

■ METHADONE MIXTURE

Society's guidance is too prescriptive

From Mr M. Bennett, FRPharmS

I was pleased to read (*PJ*, 25 February, p245) that the Royal Pharmaceutical Society's Council has made an exception in allowing the extemporaneous preparation of methadone mixture 1mg/ml, despite the fact that products with a marketing authorisation exist. This makes sense given the problems with Controlled Drugs storage because the alternative could have severely reduced the number of patients that some pharmacies can treat.

I was less impressed with the need to go into such detail regarding the method of manufacture. Obviously, safe methods have to be employed with a proper audit trail, but I fear the suggestion that no reliance can be placed on the quantity stated on manufacturers' packs will prove counter-productive and will potentially increase the risk to patients. I looked into this in 2002 and I spoke to the pharmacist at one of the companies that distribute the powder and green syrup to check the tolerances that they work to. He assured me that:

- 1g bottles of methadone powder contain between 997mg and 1,003mg; this is critically important to the company because it is equally bound by the CD legislation
- 1L bottles of green syrup are filled by weight to give a target volume between 1,005 and 1,015ml

So a worst-case scenario would result in 997mg being dissolved in 1,015ml at one end and 1,003mg being dissolved in 1,005ml at the other, providing 0.9823mg/ml and 0.998mg/ml, respectively. Discarding 10ml of the green syrup before adding the methadone would result in a more accurate product with a variance of 997mg/1,005ml = 0.992mg/ml at the low end and 1,003mg/995ml = 1.01mg/ml at the high end. Surely this is accurate enough, particularly when linked with recording of batch numbers so as to relate back the final product to the original manufacturers' packs. After all, we are accepting that the powder is what the manufacturer claims it to be — methadone. We do not analyse that.

It is my belief that the risks involved in manufacturing 1mg/ml

methadone mixture are less if you reconstitute this by adding a manufacturer's sealed 1g of methadone powder to a manufacturer's sealed 1L of green syrup, recording batches etc, than if you attempt to follow the Society's guidance in weighing and measuring both the powder and the liquid.

The significant errors I have come across in the past are where pharmacists have managed to add 10g of methadone to 1,000ml of syrup and inadvertently dispense 10mg/ml for 1mg/ml. That error is almost impossible with the method stated above, but much more likely when the pharmacist (or a delegated member of staff) weighs from, say, a 25g or 50g container of methadone powder and makes the mistake of placing a 10g weight rather than a 1g weight on the scales.

I would ask the Practice Committee to reconsider the detail within the guidance provided. Perhaps a statement that "robust standards and systems must be in place to ensure the quality of extemporaneously prepared methadone mixture so that patient care is not compromised" is all that is required along with some examples of how this might be achieved, rather than the prescriptive text that has been produced.

Martin Bennett
Managing Director
Associated Chemists (Wicker) Ltd
Sheffield

■ BRAND PRESCRIBING

Improving patient safety and quality of care

From Mr A. Dickman, MRPharmS

Generic prescribing is generally considered to be the norm. However, there are exceptions to the rule, such as modified release diltiazem formulations. As pointed out in the Royal Pharmaceutical Society's recent statement (*PJ*, 18 February, p215), the chief pharmaceutical officer in 2004 recommended that sustained release opioids should be prescribed by brand name to avoid ambiguity. Patient safety is paramount, yet medication errors continue to occur and represent a huge financial burden for the NHS. The simple measure of brand prescribing modified release morphine preparations and opioid patches can help to improve patient

safety and the quality of care that we provide. The cost of prescribing branded strong opioids is negligible when litigation costs are considered.

I am pleased to see the Practice Committee press for the branded prescribing of modified release morphine preparations and opioid patches. This is something that I strongly recommended last autumn (*PJ*, 29 October 2005, p546). In fact, the Palliative Care Pharmacists' Network (formerly the Hospice and Palliative Care Pharmacists' Association) contacted the British National Formulary in January 2005 to consider including the recommendation for branded prescribing of strong opioid preparations. It was thought, however, that such action was unnecessary. I sincerely hope that the BNF and the Council take note and put this simple recommendation into practice.

