

■ MEDICATION REVIEW

Pharmacists well placed to provide training

From Dr J. Kraska, MRPharmS, and others

In the light of the recent concerns over whether there are benefits for patients in pharmacists providing medication review services, Petty *et al* (*PJ*, 21 May, p618) suggest that there are questions about who should perform reviews. Although we would agree there are no published randomised controlled trials of reviews performed by GPs or nurses, we would draw your readers' attention to the extensive training programme we have undertaken in Angus Local Health Care Co-operative.

Following a pilot study in one practice in which five GPs and six nurses were trained to carry out reviews,¹ all GPs and primary care nurses in the LHCC have been offered training. Initially 45 GPs took up this offer, which they perceived to be beneficial² and others have since received the training. A total of 49 nurses have also received basic training in adding aspects of medication review to their routine practice.

Training enhanced the quality of GP reviews in the pilot practice¹ and the outputs from GP reviews suggest that, given the same time and systematic approach used by clinical pharmacists, GP reviews are likely to be as effective as pharmacist reviews (data in preparation). The nurses' reviews are still being evaluated, although we believe nurses are capable of identifying many common issues, addressing some themselves and referring onwards, most likely to pharmacists, for further advice.

Initial data suggest that more patients appear to prefer that a review be carried out by their GP than by a pharmacist.³ However, far from suggesting that pharmacists should abandon the concept of a medication review service, we believe our data support the idea that scarce pharmacist resource should be targeted to patients least likely to receive a review from a nurse or GP. This could include patients on large numbers of medicines, for whom a review will be time-consuming, and those in care homes or the housebound who are less likely to have a domiciliary review by a GP.

For the last year practices throughout the UK have been working towards targets set by the

general medical services contract which includes a medication review, carried out by a doctor, nurse or pharmacist. Therefore it would seem appropriate to ensure that these other professionals receive some training in the process, so that all patients can benefit. Pharmacists are well placed to provide such training, as well as carrying out reviews themselves and perhaps supporting pharmacy technicians to contribute to review services in the future.

Janet Kraska
David Gill
Angus LHCC

Denise Hansford
School of Pharmacy,
The Robert Gordon University,
Aberdeen.

References

1. Kraska J, Ross SM, Watts M. Medication reviews provided by GPs and nurses: an evaluation of their quality. *International Journal of Pharmacy Practice* 2005;13:77–84.
2. Hansford D, Kraska J, Gill D. General practitioners' views of pharmacist-supported training in medication review. *International Journal of Pharmacy Practice* 2004;12(Suppl):R79.
3. Kraska J, Ross SM. Medication review — whose job is it? *International Journal of Pharmacy Practice* 2002;10(Suppl):R86.

■ CLINICAL TRIALS

Guidance ignores trials involving several drugs

From Mrs S. J. Buckham, MRPharmS

Clinical trial guidance issued recently (*PJ*, 21 May, p601) fails to help pharmacists who are trying to bring academic trials of drug “cocktails” into line with the EU directive.

When the directive was published last year the Paediatric Oncology Pharmacists (POP) Group identified that for just one paediatric leukaemia trial there were, by EU definition, potentially 66 investigative medicinal products (IMPs). All are unlicensed for the disease and age group, but are used as part of trial therapy.

There is no funding body to cover the cost of drug treatment for trials like the one above, since the trials are a collaborative agreement to improve treatment of childhood cancer on the NHS.

As NHS contracts demand that we regularly change suppliers, we may have to swap mid-trial to an alternative manufacturer;

effectively a new IMP. We therefore use standard stock and not a separate trial supply.

There are currently about 30 active paediatric oncology trials co-ordinated by the UK Children's Cancer Study Group (UKCCSG). To persuade children to take medicines we may have to use several formulations for any drug in the trial protocol — some unlicensed “specials”. Even allowing for the few drugs that are fully licensed in this context, this leaves us with vast numbers of potential IMPs. The requirement for one set of stock for those “on trial” and one for those who receive “non trial standard” therapy, rather than them being randomised possibly to receive the investigative “cocktail”, is an additional headache.

