

## ■ PRESCRIPTIONS

**Comments from Welsh Executive on charges**

From Mr P. J. Jones, MRPharmS

Malcolm Allan (*PJ*, 19 November, p631) asked if the Royal Pharmaceutical Society's Welsh Executive had any evidence to show that the phased elimination of prescription charges has led to frivolous use of NHS resources.

It has been difficult to draw any conclusions about the impact of the abolition due to its phased nature over a long timescale. Full abolition will not occur until April 2007.

The implementation so far has not been without difficulties. We will continue to monitor the situation and engage with the Welsh Assembly Government to highlight the practical implications of abolition. This engagement is informed by Royal Pharmaceutical Society policy and the comprehensive review of evidence that was commissioned by the Society. Our views match those submitted by our colleagues in Scotland to the Scottish Parliament.

As with all of our work streams, we will share our experiences with colleagues in Scotland and England on an ongoing basis.

**Peter Jones**  
Chairman  
Welsh Executive,  
Royal Pharmaceutical Society

**Scottish Executive discusses prescription charges**

From Ms A. T. Timoney, MRPharmS

Malcolm Allan (*PJ*, 19 November, p631) asks for evidence that the phased elimination of prescription charges leads to frivolous use of NHS resources. In his letter he seems to suggest that all pharmacy organisations represented at the Health Committee of the Scottish Parliament opposed Colin Fox's Bill. This is not true — the views he quotes are from the Scottish Pharmaceutical Federation. There is diversity of opinion within pharmacy and the Royal Pharmaceutical Society's views were clearly stated.

The Society commissioned a review of evidence both within the

UK and internationally. This concluded that many questions remained unanswered. For this reason, when I spoke at the Health Committee meeting of the Scottish Parliament, I pointed out our view that further research is required and the consequences of abolition of prescription charges on patients, the public and NHS professionals must be considered. It is our view that the current system is both

illogical and unfair but any replacement must improve the situation.

This issue is complex and for this reason we organised a briefing session in June of this year for members of the Scottish Parliament and their researchers, with the Royal College of General Practitioners. In this session, in our written reply to the consultation, and at the Health Committee

**Letters to the editor**

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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.

meeting, we repeated our view that where total abolition is contemplated we would advise that this should also be accompanied by measures to reduce any negative impacts, such as increased pharmacy and GP workloads, the potential to undermine minor ailments schemes and moves to increase reclassification of medicines.

Mr Allan is right to say that we must learn from experience in Wales. The issue of prescription charges will come back to the Scottish Parliament as the Government has committed to a review of exemption for those in full-time education and people with long-term medical conditions.

The Society's Scottish Department will contribute to this discussion and continue to work with our colleagues in Wales to ensure that lessons learnt there can be shared across Great Britain.

#### Angela Timoney

Chairman Scottish Executive,  
Royal Pharmaceutical Society

#### ■ CONTROLLED DRUGS

### Notice of change to handwriting requirements was too short

From Mr A. C. Dean, MRPharmS

The significant change to the legal requirements for Controlled Drug prescriptions, ie, the abolition of handwriting requirements will, no doubt, be widely welcomed.

It is of some concern, however, that the notice given (as far as I am aware it was just a news item [p597] and an article [p617] in the *PJ* of the 12 November) was short and poorly publicised, leading to many pharmacists I know being unaware of the changes prior to their taking effect.

It is to be hoped that future changes to legislation (including changes following the Shipman inquiry) will be better communicated to both the pharmacy and medical professions.

#### Anthony Dean

Executive Officer  
Norfolk Local Pharmaceutical  
Committee

### Confused over changes to handwriting requirements

From Mr R. A. Hancocks,  
MRPharmS

I write because I am now somewhat confused over the purpose of the prescription requirements for Controlled Drugs following the amendments to the Misuse of Drugs Regulations (*PJ*, 12 November, p597 and p617). When a doctor was required to handwrite the prescription it was my assurance that I was interpreting his or her own prescription; the additional requirements such as total quantity in words and figures, and pharmaceutical form were there to ensure the prescription was unambiguous. The removal of the handwriting requirement means that when details are missing anyone can insert them: the pharmacist, receptionist, nurse, ward clerk, or patient. Once the pharmacist is assured that they are dispensing the prescription as intended, this subtle change has turned a prescription requirement into an endorsement requirement and I am not sure how that adds to the control of Controlled Drug.

I am fully supportive of computer generated prescriptions for Controlled Drugs and these should be the "norm" as they are clear and unambiguous. I am sure that the regulations could have been formulated to allow computer prescribing but to retain the handwriting requirement in other circumstances. As the regulations stand at present, they appear pointless.

#### Roger Hancocks

Worksop,  
Nottinghamshire

#### ■ MEDICINES USE REVIEWS

### Am I wrong?

From Mr M Goldin,  
MRPharmS

It was with great relief that I read the letter from Susan Coyle (*PJ*, 19 November, p633) about medicines use reviews.

It is good to know that I can now feel more comfortable in wanting to do MUR in a community pharmacy environment.

All it seems to boil down to is that I only have to advise on concordance and compliance. Would it not just be far simpler to

encourage patients to make the effort and read the patient information leaflet that is now standard issue with every prescription, or is that too simple or too much to ask of the general public?

Please correct me if I am again wrong in my assumptions.