Andrew Dickman
Specialist Principal Pharmacist
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Merseyside

■ OXYGEN SERVICES

We must learn from what has gone wrong

From Mr M. Beaman, MRPharmS

There has been considerable coverage of the recent changes to the home oxygen service and the letters from Beryl Bevan and Paul Breame (*PJ*, 25 February, p229 and p230) provide an accurate and comprehensive overview of the issues involved.

In the midst of all the negative points expressed in the media we

should not lose sight of the fact that the place of oxygen in respiratory medicine has changed considerably in recent years and modernisation of the service was inevitable. This is no criticism of community pharmacists, who have provided an excellent service over the years within the constraints provided.

In my own area of Eastern England, there has been detailed planning in place for over a year consisting of a network of local implementation groups co-ordinated and ably led by the regional reference group. The fact that implementation has been problematic is in no small way due to the fact that the key players involved in primary care, both users and commissioners, have been operating against a background of unprecedented change in the NHS, coupled with financial and management cuts this year with an uncertain future for a number of us in 2007. Small wonder that events have not gone smoothly. A number of us in primary care trusts have worked hard to resolve local problems of supply for our patients, yet none of this has been reported in the press — but then why should one be so surprised by that?

We must now learn from what has gone wrong and renew our focus on improving patient care in this area of medicine.

The challenge to the NHS is to continue to modernise this area of patient care engaging the best elements of community pharmacy with the advantages of the national provider companies.

Mike Beaman
Chief Pharmacist
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Primary Care Trust

Letters to the editor

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 BUTRANS AND THE SMC

BuTrans does not lack efficacy

From Dr J. P. Schofield, MRCP

I refer to your news article (*PJ*, 18 February, p193) in which you incorrectly state that the weekly transdermal buprenorphine patch BuTrans was found to be lacking in efficacy compared with other pain therapies.

An important omission was that the Scottish Medicines Consortium press release stated that there was a lack of comparative efficacy with a clinically relevant treatment for chronic pain available in the UK. Napp does have positive comparative efficacy against analgesic products that are widely available throughout the rest of the world, as well as the components of certain combination analgesics that are extensively used within the UK. We are having a constructive dialogue with the SMC with the intention of submitting a case which would gain the acceptance of BuTrans for the treatment of appropriate Scottish patients.

We do not wish your readership and, importantly, patients to be left with the impression that BuTrans is lacking in efficacy.

J. Paul Schofield

Medical Director and Consultant in
Pharmaceutical Medicine
Napp Pharmaceuticals Ltd

 THE PROFESSION

Please just stop being a pharmacist

From Mr A. R. Grierson, MRPharmS

The letter from Amit Matalia (*PJ*, 25 February, p233) raised a number of points, all of which were awful to read. Is our registration with the Royal Pharmaceutical Society on an equal level with a Corgi registration? If anyone honestly believes that, please just stop being a pharmacist, since it is a sad point to hold your own professional body in so little regard.

Many pharmacists are a little put out that we are not held in as high regard by the public as was once the case but, if this is the viewpoint of one of our own, what can we expect? If the profession is held in poor regard now, how would it be seen if the Statutory Committee simply gave every wrongdoer a slapped wrist? "You've held up a bank at gunpoint, sir? Never mind. As long

as you're still competent to carry out your white-collar, unprofessional role, it's fine." We are still a profession, and that profession must be safeguarded against the actions of a few for the benefit of the whole. Hence the ruling of "bringing the profession into disrepute".

All I can hope is that Mr Matalia wrote his letter purely to get a rise out of someone, so well done. If it was actually how his logic works, then I am shocked that he still bothers to call himself MRPharmS if it means so little.

