

■ DISPENSING

Occurrence of bisoprolol/carvedilol dispensing confusion

From Ms H. J. Williams, MRPharmS

As a member of a specialist heart failure team and a supplementary prescriber working in an outpatients clinic, I can see first-hand the difficulties both patients and health care professionals face in managing the supply of complex medication regimens for heart failure, particularly beta-blocker dose titration regimens. From experience in my own practice, I would like to raise awareness among pharmacy colleagues of the potential for confusion when interpreting prescriptions and dispensing beta-blockers for patients with heart failure.

Over recent weeks a number of errors from primary care have become apparent in the clinic, where we check through each patient's medication supplies carefully at each visit as part of a medication review. For example:

- Bisoprolol 1.25mg tablets labelled as bisoprolol 10mg tablets
- A prescription for carvedilol 3.125mg *bd*, dispensed as bisoprolol (Cardicor) 3.75mg *bd* but labelled as carvedilol
- A patient who had been dispensed bisoprolol at a dose of 37.5mg daily instead of the prescribed 3.75mg daily

In only one of these cases was the patient aware of the error and had therefore been able to take steps to rectify it.

At the point of prescribing and dispensing there are a number of areas for potential error when using beta-blockers in heart failure:

- **Drug choice** — only carvedilol (Eucardic) and bisoprolol (Cardicor) are licensed for the management of heart failure. Care needs to be taken here as there is the possibility of confusion between generic and brand names
- **Dosing frequency** — carvedilol should be prescribed twice daily for heart failure, while bisoprolol (a long-acting beta-blocker) should be prescribed once daily
- **Dose titration** — each drug must be initiated at low dose and titrated slowly according to the product licence to minimise the risk of adverse effects

Each of the errors highlighted here could have had potentially serious consequences. I would therefore urge pharmacists to check prescriptions for these two drugs, carvedilol (Eucardic) and bisoprolol (Cardicor), carefully at the point of dispensing and ensure the appropriate drug, brand, strength and dosing instructions are provided to the patient.

Helen Williams

Pharmacy Team Leader, Cardiac Services, King's College Hospital NHS Trust, London

■ LEVOTHYROXINE

Liquid preparations should be a high priority

From Mr A. J. Nunn, FRPharmS

The method of preparing levothyroxine solution suggested by James Wells (*PJ*, 11 December, p852) is impractical for extemporaneous dispensing in the hospital or community pharmacy and has great potential for error if pure drug is used. The quantity of pure drug required for 100ml of solution of the strength stated is only 1mg and would require weighing of a much larger amount, measurement of aliquots from a solution and further dilution. Furthermore, no evidence of stability has been provided with the suggested method.

The recent series of letters (*PJ*, 6 November, p680, and 27 November, p785) about problems with oral liquid preparations of levothyroxine illustrates another aspect of the ongoing issues with medicines for children: an authorised indication and dose are

available for levothyroxine but no satisfactory dosage form is marketed for babies and young children. Tan *et al* reviewing the Australian market suggest that this is the case for approximately 25 per cent of medicines intended for children. In France an oral liquid preparation of levothyroxine (L-Thyroxine Roche; 5µg per drop) is authorised for children. This preparation can be imported into the UK but why is it not authorised and marketed here?

The Department of Health and the Medicines and Healthcare products Regulatory Agency have recently announced a paediatric strategy to improve the availability of medicines for children and to standardise the quality of extemporaneous formulations (*PJ*, 21 August, p246). This will include invitations to manufacturers of appropriate preparations authorised in other European countries to register and market them in the UK. However, this may not be viable if demand is low and it may be appropriate for importation to continue, but pharmacists need to know of the availability of these medicines and both technical and patient information must be translated into English. Rationalisation of the many different formulae used in extemporaneous dispensing is to be welcomed if this also leads to evaluation of their quality, stability and bioavailability. Comparison of preparations from different commercial and NHS sources has not been undertaken. Such research should be part of the programme for the Medicines for Children Research Network, in the process of being established by the DoH, and the issues should be addressed by the NHS manufacturing review.

