

■ VETERINARY PHARMACY

Pharmacy course is of finite length

From Professor B. L. Furman, FRPharmS

I was interested to read the report from the June meeting of the Royal Pharmaceutical Society's Council (*PJ*, 16 June, p716), at which Bob Michell advocated the inclusion of veterinary pharmacy in the indicative syllabus.

I agree that pharmacists should be willing to dispense veterinary prescriptions and offer the professional advice that goes along with the provision of the medicine. The undergraduate training should equip the pharmacy graduate with the sound scientific knowledge and understanding that underpins the actions, uses, formulation and adverse effects of medicines for whatever species they are intended. However, the course is of finite length and knowledge is infinite. If schools are to include veterinary pharmacy as a specific topic, the corollary is that something must be removed. Looking at the present indicative syllabus, I would find that hard to call.

The principles underlying the use of medicines in animals are exactly the same as those underlying their use in humans. Of course, species differ in their responses to drugs and how they metabolise them but there is also marked variability in human responses to these agents. If we have got education and training right, we should have inculcated in our undergraduates a desire to carry on learning throughout their professional lives and, indeed, this is becoming formalised through mandatory continuing professional development. Faced with a

veterinary prescription, the pharmacist has a duty to ensure that the right medicine has been prescribed in the right dose for the appropriate animal, just as he or she would need to do when faced with any prescription, especially the first prescription for a drug that has just come onto the market for human use. There are many resources available, including those referred to in the Council report, as well as numerous web-based materials.

Our graduates are, or should be, equipped to find rapidly the right information, assimilate it and make a professional decision in any novel situation. All of this is dependent upon maintaining a strong science base in the undergraduate course. If we dilute the science base, the long-term future of our profession is in serious jeopardy.

Brian Furman
University of Strathclyde

■ ANTIBIOTIC RESISTANCE

Specialist role of microbiology pharmacist

From Dr P. Long

In the UK, some 20 per cent of all prescriptions for antibiotics are dispensed through hospital pharmacies. About one third of in-patients receive antibiotics at some point during their stay, but up to 50 per cent of these prescriptions may be inappropriate or unnecessary and at a huge cost to the taxpayer. Common prescription errors include improper dose or formulation, using a drug that is more expensive than an equivalent alternative, duplication of drug therapy, or use of a drug not fit for purpose. Additional factors that

may contribute to inappropriate use include patient expectations, clinician inexperience or diagnostic uncertainty, and an increased tendency to practise defensive medicine due to constraints in consultation time. Misuse of antibiotics is widely recognised as a major contributing factor to the emergence of drug-resistant microbes. Resistance to antibiotics makes infections more difficult and expensive to treat, increasing the likelihood of complications and the length of hospital stay.

In response to the World Health Organization, the European Union and recommendations from the 1998 House of Lords Science and Technology Select Committee report "Resistance to antibiotics and other antimicrobial agents", the Department of Health issued guidelines with the core aim of decreasing the emergence and spread of antimicrobial drug resistance and its impact on the treatment of infection. The action plan outlined eight areas, among which were strategies to monitor and optimise prudent antimicrobial use. In 2003, the DoH allocated funds of £12m to acute NHS trusts to extend clinical pharmacy services to areas of antibiotic use, thus the role a microbiology pharmacist was formally created.

To date, over 140 pharmacists across 130 NHS trusts have been appointed, each with a strong background in infectious disease and antimicrobial management. In addition to auditing local antibiotic use, the microbiology pharmacist may also take on additional roles including counselling other health care professionals in best practice for antibiotic prescribing and infection control, formulary developments and appraisal of new antimicrobials to improve clinical management guidelines. Overseas studies have shown an apparent overall health care benefit to patients after the introduction of pharmacy-led programmes, including a reduction in drug tariffs. Unfortunately, this seems not yet to be the case in the UK where the current role of the microbiology pharmacist in promoting prudent and responsible antibiotic prescribing has been seen from some quarters as a corrective measure to reduce overall costs rather than an active contribution to patient care. Prescribing control systems support sensible antibiotic use and facilitate a better understanding of the roles different health care providers contribute towards improving patient care. The key components for successful

management of antimicrobial use are the formulation, implementation, surveillance and update of antibiotic policies that are based on the local epidemiology of both prescribing and antimicrobial resistance patterns.

