

■ SUPERVISION

The role of "responsible pharmacist"

From Mr P. Patel,
MRPharmS

Under forthcoming legislation, the role of a "responsible pharmacist" will be introduced, changing dramatically the concept of supervision. It will mean that the requirement for pharmacists to be on the premises at all times will be relaxed — a landmark change for the profession and also an opportunity for pharmacists to develop their role in the community to the benefit of their patients.

What is not in doubt is the fact that a responsible pharmacist will retain the same overall accountability for the provision of pharmaceutical services, whether on the premises or not. This means that there are important considerations to note.

Before contemplating any period of absence from the pharmacy, pharmacists will have to be satisfied that it will operate safely in their absence. Some of the issues that will need to be addressed in the pharmacist's assessment are likely to include:

- The proposed length of and reason for absence
- Any relevant professional or Department of Health guidance on absences
- The number, training and competency levels of support staff
- Willingness of support staff to accept increased levels of responsibility
- The existence and use of standard operating procedures
- The ease of contacting the pharmacist in emergencies
- Whether the personal presence of the pharmacist will be required during the proposed period of absence, eg, patient group directives, medicines use review appointments, services to drug misusers
- Patient expectation and demand and the likelihood of customer complaints

All these may seem simple issues and, in a busy pharmacy, the pharmacist will have to assess them

Telephone number

All correspondents should supply a daytime telephone number, in case we need to contact them urgently

and form a judgement on whether he or she is satisfied that it is safe to leave the premises. In many instances, the issues will be straightforward and clear. But, inevitably a small number of incidents will arise, which may raise fitness-to-practise issues for the responsible pharmacist and their health care team. In this case the pharmacist's judgement may be questioned.

It remains early days in the development of the concept of responsible pharmacist and I encourage all pharmacists to take an interest in this debate. If I am fortunate to be elected to the Royal Pharmaceutical Society's Council, I will use my voice to represent the interests of all pharmacists, to ensure that clear and unambiguous guidance and support is given. Patient safety should be paramount along with clear professional accountability.

Pradip Patel

Council election candidate
Royal Pharmaceutical Society

■ SUBSTANCE MISUSE

Identification of clients breaks confidentiality

From Mrs G. Hargreaves,
MRPharmS

I was appalled when reading this week's *PJ* (25 March, p340) to see a blatant breach of patient confidentiality. The article triumphing a community pharmacy's first place in the Northumberland Care Trust Good Practice awards 2005 for its substance misuse service, published the full names of two people using this service. I know that the *PJ* is mailed only to pharmacists, but who is to say who will have access to it later on? It could be left on a bus, read at work by staff who pass information on to friends, or taken from a recycling bag. Even if the two participants gave consent to publish their names, I think that the *PJ* was irresponsible in printing these for general circulation.

Glenda Hargreaves

Chorley, Lancashire

The two clients were delighted to have been photographed and identified. Staff at the trust discussed the consequences with them before they were interviewed and they signed a document agreeing to participate. —
EDITOR

■ CLASSIFICATION

Inclusion of devices "less suitable for prescribing"

From Dr C. Johnson,
MRPharmS

The inclusion of magnetic leg ulcer wraps in the March edition of the Drug Tariff leads me to wonder

if the time has come for devices to have the category of "less suitable for prescribing".

This would bring devices in line with drugs which are marked in this way in the British National Formulary, such as clonidine hydrochloride.

Claire Johnson

Sevenoaks,
Kent

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 and should cover one topic only. *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.

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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.

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STATINS

Pharmacists should be aware of the benefits

From Professor J. Smith,
FRPharmS

Cardiovascular disease (CVD) is the leading cause of death in England, with 238,000 deaths in 2002. It accounts for about a third of all premature deaths. Non-fatal CVD can seriously impair quality of life and is estimated to be the leading cause of disability in Europe. Mortality rates are declining, thanks to a combination of lifestyle changes, improved diagnosis, improved treatment and better primary and secondary prevention. We are on course to achieve the national service framework target of a 40 per cent reduction in mortality over 10 years. Effective use of statins is central to this strategy. It is therefore unfortunate to see the recent National Institute for Health and Clinical Excellence guidance on statins, for the prevention of cardiovascular events, dismissed in your columns as "no more than a gamble" (**Broad spectrum**, 11 March, p290).