The recent correspondence about liquid preparations of levothyroxine suggests that this drug should be given a high priority for attention by the DoH, the MHRA and developing research networks.

Tony Nunn

Clinical Director of Pharmacy, Royal Liverpool Children's NHS Trust

Reference

1. Tan E, Cranswick NE, Rayner CR, Chapman CB. Dosing information for paediatric patients: are they really "therapeutic orphans"? *Medical Journal of Australia* 2003;179:195-8.

■ CAM

I know enough to know I don't believe it

From Mr C. Morris, MRPharmS

In his **Broad spectrum** article on complementary and alternative medicine (*PJ*, 11 December, p848), Mike Price mentions taking a holistic approach. Have any studies been done to test the efficacy of prescribers spending more time with their patients and supplying conventional medicines? If not, maybe this is an area of study that needs exploring; maybe a holistic approach to conventional medication would improve patient outcomes. Maybe this is the answer to the powerful placebo effect.

I disagree with Mr Price's statement that "pharmacists should ask whether their knowledge is sufficient [regarding giving advice on CAM] and if it is not, to recognise the training gap". I do not supply advice on CAM. I do not know enough to do this but I consider that I know enough to know that I do not believe it is a sensible treatment.

I have always taken the stance that if someone told me that for years they have jumped in the River Exe every morning and eaten a pound of mud from the river bed to treat their sciatica and it does them the world of good I would be loath to talk them out of doing it — but I would not recommend that course of action to everyone who complained of sciatica.

I do have a knowledge gap regarding CAM but I consider it the same as my knowledge gap of cold fusion or contacting the dead: I believe I know enough not to waste any more time on it.

Chris Morris

Newquay, Cornwall

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.

■ HANGOVERS

No sympathy

From Dr R. C. Jacob, MRPharmS

I am writing with regard to Pamela Mason's continuing professional development article "Can hangovers be prevented or cured?" (*PJ*, 4 December, p817). On reading the conclusion I was not a little angry over her assertion that pharmacists should be sympathetic to hangover sufferers. Balderdash and poppycock! Those who drink themselves into such a state deserve everything they get.

Many years ago it was put to me that an "effective hangover cure" was a single 30ml dose of a mixture containing equal parts of Largactil syrup and the supernatant liquid from kaolin and morphine mixture. Is this worthy of inclusion in a CPD portfolio?

Roger Jacob
Orpington,
Kent

■ CPD

A Cub Scout's guide to getting started on CPD

From Ms R. Ramsey

Although unlikely to become a popular Cub Scout badge, the following "Stage I CPD Badge" may be helpful to pharmacists still contemplating opening their pizza box.

Complete four clauses:

- Find out what another pharmacist does and present it to the rest of your unit in an interesting way
- Learn to use the CPD website and demonstrate what you have learnt to the tester
- Attend several hours of presentations and make a decorated binder on a pharmacy theme to keep your notes in
- If you are a hospital pharmacist, be nice to a community pharmacist for a month
- If you are a community pharmacist, be nice to a hospital pharmacist for a month
- If you are an industrial pharmacist, do not complain about the Royal Pharmaceutical Society for a month
- If you are an academic pharmacist, do not complain for a month about the fact that everyone forgets that you (a) exist or (b) are nurturing the development of future pharmacists
- Take part as an extra in a CPD video

- Cut out pictures from the *PJ* and make a collage to show what pharmacy means to you. Explain your collage to the tester
- Explain to the tester the difference between CPD and COPD
- Grow your own *Amanita muscaria* or *Cannabis indica* and sell it to local schoolchildren. Send the proceeds to the Society
- Show the tester a draft letter to the Society telling it how much you have enjoyed your CPD

If you complete four more clauses you may be awarded another CPD badge. After a year you must either renew the CPD badge or remove it from your uniform.

Rebecca Ramsey
Pharmacy Student, Hertfordshire

Is it process or quality that is important?