POP is wholeheartedly behind properly conducted clinical trials, but the Royal Pharmaceutical Society has taken little account of the practicalities of its guidance in this area. Even the Medicines and Healthcare products Regulatory Agency failed to clarify the IMP status of the chemotherapy we use when they were requested to do so by ourselves and the UKCCSG.

Yet again children's services are being penalised due to a history of inadequate licensing of paediatric medicines. We need support from, and consultation with the Society, rather than an unworkable guidance that is clearly geared to a single investigational drug.

Jane Buckham
POP Group,
Sheffield Children's Hospital

■ THE COUNCIL

Call for debate!

From Mrs E. A. Mishon, MRPharmS

Graham Phillips *et al* (*PJ*, 14 May, p580) addresses the issue of those pharmacists who feel they have been disenfranchised. They emphasise the importance of the debate moving on from “who sits on the Council as of right?” to “how can the Council best represent the profession?”. They use the word “debate”, again inviting the membership to write to the columns of the *PJ*, or writing “direct to us at Lambeth”.

Here, we have four of the successful Save Our Society Council candidates demonstrating a willingness to listen. Does this invitation set a precedent? Will it

be ignored? The membership now certainly have a chance to be heard: we should take advantage.

Before their letter was published, Mr Phillips invited members of the “Private-Rx” discussion forum to contribute their views about how to encourage Society members to make their wishes known. The response was an overwhelming silence except for me. My suggestion that the *PJ* was the proper place for such a debate was ignored or met with disdain.

If the present lack of debate is an indication of the level of interest in the Society, its leadership, and where the Society is heading, then it is not surprising that decisions in the past were made without consultation. We can all criticise, constructive suggestions are harder to find. Mr Phillips is asking us to make our views known. Let us debate!

Anne Mishon,
Laurac le Grand,
France

■ ANNUAL GENERAL MEETING

Wrong impression

From Mr J. E. Balmford, FRPharmS, and Mr I. M. Caldwell, FRPharmS

We would like to correct the wrong impression given by your headline “AGM calls for the establishment of three new Society committees” (*PJ*, 28 May, p661).

The motion we proposed, and which was carried by the meeting, was to establish a group of members to consider the activities of the Royal Pharmaceutical Society; such a group would not be a committee of the Council. The whole purpose of our motion was that the group would be directly elected by the membership, in a way similar to how the honorary auditors have been elected in the past, ie, completely independent of the Council.

John E. Balmford
Ian M. Caldwell
Past Presidents
Royal Pharmaceutical Society

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 grae.smith@pharmj.org.uk for consideration

■ PHARMACOLOGY

Convulsions puzzle

From Mr A. C. Carter, MRPharmS

Would any colleague be able to throw light on the following unsolved problem?

A young woman suffering from fibromyalgia was prescribed hydroxychloroquine and amitriptyline by her GP. With her GP's consent, she attended a private fibromyalgia clinic where she received trigger-point injections of lignocaine, plus magnesium and Pabrinex. The consultant recommended that she discontinue the medication prescribed by her GP, which she elected to do abruptly rather than gradually.

Two weeks later, she returned to the clinic and the injections were repeated. Five hours later she collapsed and was admitted to hospital with convulsive episodes, which continued with varying severity for two weeks. Exhaustive tests at the hospital found no organic abnormalities and she was discharged.

Since no cause has been found for these convulsions, is any reader able to offer any plausible pharmacological hypothesis to account for them? This might possibly involve some form of delayed neurotransmitter surge following tricyclic antidepressant cessation, or the production of a super-sensitivity state in the skeletal muscle receptors.

Anthony Charles Carter
Paignton, Devon

■ GENERAL ELECTION

Not disappointed

From Mr D. Wood, MRPharmS

As you rightly say in a news item (*PJ*, 14 May, p572), I did lose my deposit in Barnsley Central in the general election, but I was far from disappointed by my result.

