

■ SKIN CONDITIONS

Fungal nail infections are not trivial

From Mr P. Lapsley

Run by patients for patients, the Skin Care Campaign represents the interests of all people with skin diseases in the UK. We, at the campaign, have become concerned recently to learn that several primary care trusts have removed treatments for fungal nail infections from their formularies, preventing GPs from prescribing them.

Skin diseases and, with them, dermatology are not always taken seriously enough, either by those members of the public who are not affected by them or by health professionals and managers. Potentially fatal conditions like skin cancer and epidermolysis bullosa aside, the quality of life issues associated with many skin diseases can be serious.

Fungal nail infections are not trivial. Left untreated or treated inappropriately, they can cause severe complications and be damaging to patients' quality of life.

Treatments for fungal nail infections are widely used throughout the UK and we find it difficult to understand why some PCTs are apparently determined to deny such treatment to their patients. Such cases seem to us to be clear examples of so-called "postcode prescribing" — one of the least attractive, residual characteristics of the old NHS.

We would ask pharmacist advisers to bear this in mind when reviewing formularies.

Peter Lapsley
Chief Executive
The Skin Care Campaign

Dangers of the sun outweigh a lack of vitamin D

From Mrs N. R. Soulsby, MRPharmS

I am a British pharmacist who has been living in Australia for the last five years. I read Oliver Gillies's **Broad spectrum** article (*PJ*, 7 January, p10) and was astounded by his recommendations. I was diagnosed with melanoma in November last year and had to have extensive surgery. Fortunately it had not spread and I am just left with physical and psychological scarring. My melanoma was picked up during a routine mole check carried out by my GP. Thankfully, I live in a country where the dangers of sun bathing are well known and we are on our guard. My mole was not typical since it had been there for years and had not changed in any way. If I had still been living in the UK I would never have thought to have had my moles checked. Melanoma is associated with being burnt in your formative years but the risk continues, especially if you expose yourself to the sun in the middle of the day. I was put at risk (unknowingly) when I lived in the UK and had holidays in Europe.

If I were worried about a lack of vitamin D in my or my family's diet, I would rather ensure that we took vitamin D supplementation than run the risk of getting skin cancer. It can happen to anyone — I do not have fair skin. In fact, I tan and have dark features.

Skin cancer is preventable but only if we are sun safe. That includes avoiding sun beds, too.

Natalie Soulsby
Clinical Pharmacist
Royal Adelaide Hospital and
University of South Australia

■ STATINS

Dosing issuesFrom Mrs I. Gummerson,
MRPharmS

At a recent multidisciplinary meeting, a consultant (from Northern Ireland) criticised pharmacists, saying that he wished that when he wrote "one in the morning" on prescriptions for statins, that the pharmacists would not advise the patient to take them at night. He explained that in his experience, some patients had side effects if they took a statin at night and he had read no evidence that he should not prescribe them to be taken in the morning. Surely, he said, it was better for a patient to take the statin, than not comply due to side effects.

After the meeting, I telephoned Merck Sharpe and Dohme and asked about Zocor (simvastatin). The adviser there said something to the effect that 36.3 per cent of the dose was effective if the tablet was taken at night, and only about 20 per cent if taken at lunchtime.

I would welcome pharmacists views on the following issues:

Liaison issues I felt if the consultant had a problem with local pharmacists he should contact the local primary care trust (or equivalent health authority) adviser or the local pharmaceutical committee (or equivalent for NI) and come to some amicable arrangement. Perhaps pharmacists, not knowing his reasoning, might have thought the morning dosage was a typing error, and amended it to the licensed dosage.

Licensing issues If the medicine was licensed to be used at night,

would it be right for the PCT or LPC to advise pharmacists to comply with the prescription and type "one in the morning"?

Compliance issues If the patient could only take it in the mornings, should pharmacists say anything to the patient about it being an unlicensed dosage? Would this put doubt in the patient's mind about conflicting messages? As a result they may not take the dose at all.

Medicines use review opportunity? Perhaps pharmacists should see a morning dosage written for statins that are licensed for night time as an opportunity for an MUR intervention, and ask whether the patient has had side effects with a night-time dose.

Typing error or policy? Perhaps pharmacists seeing a morning dose should have a discussion with the prescriber to see whether they have a deliberate (occasional) morning policy, rather than just assuming it is a typing error.

Irene Gummerson
Wakefield, West Yorkshire

■ INDEPENDENT PRESCRIBING

Not just an extension of our present duties

From Mr G. M. S. Hill, MRPharmS

I would like to respond to the **Broad spectrum** article by Roger Cotton (*PJ*, 14 January, p38). I would like to think that I have some expertise in the field of prescribing, since I qualified as a supplementary prescriber last year.

The arguments used to urge caution against independent

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Letters to the editor

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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.