From Mr P. Melnick, MRPharmS

At a local branch meeting held on 16 November, the Royal Pharmaceutical Society's appointed speaker stated that the Society would be monitoring the continuing professional development process rather than the content. Now, my only previous attempt to read the soporific "Plan and record" booklet had been less than successful but, spurred by her remarks, I took another look.

There, on the first page, it states that the emphasis will be on quality rather than quantity, when the Society monitors your CPD.

So which is right? Process or quality, bearing in mind that non-pharmacists can only monitor the former, while pharmacists can examine either?

Further, on p3 of the introduction, it mentions that some pharmacists are already recording their CPD in other formats and can continue to do so, provided it is more than simply a record of continuing education. But it is not

clear what is meant here. Speaking for myself, I have considerable difficulty in thinking in terms of reflection, planning, action and evaluation. If I need to find out something, I just do it. I do not feel the need to plan for it or justify it. I have therefore been recording my CPD in an exercise book without going through that process. Will that be acceptable in future?

Perry Melnick
Ilford, Essex

PETER WILSON, head of post-registration, Royal Pharmaceutical Society, replies: The quality of CPD records will be judged by comparison with the good practice criteria in Appendix 6 of the "Plan and record" document.

Pharmacists practise in a wide variety of contexts. Some are generalists and some are specialists. It would not be possible for the Society to make judgements of the quality of the content of CPD records submitted by every pharmacist.

Although pharmacist reviewers are not asked to make judgements about the quality of the content of CPD records, there are times when they are in a position to do this, for example, when a community pharmacist is reviewing another community pharmacist's CPD record. Having reviewed many thousands of CPD entries submitted by pharmacists participating in the Society's CPD pilots, it is rare for a pharmacist reviewer to identify an issue with the quality of the content. It would seem that once pharmacists identify what it is they want or need to learn, they are good at finding accurate information.

Nonetheless, if CPD reviewers identify CPD records where they have doubts about the quality of the content, the Society will look into these. But more commonly the problem lies with vague or unachievable objectives, little or no clarity as to why or how a particular topic is being learnt or little evidence that much development is actually making a difference to the services being delivered. The root of these problems lies in a lack of quality in the process or, to put it another way, the thinking behind the approach taken.

Alternative formats for keeping CPD records are acceptable but they require prior approval by the Society. The Society has agreed the format of CPD records provided to pharmacists employed by some of the multiples and some parts of the NHS. This policy allows

pharmacists keeping CPD records for their employer or for another professional organisation to submit those records to the Society for review without transcribing them to the Society's format. All the formats approved so far are structured around the four stages of the CPD cycle. A series of records in an unstructured exercise book would not suffice.

■ THE SOCIETY

A lot of pharmaceutical Pooh-Bahs

From Dr G. B. Drummond, MRPharmS

At a time when the Royal Pharmaceutical Society's finances are under some scrutiny, I am intrigued to discover members of staff of the Society (there seems to be a new one every week) whose function is to provide erudite footnotes on the letters pages of *The Journal*. Their job descriptions are reminiscent of Jim Hacker's department of administrative affairs and would certainly delight any pharmaceutical Pooh-Bah.

In these days of "open governance" is it possible that sometime we may see a complete cast list of these shadowy "Sir Humphreys"? If the *PJ* can do it, why not our pharmaceutical Whitehall?

G. B. Drummond
Hull, East Yorkshire

I am proud to belong

From Mrs R. M. Scott, MRPharmS

I am 83 years of age and recently widowed. My father and grandfather were both chemists and druggists. My father practised until he was 70.

My daily voluntary work gives me *raison d'être* and my luxury is remaining on the Register and receiving *The Pharmaceutical Journal*. So, therefore, I hope to continue paying the non-practising subscription.

I treasure my "Royal Pharmaceutical Society of Great Britain — Pharmacist" badge and I am proud to belong to this great Society, whose crest hangs on my bedroom door. And, in the night, I remembered: the Benevolent Fund supported my mother in her poverty.

