of all these patients stopping smoking is that they will pay less tax, which amounts to 80 per cent of the cost of a packet of 20. So maybe this explains why the Government is only partly interested in tackling this addiction.

However, let us go back to the £844,000 that my community will be encouraged to spend on medicines that will have a

marginal effect on health over a five-year period. What else could a community do with that sort of money that would benefit its long-term health? Let us suppose that the local school roll is also 1,000 and that the kids are in school for 200 days a year. That sum would be equivalent to £0.85 towards a healthy, nutritious meal (no chips) per child per day. This, I wager will be of much greater benefit to the long-term health of our society and will improve the quality of the raw material available to the national football team.

Now, I have made some sweeping assumptions in this simplistic little analysis, but none as unreasonable as assuming that a medicine given at a dose that many consider to be subtherapeutic will have a clinical benefit in the absence of clinical trials in the target population and setting.

Findlay M. Hickey

Strathpeffer,
Ross-shire

References

1. Hird M. Over-the-counter simvastatin — is it hype or a genuine hope for the future? *The Pharmaceutical Journal* 2004;273:156–60.
2. The economics of tobacco. London: Action on Smoking and Health; 2004.

Not convinced of value of Zocor Heart-Pro

From Mr M. Goldin,
MRPharmS

My understanding is that POM-to-P switches are for drugs that are used to treat relatively minor, self-limiting conditions that are characterised by obvious

symptoms. Now we have simvastatin making this giant leap for mankind; but does it fit the case? I am not convinced that it does.

It is going to take a lot of persuasion to get me to sanction a sale for this product. As an occasional locum pharmacist I have little contact with drug companies or their representatives. If the makers of Zocor Heart-Pro want to convince me so to do they are welcome to try. It is going to take a lot of biros, paper clips and Post-it pads to get me even to listen to their reasons in their effort to convince me to consider recommending it.

Monty Goldin

London NW11

ENHANCED SERVICES

Shooting the profession in the foot

From Mr S. Vohra,
MRPharmS

I note that Moss Pharmacy is offering free cholesterol tests albeit only to "at risk" customers (*PJ*, 7 August, p178). This initiative, as well as Lloydspharmacy providing free blood pressure and blood glucose monitoring, is, in my opinion, detrimental to the profession. This is because, with the advent of the new contract, these types of services should be locally funded by primary care trusts as enhanced services. If pharmacies are providing these services for free then why should PCTs ever think about funding them? Considering community pharmacists already provide a number of key services free, especially collection and delivery and monitored dosing systems, is it not about time that the multiple chains thought about the profession as a whole and how best to proceed together to achieve better funding for every contractor for all services provided, rather than thinking of their own selfish and narrow interests?

The free services that Moss and Lloyds provide may seem noble and give them good publicity but, as far as securing long-term funding is concerned, these companies are shooting themselves, and the whole pharmacy profession, in the foot.

Samir Vohra

Clinical Governance Facilitator
Chorley & South Ribble Primary
Care Trust

Letters to the editor

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.

SHIPMAN INQUIRY

“Professional responsibilities” need rewriting

From Ms H. D. Marsden,
MRPharmS

The controversy over the Shipman Inquiry has highlighted faults in the “professional responsibilities” laid down by the Royal Pharmaceutical Society.

The Society, which I understood was there to support pharmacists, instead gives us professional duties that are impossible to uphold without psychic powers. For example: “Pharmacists have a professional duty to assess every prescription to determine its suitability for the patient.” How can this be achieved without full access to all patients’ records? All we have is the prescription, and, in many cases, no access to the patient.

The dispensing fee buys approximately 60 to 90 seconds of our professional time. To carry out this first point, we must:

- Contact the GP, get full copies of records, ascertain contraindications, allergies, past history, etc
- Question the doctor on the indication for which he is prescribing the medicine (patient confidentiality springs to mind here)
- Interview the patient (at his or her home if housebound) to find out if he or she is taking any over-the-counter medicines, herbal remedies, illicit drugs, excessive amounts of alcohol, etc

And this must take place with “reasonable promptness”. Imagine the damage this sort of questioning to GPs on every single item would produce.

“The pharmacist must be satisfied as to the product and dosage supplied and that it will not harm the patient.” For this we also need a full medical history, including allergies, renal and hepatic values. We need to ensure the patient has no enzyme deficiencies, blood disorders, genetic or ethnic factors that might affect the drug metabolism, and do a full review of all medicines they are currently taking which they may have obtained from other pharmacies.

I would recommend that these “professional responsibilities” be rewritten by someone who works regularly in a busy community

pharmacy and based on what can be achieved in the 60 to 90 seconds per item that we are reimbursed for, taking into account the lack of other patient information we have at our disposal and the difficulties in contacting GPs that we all experience, especially at weekends and out of hours. Either that, or the dispensing fee has two noughts added and patients expect to wait for a few hours while we make the necessary investigations.

Ghislaine Brant has my sympathies (*PJ*, 24 July, p103); I do not believe there are many of us who would have questioned a GP we knew on whether a prescription (correctly written and legal in every sense) for a single ampoule of diamorphine for an elderly patient (unknown to us) was “suitable”.