With the introduction of supplementary prescribing and the evolution of the consultant pharmacist grade within the NHS, microbiology pharmacists should be able to make evidence-based decisions to modify or stop "inappropriate" dispensing, without prior reference to the clinical team, albeit within the remit of stringent guidelines. This will lead the way for career development of an independent microbiology pharmacist who is involved in all aspects of infection control. Undergraduate curricula will have to develop to reflect the rigorous life-long learning skills required of tomorrow's pharmacists to fulfil the evermore demanding and challenging aspects of this specialist role.

Paul Long
*Senior Lecturer in Molecular Microbiology
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University of London*

■ COMMUNITY PHARMACY

Recycling bags

From Mrs Y. H. Taylor, MRPharmS

Pharmacists should be looking to reduce the wastage of paper and plastic bags containing dispensed medicines.

Most dispensing standard operating procedures include the use of prescription baskets. Could checked medicines be left in the basket until the patient collects the medicines? (This would also allow for visual inspection and counselling, if necessary.) The medicines could then go straight into a recyclable bag, possibly with a slot for a patient medication record card. The patient would have been issued with such a bag, the size reflecting the amount of medicines collected.

I work at an independent pharmacy. However, I am sure that Tesco, Sainsbury's and ASDA, which are taking positive steps to encourage their customers to recycle shopping bags, would embrace this idea. The large multiples may also like to give it some thought.

Yvonne Taylor
Shoreham-by-Sea, West Sussex

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■ OPIATE ADDICTION

Codeine addiction is a serious problem

From Mr R. I. Dunkley,
MRPharmS

Some pharmacists have to deal with the ravages of heroin addiction by supplying methadone or buprenorphine to their patients. But how many pharmacists have given thought to the patients that receive prescriptions for co-codamol or co-proxamol?

Some of these patients are just as addicted to their medicines as any of the heroin users and they will experience a withdrawal syndrome if the medicine is withheld — albeit not as severe as that from heroin but enough for it to be terribly uncomfortable.

The purchase of co-codamol over the counter is another source of worry to community pharmacists and the purchase of Solpadeine by addicts has become enough of a source of worry to the general public to spawn a website for people to share their experiences (www.rsdalert.co.uk/drugs/solpadeine.htm). Clearly, there is a problem with codeine.

However, I would ask fellow pharmacists to look at the composition of the tablet the public can buy over the counter. It consists of codeine 8mg and paracetamol 500mg. The addict wants the codeine but has to take a huge dose of paracetamol as well to get the hit. The danger is, of course, that the paracetamol will damage the liver, possibly resulting in death.

Could I suggest a way forward? There has recently been released a low-dose buprenorphine patch that gives a low level of the drug to the body and this, I think, would make people who have been on long-term codeine therapy able to give up the codeine and hence the paracetamol. The only other therapy for these people would be methadone.

I came across this medicine the other day with a visit from a drug company representative and I thought that it could make a really good treatment for codeine addicts.

Bob Dunkley
Leeds

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■ CLINICAL TRIALS

Scepticism is healthy

From Mr J. P. Miller, MRPharmS

I read with interest your news item referenced from *PLoS Medicine* that stated "head-to-head drug comparisons are more likely to favour a sponsor's drug than its comparator" (*PJ*, 9 June, p666). Large pharmaceutical companies clearly have a vested commercial interest in setting up randomised controlled trials. Because of the huge costs involved they are often the only people able to conduct these, and larger outcome-based trials, where huge patient numbers are often needed to demonstrate significant benefits.

RCTs are usually set up to prove or disprove a hypothesis and to generate data, which are often produced by pilot studies or from secondary/tertiary endpoints in other trials. This, in effect, means that companies have a good idea of the expected outcome based on these data, power the trials accordingly and are able to back the right horse. Why does it come as a surprise that a commercial organisation would fund trial work that has a good chance of being positive for that organisation? Few chief executives would last long in an organisation that continually conducted work showing no benefit or little commercial return.