The meta-analysis of primary prevention trials commissioned by NICE showed that in people without CVD, taking a statin reduced the risk of fatal myocardial infarction (MI) by 59 per cent and of non-fatal MI by 40 per cent. To someone at or above the new NICE threshold for treatment (a 20 per cent risk of developing CVD over 10 years), this means statins offer a substantial degree of protection against premature death or disability. If anything, the NICE guidance is conservative. New Zealand national guidelines recommend statins at, or above, a 15 per cent 10-year CVD risk. And, a Canadian analysis published last week showed that treating at the 15 per cent risk level would save 35,800 lives over 10 years — nearly 0.3 per cent of the entire population.

The real gamble would be for people at risk — and their professional advisers — to reject the benefits that statins offer. A Market and Opinion Research International poll in 2003 showed that people use pharmacists as a health resource, second only to GPs. In "Choosing health through pharmacy", ministers powerfully supported our expanding role as advocates for health. Pharmacists would be in default of that role were they to fail to advise people, in the light of their own particular

circumstances and wishes, that statins can significantly protect their health.

Jim Smith
Professor of Pharmacy Practice and Policy
University of Sunderland

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SELF CARE

Pharmacists are ideally placed to grasp opportunities

From Mr C. Cooper,
MRPharmS

The NHS has set out its priorities for the next five years. They include improved access and improved patient experience, improved management of long-term conditions and a greater choice for patients.

As pharmacists, whether working in community or primary care settings, hospital, industry or academia, we all need to be aware of the direction of the Government's health policy and the opportunities arising through patient choice and from a patient-centred NHS. We are seeing a move away from a centralised NHS to more local level decision-making, as seen already by the enhanced services tier of the new pharmacy contract in England and the imminent arrival of practice-based commissioning of services.

Pharmacy is ideally placed to grasp the opportunities that exist for developing self care support in the five identified key areas:

- Staying fit and healthy
- Taking action to prevent illness
- Better use of medicines
- Managing minor ailments
- Improving care of long-term conditions

We are able to play a role in all levels of self care, whether it be

proactive, facilitated, or more supported self care. I guess many of us, however, are still coming to terms with the enormity of the change agenda and how we grasp the opportunities that are opening up.

I welcome the publication of the Royal Pharmaceutical Society's guide — "The self care challenge — a strategy for pharmacists in England". It is timely in providing the information and guidance needed to move the agenda forward and provides useful background, suggestions and practical help on engaging with the self care agenda both inside and outside the NHS. I would encourage colleagues to make use of it.

We all know there are approximately 1.8 million visits to pharmacies in Great Britain every day, hence the potential to influence the health of the nation is enormous. New prescribing opportunities, including independent prescribing, will increase pharmacists' potential to further improve patient care. Now is the time for pharmacy to get "on the front foot" and truly deliver to its potential.

If you would like to comment on this topic please contact me at www.voteforchriscooper.blogspot.com.

Chris Cooper
Council election candidate
Royal Pharmaceutical Society

OXYGEN SERVICES

Expressing my point of view from a primary care perspective

From Ms L. Perkins,
MRPharmS

I know there has been a great deal of correspondence about the new home oxygen service but I should like to express my point of view from a primary care perspective.

Seven weeks after the start of the new contract, it seems we are no nearer to receiving the service we have been promised. As I see it, there are a number of reasons for this: the lack of preparedness of the new oxygen suppliers, the lack of preparation by primary care trusts and the Department of Health's specification.