It was my first attempt and I received 1,175 votes. I helped to reduce the New Labour majority by 2,500 votes. In eight years, it has dropped from 24,501 to 12,732 — which is quite a change for Barnsley. A “national figure” — Robert Kilroy Silk — only managed just over 2,000 votes and Arthur Scargill's Labour Socialist Party, only managed 740 votes in Barnsley East.

Six years ago I was the first independent candidate to stand in a local election in Barnsley, when the

opposition was three out of a council of 66 members. I did not get elected, but that does not matter. Now the opposition is 23 out of 63 so I did start the ball rolling for change.

Donald Wood
Barnsley, South Yorkshire

■ TECHNICIANS

Society refuses to recognise qualification

From Ms D. Reece

After deciding to work in pharmacy on finishing my A levels, I joined Boots The Chemists. This was in 1994. I qualified as a health care assistant in 1995 and when the opportunity came up to train as a technician, I jumped at the chance. I qualified in May 1996 and have never looked back.

Since qualifying, I have worked in community, NHS hospitals, private hospitals and industry, as well as in locum positions for a short period. I have only been asked once about not having a hospital qualification (at my first job after leaving Boots) and was offered a conversion course to obtain the NVQ. I started this, then the funding disappeared. I was assured that I had proven myself and it would no longer be a problem. This was back in 1998.

I have now progressed further and am happy in my role as a MTO4+++ . On attempting to register with the Royal Pharmaceutical Society a few months ago, I was told that my qualification and experience are not valid to register as a technician and I must re-train. This is not what I wanted to hear.

Boots has written a conversion course, which apparently only applies to those still working in a community environment, so this is not helpful. I am studying management in my spare time after work, so time to retrain or do NVQ modules in between is not feasible.

The idea of me being penalised on a qualification I attained in 1996 is ludicrous. Had I known then that I would be in this position, I would not have undertaken that training.

I have also been advised by the Association of Pharmacy Technicians that I should be able to go via the grandparent route, but the response I have had so far from the Society is contrary to this.

I would be interested to hear from anybody else in a similar

situation (dawn.reece@uclh.org), since I am sure that I cannot be the only one with this problem.

Dawn Reece
*Pharmacy Distribution Services
Manager,
University College Hospitals London*

■ ISCHAEMIC EVENTS

NICE guidance fails to address key issues

From Dr S. Jarvis and others

After two years of review and consultation, the National Institute for Clinical Excellence has just published guidance on the use of anti-platelet agents for the prevention of occlusive vascular events in high risk patients. As physicians with expertise in the management of these patients, we had some concerns when the two appraisal consultation documents were published. We highlighted these concerns to NICE and the institute has taken some of our recommendations on board. However, two of our key issues have not been addressed, and NICE appears to have missed the opportunity to make a major contribution to government targets for reducing heart disease in the population.

One problem is the inconsistency in NICE's approach, such as the decision to view each manifestation of occlusive vascular events separately, even though NICE itself concedes that they have a common underlying cause. The fundamental thrust of secondary prevention in ischaemic vascular disease rests on the increased risk of patients who have suffered a cardiovascular event.

However, there is extensive evidence that patients suffering symptoms in one vascular bed (eg, stroke or peripheral arterial disease) are at greatly magnified risk of further events in another (eg, myocardial infarction), as well as at the site of the index event. Surely, then, effective prevention needs to address all manifestations of ischaemic vascular disease and not tackle events in isolation.

We are also particularly concerned that NICE fails to achieve its stated goal of offering practical guidance for doctors — where is the advice on how to treat the many patients who have an event despite taking the first choice of treatment, aspirin? These patients are at high risk of having future vascular events, but NICE has steered away from the issue. NICE has a difficult task trying to balance clinical improvements with cost containment but, on this occasion, the messages lack clarity and ignore the position of patients who fail to fit the criteria of an artificially simplistic care pathway. The limitations of the new guidance on occlusive vascular events need to be made clear to doctors, so that they understand the need to continue to use their clinical judgement in complex cases. Only by so doing can we ensure that, where NICE has failed to address all issues, patients continue to be offered optimal care.