As to this being repeated regularly over a period of years, I for one would have assumed he has a high percentage of elderly patients or a special interest in palliative or cardiac care (perhaps locuming for a local hospice). How would we know any different?

Hazel Marsden
York

A dilemma about a doctor

From “Concerned Pharmacist”

Further to the letter about reporting GPs by Chris Morris (*PJ*, 31 July, p147) I, too, have a similar dilemma.

I have recently moved pharmacy and was presented with a private prescription for 100 temazepam 20mg tablets written by a local doctor for himself. The prescriber, who presented the prescription personally, was well known to the staff. Upon entering the prescription in the register later that day I was alarmed to find that a similar quantity had been dispensed approximately monthly going back a number of years. A week later, I found out that he is the substance misuse consultant at a local hospital. Even though the POM register goes back many years this has not been picked up by either the inspectors, the drug squad on their visits or by the numerous pharmacists who have worked at this pharmacy over the years. If I now report this do all the pharmacists and police officers who have gone before me get reprimanded for “not fulfilling professional obligations to scrutinise the prescriptions”? Who

would make the final decision about this prescriber’s actions if it were reported — would it be the local substance misuse consultant?

Concerned Pharmacist
297/29

SHONA COY, head of fitness to practise and advisory services, Royal Pharmaceutical Society, replies: Where a pharmacist has concerns about the prescribing practices of a doctor, the appropriate body to consider the facts of the case is the General Medical Council. It is for the GMC to investigate the allegations and having considered the facts of the case decide whether it constitutes misconduct and what action, if any, is appropriate. A pharmacist who has concerns about the prescribing practices of a doctor may wish to contact the fitness to practise directorate to discuss the matter further.

DISPENSING ERRORS

Counselling helps reduce errors

From Dr T. U. Qazi,
MRPharmS

Counselling saves lives by cutting serious dispensing errors. It also improves patients’ quality of life by maximising compliance among most patients through a valuable interaction between pharmacist and patient. This also develops working relationships with members of the health care team.

A recent error was highlighted when a patient’s father returned to collect a prescription for carmellose sodium oral paste: the locum pharmacist had dispensed carmellose sodium eye-drops for a four-year-old girl. The pharmacist in charge when the father returned to collect the prescription strongly believed in counselling and, only when he counselled the father on the use of the eye-drops, was the error realised.

Such dispensing errors can take place in a busy pharmacy where there is limited time and absence of a working relationship with the dispensing team. Even with the implementation of standard operating procedures, errors such as these are only highlighted when patient counselling takes place — although time and other pressures on the pharmacist are limiting factors. However, it is impractical to open each bagged prescription and go through counselling points with every patient.

An interesting point to note is that counselling and clinical governance share some common ground — both strive to ensure accuracy in the dispensing process and to improve the quality of life of patients through concordance.

T. U. Qazi
Halifax,
West Yorkshire

LANGUAGE SKILLS

“Proper” English or American English?

From Mrs S. J. L. Barrow,
MRPharmS

Further to the comments in recent months about testing the language skills of pharmacists from overseas, readers may be interested in the requirements of the Foreign Pharmacy Graduate Examination Committee in the US: “To be eligible for FPGEC certification candidates must pass the TOEFL with a total score of . . . Candidates must pass the TSE with a score of . . . The TOEFL and TSE must be completed by all foreign pharmacy graduates, even those who are native English speakers. There are no exceptions or waivers to these requirements.”

The privilege of being tested in my native language will cost me \$130 (about £75), and my nearest test centre is about 60 miles away. Now, I wonder whether I will be tested on my competence in “proper” English or American English.

Sara Barrow
Montesano,
Washington

Hints on registering in France

From Mr R. Richardson,
MRPharmS

Further to a conversation with a fellow British pharmacist having difficulty in obtaining part-time employment in France. I would wish to pass through your letters section what I would regard as some essential information.

As a professional you are obliged to have a competence in the language with which you are to work. Since there is no formal examination for any EU state for a member within the EU, your future employer’s problems and responsibilities start at this point. The employer needs to be

E-mail

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

absolutely sure of both your professional and linguistic abilities. Help can be obtained by becoming a member of the Red Cross and helping a volunteer (*secouriste*). It improves language skill, gains entry free into top class football matches, etc. It also gives friendly contact with other health professionals local to your new home who can help with references.

And please go to classes before you come over and find your old GCE is no good — preferably long before you up and move.

Good luck!

Roland Richardson

Monaco

■ PHARMACY EDUCATION

Do you want medicines developed by a bunch of arbitrary scientists?

From Ms E. Harrop, MRPharmS

Being “someone who works in a research and development laboratory”, I would like to respond to Ms Wakeling’s letter (*PJ*, 31 July, p148) about training of pharmacists. The question keeps arising — what is a pharmacist? There are some who like to believe that only those pharmacists who dispense prescriptions or wander around hospitals in white coats are worthy of using the title. Perhaps this is their lack of understanding of the different opportunities available or the wide range of ways in which their colleagues contribute outside the stereotypical roles.

