WORKPLACE PRESSURE

We would like to hear from members

From Mrs L. K. Gilpin, MRPharmS

The English Pharmacy Board is not waiting until after the Royal Pharmaceutical Society separates to involve itself with such an important issue as workplace pressure. We have been researching into the background and have been concerned to read the recent Department of Health report into health workers, which stated that "excessive workload is perceived as a key contributor to rising levels of stress among pharmacists".

Last year, the Society and the Pharmacy Practice Research Trust held a two-day symposium on "workload pressure and the pharmacy workplace". This was attended by employers, policy makers, pharmacy academics, and leaders of the profession, who heard presentations from academics and pharmacy organisations reporting on research and evidence. This symposium led to a report and a series of recommendations.

The people we have not heard from, however, are individual members — the people at the front line or, indeed, behind the front line — in each sector. What are the issues for them and what makes their working life harder and more stressful than it needs to be?

It might be that previous research work has captured everything. It may be that there is more to know before we start to work on answers. Either way, we would like to know either by e-mail to lindseygilpin@hotmail.com or by letter to me c/o the Royal Pharmaceutical Society. I will not pass on names or e-mail addresses. I will, however, repeat what members tell me unless they instruct me otherwise.

We look forward to hearing from everyone.

Lindsey Gilpin
Chairman
English Pharmacy Board

References

NEW PROFESSIONAL BODY

Retired pharmacists focus group

From Mr R. Lane, MRPharmS

I have recently been appointed moderator of the retired pharmacists focus group for the Royal Pharmaceutical Society, a new online group exclusively for pharmacists retired from practice who would like to stay in touch with the profession. The Journal has published several letters from pharmacists who have expressed their desire to be still in touch with matters pharmaceutical, and are willing and able to share their experiences of many years activity in the profession. This includes letters from Ian C. Cowan (PJ, 20 March 2010, p288) and Bill Brooks (PJ, 19/26 December 2009, p679).

I am a retired proprietor pharmacist with experience as an audit facilitator and, for many years, was treasurer of a local branch of the Society.

Those who would like to find out more about the retired pharmacists group should contact Nicole Baines, membership officer at the Society (e-mail nicole.baines@rpsgb.org).

Roy Lane
Rochdale, Lancashire

Three main duties

From Mr A. P. Gledhill, MRPharmS

Am I right in thinking that the three main duties of the General Pharmaceutical Council will be to protect the public from dodgy pharmacists, to protect pharmacists from dodgy employers and to monitor and give feedback on the professional development of individual pharmacists and pharmacy technicians in a supportive and constructive way?

On the subject of dodgy employers, will the GPhC inspectors’ regular visits to community and hospital pharmacies include assessments of working conditions, such as prescription turnover per pharmacist, physical space in the dispensary to work in a safe and effective way, regular breaks away from work (not more than a four-hour shift without a break), only conducting medicines use reviews on patients who really need them (how much are these costing the taxpayer), and only conducting MURs when a second pharmacist is available to cover the dispensary, etc?

Finally, I doubt the pharmacist and pharmacy technician workforce will be happy to pay more than £120 per year for the privilege of paying for a body to police its own members.

Andrew Gledhill
Burnley,
Lancashire

The General Pharmaceutical Council has indicated its intention to respond to this letter in due course.

EDITOR,

TAMSULOSIN

Tamsulosin and intraoperative floppy iris syndrome

From Mrs L. C. Titcomb, MRPharmS, and Dr L. J. Jones, MRPharmS

As specialist ophthalmic pharmacists, we have followed with interest the reclassification of tamsulosin from prescription-only to pharmacy medicine and its introduction as Flomax Relief MR for the treatment of symptoms of benign prostatic hyperplasia (BPH).

We wish to emphasise to those pharmacists recommending this product the importance of the frequent occurrence of difficulties encountered by ophthalmic surgeons undertaking cataract surgery on patients taking this drug.

Intraoperative floppy iris syndrome (IFIS) was first described in 2005 and is characterised by a flaccid and billowing iris, prolapse through a surgical incision and progressive pupillary constriction. This may lead to increased procedural complications during cataract and other intraocular surgery. IFIS is frequently seen in patients taking alpha-adrenoceptor blockers, particularly tamsulosin, which is a highly selective alpha-1a blocker. The alpha-1a receptor, as well as being the predominant receptor in the bladder neck and prostate, is the most abundant receptor in the iris mediating pupil dilation.