Sarah Jarvis
GP, Richford, London
David Lindsay
*Consultant Cardiologist, Gloucester
Royal Hospital*
Jonathan Morrell
GP, Hastings, East Sussex
Maureen Richmond
*GP, St Hilary Brow Group Practice,
Wallasy, Merseyside*

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.

■ COMPLEMENTARY THERAPIES

“Belief” article prompts comment

From Mr J. Sharp, Hon MRPharmS

Ray Sturgess's interesting article “Belief: an amazing healing device” (*PJ*, 14 May, p590) makes a number of points which prompt comment, including: “The era of effective medicines came in only 60 years ago. Before then there was only digitalis . . . mercury compounds . . . opium and aspirin.”

Although it is, indeed, true that the great majority of currently used medicinal substances of proven efficacy were introduced only within the past 60 years, Mr Sturgess's second statement is untrue. Many more than four efficacious drugs were available, and in use, before 1945, some well before. They include arsephenamines, sulpha drugs, diamorphine, atropine, hyoscyne, strychnine, insulin, phenytoin, quinine, cocaine, physostigmine, smallpox vaccine and diphtheria vaccine, etc. Even penicillin, streptomycin and aminosalicylate sodium (PAS) might just about be included in a list of effective medicines in use over 60 years ago.

To assist in the “understanding of the action of complementary medicines”, Mr Sturgess recalls “a classic study in a factory in Holland” in the late 1940s. Here, after discussion with the workers, overhead lighting was boosted. Productivity increased. However, when the lighting was reduced to below the original level, productivity increased yet further. Mr Sturgess may like to be aware that the classic study along these lines, where a series of operator benefits (more breaks, shorter hours, free hot meals and so on) were sequentially introduced, and then sequentially taken away (with increased productivity in both the “giving” and the “taking away” phases) is the so-called Hawthorne experiment of the mid-1920s.¹ “All new ideas are ignored or rejected until their time is ripe. Copernicus argued that the planets . . . revolved round the sun almost a century before Galileo did.” Yes indeed, although it is not entirely true to say that Copernicus's ideas were “ignored or rejected” any more than were those of Galileo. In any event, both of them were beaten to it, in proposing a heliocentric planetary system, by around 2,000 years, by Aristarchus of Samos (ca 310–230 BC).

Having stated that “the fact is that homoeopathic preparations

have consistently failed to produce results better than those achieved by placebos”, Mr Sturgess later states that “only those herbal medicines that have been shown to be effective should be stocked in pharmacies”. By this token, surely, should not this also apply to homoeopathic “remedies” which have not been shown to be effective, that is (as Mr Sturgess indicates), all of them?

“The one area where complementary medicines score over conventional drugs is in their safety.” I have seen various homoeopathic preparations advertised for the treatment of, for example, cystitis, “piles which ooze dark blood”, whooping cough, “burning pain in stomach”, food poisoning, “vomiting with abdominal pains”, “falls injuring the spine” and so on.² Is it really “safe” to reject proper treatment for such conditions in favour of unproven mumbo-jumbo “remedies”?

John Sharp

Woodley, Berkshire

References

1. Brown JAC. *The social psychology of industry*. London: Penguin Books, 1964: p69 et seq.
2. Sharp J. Some reflections on homoeopathy. *Pharmaceutical Journal* 1986; 236: 758-60.

“Belief response” article contains several inaccuracies

From Dr L. R. Kayne, MRPharmS

I read with interest Ray Sturgess's article on belief (*PJ*, 14 May, p590). His ideas are not new — indeed many others¹⁻³ have made similar suggestions without feeling the need to attack homoeopathy specifically. Unfortunately, in Mr Sturgess's haste to denigrate the therapy, some inaccuracies have crept in.

Relatively minor errors such as the point “diluted to infinity” appear early in the article. Although true that many homoeopathic remedies are diluted beyond Avogadro's number, the majority of those available for OTC sale in pharmacies are not.

As the article continues, we find that Mr Sturgess wrongly quotes Hahnemann's first principle (a simple internet search reveals this is actually “similia similibus curentur”) and continues to argue that homoeopathy has “consistently failed to produce results better than . . . placebos”. Several widely cited papers, including for example, those of Taylor/Reilly,⁴ Mathie⁵

and Linde,⁶ would appear to suggest that the true situation is not quite as straightforward as this article would have us believe.

