

■ CONTROLLED DRUGS

### Milligrams or millilitres?

From Mr N. K. K. Aling, MRPharmS

I was recently presented with a FP10MDA prescription where the right portion had been cut out and destroyed. It was for 490mg of methadone mixture 1mg/ml (sugar free). From my interpretation of the guidance provided in "Medicines, ethics and practice", the total quantity should be expressed as 490ml rather than 490mg. This was confirmed by calling the National Pharmacy Association and the Royal Pharmaceutical Society. The Pharmacists' Defence Association initially responded that the prescription was fine even when the total quantity was expressed in milligrams rather than in millilitres. But, after my input and further investigations on their part, I was advised that the prescription was not actually correct to dispense as such.

I then got in touch with the doctor who wrote the prescription, but he was not prepared to write the prescription with the total quantity of methadone mixture expressed in millilitres. He told me that he always writes his methadone mixture prescriptions with the total quantity to supply expressed in milligrams rather than millilitres to be safe in the event that the wrong concentration of methadone mixture has been either written on the prescription or dispensed at the pharmacy. In each of those cases, the patient would still receive the intended dose of methadone. Furthermore, he added that he had never had a pharmacist advise him to express the total quantity of methadone mixture in millilitres rather than

milligrams. So, was I being difficult?

This shows that there is still some confusion over how the total quantity of schedule 2 and 3 Controlled Drugs should be expressed on prescriptions. It would be of great help if the Royal Pharmaceutical Society would issue some clear guidance on this issue. This will resolve the issue of pharmacists giving out different advice.

The National Pharmacy Association added that: "If there was a local agreement to express the total quantity of methadone mixture to be supplied in terms of milligrams rather than millilitres for safety, it would have to be initially approved by the Home Office, otherwise the prescriptions would not be complying to CD requirements." I would also like to know what can be done in cases where the right portion of the prescription has been cut out and destroyed. Can we staple a blank sheet of paper to the FP10MDA prescription so that details of the items dispensed and supplied can be recorded as usual? Would that be legal and accepted by the Prescription Pricing Authority?

**Nicholas Aling**  
*London*

CAROLE GREEN, pharmacist adviser, Fitness to Practise and Legal Affairs Directorate at the Royal Pharmaceutical Society, responds: Regulation 15 of the Misuse of Drugs Regulations 2001, as amended, states that a prescription should specify, in the case of a prescription containing a Controlled Drug which is a preparation, either the total quantity (in both words and figures) of the preparation or the

number (in both words and figures) of dosage units to be supplied; in any other case, the total quantity (in both words and figures) of the Controlled Drug to be supplied.

The Home Office, as the enforcement authority for the Misuse of Drugs Regulations, has confirmed that where a Controlled Drug is available as a dosage unit, the total quantity on a prescription should be expressed in terms of the number of dosage units, eg, the number of tablets or capsules and where the total quantity is of a liquid preparation, such as methadone mixture, it should be expressed as millilitres (ml). Therefore, the total quantity of methadone mixture as referred to in your letter should be expressed as 490ml. Further information can be obtained from the Home Office Drug Legislation and Enforcement Unit by telephoning 020 7035 0464.

In response to Mr Aling's second question, Regulation 16, paragraphs (2) and (4) of the Misuse of Drugs Regulations 2001, as amended, state that a person supplying a Controlled Drug, other than a Controlled Drug in Schedules 4 or 5, on a prescription, shall mark the prescription with the dates on which each instalment of the drug is supplied. This is a legal requirement. The endorsements made by the pharmacist on the right side of the FP10 (MDA) of instalments supplied are to comply with this requirement.

Importantly, the right side of the prescription includes columns to record additional information that is invaluable for maintaining a complete audit trail. The additional columns allow the recording of the quantity of methadone supplied on each occasion and the supplying pharmacist's initials for each

instalment given. This information should be recorded, since it is a Code of Ethics requirement that there is a retrievable record of the pharmacist who has taken responsibility for the provision of a particular pharmacy service and that there is an accountable identifiable pharmacist for each activity.