I am a practice pharmacist working in two GP surgeries in Skipton, North Yorkshire. We have between 20 and 30 patients currently using oxygen. At the beginning of February, I submitted

home oxygen order forms for those patients I thought would need supplies during February. I have yet to receive acknowledgement of these orders. I am receiving faxed acknowledgement of new HOOFs, but still with instructions to issue an FP10. The supplier is required to confirm to the GP when oxygen has been provided to a patient — Air Products has yet to do this, although I know of some patients who have received their oxygen. As GPs are continuing to issue FP10s there is potential for duplication of the service.

I admire those correspondents from PCTs who have spent months preparing for the new contract, but in my area there was no communication with my practices by the PCT or Air Products until one week before the start of the new contract. I have also been unable to get any indication from the PCT or the supplier of when I can expect the service to be delivered to specification. The latest Primary Care Contracting Oxygen newsletter says FP10s should be issued until further notice. This implies that the situation will not be resolved soon.

The Department of Health specification provided for a six-month transition period to the new suppliers. How does this equate with the directive to GPs not to issue FP10s after 31 January? Jeanette Howe in her reply in the *PJ* of 18 February (p204) seems unaware of this contradiction.

The specification is also short on detail of equipment to be provided. The new suppliers are providing concentrators as standard, without any regard for patients' or carers' individual requirements. The provision of portable cylinders for patients using short-burst oxygen is a particular concern. Air Products appears unwilling to provide these in the number and capacity required.

Can the Department of Health solve the problem? The contract seems to have been so ill-thought-out that I think it needs radical revision.

The other option would be to hand the provision of oxygen back to community pharmacists, who have provided a responsive, professional service for many years.

Lesley Perkins
Practice Pharmacist
Dyneley House Surgery and Fisher Medical Centre
Skipton,
North Yorkshire

■ PACKAGING

Packaging drugs similarly can increase the risk of a dispensing error

From Dr C. Green, MRPharmS

I note the photograph of the recently launched Pfizer product "Revatio" in the *PJ* of 4 March 2006 and am both disappointed and alarmed that, yet again, Pfizer is introducing a product onto the market that looks largely the same as all its others. It is well known that similar looking packaging increases the risk of dispensing errors, and this is highlighted in a number of reports.

At the recent National Patient Safety Agency conference date, I attended a session presented by Pfizer regarding the safety of its packaging. Fantastic, I thought. It is finally doing something about its awful packaging. But, alas, its presentation was all about preventing counterfeit medicines, which cynics might suggest is a more important issue due to its effects on profits. It is a real shame that Pfizer has made no effort to do something about the safety of its corporate packaging, although it is not the only culprit.

It is also a real shame, and in fact worrying, that in the absence of action by the company, the Association of the British Pharmaceutical Industry, Medicines and Healthcare products Regulatory Agency and the NPSA have yet to take action that is clearly needed. How can this be allowed and when is someone in authority going to do something about it?

Chris Green
 Director of Pharmacy and Medicines
 Management
 Countess of Chester NHS
 Foundation Trust

BRUCE CHARLESWORTH, head of medical affairs at Pfizer UK Ltd, responds: Pfizer takes the packaging of medicines as seriously as the development of the medicines themselves and recently responded to a similar query in the *PJ* (3 December 2005, p686) to highlight this fact.

I would like to reiterate that patient safety is paramount to Pfizer.

The packaging of medicines is an extremely complex business, which appears somewhat oversimplified in the letter from Dr Green. In addition to ensuring that pharmacists can adequately differentiate between medicines, pharmaceutical companies have to consider regulatory constraints, practical considerations, user-acceptability issues, tampering potential and many other factors in the development of packaging for our medicines.

It is also desirable and sensible to have a global brand essence across the packaging to allow recognition by health care

professionals, but also importantly to let patients know they are taking a Pfizer medicine.

As an ethical pharmaceutical company Pfizer devotes time, resource and money to developing effective, well tolerated medicines and likewise insists upon effective, recognisable and regulatory compliant packaging. Differentiations across brands are clearly marked wherever possible and there are many initiatives to ensure braille, anti-tamper features, adequate labelling, and other patient safety and convenience features are addressed.