As a pharmacist, I think that the whole “homoeopathy as placebo” argument is getting rather old now — if the patient gets better, I have effectively performed my professional role. Is the why and how really that important? How does one measure a placebo effect in babies, in whom homoeopathy is widely used? I can offer many such cases, even where the parents were sceptical. . . so no belief mechanism at work there. Then there is the fact that homoeopathy appears to be beneficial in veterinary medicine. . .

Mr Sturgess then proceeds to ridicule the Royal Pharmaceutical Society's Code of Ethics, specifically the paragraphs on complementary medicine. I would suggest that his criticisms may again have been a little hasty for the following reasons: a number of homoeopathic producers in the UK hold a Medicines and Healthcare products regulatory Agency licence — surely the definition of “a reputable source of supply”. Mr Sturgess notes that pharmacists are apparently not prevented by the code from selling “dubious” remedies (you can hear the manufacturers of cough and cold preparations breathe a collective sigh of relief). Check the *BNF* 49 section 3.9.2 — “there is no evidence that any drug can specifically facilitate expectoration . . . However, a simple expectorant mixture may serve a useful placebo function” and that “compound preparations are on sale to the public for the treatment of coughs and colds; the rationale for some is dubious.” Should we clear these “hocus-pocus” items off our shelves?

A number of accredited postgraduate courses are offered for pharmacists in complementary medicine, and the subject is taught at undergraduate level throughout the UK.

Mr Sturgess concludes that a pharmacist's motivation to become involved in complementary therapies is money. This is an unnecessary slur on the professionalism and education of

those pharmacists who are involved for a more traditional reason — helping the patient. I am forced to wonder when Mr Sturgess was last faced with a pregnant woman with morning sickness or a week-old baby with severe colic for whom homoeopathy is safe and, in my experience at least, effective. Because of homoeopathy, I have something to offer rather than an apologetic shrug.

Lee Kayne

Glasgow

References

1. Lundh LG. Placebo, belief, and health. A cognitive-emotional model. *Scandinavian Journal of Psychology* 1987; 28: 128–43.
2. Hrobjartsson A, Gotzsche PC. Placebo interventions for all clinical conditions. *Cochrane Database Systematic Reviews*. 2004; (3): CD003974.
3. Kradin R. The placebo response complex. *Journal of Analytical Psychology* 2004; 49: 617–34.
4. Taylor MA, Reilly D, Llewellyn-Jones RH, McSharry C, Aitchison TC. Randomised controlled trial of homoeopathy versus placebo in perennial allergic rhinitis with overview of four trial series. *BMJ* 2000; 321: 471-6.
5. Mathie RT. The research evidence base for homoeopathy: a fresh assessment of the literature. *Homeopathy* 2003; 92: 84–91.
6. Linde K, Clausius N, Ramirez G, Melchart D, Eitel F, Hedges LV et al. Are the clinical effects of homoeopathy placebo effects? A meta-analysis of placebo-controlled trials. *Lancet* 1997; 350: 834–43.

RAY STURGESS, author of the article responds: It was predictable that my article, proposing the belief response as the mechanism for the working of homoeopathy and other complementary medicines, would engender objections from homoeopaths. Man has an innate urge to believe and many believers remain blinkered, however convincing the contravening evidence.

G. K. Chesterton observed that when man ceases to believe in God, he does not believe in nothing — he believes in anything. The proliferation of complementary medicines, including homoeopathy, reflexology, Reiki, Bach flower treatment, healing crystals and copper bangles, as Christianity has declined, suggests that he was right.

As for homoeopathy itself, until its protagonists come up with demonstrable evidence of its mode of action, then belief seems by far the most likely explanation of the benefits it confers. Homoeopaths have not, after all, yet produced an alternative answer, in spite of having had a century and a half to do so.

Telephone number
All correspondents, including e-mail correspondents are asked to supply a postal address and a daytime telephone number, in case we need to contact them urgently