If the right side of the prescription is missing, the Prescription Pricing Authority has confirmed that they will accept a blank piece of paper stapled to the prescription for the marking of these endorsements. However, the marking of the date of supply would still have to be made on the prescription. Pharmacists should exercise caution if considering making a supply against such a prescription. The pharmacist would have to make any necessary checks to ensure that the prescription was genuine and establish that the prescription has not been previously dispensed, before making any supplies. If the pharmacist is satisfied that the prescription is authentic, then there is no legal restriction on making a supply provided that he or she has added the required information to the prescription.

### Stress?

Are you suffering from stress? Do you need help in coping with it?

The Listening Friends Scheme, set up by the Royal Pharmaceutical Society, provides an opportunity for you to talk about your problems with a fellow pharmacist who is trained in listening skills. All you have to do is telephone the scheme's help-line on 020 7572 2442.

### 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.

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## ■ PFIZER PRODUCTS

### Deltacortril — the wrong target

From Mr J. Barber

C. F. Brewer and A. McCourt in their letter (*PJ*, 21 October, p480), suggest generic prescribing of a number of Pfizer brands as a means of protesting about the Pfizer and UniChem distribution arrangements. Unfortunately, in selecting Deltacortril they have chosen the wrong target on two counts.

First, Deltacortril is no longer a Pfizer product, having been acquired by Alliance Pharmaceuticals at the beginning of October (*PJ*, 14 October, p445).

Secondly, the Drug Tariff price for Deltacortril is significantly less than for generic enteric-coated prednisolone:

■ Enteric-coated prednisolone — 2.5mg x 30 = 160p (equivalent to 5.3p per tablet) and 5mg x 30 = 188p (equivalent to 6.3p per tablet)

■ Deltacortril — 2.5mg x 100 = 68p (equivalent to 0.7p per tablet) and 5mg x 100 = 122p (equivalent to 1.2p per tablet)

So, switching to generic enteric-coated prednisolone will have no effect on Pfizer and will result in an increase in direct drug costs.

#### John Barber

Director, Scientific Affairs  
Alliance Pharmaceuticals Limited

## ■ COUNTERFEIT MEDICINES

### Do not blame counterfeits on parallel trade

From Mr R. Freudenberg

The article by David Taylor, “Dealing with the EU counterfeit threat”, in *The Pharmaceutical Journal* (25 November, p638) once again paints a highly misleading picture of the role of parallel medicines in the legitimate supply chain.

As the author himself states, “there have been no recorded deaths resulting from medicines counterfeiting in the EU”, and indeed the Medicines and Healthcare products Regulatory Authority has confirmed on many occasions that there has been no case of counterfeits in the UK entering the legitimate supply

chain via parallel trade. Former Secretary of State for Health, Jane Kennedy, underlined this fact in July 2005 when she said that “there is no evidence to suggest that licensed parallel trade provides any more of an opportunity to introduce counterfeit medicines into the country over non-parallel traded products”.

Professor Taylor claims that “there are opportunities for both error and . . . the deliberate insertion of fake products”. This is simply not the case. The industry is subject to strict national and European regulations and is required to keep meticulous batch records of all sales and purchases. In fact, parallel imports are subject to a level of secondary checking which drugs distributed direct from manufacturer to wholesaler are not.

He also claims the impact of parallel importing on the overall economy is negative. However, a recent report by renowned Danish health economist Kjeld Møller Pedersen showed direct savings in the UK were £162m. The study also suggested savings could be larger if parallel distributors could secure more supplies and if governments put in place effective systems that encourage savings.

Health experts and the pharmaceutical industry are right to worry about the worldwide risk of counterfeits. But they are looking in the wrong place when putting the spotlight on parallel distributors who provide a valuable service to patients and national health care systems by providing safe and more affordable access to innovative branded medicines.