The current pharmacy course is an eclectic mix of a variety of different sciences and disciplines, which covers the whole sphere of drug delivery and development, and gives a pharmacist a unique position among graduates, to be able to converse confidently with a wide range of scientists and health care professionals including pharmacologists, toxicologists, chemists, nurses, microbiologists, senior consultants — the list goes on. Although I do not legally need to be a pharmacist to do my job I have found it brings a range of experience that, far from being a hindrance, is actually a great asset.

I think it is short-sighted to suggest that pharmacists are not required to be involved in the development process. Would you really want your medicines of tomorrow developed by a bunch of arbitrary scientists or would you prefer these advances to be made with the help of pharmacists, who have trained in the whole pharmaceutical process but bring with them their experiences of patient care and end user knowledge? I know which I would rather have.

Elaine Harrop

Cropston,
Leicester

■ TABLET IDENTIFICATION

TICTAC can be used to check proposed markings

From Mr J. Ramsey and Ms J. Woolley

TICTAC is the national solid dose form drug identification system. We read with interest the letter from Chris Toothill (*PJ*, 31 July, p149). We had also noticed the near identical tablets marked G 25 that contain different active ingredients. It was discovered by a TICTAC subscriber performing a routine identification.

Ecopace 25mg by Goldshield contains captopril and is 8.2mm diameter, 2.9mm thick and weighs 179mg. The gliclazide 80mg tablet is 8.0mm diameter, 2.6mm and weighs 158mg and is from Milpharm (the product licence holder) but also marketed by Ivax, Karib Kemi and perhaps others.

Ecopace has been in the TICTAC database since May 1998 but we were unaware of the gliclazide product, or the company (Milpharm) that supplied it, until alerted by our subscriber.

As Mr Toothill implies, this highlights the need for a formal mechanism to avoid duplication of tablet appearance. Our database (www.TICTAC.org.uk), although primarily used for identification, is also used by industry to check proposed markings. If companies were encouraged to contribute to and use TICTAC (as many already do) the problems illustrated by Mr Toothill would soon disappear.

John Ramsey

Director

Jean Woolley

Administrator
TICTAC Communications Ltd

■ TCM

Greater expertise in TCM needed worldwide

From Mr D. R. Williams, MRPharmS

I read with great interest, the article by Peter Houghton (*PJ*, 24 July, p125), concerning the joint meeting at Kew Gardens on 12 June this year, particularly since I was there.

It is not only the UK which needs greater expertise in traditional Chinese medicine but the rest of the world and, indeed, China itself. Practically all of these products are not manufactured to international standards in any respect. Evidence presented at the meeting by Mary Samuel of the University of Bradford, who practised with TCM in the UK for a number of years, indicated that many of the products available are spurious.

I and my company have specialised in so-called “alternative medicines” for many years and I have heard some real horror stories. I have also visited China on several occasions during the past 20 years and, apart from those manufacturers who have joint ventures with western companies, companies have little or no concept of international standards of good manufacturing practice, good laboratory practice or good clinical practice, etc.

In my professional opinion, as a pharmacist who has worked in the international pharmaceutical industry for the past 40 years, the availability of TCMs in the western world will, at some time in the future, pose serious problems.

David R. Williams

Loughborough,
Leicestershire

■ THE CHARTER

Credit where it is due

From Ms J. Goulding, MRPharmS

Colin Ranshaw in his letter (*PJ*, 7 August, p186) states that the Privy Council agreed to put the original Charter petition on hold so that minor amendments could be made. He concludes that, substantially, the original Charter petition was almost satisfactory. Surely he is hugely mistaken. First, the original Charter petition was put on hold because of legal action

taken by four members of the profession who made a huge personal sacrifice in so doing. Secondly, how can the original Charter petition have been substantially satisfactory when it directly led to the removal of those Council members who supported it in this year’s Council elections? How can it have been substantially satisfactory when it ultimately led to the removal of the previous president, vice-president and treasurer? Surely, had it been substantially satisfactory, it would not have led to what can only be described as the biggest constitutional crisis in the Society’s history? Perhaps Mr Ranshaw has also forgotten that it was he who stood up at the Society’s annual general meeting this year to warn pharmacists that they were delivering a vote of no confidence in the previous Council by voting to stop the previous draft (*PJ*, 22 May, p652).

Mr Ranshaw has suggested that it would be unfortunate if history wrongly attributed this draft Charter only to the present Council’s deliberations. He is correct; this new Charter draft was arrived at, not only because of the new Council’s efforts, but also because of what can only be described as unprecedented affirmative action taken by some members of this profession who managed against all odds to stop the highly damaging proposals laid by the previous Council.

Let the historians ensure that credit is given where it is due.

Jo Goulding

Warwick

Off the record

Our occasional series is open to any writer. Readers are invited to send either 400- or 600-word items about some anecdotal aspect of pharmacy practice that they think is worth sharing. Items are published anonymously but contributors must supply their full name and address. Items should be sent to graeme.smith@pharmj.org.uk for consideration

Broad spectrum

The Broad spectrum feature is open to any reader. Contributions of around 1,100 words commenting on topical issues should be sent to graeme.smith@pharmj.org.uk for consideration