Ruth Scott
Hove, East Sussex

Seasons Greetings!
The Journal would like to extend the compliments of the season to all those correspondents who have helped to keep the letters pages lively and interesting throughout the past year. The next issue of *The Journal* will appear on 8 January 2005, and letters for consideration need to be received by noon on January 4

THE REGISTER

An impossible situation

From Professor Trevor M. Jones, FRPharmS

I have been following with interest, and difficulty, the correspondence in your columns on the new registration requirements.

I have no statutory reason to maintain my membership of the Royal Pharmaceutical Society but, after a lifetime of commitment to our profession (and, I hope some would agree, being a constant ambassador for pharmacy and for pharmacists both here and abroad), I would like to continue to be recognised as a pharmacist and as a member of the Society.

However, the declaration that I am now being asked to sign puts me in an impossible situation in that it demands that I declare that I "will not work in or give advice in relation to the science of medicines". That I cannot do.

Beyond my role as director general of the Association of the British Pharmaceutical Industry, I am daily giving advice to a variety of public and private organisations, governments, etc, on the science of medicines. This is a central part of (i) my work on the World Health Organization Commission on Intellectual Property Rights, Innovation and Public Health, (ii) my role as chairman of several scientific advisory boards, and (iii) my role as a trustee of a number of scientific foundations and as a member of several boards of pharmaceutical or biotechnology companies.

My profession has been generous to me over the years through the award of the Charter gold medal and the Harrison memorial medal, in addition to the five honorary degrees and two honorary fellowships that I have been privileged to receive.

In addition I was particularly proud to be designated a fellow of the Society, but I have learned from my enquiry to Lambeth this week that if I do not sign the declaration I will be stripped of this honour.

It is clear from the correspondence in recent months that others who have served the profession well over many years feel equally let down by the Society. For me, as for them, it will be particularly sad not to be able to continue to be regarded, or even refer to myself, as a pharmacist.

Trevor Jones

Reigate,
Surrey

Returning to practice

From Mrs S. Campbell, MRPharmS

The **News feature** "To practise or not" (*PJ*, 4 December, p809) was an interesting read.

I am expecting my second child in January 2005 and will be on maternity leave from the end of 2004. As an NHS employee, I have the option of extending my leave for a full year until January 2006, although I am currently planning to return to work in September 2005.

I will be faced with a dilemma this January — to pay or not to pay? So what are my options?

1. I can pay £256 for the privilege of working part-time for four months of the year — knowing that if I change my mind about returning to work then I have effectively thrown £210 down the drain.
2. I can pay £46 and then top-up the full fee next September, if and when I return to work. (Is this an option? I do not know.)
3. I can choose to be neither practising nor non-practising, save my cash for now and make a decision later in the year. (Why pay £46 a year for the *PJ* when you are married to a pharmacist?)

Are there any other alternatives I have missed? Is it really fair to ask £256 for four months' part-time work?

Sally Campbell

Huddersfield

Clarification required

From Mr I. D. Spiers, MRPharmS

Having read the Royal Pharmaceutical Society booklet on whether I am to become a practising or non-practising pharmacist, I fall into the non-practising category. What has not been defined is how a non-practising pharmacist becomes practising again. How can we make important decisions without crucial information? I ask the Society to be reasonable in giving pharmacists a choice based on fact, not statements like "we will tell you in due course".

Even if it is not set in stone can someone tell me the likely path for conversion from non-practising to practising in the future?

Ian Spiers

Birmingham

ANDREW GARDNER, head of registration, Royal Pharmaceutical Society, replies: The need for pharmacists to be able to transfer from the non-practising to the practising section of the register was emphasised by pharmacists who responded to the continuing professional development consultation in March 2003. Respondents were keen to ensure pharmacists who were returning to practice were adequately prepared.

The requirements for transfer to the practising section will be agreed during 2005 and we expect them to come into effect in January 2006. While it is not possible accurately to predict the outcome, the regulations are likely to require a pharmacist who has been out of practice for more than 12 months (or is changing sector of practice) to confirm to the Society that they have completed a period of adequate preparation, for example, working alongside a practising colleague for an agreed period.