#### Richard Freudenberg

Secretary-General  
British Association of European  
Pharmaceutical Distributors

## ■ THE PROFESSION

### Reluctant to help GMC again

From Mrs E. Homer,  
MRPharmS

I recount a salutary tale for any pharmacist performing his or her professional responsibilities. Just over two years ago I identified a patient who was “double-scripting”. The patient presented a private prescription for dihydrocodeine and diazepam from a doctor in London. This patient was also registered with one of the local GP practices. After speaking to the patient’s GP who was

unaware of any other doctor prescribing for his patient, I contacted the police drug officer. The case was investigated and sometime later I was asked to give a written statement to a solicitor at the General Medical Council. About 12 months ago I received a letter from the GMC saying that I would be required to give evidence in person at a fitness-to-practise hearing against the doctor under investigation. I spoke to the GMC several times to confirm that I would be needed in person and it was categorically confirmed on each occasion that this was the case. I was instructed to book the time off work for the duration of the hearing.

After the hearing I completed an expenses form and submitted it to the GMC. The GMC does not recognise pharmacists as professional people and will only pay about £50 per day loss of earnings. (I expect plumbers, electricians, etc, would also be disappointed with this). I have written and explained that in order to practise a pharmacist has to be registered with the Royal Pharmaceutical Society and pay an annual membership fee. Despite this information the GMC is still disputing my claim for locum rates. The whole exercise has cost me in the region of £1,000 (two days loss of earnings, hotel accommodation, travel costs, etc, to London) and so far I have received nothing. In view of my experience I would be reluctant to get involved with such a case again. Incidentally the doctor in question was reprimanded by the GMC and banned from prescribing opiates and benzodiazepines in the future — so at least the general public are being protected thanks to my vigilance.

#### Eleanor Homer

LLangattock, Monmouth

PETER SWAIN, head of case presentation at the General Medical Council, responds:

Because we are unable to see the name of the correspondent when issuing this response we are unable to identify the particular case that they are referring to and therefore cannot directly respond to the points raised.

We are grateful for the assistance of witnesses in helping our fitness-to-practise procedures and we certainly do not wish to see people left out of pocket by attending a hearing. We must comply with the requirements of the Inland Revenue and, as a registered charity, the Charity

Commission, so we only reimburse expenses within a defined policy. Our rates for loss of earnings are taken from the rates paid to witnesses in criminal or civil court proceedings. This includes an enhanced rate for professional witnesses such as pharmacists. We are unable to pay above the court rates for notional loss of earnings where no locum was engaged; we will reimburse the reasonable costs of a locum for a pharmacist or other professional witness on receipt of evidence of the actual cost incurred in engaging the locum. We would welcome the opportunity to review the relevant claim if the person concerned contacts us directly.

## ■ STATUTORY COMMITTEE

### Justice for everyone

From Dr M. E. King,  
MRPharmS

I was concerned to read the following comment by Lord Fraser of Carmyllie QC in the report of the Royal Pharmaceutical Society’s Statutory Committee meeting (*PJ*, 11 November, p590): “we must be particularly attentive to the burden on the Royal Pharmaceutical Society to establish its disciplinary case. The committee has therefore put the Society’s lawyer through the mill.”

Now I know from reading previous reports that Lord Fraser comes across as a fair and effective chairman of the Statutory Committee but I would like reassurances that the committee always ensures the Society establishes its case in a robust manner and that the Society’s lawyer is always put through the mill. Anything less and they are not doing their job with sufficient rigour both for and against any of the plaintiffs. The Statutory Committee is there to ensure justice is done for everyone not just the Society.

#### Martin King

Cardiff

The report made it clear that it was because the pharmacist concerned was neither present at the inquiry nor legally represented that the committee had a particular duty to “put the Society’s lawyer through the mill”. At most inquiries a lawyer representing the pharmacist would be present to challenge the case put by the Society’s lawyer and cross-examine the Society’s witnesses. — EDITOR