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prescribing are disingenuous and reflect unfairly upon a group of practitioners who are pioneering in their training and consequently their approach to the consultation process. It is regrettable that the term "independent pharmacy prescriber" should be prevalent, rather than a more relevant description such as, specialist prescriber in "specialty" or prescriber (competent in "specialty"). This distinction is important for two reasons:

- It dissociates the health care professional from his or her original chosen field (after all, the legislative changes affect nurses and other sub-groups of the health care field).
- The intention is surely not to compete with GPs but rather to pursue the Government's agenda of greater access to medicines and an improvement in clinical governance.

Mr Cotton has made the mistake of assuming our powers will be the same as that of the local doctor. This is simply not the case because:

- The new generation of prescribers are bound by national or local guidelines and will be obliged to adhere to best practice. Protocols will have to be in place from everything from taking blood to ensuring notes are entered on patient records in the appropriate format.
- Accountability is a cornerstone of the contractual obligations of workers in these fields. Being signed off as an independent prescriber will not be a satisfactory conclusion to the audit process of a pharmacist or nurse practitioner. Rather, the highest standards will have to be maintained to justify our existence to our paymasters, the primary care organisations.

We are not accountable for the culture of prescription "expectation" and have been trained how to deal with such situations in our supplementary guise. Furthermore, the explicit detail of guidance for each particular area of competence will ensure no over-prescribing can nor will take place. Any individual found wanting should not be allowed to practise as a prescriber (not every pharmacist is going to be an independent prescriber, the same as not every pharmacist is a supplementary prescriber). The principal reason for the existence

of such prescribers is to oversee chronic conditions already diagnosed. If any diagnosis takes place it will only be when the prescriber has had the necessary training or demonstrated they have had the necessary experience.

The professional that Mr Cotton describes is a new one and should be valued as such. It is wrong to assume the matter of prescribing is simply an extension of our present duties.

Graeme Hill

*Halsall,
Lancashire*

■ COMPLIANCE AIDS

To repackage or not to repackage?

From Mr P. Williams,
MRPharmS

I read with interest the article highlighting the research done by Claire Church and Jane Smith into the stability of medicines when repackaged into compliance aids (*PJ*, 21 January, pp75–81). The article would appear to suggest that one of the main issues is the unknown impact on stability versus the known impact of withdrawal of compliance support.

However, I believe that what should actually be central to this issue is the welfare of the patient. On the one hand, we know from the results of an assessment tool, that if compliance support is withheld, patients will struggle to self manage their medicines. On the other hand, the unknown is the impact on the stability of the medicine that might result from repackaging it.

As pharmacists we are professionals and are supposed to make decisions which will benefit our patients' health. If we turn our backs on our responsibility to make these decisions or judgements and instead rely on charts and tables, then we would be seen as being of little more value than dispensing robots.

I do understand the dilemma that drug manufacturers face in providing advice when there is no specification, measure or indication as to the degree of protection that various packaging products offer. There are obviously going to be differences in moisture and light permeability of different packaging design and materials. There is also little information available as to the impact on the efficacy of a treatment that may be contaminated as a result of reusing

a plastic box that has not been cleaned.

Yet, while I understand this dilemma and appreciate the information made available following Church and Smith's research, I do suggest caution in pharmacists hastily translating the "where there's no information available, do not" comment. Particularly in relation to changing the compliance service a patient has been successfully receiving for a period of time.

As Chris Toothill mentioned in his letter last week (*PJ*, 28 January, p105), this makes a grey area even greyer. He asks the question if the preferred option is to stop dispensing with compliance aids and risk complicating a drug regimen for a vulnerable patient, or carry on and ignore the product licence. I would answer that surely, where there is information from the GP that the treatment managed in such a way, is functioning satisfactorily for the patient, withdrawing the compliance support — and risking the negative impact on the patient as a result — is actually putting the efficacy of the treatment at risk.

To help us make these decisions though, we must focus attention on researching the evidence of clinical and health economic benefits of a pharmacist-led compliance support and not just rely on anecdotal evidence, however compelling it may be.

Peter Williams

*Pharmacy Proprietor and Managing
Director
MTS Medication Technologies
Blackburn, Lancashire*

Labelling individual blisters

From Dr M.-L. Truong,
MRPharmS

I write after reading the article on the stability of medicines in monitored dosage systems (*PJ*, 21 January, pp75–81). During my training I worked in a hospital in France where they had hospital packs. These are blister packs intended for hospital use: they are designed with cutting in mind, to allow for the dispensing of individual tablets onto the wards. In these hospital packs, each tablet is clearly identified with the drug name, dosage, batch number and expiry date. The blisters are of sufficient size so that each individual blistered tablet can be cut from the strip and handled without problems (about the size

of half a dispensing label). However, not all medicines were available as such from the manufacturer. This problem was addressed in at least one hospital that I visited: tablets were reconditioned into individual blisters, again each tablet being individually identified.

In the UK I worked in a medical care unit with Lloyds and one main feature of that work was transferring tablets from blister packs into proprietary blister packs.

If MDSs are to become more widely adopted, it would be a good idea to have blister packs designed with MDSs in mind.