A degree of scepticism is healthy. However, to suggest that the positive outcomes favouring a sponsor's drug are due to unfair bias does a disservice to the huge amount of robust work conducted by the pharmaceutical industry. Perhaps in days gone by trial work was less rigorous. However initiatives like Good Clinical Practice, the Helsinki Declaration and web postings of studies from the Medicines and Healthcare products Regulatory Agency make this highly unlikely today.

J. P. Miller
Leeds

■ RETENTION FEES

Decision will be made in long-term interests of the profession

From Mr A. C. Gush, MRPharmS

Paul Breame (*PJ*, 16 June, p716) raised his concerns about the "substantial increase in retention fee" for 2008 as announced by the

President during the Royal Pharmaceutical Society's annual general meeting in May (*PJ*, 26 May, p624).

Although a final decision has yet to be made in respect of the 2008 fee increase I thought, as the Society's new Treasurer, that it would be useful for me to outline some of background that is at the core of the Council's ongoing discussions on this understandably emotive issue.

In 2004 the Council adopted a financial strategy with the aim of achieving long-term financial sustainability for the Society. There were three main planks to this strategy: (i) to reduce reliance on the financial contribution from RPS Publishing, (ii) to fund regulatory and professional activity from premises fees and retention fees and (iii) to build the Society's reserves from the publishing contribution.

Although movement has been made towards these objectives, progress has been slower than expected. There are a number of reasons for this, including a decrease in the revenue from publications, the escalating cost of regulation, the costs relating to continuing professional development and the large deficit in the Society's pension fund. Another key factor relates to the Council's reluctance over the past two years to raise significantly retention fee levels in an effort to restrict the financial burden on the membership. However we are now in a position where, in the absence of any new funding, our reliance on traditional sources of income will need to increase substantially.

I am aware that the timing of fee payments is far from ideal and members will be glad to learn that I am investigating ways of introducing staged payments. However I cannot make any promises that this will be introduced in time for January 2008 as regulations will need to change to allow this to happen, but if it can be done it will be done.

There is probably no aspect of the Society's work that is more likely to attract criticism from members than the retention fee issue. But I give you my assurance that the final decision taken by the Council regarding fees will not be made lightly but will be made in the long-term interests of the pharmacy profession and the Society, with the well-being of members being a primary concern.

Andrew Gush
Treasurer
Royal Pharmaceutical Society

Technicians' fee does not reflect income

From Mrs S. J. Lowdon,
RegPharmTech

Further to the letter from Paul Breame (*PJ*, 16 June, p706) I would like to add my concerns as a pharmacy technician about the "substantial" rise in retention fees, as yet unannounced.

I have no doubt that when the retention fee for pharmacists goes up so will the retention fee for technicians. Mr Breame rightly states that this rise is not always reflected in the wages that we earn each month, particularly the wages of those who work part time. I agree with him.

Why can we not pay our fees monthly or quarterly by direct debit or, if not, why does the fee have to be paid around the Christmas period? Why not at the end of the financial year? I would also like to add that previously, my employer, Boots the Chemists, paid my fee. However, I now work for the NHS and it does not pay my fee. I am assuming that this is the same for pharmacists. How can this be just?

Surely if it is necessary to be on a Register, employers should either pay the fee or it should be reflected in our wages?

Sarah Lowdon
Yateley,
Hampshire

What are our fees for?

From Mr A. Matalia, MRPharmS

Membership of the Royal Pharmaceutical Society has never been based upon salary. Pharmacists who earn £35,000 pay the same as those earning £100,000. Therefore, in my view, technician registrants should pay exactly the same sum as pharmacists, whatever their salary.

On the subject of fees, I find it unacceptable that Hemant Patel believes "substantial increases in the retention fee are inevitable" (*PJ*, 26 May, p624). Pharmacists should protest against this unacceptable "conscripted" fee. Fee increases should require the approval of members and not just the Privy Council. Let us have a breakdown of what fees are for, just as we have a breakdown in our council tax bills. Let us decide which parts we wish to pay for.

A. Matalia
Coventry