#### Monty Goldin

London

#### ■ IT SUPPORT SYSTEMS

### Patient administration systems

From Mr A. P. Gledhill, MRPharmS

Keith Kirtland (*PJ*, 26 November, p660) is correct in emphasising the importance of decision support software in reducing and minimising prescribing errors. Secondary care has so far been unable to benefit from this technology due to lack of investment and poor information technology infrastructure. Fortunately that is now changing and most hospitals will have new nationally designed and accredited patient administration systems

(PAS) installed over the next 12 months. When this is done it should be possible to start the implementation of sophisticated ward-based electronic prescribing and drug administration systems. As this software is still in development I urge senior pharmacists in secondary care to find out from their local service providers (see "Connecting for health" website: [www.connectingforhealth.nhs.uk](http://www.connectingforhealth.nhs.uk)) about what is the output-based specification, who is involved in their design, what local input is required and when the date of implementation is likely to be. We have been waiting too long for this technology and the sooner it is installed and up and running, the more lives will be saved.

#### Andrew Gledhill

Burnley, Lancashire

#### 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](mailto:graeme.smith@pharmj.org.uk) for consideration

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#### E-mail

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■ SAFETY

## Packaging of methotrexate tablets

From Mr C. F. Brewer, MRPharmS

Since methotrexate is normally prescribed as a weekly dose (and now commonly labelled with a warning to that effect), why are the 2.5mg tablets still supplied in packs of 28? Surely the potential for a dangerous dispensing error would be reduced if they were not packed in a multiple of seven.

**Chris Brewer**  
Cockermouth,  
Cumbria

BRUCE CHARLESWORTH, head of medical affairs at Pfizer UK, responds: As one of several manufacturers of methotrexate, Pfizer can only comment on its own packaging practice which differs from the "multiples of seven" approach under scrutiny here. On the whole we agree that the potential for confusion exists when a weekly medication is packaged in multiples of seven — this is one of the reasons Pfizer only packages methotrexate in quantities of 100.

This does not simply mean we disregard the need for further improvements to our medicines — on the contrary, we continually review and agree the nature of our packaging and our labelling alongside regulatory bodies such as the Medicines and Healthcare products Regulatory Agency, health care professionals and patients as necessary, in order to ensure effective and safe administration. To this end, Pfizer is actively working with the National Patient Safety Agency (NPSA) to find optimal packaging for this particular medicine by addressing opportunities beyond simply the number of tablets per pack. As an example of our commitment, Pfizer has already opted to change the shape of the 10mg tablet in line with recommendations to clearly differentiate the 10mg and 2.5mg tablets. Evidence from the NPSA also suggests that methotrexate should be available in packs of one, two or three months' supply depending on the individual patient, and this is in hand.

A change in packaging is an involved undertaking and cannot be addressed with a short-term solution. Any change implemented must address public needs such as the shelf life, the usability and convenience as well as maximising

patient safety wherever possible. With this in mind, any further changes to the packaging in light of our collaboration with the NPSA, will be addressed in tandem with ensuring it is also acceptable to rheumatoid arthritis patients. We have made sure that research into the suitability and safety of all packaging is undertaken wherever necessary.

MIKE REARDON, group executive director, Goldshield Group Plc, responds: Although Goldshield is not currently the marketing authorisation holder for this product, the company has made a full contribution to the National Patient Safety Agency initiative on improving patient safety, with respect to methotrexate use.

When Goldshield takes over responsibility for the supply of this product from Wyeth Pharmaceuticals, we are committed to introducing (as quickly as possible) a 24-tablet pack with revised labelling, designed to reduce the risk of daily dosing and equivalent to a one-, two- or three-month supply depending upon individual dose. The pack designs have already been agreed with the manufacturer and the revised labelling is currently with the MHRA for approval.

We would hope that the new pack initiative will have been fully implemented by all suppliers within a few months.

GERAINT MORGAN, manager of medical information, Mayne Pharma Plc, responds: Mayne supplies methotrexate tablets (2.5mg and 10mg) in a bulk pack containing 100 tablets, as opposed to the packs of 28 described. This minimises the potential for inadvertent daily dosing as a result of being supplied in a multiple of seven tablets.

Mayne has been working with the National Patient Safety Agency as part of the Pharmaceutical Industry Reference Group to reduce the potential for harm caused by oral methotrexate. This has resulted in several positive changes that minimise the risk of inappropriate dosage including:

- A shape change to the 10mg tablets to make it easier to distinguish between the Mayne Pharma/DBL 10mg and 2.5mg methotrexate tablets
- A change in the packaging of both the 2.5mg and 10mg tablets to highlight clearly the tablet strength, dosage warning, and the tablet shape

■ COMPLEMENTARY MEDICINE

## The roots of our profession

From Mr M. Levy, MRPharmS

The article on complementary medicine (CM) by Edzard Ernst (*PJ*, 12 November, p612) was interesting, and hit on an important number of points.

I agree with the article in that for any treatment, the efficacy, cost effectiveness and, in the end, the continued well-being of the patient, are important. Clinical trials show the reproducibility and viability of these results.

While we are trying to compare the effectiveness of treatments in CM related to conventional treatment, and placebo, there are problems in taking a look at the whole treatment process and comparing them. In CM and, to a much lesser degree, in conventional medicine, the treatment is often based on the individual practitioner, sometimes with many repeated visits. Since we are comparing the whole treatment (doctor, treatment, outcome), we should be able, to a degree, to compare net results. That

there may be a large placebo effect should not be such a problem as long as the required results are achieved.

CM practitioners should also be open to the fact that while some of their treatments may not work, others may be effective.

At the end of the article are examples of treatments with evidence of efficacy. The public (and pharmacists) forget about the roots of our profession. Digitalis, quinine and opium are a few examples.

**Morris Levy**  
Jerusalem, Israel

### Off the record

Our new 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](mailto:graeme.smith@pharmj.org.uk) for consideration

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