Andrew Grierson

Accrington, Lancashire

Actions have consequences

From Mr A. B. Sutherland,
MRPharmS

May I express my feelings of insult and annoyance at Amit Matalia's letter (*PJ*, 25 February, p233). I think he would find that a plumber who lost his driving licence as a result of drink-driving would soon find himself out of work. Also, if one is so stupid as to drive a car while under the influence of drink, it makes people wonder what they are doing in control of a pharmacy. Actions have consequences and as professionals we must expect to take responsibility for them.

To his second issue (distinctly separate despite the context) about pharmacists' standing, your standing in front of patients and other professionals is directly related to your own actions. I have worked hard to assert my professional position in my area of practice, among patients and carers, and my direct service users, and so I am as valid a health care professional as any of his examples. I wonder if Mr Matalia should now reflect on his own actions as a partial solution to his sense of being undervalued.

Adam Sutherland

Glasgow

Upwardly mobile?

From Mr C. G. Murray, MRPharmS

I trust Amit Matalia (*PJ*, 25 February, p233) will, in future, withhold his retention fee in order to retrain as a gas-fitter to enhance his upwardly mobile aspirations.

Clive Murray

Tipton, West Midlands

Think again!

From Mr G. Southall-Edwards,
MRPharmS, Barrister

I read the letter from Amit Matalia (*PJ*, 25 February, p233) with some surprise. He writes, "so what if a pharmacist is convicted of speeding, drink driving, theft, violence or any other matter", and several answers immediately come to my mind. These are that (i) they all potentially indicate a possible disregard for the law in a person who is charged with a duty of following it to the letter, (ii) drink driving may (and often does) reveal an underlying history of alcohol addiction or abuse and (iii) theft clearly indicates that the person in question may not be trustworthy.

Now Mr Matalia should perhaps ask himself how he would feel if he were a member of the public, relying on and trusting in the advice of a local pharmacist and he were suddenly to discover that this person regularly drove down the high street at night at 70 miles per hour with a skinful of alcohol, then that he went home later to beat up his wife, because he was high on the drugs he had stolen from his employer and taken to enhance the effects of the alcohol he had consumed earlier, the effects of which would persist well into the next day when he was again in charge of a pharmacy. I venture to suggest that Mr Matalia might think twice about using that pharmacist's (or his employer's) services in future.

Graham Southall-Edwards

Tyrol, Austria

 THE SOCIETY

Concern at time taken to resolve infringements cases

From Dr G. E. Appelbe, FRPharmS

There is a long-standing maxim in law stating that justice delayed is justice denied and this is also enshrined in the Article 6 of the Human Rights Act 1998, namely, that "everyone is entitled to a fair and public hearing within a reasonable time". It is of concern, therefore, that infringements, either criminal or professional, which are dealt with by the Royal Pharmaceutical Society's inspectors are taking so long to resolve. No fault lies with the inspectors in this regard. Every infringement, however small or large, appears to

be dealt with formally in that first there is an interview between inspector and offending pharmacist and the matter is then referred direct to the Infringements Committee. There appears no longer to be any screening process in the Society as in the past.

Over the past 12 months I have been acting as a legal adviser to several pharmacists who have been so interviewed. However, not one of them has yet had their case dealt with by the Infringements Committee even after nearly a year. Even after consideration by the Infringements Committee these pharmacists could be subject to sanctions ranging from a warning to referral to the Statutory Committee. After this it is not unknown for cases to take over 12 months to be heard by the Statutory Committee. This situation is unacceptable.

There are at least two points to be made. First, the pharmacist's conduct could be such as to justify his name being removed from the Register as soon as possible in the interest of the public. Secondly, for many, although the ultimate sanction is not applied, the sword of Damocles hangs over their heads for far too long. I would be surprised if defence lawyers do not make use of the delay issue in future cases should the situation not be remedied. The chairman of the Statutory Committee has in the past, when administering a reprimand, said it was because there had been a delay in bringing the case to the committee. Presumably if there had been no delay, erasure, in the public interest, may well have been the outcome.

