

■ SUPERMARKET PHARMACY

Position regarding alcohol sales

From Mr K. M. J. Tull, MRPharmS

I received a telephone call recently from a locum who wanted to clarify the position of sales of alcohol through a pharmacy till in a supermarket. The manager of the store was insisting that alcohol be sold through the pharmacy till to aid congestion at the other tills. The locum deemed this not to be professional and rightly questioned the order. I told him my version of what I have instilled in my pharmacy operation, which is that the alcohol licence is held by the store manager for the store. However the pharmacy is a registered premises within that store and thus the tills are registered to the pharmacy premises. Therefore, the pharmacy does not possess an alcohol licence and may not, therefore, put alcohol through its tills. This argument seems logical to me. I also stated that I do not deal with fresh meat or fish products either as this could contaminate my pharmacy area.

On further investigation of "Medicines, ethics and practice" (no 30, July 2006), I could only find a reference to alcohol sales in "Part 3, Service Specifications, Stock" (p93), which stated the following: "Pharmacists must not purchase for sale on registered pharmacy premises any product which may be injurious to public health or bring the profession into disrepute. This includes tobacco products other than nicotine replacement therapies, alcohol and products intended to mask signs of alcohol or drug addiction."

Unfortunately this statement is flawed when applied to a

supermarket pharmacy because the pharmacy has not bought the alcohol but is being forced to sell it on their premises. I can see that the above statement has been written with the correct intent of restricting alcohol sales from a pharmacy but it only applies if the pharmacy buys the alcohol in the first place. Therefore there is a loophole that needs to be closed rapidly. I would be grateful for advice on the correct procedure for dealing with such sales.

J. Tull
Secretary
Herefordshire Local Pharmaceutical Committee

LYNSEY BALMER, head of professional ethics, Royal Pharmaceutical Society, replies: As Mr Tull highlights, the Code of Ethics and Standards states that pharmacists must not purchase for sale on registered pharmacy premises any products, such as alcohol, which may be injurious to health or bring the profession into disrepute. In stating that pharmacists must not purchase alcohol to sell on registered premises, it is intended that alcohol should therefore not be sold from registered pharmacy premises. A view that it is ethical to sell alcohol from registered premises, provided the alcohol has not actually been purchased for sale from the premises by a pharmacist, is contrary to the spirit of the Code of Ethics requirement. The Code of Ethics and Standards is currently being reviewed and the requirements relating to the sale of alcohol from registered pharmacy premises will be considered as part of the review process.

Any pharmacist who assumes responsibility for a pharmacy premises, whether as an employee,

locum or otherwise, is professionally accountable for overseeing the activities carried out from that premises while he or she is in control. When assuming this responsibility, a pharmacist is expected to use his or her professional judgement to determine whether a transaction should proceed and must be prepared to justify their decision. Pharmacy owners and superintendent pharmacists have a professional responsibility to ensure the observance of all legal and professional requirements in relation to pharmaceutical aspects of the business, and must not seek to impose conditions on pharmacists which may adversely affect their ability to comply with their professional and legal duties. If a pharmacist is being pressured by a non-pharmacist member of the management team to take a course of action that he or she does not believe to be appropriate, the pharmacist should in the first instance confer with the area or regional pharmacy manager or superintendent pharmacist, or both.

With the current financial pressures on primary care trusts to reduce their drug budgets, many PCTs have issued guidance to their GP practices to substitute simvastatin 40mg for atorvastatin 10mg or 20mg.

Using this hook to identify patients, who are clearly a target for PCTs, pharmacists can carry out medicines use reviews and recommend a switch if the patient's clinical history does not contraindicate it.

This is a win-win situation: the pharmacist gets a £25 MUR fee, while the PCT, NHS and taxpayers save over £25 per month for the remainder of the patient's treatment. Clearly more savings can be achieved if branded products are also identified for generic switching when appropriate and suitable. On the other hand, the pharmaceutical industry will be likely to lose out financially.