Maybe the pharmaceutical industry could think of a way to do this. It would be more time efficient and safer.

Minh-Loc Truong
Coventry, West Midlands

■ UNIVERSAL HEALTH CARE

A more positive approach is needed

From Mr B. D. Nathwani,
MRPharmS

The leading article (*PJ*, 4 February, p122) highlights the issue of what we as a society value most. It is clear from the tone that the *PJ* does not share the values of New Labour or the electorate that put New Labour in power for three successive terms.

The article makes a presumptive statement that it is prohibitively expensive to provide health care for all (and I presume it left out the words "and sundry") so as not to cause offence. And yet, as the fourth richest nation on earth, we are still merely in the middle of the European league of health care expenditure.

As health care professionals, we should share in the vision for universal good health care available for all and free at point of delivery. We should aspire to a fair tax system that values health care based on need rather than postcodes, or the ability to jump the queue, or the ability to shout the loudest.

It took 18 years of under-investment in human and physical capital by the Conservatives during 1979–1997 to create million-plus waiting lists and a shoddy second rate physical infrastructure. To expect this to be reversed in a mere eight years is pure fantasy.

Bharat Nathwani
*Member of Council
Royal Pharmaceutical Society*

■ ASSISTED DYING

Dying with dignity

From Miss S. M. Boorman,
MRPharmS

I read with great interest and concern the unfolding debate concerning end-of-life issues and assisted dying. From a personal perspective, I had the great privilege of caring for my dying father, who experienced a long, protracted illness, which led to his untimely death from motor neurone disease. I experienced first hand the tragedy of the gradual loss of independence of someone who had spent his entire life being active, independent and caring for others. At no time did he ever even consider end-of-life issues despite him suffering greatly and becoming entirely dependent on me. He taught me not only how to live, but ultimately also how to die with great dignity.

From a professional perspective, I work on care of the elderly wards where end-of-life issues are a common occurrence; we care for patients in the terminal stages of stroke, cancer, dementia and heart failure. I have great respect for the consultants who lead the multidisciplinary team of which I am a part. I see first hand how decisions are made to withdraw active treatment. This is done in a way that allows patients to die with dignity. Our clinical skills become even more important as we strive to alleviate symptoms associated with terminal stages of disease. Palliation, when done skilfully, as I witness on the wards, is the way forward.

As a practising Christian, I believe that life is a precious gift from God. I also believe that it is our duty as pharmacists to first do no harm.

Susan Boorman

*Clinical Services Pharmacist
Darent Valley Hospital
Dartford, Kent*

■ CPD

What exactly is required of me?

From Dr J. C. Gilbert,
MRPharmS

I have received a letter about continuing professional development, dated January 2006, from Hemant Patel and I seek further clarification from the Royal Pharmaceutical Society.

The information that I have read on CPD seems to treat our "profession" as a homogenous group. However, we are distinctly heterogeneous. A minority of us work within the pharmaceutical industry. Even within this subset, pharmacists have a huge variety of roles. I, for instance, work within the commercial business development function of a start-up pharmaceutical company. It is clear that my job could be performed equally as well by a non-pharmacist. This is the same for many other roles within the pharmaceutical industry. The job does, however, require that I keep abreast of scientific, clinical and commercial advances that are pertinent to my company's business.

I therefore seek guidance from the Society as to what exactly it is that I must do successfully to complete my CPD requirements that is in some way linked to my day-to-day role?

I would like to remain on the Register. However, I am yet to be convinced that I can do this unless someone can explain succinctly what is required of me.

Julian Gilbert

*Steeple Morden,
Cambridgeshire*

PETER WILSON, head of the Royal Pharmaceutical Society's post-registration division, replies: We recognise the heterogeneity in the profession and the Society's continuing professional development framework has been designed specifically to accommodate this. The CPD materials supplied to members have been tested and used successfully by pharmacists in all major sectors of the profession, including industry.

The correspondent states that he needs to keep abreast of scientific, clinical and commercial advances in his company's business.

This learning is part of his daily work and should form the basis for entries in his CPD record. Each entry can be completed by responding to the questions in the recording framework. Pharmacists, on average, complete one CPD entry per month.

■ THE SOCIETY

Preparing for split of regulatory and representational roles

From Mr A. R. Cox, MRPharmS

As an earlier advocate (along with a colleague) of the splitting of the regulatory and representation roles of the Royal Pharmaceutical Society (*PJ*, 19 August 2000, p263), it is encouraging to see that the Government may be considering this course of action (*PJ*, 28 January, p97). Five years ago we wrote: "If we are to place a literal interpretation upon the Government's expressions of intent with regard to self regulation among the professions then it might be prudent for the Society to have in place a plan for the separation of its own representative

and regulatory functions (*PJ*, 16 September 2000, p394)."

One hopes the Society is currently dusting its plans for this eventuality, before any such plan is imposed on us from above.

Anthony Cox

Sutton Coldfield, West Midlands

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 for consideration

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