If it is a resource problem then it is for the Society to redress any omission. Perhaps by not having such a rigid formal system but by reinstating a form of screening process, even suggested by Dame Janet Smith in the Shipman case, justice would then not only be done but also seen to be done.

Gordon E. Appelbe

London

JO RAFFAITIN, head of investigation, Fitness to Practise and Legal Affairs Directorate, Royal Pharmaceutical Society, responds: Dr Appelbe is of course correct that in dealing with cases the Society must be mindful of the requirements of Article 6 and, indeed, the Society's fitness-to-practise procedures take into account all such responsibilities.

However, it is incorrect that all complaints made to the Society are

dealt with in the formal way Dr Appelbe describes. The Infringements Committee, in deciding whether a case should be referred to the Statutory Committee, takes into account all the factors listed in its published referral criteria. These criteria are also used by the inspectorate when deciding how to investigate any particular allegation and to ensure consistency. Only cases that are likely to meet the referral criteria are investigated formally. The majority of cases are not so serious and these will be dealt with informally by the inspectorate before referral to the Infringements Committee.

Dr Appelbe is also correct that no screening is undertaken by office staff and all complaints within the Society's enforcement jurisdiction are referred to the Infringements Committee, whether they have been investigated formally or not. This is in line with the role of the Infringements Committee as defined in the Council Governance handbook and the Infringements Committee (Procedure) Rules 2005.

In Chapter 19 of her fifth report, Dame Janet Smith, chairman of the Shipman Inquiry, was critical of other regulators that undertook screening of cases. Only by routing complaints through proper fitness-to-practise procedures, in line with published rules, referral criteria and sanctions guidance, can transparency and fairness be maintained.

In 2005, the Society received a 21 per cent increase in the number of complaints received as compared with the previous year.

■ RECIPROCITY

Window dressing

From Mr I. Dean, MRPharmS

The announcement that the Royal Pharmaceutical Society's Council had decided to amend its post-reciprocity requirements for Australian and New Zealand pharmacists (*PJ*, 17 December 2005, p759) has gone unremarked, and perhaps unnoticed, by *Journal* readers. For those who missed the news it may be helpful to review the change and its likely effect.

The Council resolved that, after 1 July 2006, Australian and NZ pharmacists will not be required to complete the 12-month overseas pharmacists' assessment programme at a British university. Instead they will be required to complete a

course and examination in British pharmacy law and ethics and the NHS in their home countries.

After successful completion of the course, they will be required to complete 12 months of supervised practice in Britain and then sit the Society's registration examination. This reduces the training period in Britain from 24 months to 12 months and coincides with the indication by the British Government that working holiday visas are to be reduced from 24 months to 12 months.

It is difficult, even impossible, to imagine a circumstance where a young Australian pharmacist will be prepared to spend his or her 12-month working holiday completing supervised practice. This effectively limits the scheme only to those pharmacists who are able to migrate to Britain.

Thus, although the door will not be closed entirely to Australian and NZ pharmacists, few will be able to squeeze through the crack. Even fewer Australian pharmacists are likely to be willing to do so.

There is no point in beating about the bush: from 1 July the number of Australian pharmacists becoming registered to practise in Britain will effectively fall to zero.

This will come as no surprise to the Council. In December 2005 the Society's head of accreditation, Damien Day, met in Australia with representatives of Australian and NZ registering authorities to explain the changes. I understand that Mr Day was advised then of the likely impact of the changes.

In light of Mr Day's meeting it is hard to reconcile the comment of Alan Kershaw, a member of the adjudicating committee, that the amendments "provided a practical solution to the Australia and New Zealand problem" — a most unfortunately worded comment.