I would refer Dr Green back to *The Journal* (3 December 2005, p686) where he can read about Pfizer's work with the National Patient Safety Agency (NPSA) with regard to product packaging. As an example of our commitment, Pfizer has already opted to change the shape of certain tablets in line with recommendations to clearly differentiate doses.

Pfizer objects strongly to the implication that tackling the counterfeiting of medicines is about maintaining profit. Given recent media coverage of this, readers will be aware that the counterfeiting of prescription medicines is a public health issue of huge importance. Although some may choose to be cynical, the World Health Organization estimates as much as 10 per cent of the pharmaceutical market to be counterfeit, an estimated 100,000 people die in China each year from consuming counterfeit medicines¹ and that up to 40 per cent of products labelled as containing artusenate (the best medicine to combat malaria today) contain no

active ingredients and therefore have no therapeutic benefits.²

These are sobering statistics that industry and health care professionals should be united in tackling. Appropriate and recognisable packaging is just one element of the effort to wipe out counterfeiting.

The seriousness of the risk patients may face by consumption of counterfeit medicines should not be trivialised. It is vital that both companies and health care professionals can expect our medicines to deliver a predictable response; the tracking of adverse events and the recall of faulty medicines if required, is too important to be dismissed by remarks such as those of Dr Green.

The reputation of a company stands or falls on the effectiveness of its products. For Pfizer and other innovative pharmaceutical companies, the growth of counterfeit medicines is an assault on our reputation, rather than our profits, as suggested by Dr Green.

Medicines packaging is one of our defences against that assault. Compliance with our tight European and UK regulations is a requirement to protect the patient from counterfeit products and demands certain constraints which are not applicable to the average consumer product.

References

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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 for consideration

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■ RECIPROCITY

Hoping for a sensible solution

From Mr I. W. A. Dean, MRPharmS

I am grateful to Philip Green, deputy secretary and registrar at the Royal Pharmaceutical Society, for his immediate response to my recent letter (*PJ*, 4 March, p265). I particularly thank him for telling us that the principal reason for ending reciprocity was because "it does not allow us (the Society) 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".

This is new information. Therefore, I do not agree with Mr Green in saying that I was wrong to assert that the Society had "not yet shared with members the real reason" for ending reciprocity. I presume that this new and real reason supersedes the original reasons provided in the Society's news release (*PJ*, 16 April 2005, p465), which were subsequently demolished by John Ferguson (*PJ*, 24 September 2005, p374).

I do agree that other UK health care regulators (those governing dentists, doctors, nurses and physiotherapists) discontinued their various reciprocal arrangements some time ago. But those regulators replaced reciprocity with an "assessment of qualifications" and the international English language test, rather than the draconian system chosen by the Society.

Following the start of the "assessment of qualifications", the flow of dentists, doctors, nurses and physiotherapists between Australia and Britain, and vice versa, has apparently continued without interruption. This may be surprising because, to some, the prospect of an Australian successfully completing an English language test in Britain may be considered to be a hurdle too high.

It is especially pleasing to read that Mr Green will be returning to Australia in May 2006 to participate in further discussions about the registration of Australian and New Zealand pharmacists in Britain. His Australian, British and, I am sure, New Zealand colleagues will wish him every success.

The mere fact that he is making such a long trip for the second

time in six months is perhaps a sign that not only is Mr Green's mind open but he may even be seeking a sensible solution to the issue. Let us all hope.

Ian Dean

*North Turramurra,
New South Wales, Australia*

■ OVERSEAS PHARMACISTS

Society moving further away from my needs

From Mr M. Anisfeld, MRPharmS

In a recent edition of the *PJ* (25 February, p234), Philip Green, deputy secretary and registrar, Royal Pharmaceutical Society, explained that the difference in non-practising fees for UK and overseas pharmacists is solely due to the cost of airmailing the *PJ*.

I have worked in the US for 30 years in the pharmaceutical industry and find the *PJ* of little use to me. Since I can read the *PJ* on the internet, I have no need to receive the print copy. So why am I not being offered the choice, as I used to be, of paying a supplement for airmailing the *PJ*, or paying the

UK non-practising membership fee without receiving the *PJ*?