Pharmacists must use their heads and their training for the benefit of patients and the public.

Hassan Argomandkhah
Halewood, Merseyside

■ PFIZER PRODUCTS

An opportunity or a threat?

From Mr H. Argomandkhah, MRPharmS

The outrage by community pharmacists about the Pfizer distribution is generally seen as a threat. However a proper SWOT (strengths, weaknesses, opportunities, threats) analysis should point to the many opportunities this will provide to all community pharmacists, regardless of their choice of mainline wholesaler.

A risk to the viability of the community pharmacy network

From Mr S. R. Newbury, MRPharmS

As an independent community pharmacist and customer of UniChem since 1985, I would like to add two comments to the current debate surrounding the proposed new arrangements for the distribution of Pfizer products.

First, the long-term future of the community pharmacy network in the UK is dependent on a strong and competitive wholesaler industry. The massive changes that

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.

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.

Advertisement

will accompany this proposed manoeuvre will, I have no doubt, create distortions in the market, both in the way UniChem will have to gear up to deliver the service and in the way in which other wholesalers will respond in order to safeguard what they will perceive as their futures.

Secondly, Pfizer's initiative is an implicit criticism of the safety and probity of the pharmaceutical supply system in the UK, today and historically. Pharmaceutical wholesalers are fully licensed and controlled by the Medicines and Healthcare products Regulatory Agency and community pharmacies by the Royal Pharmaceutical Society and others. If there are concerns regarding any aspect of pharmaceuticals in the supply chain there are existing mechanisms through which these can be resolved in the interests of patients and which have been seen to work perfectly well for other pharmaceutical manufacturers. If Pfizer has a problem with these organisations or mechanisms this is where it should focus its attention.

If this scheme is imposed on community pharmacy, dispensing doctors etc, by Pfizer, I fear that it will be as big a risk to the viability of the network in the longer term as control of entry, and so actions recommended by others to move away from Pfizer products would be seen as a natural survival mechanism.

Stephen Newbury
Swansea

PROFESSIONAL IMAGE

Standards are slipping

From Mr S. Maddern,
RegPharmTech

I could not agree more with Alexander Florence (*PJ*, 28 October, p516). For years I have struggled in community pharmacy to fulfil simple dispensing tasks due to customer queries such as "which baby monitor is the best?", "should this smoothie be this thick?", "do you have this baby outfit in any other sizes?".

I have seen pharmacy floor plans moved and rearranged to accommodate baby photographers (screaming children and flashing lights really help the dispensing process) and Christmas toy displays, not to mention the removal of key pharmacy items like patient leaflets and chairs for patients awaiting their medicines.

I have had pharmacists arrive

for work in jeans and even attempt to straighten their hair in the dispensary. There is a time and a place for wearing jeans and hair straightening, and the dispensary is not it.

I shudder when I pass chemists' windows covered in poster after poster with tacky window displays that most certainly do not reflect the professional standards of pharmacy, or what pharmacy should be.

So come on! Our professional standards are slipping. Let us get them back up.

Steve Maddern
Haverfordwest, Pembrokeshire

PARACETAMOL

Overdose mortality at an all time low

From Dr G. Brandon

Shazia Nazmeen and colleagues suggest that easy availability of paracetamol is responsible for its use in overdose and yet also lament the withdrawal of co-proxamol (*PJ*, September 23, p365). Co-proxamol was a prescription-only medicine, ie, carefully controlled by doctors, and yet was responsible for twice the overdose mortality of paracetamol, according to Office for National Statistics (ONS) data.

The 1998 legislation restricting paracetamol pack sizes appears to have been beneficial and paracetamol overdose mortality is now at an all time low (ONS data). It is important to note in this context that nearly all paracetamol overdoses are deliberate (*BMJ* 1994;310:164) so it is unlikely that tighter controls, as suggested by Ms Nazmeen, would add any further benefit. However they would certainly add considerably to consumer inconvenience.