Far from being a practical solution, the Council's amendments are simply window dressing and have thrown the baby out with the bathwater. The effect of the unilateral and unexplained dumping of the reciprocal arrangements will remain the same: Australian (and presumably NZ) pharmacists will rapidly become an extinct species in Britain.

I do not question the Society's legal, professional and social obligations to decide who is fit to practise in Britain. However, John Ferguson (*PJ*, 24 September 2005, p374) comprehensively showed the reasons the Council originally gave for ending the reciprocal arrangements to be spurious.

In view of the concern being felt and expressed by the

profession, and perhaps even out of fairness to their former Australian and NZ colleagues, now that the Council has finally resolved the Australia and NZ problem, perhaps it will now take members into its confidence and provide its real reasons.

Ian Dean

North Turrumurra,
New South Wales, Australia

PHILIP GREEN, deputy secretary and registrar, Royal Pharmaceutical Society, replies: When I met Australian and New Zealand registering representatives in December 2005 we did discuss the likely impact of the Society's revised policy on additional education and training requirements for overseas pharmacists as it might affect registrants in those countries. It was clear that the change in policy could influence the decision of some pharmacists to practise in the UK but Australasian colleagues did recognise the positive features of the Society's proposed new procedures. At that time the Society was not aware of the Government's intention to reconsider the length of a working holiday visa from 24 months to 12, which is unfortunate but beyond our control. Whether Government policy will change remains to be seen but I agree with Mr Dean that if it does it might have an influence on whether Australian and NZ pharmacists decide to spend one year as a preregistration trainee in the UK and that their reasons for doing so may have to be more compelling than if they had been able to spend an additional year overseas on a single visa.

Mr Dean is wrong to assert that the Society has not yet shared with members the real reason for ending reciprocity: we have explained our reasons fully and have hidden nothing. For the record let me repeat the principal reason for ending reciprocity: it does not allow us to exercise any influence over the length, content, delivery or duration of education and training or even to inquire into the education and training of anyone covered by such an agreement. That is no way to regulate a profession. The Society's decision to end reciprocity was unilateral in the sense that Australian and NZ registering authorities did not reciprocate but it was not alone in doing so among UK health care regulators: the General Dental Council and General Medical Council did the same thing for precisely the same reasons.

To return to my meeting in Australia, on behalf of both the President and the Secretary and Registrar I undertook to review the requirement for Australian and NZ pharmacists to enter a year of preregistration on a regular basis. Members should be reassured we are doing just that. We are not in a position to change our policy at the moment but we are actively exploring what alternatives are available to us. Mr Dean should be aware that we are maintaining a dialogue with registering authorities in Australia and NZ and I will be discussing progress with them, on the Society's behalf, at their next meeting in May.

■ CPD

A bureaucratic impediment and not constructive assistance

From Dr M. J. Shott, MRPharmS

Julian Gilbert (*PJ*, 11 February, p168) and Stephen Mather (*PJ*, 25 February, p233) have expressed concern and confusion about how to implement continuing professional development in industrial and academic practice. As an industrial pharmacist directing research into dosage form development, I spend a considerable amount of my time, and my employer's money, keeping abreast of the scientific literature and attending congresses. However, since I am seeking to keep myself up to date with new developments with no specific learning need in mind, I share Professor Mather's view that this does not fit into the CPD recording cycle expected by the Royal Pharmaceutical Society.

Given sufficient effort, I could force some of my activities to fit into an acceptable form for a record, but the activities I already undertake are best adapted to the particular area of pharmacy in which I practise, and this seems to make CPD a bureaucratic impediment rather than a constructive assistance to good practice. If learning how to master a Microsoft Word function is acceptable as CPD, as has been suggested in *The Journal* (*PJ*, 30 August 2003, p265), then why is not attending a congress with the world leaders in my area of drug delivery, even if I have not identified any specific area where this will improve my professional practice?

Martin Shott
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