If these arrangements are confirmed, a pharmacist who has been registered in the non-practising section of the register for less than 12 months will be able to transfer to practising status on payment of the upgrade fee (£210).

A pharmacist who returns to the register as practising or non-practising having voluntarily retired from it will be required to pay a restoration application fee (£125) plus the current year's retention fee.

Superficial and rigid definition

From Ms A. B. Prasad, FRPharmS

It is with a Kafka-like sense of despair that I have studied the Council's narrow, superficial and rigid definition, of a "non-practising pharmacist".

As a retired pharmacist, I rarely "counsel", but must confess that I occasionally pass remarks on topics such as the importance of childhood vaccination, the value of antimarial prophylaxis, the dubious merits of "cough and cold cures" and the potential hazards of some herbal remedies. Moreover, I occasionally provide editors with suggestions on the content of the Royal Pharmaceutical Society's publications, such as the British National Formulary. Comments on the editorial content of the Society's publications cannot easily be dissociated from pharmaceutical insight.

Rather than use my own professional judgement as to whether or not it is appropriate for me to comment on the above matters, I shall soon need to pick my way through a minefield of Council-generated taboos.

I am (by and large) proud of my profession and trust that I have served it well. It saddens me to think that I may soon have to retire from the Register in order to retain my freedom of speech and judgement.

Anne Prasad

London NW3

Can the profession afford to haemorrhage?

From Mr B. G. Spencer, FRPharmS

Your editorial (*PJ*, 4 December, p802), which says that you hope members will think twice before deciding to leave the profession, and not just for 2005, is clearly sincere, tinged I dare say with a hint of self interest at the prospect of losing a significant proportion of the membership, and thus readership and potential income from advertisers.

It is to be expected that given a situation of pretty radical change within any group and its membership, many of whom resent having to pay compulsorily in any case, that they and others will consider their positions. Does the loyalty of having belonged and supported a profession for a working lifetime, as many members have, weigh heavily to counterbalance the affront at being so cursorily sidelined or marginalised, as the new edicts from Lambeth have done so effectively?

We live in an age of blame, litigation and in many cases rancour, much of which has been imported from our transatlantic cousins' lifestyle. We are also not blame-free as a profession, since there are many pharmacists and pharmacies who bring the profession into disrepute on a daily basis, many of whom are never caught in the act. With this Government's predilection for interfering and centralised control becoming ever more evident, it is surprising that our ancient profession has survived this long without major surgery.

So we have a choice, many will opt to stay temporarily, many will not, and others will discount ever returning to retrain or to re-enter the profession after a career break. The question is, can the profession

afford to haemorrhage in this way, losing the wisdom, experience and enthusiasm of so many able minds from the membership?

Brian G. Spencer
Sutton Coldfield,
West Midlands

■ RETENTION FEE

I had hoped to die as a pharmacist

From Rev D. Postles, MRPharmS

On 7 December I returned my retention fee form and indicated my intention to retire from the Register. I have done this with great regret after 53 years on the Register and a feeling not so much of retirement, but of having been “dumped”. The reasons for this decision are twofold.

First, the withdrawal of the retired members fee, which I have paid for the past 10 years, meant a 220 per cent fee increase to £46. This is more than the whole annual increase in my state pension for next year and with falling pension income it is just not possible to pay.

Secondly, the limitations placed on non-practising members by the retention form declaration seem unthinking, ludicrous and draconian. Unthinking, because they ignore the expertise and experience of many retired pharmacists more highly qualified and distinguished than me. Ludicrous, because in this age of the internet my lay friends can download masses of information, but I cannot express an opinion on it to them. Draconian, because if I tell my friend with stomach pains to stop taking aspirin and see his GP, I would risk “action by the Society commensurate with circumstances”. At least, as retired, I will have the same rights as the till operator in a supermarket or discount store with regard to advice.

