

To switch or not: pharmacists opinions

What do pharmacists think about the POM-to-P overhaul announced earlier this year? Clare Bellingham finds out what comments were made during the consultation period which recently ended

THIS week's announcement that POM-to-P switches are to be made faster (see p598) follows the publication of a strategy document earlier this year which proposed a large number of potential switches.

The document, "Potential candidates for reclassification from POM to P", suggested candidates for switching including medicines used for managing chronic diseases (*PJ*, 2 February, p131). Examples include beta-blockers, diuretics, statins, oral contraceptives, hormone replacement therapy and proton pump inhibitors.

The consultation period on the strategy document has now ended. Comments received by the Royal Pharmaceutical Society (which led the working group that produced the document) were generally supportive of the concept of identifying categories for potential POM-to-P switches. However, concerns were also raised.

SUPPLEMENTARY PRESCRIBING

Many respondents suggested that making some of the medicines included in the list available as P medicines was a step too far.

Robert Gillespie, senior pharmaceutical prescribing adviser, Argyll and Clyde Area Pharmaceutical Committee, suggested that a new category of drugs that pharmacists could prescribe would be more appropriate. "We are not convinced that the switch from POM to P is appropriate. The majority of the drugs listed require medical initiation or guidance," he explained. In addition, "reclassification of these drugs from POM to P would presumably also allow them to be prescribed by nurse prescribers which may be inappropriate", he said.

The solution offered by Mr Gillespie is a new category of drugs: "We would prefer to see a new category of drugs which can be prescribed by pharmacists on a repeat basis following initiation by a medical practitioner with the repeat prescriptions issued under an agreed protocol."

Kathryn Featherstone, prescribing adviser, South Tyneside Primary Care Trust, expressed similar concerns. "The PCT's main concern is who would be responsible for monitoring patients." This demonstrated the need for supplementary prescribing because it should overcome the problem of patients buying medicines for themselves without receiving regular monitoring.

In fact, the recent proposals on supplementary prescribing for pharmacists (*PJ*, 20 April, p521, and 27 April, p562) were published after the consultation period on the POM-to-P switches had ended. Many of the concerns expressed could be largely superseded by the introduction of supplementary prescribing.

John D'Arcy, chief executive of the National Pharmaceutical Association, said: "Most chronic conditions would be dealt

with best using supplementary prescribing." He pointed out that making more medicines available over the counter would not necessarily take the burden away from doctors because people who are exempt from prescription charges are unlikely to want to pay for medicines at the pharmacy if they can get them free on prescription. This provided a case for supplementary prescribing.

At the launch on 1 May of a new strategy to increase availability of OTC medicines, Lord Hunt said that reclassification could not be looked at in isolation. Developments in supplementary prescribing and repeat prescribing in addition to increasing the availability of OTC medicines would ensure the public had greater access to medicines. These developments together would allow "the kind of flexibility we want to bring in".

However, POM-to-P switches might still be useful. Ms Featherstone commented: "Some of the changes might be of use in easing the way towards prescribing for pharmacists and nurses." She added: "We will have to wait and see what happens with supplementary prescribing."

RECORDS AND REGISTRATION

If drugs for chronic diseases are to be made more widely available, access to patient records and registration of patients in pharmacies were expressed as issues that needed to be addressed.

Mr Gillespie commented: "We consider that it is vital to establish robust and secure electronic links with community pharmacies and to agree appropriate levels of access to patient-sensitive information. This must ensure that any drug issued to a patient should be recorded on their medical record to ensure that a complete account of their medication history is available." Patients should be registered with one community pharmacy to ensure that chronic conditions are properly managed, he added.

Anne Joshua, principal pharmacist, NHS Direct and Walk-in Centres, Department of Health, pointed out that lessons that could be learnt from widening access to medicines using patient group directions. "The lesson we can learn from patient group directions is that consultation following a clear treatment guideline with good documentation provides quality health care with a feedback mechanism to the GP to complete the patient record. It is to be encouraged that any professional practice guidance for the sale of a P medicine includes treatment guidelines, encourages documentation and with patient consent a copy of the consultation record to go to the GP," she commented.



Many medicines currently only available on prescription might become pharmacy medicines in the future

SPECIFIC DRUGS

In terms of the specific drugs for which reclassification is proposed, Mr Gillespie said that it would be appropriate for analgesics for migraine, treatments for motion sickness, malaria prophylaxis, water for injections and antifungal treatments for topical and oral use (but not for systemic use).

Respiratory consultants at the Royal Alexandra Hospital in Paisley were in favour of inhaled bronchodilators being reclassified, but not inhaled steroids due to cost and concern about inappropriate use. Choice and cost of device would also be a factor to be considered. Consultants and clinical pharmacists at the hospital felt that newer, expensive drugs such as clopidogrel, statins, influenza treatments, cyclo-oxygenase-2 inhibitors and migraine treatments would benefit from being under direct medical control for both safety and economic reasons. In addition, they expressed concern over reclassification of anti-obesity drugs and beta-blockers for anxiety.

Ms Featherstone said that South Tyneside PCT is particularly concerned about switching cardiovascular drugs because of the large amount of monitoring that is required for them to be used properly, for example, measuring blood pressure and cholesterol levels. Another area of concern for Ms Featherstone is the POM-to-P switch of hormone replacement therapy because she believed that patients taking HRT needed to be regularly monitored.

How many medicines are reclassified and how quickly this happens remains to be seen. But with other developments, including the introduction of supplementary prescribing, it is an important step in expanding the role of pharmacists.