As the Society moves further and further away from meeting any of my needs, the value of retaining membership recedes ever more rapidly. My membership of the International Pharmaceutical Federation, the Organisation for Professionals in Regulatory Affairs (TOPRA), the British Parenteral Society and other professional organisations, means that I can attend jointly sponsored Society meetings (nominally organised by Society's Industrial Pharmacists Group) at the same reduced rates as Society members. If I ever need to use the services of the Society's excellent library, payment of the daily user fee means that I will financially be ahead of the game if I cease being a member of the Society. I would have to use the library for 21 days to equal the overseas retention fee (something that is highly unlikely).

Membership due to nostalgia is one thing, but discriminatory fees that provide no practical value are another.

Michael Anisfeld

*Globepharm Consulting
Deerfield, Illinois*

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■ COUNCIL ELECTIONS

This is no time for reluctance

From Mr D. I. Simpson, FRPharmS

Ray Fitzpatrick and Tony West suggest that there may now be a reluctance to stand in the election for the Royal Pharmaceutical Society's Council (*PJ*, March 25, p347). With only eight candidates for the available five places this year, they might be right.

It could be that the democratic instincts within the profession have been dulled because over a third of the members of the new Council are appointed rather than elected and only just over half of the Council is elected by pharmacists. If that is the case, it is to be regretted. It is essential that members of the Society are well represented on its governing body. This is especially important today, with the Government about to interfere once more in the way that the Society operates — I am referring to the as yet unknown steps that the Government may take as a result of the as yet unknown contents of the Foster and Donaldson reviews of health

regulatory bodies. This is no time for members to be reluctant in coming forward to promote the interests of pharmacists.

As Professor Fitzpatrick and Mr West indicate, there is also another forum where candidates will soon be needed. This will be for the new pharmacy board for England. This is to be set up within the Society to represent the interests of pharmacists working in England. This will be a more democratic body than the Council, with 80 per cent of its number being elected by pharmacists. And, yes, there will be a reserved place for a hospital pharmacist (*PJ*, February 25, p243); so it is essential that at least one of their number puts his or her name forward.

I was one of only two Council members who attended all of the meetings at which the composition of the English board was discussed and made the initial proposal that it should have sectoral representation. I am pleased to say that this proposal was eventually accepted by the Council as a whole.

Douglas Simpson
*Member of Council and Council
election candidate*
Royal Pharmaceutical Society

■ CPD

No time to record it

From Mr A. Jukes, MRPharmS

I sympathise with Peter Penson — what a disappointment (*PJ*, 18 March, p322). I agree with the concept of professional development and the need to have a competent skills base to carry out your duties as a pharmacist. However, in reality, I spend all day at work providing professional services to patients and most employers do not allocate continuing professional development time due to pressure on resources. I undertake CPD frequently but never have time to record it, because in my own time I like to have a life outside work. It is good to have a balance.

I wonder how all this will pan out. My CPD pack is still unopened after two years. Two days after my birthday I received a card from the post office saying I had a parcel to collect — a present I thought — excellent.

Imagine my deflation when I trotted away from the post office with another pile of paperwork I would not have time to tackle.

Here we are and how right I was. So Mr Penson, I am with you on that one.

Andrew Jukes
Brighton, East Sussex

■ ASSISTED DYING

Involved for years

From Mr J. A. Tweed, MRPharmS

If we believe the research by GP NET (NOP) (11 March, p286) then pharmacists have been helping with "assisted dying" for years, wittingly or unwittingly.

One can understand differing moral stances because of differing beliefs. Might it be better if we could leave monotheistic religions out of the argument, since they do not stand up to scrutiny with regard to their attitude towards killing people? After all, do we not have padres in the army (whose purpose is to kill the enemy)?

The pharmacist should be in a position to refuse if their consciences so dictate.

Jack Tweed
Nottingham

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