I am proud to have been a pharmacist, especially in the early days in NHS hospitals. The pay was poor, but morale was high and the commitment was terrific. I wish the Royal Pharmaceutical Society

well for the future, but cannot feel it is still the caring one I joined in 1951. Having lived as a pharmacist for so long I had hoped to die as one. However, the church will still let me put “Rev” in front of my name and my university “MA” after it, even if the Society will not let me call myself a pharmacist.

Donald Postles
Abergele,
Chwyd

Who has resigned from the Register?

From Mr M. D. Mochan, MRPharmS

Having recently resigned my membership of the Royal Pharmaceutical Society I would ask that the Council, when the information becomes available, publishes the numbers of all former categories of pharmacists who have chosen to do likewise.

Murray D. Mochan
Nelson,
New Zealand

Care of the elderly pharmacist

From Mr R. C. Miles, MRPharmS

I was intrigued and delighted by the advertisement for a “care of the elderly pharmacist” (*PJ*, 27 November, pA20) placed by the United Bristol Healthcare Trust. As I am now in my seventh decade, do I qualify for such care, and would I have to move down to Bristol to receive it or is the care given at national level? Having been retired for over 10 years I applaud such consideration from the NHS.

Also, is being a member of the Royal Pharmaceutical Society a prerequisite of such benevolence, because I am sure that after January 2005 the membership of “elderly pharmacists” will go into a steep decline following the increase in fees?

Roy Miles
Cranleigh,
Surrey

Eat his cake and keep it

From Mr D. A. Canniford,
MRPharmS

I must bring to David Carr’s attention (*PJ*, 4 December, p816) that he can eat his cake and keep it. I have also been on the Register for about 55 years but retired 12 years ago and I have just been advised that we can get “unrestricted access” to the *PJ* by going to www.pjonline.com and downloading the latest *PJ* every Saturday morning.

We can now resign from the Royal Pharmaceutical Society, save our money to buy food, etc, in our old age but still keep up to date with all the developments in the health scene.

Dennis Canniford
Co Carlow, Ireland

A cost saving exercise?

From Mr A. Plumridge, MRPharmS

As a local branch secretary I regularly receive copies of letters congratulating members who have been on the Register for 50, 60 and even 70 years. If these members decide that it is not worth paying the non-practising fee and therefore leave the Register, these letters of recognition will become rarer or may even cease.

Congratulations to the Royal Pharmaceutical Society on another cost saving exercise!

Adam Plumridge
Cheltenham, Gloucestershire

A return to Christmas past

From Mr M. C. Motion, MRPharmS

After seeing our President’s smiling face in *The Journal* paying his retention fee online (*PJ*, 4 December, p833) it was with eager anticipation that I heard the crisp white envelope fall gently through the letter box.

Like Christmas come early, not only could I pay online, I could pay

with American Express, according to the form. No weeks of waiting for a receipt. In the old days you had to ask for one. An e-mail would confirm payment straightaway. But lo! My illusions are shattered: there is no Amex logo on the website to pay with.

Has the Grinch been at work? A quick call to the North Pole to find out what is going on. One of Santa’s little helpers comes clean. Santa’s elves made a mistake and forgot to check the label. There is clearly a lack of continuing education or an absence of operating procedures at the North Pole. Just when we thought retention fee payment had moved into the 21st century, it was just a vision of Christmas future and, as I reach for my quill and ink to scribe my cheque, I feel a return to Christmas past.

Felicitations and good tidings to you all!

Mike Motion
Wantage, Oxfordshire

The Society intended to offer the American Express payment option but a commercial agreement was not reached. Payment can be made by other major credit and debit cards.—EDITOR.

This is my swan song

From Mr A. L. Bartlett, MRPharmS

I am 87 years old, have been on the register for 63 years, retired for 22 years, and still open the *PJ* with enthusiasm every Friday when it arrives.

Why? All I read are the letters and the deaths. But what do I see now, on pA30 of the issue of 6 November under the “Market square” heading? An advertisement for “car registrations”. Blow me down! What is mine worth — LBS 12P?

Sadly, I think the new retention fee for retired pharmacists next year is a rip off, so this is my swan song. And a Merry Christmas to you all!

Les Bartlett
Southampton

Advertisement