Geoffrey Brandon
Director
Paracetamol Information Centre

VARICELLA

A commonly held but incorrect view

From Dr I. Iheanacho

The article on chickenpox and shingles infection (*PJ*, 14 October, p453) discussed potential consequences of primary infection with varicella zoster virus infection in pregnancy. In doing so, it stated:

"Infection between 20 and 36 weeks' gestation appears not to affect the fetus, but may lead to shingles in the first few years of life." The view that maternal chickenpox infection at beyond 20 weeks' gestation cannot lead to fetal damage is commonly held but incorrect. As *Drug and Therapeutics Bulletin* recently highlighted,^{1,2} there is published evidence that infection up until at least week 28 can result, rarely, in fetal varicella syndrome³ (a condition much more commonly associated with maternal infection before 20 weeks). Following our citation of this evidence, the Department of Health⁴ and the Health Protection Agency⁵ have amended their respective guidance on chickenpox to indicate the possibility of fetal damage from maternal infection at beyond 20 weeks.

Ike Iheanacho
Editor
Drug and Therapeutics Bulletin

References

1. Chickenpox, pregnancy and the newborn. *DTB* 2005;43:69–72.
2. Chickenpox, pregnancy and the newborn: a follow-up. *DTB* 2005;43:94–5.
3. Tan M, Koren G. Chickenpox in pregnancy: revisited. *Reproductive Toxicology* 2006;21:410–20.
4. Department of Health. Varicella. Available at www.dh.gov.uk/assetRoot/04/13/79/34/04137934.pdf (accessed 18 October 2006).
5. Health Protection Agency. General information — chickenpox (varicella). Available at: www.hpa.org.uk/infections/topics_az/chickenpox/gen_info.htm (accessed 31 October 2006).

PSYCHOTROPIC MEDICINES

Need for more depot preparations

From Anon Pharmacist

I believe there is a shortfall in the provision of services to mental health patients that pharmacy could address. There is a gap in the availability and range of antipsychotic depot drugs that constitutes both a sad lack for the mentally ill and possibly a gap in the market for the drug companies to explore.

Currently there is a lot of debate about the newer atypical antipsychotic drugs and their advantage over the older style antipsychotics. This discussion really only applies to oral medication because there is, to my knowledge, only one newer atypical, risperidone, available on the market as a depot preparation.

I would like to say how much "cleaner" the newer antipsychotics are in their side effect profile compared with the older drugs. It was once my misfortune to be prescribed a couple of depot drugs. It was an unpleasant time for me and I will always remember the side effects, which included simultaneous sedation and agitation (a most peculiar, restive feeling), a raging appetite and consequent weight gain, hypersalivation, an inability to speak coherently, constipation and reduced libido. The side effects of depot medications can be deeply distressing.

The mentally ill are often forgotten, I believe, and it would be a great thing if there were more atypical antipsychotic drugs available in the depot form.

Anon Pharmacist
298/2

DISPENSING

Pharmacists should be allowed to compound medicines

From Mr D. J. Willcocks, MRPharmS

The Government's latest big idea is to encourage GPs to go back to practising surgery in their surgeries.

The hope is that patients will benefit from quicker, more convenient treatment, doctors will gain added professional satisfaction and the Treasury will save money.

By the same logic, is it not time time thought was given to pharmacists resuming their traditional role of compounders of medicinal products?

I have every respect for the "specials" manufacturers. Their expertise, modern facilities and quality control systems are first class. They provide a Rolls Royce service but, it must be acknowledged, at Rolls Royce prices.

I understand that safeguards must be put in place but I do believe that a formulary could be devised of preparations that community pharmacists could make up without jeopardising patient safety and at a fraction of the present cost to the Exchequer.

It seems perverse that, at a time when we are all learning new skills, the one that pharmacists — of my generation, at least — spent long hours acquiring is denied to us.

David Willcocks
Newport