Although mention of IFIS during cataract surgery is made in the special warnings and precautions for use in the summary of product characteristics (SPC) for Flomax Relief MR, and is referred to in the patient information leaflet as a very rare side effect affecting less than 1 in 10,000 people, this is far from what is seen in clinical practice.

Since the syndrome was first reported, there have been many publications confirming the association between IFIS and tamsulosin treatment. In a review of this association published in 2009, Leibovici et al report the occurrence of IFIS in patients exposed to tamsulosin to be between 57 and 100 per cent compared with 0 to 5 per cent in those not exposed to the drug. The age group of men suffering from BPH and that of those undergoing cataract surgery are similar and therefore we would...
Tamsulosin not high on POM-to-P switch wish-list

From Mr G. P. Burke, MRPharmS

In general, I am a keen advocate of switches of prescription-only medicines to pharmacy medicines (POM-to-P switches). However, I believe reclassification of prescription medicines should be prioritised according to patient need and not motivated by fiscal gain by opportunistic pharmaceutical companies.

If one were to ask a group of pharmacists which prescription medicines they would have liked to see reclassified as pharmacy-only medicines, I am sure tamsulosin, an alpha-blocker with significant interactions and hypotensive effects, would not have appeared high on their wish-lists.

Flomax Relief (tamsulosin hydrochloride 0.4mg) is a treatment for short-term relief in men with benign prostatic hyperplasia (BPH). The manufacturer’s rationale for the switch was on the basis that men could play a more active role in their healthcare. My main concern is self-medicating with Flomax Relief could cause a delay in the investigation of a patient’s prostate symptoms. Prostate cancer, the most common cancer in men in the UK, can present with symptoms similar to BPH, a condition for which many pharmacists in my peer group do not believe they are appropriately trained to make an accurate diagnosis.

Despite the manufacturer’s stipulation for pharmacists to ask patients to visit their GP for confirmation of diagnosis, patients may continue to self-medicate, obtaining supplies from pharmacies, while an underlying prostate cancer progresses.

Perhaps it is time the Medicines and Healthcare products Regulatory Agency works to reclassify prescription drugs discerningly, according to patient need.

Gareth Burke
London

ECZEMA

The importance of nutrition and phytotherapy

From Mr N. Ali, MRPharmS

Further to last week’s letters evaluating treatment options for eczema (PJ, 17 April 2010, p364), may I propose that the correspondents explore the benefits of traditional herbal medicine espoused by great western herbalists such as Culpeper and Gerard.

Modern medicine has proved inadequate in curing many chronic conditions, particularly skin conditions such as eczema. The teachings of Hippocrates, Galen and Avicenna collectively offer a fresh approach to the treatment of disease, and it saddens me that both current pharmacy and medical education are deficient in teaching students the importance of nutrition and phytotherapy.

Herbal medicines effective in curing eczema either singly or in combination include neem, kentia, gentian, barberry, burdock and aloe vera. Dietary advice centres on a whole-food diet with the exclusion of dairy, particularly cheese and yoghurt. Soups are an ideal food during the treatment period.

Nadim Ali
Glasgow
Letters

"If you do not reach these targets I will want to know why"

From Mr L. N. Collin, MRPharmS

I read the letter of James Andrews (PJ, 27 March 2010, p315) with considerable empathy.

My own locum experiences for Rowlands these past few years have revealed a significant increase in pressure on pharmacists to conduct medicines use reviews. This can only detract from their inherent value while “five-minute-quickie” MURs become the norm.

Originally, the area manager told me that the company’s requirement was for the pharmacist to give out all dispensed medicines to patients personally, which is a perfectly reasonable directive. MURs were carried out in pharmacy extra time, charged at locum rates, as an advanced service should be. Additional income was thus generated and everyone was happy.

Last year, the directive changed. Suddenly there was a demand for five MURs a week, somehow to be magically incorporated into time already taken up fulfilling core NHS dispensing and pharmaceutical services. To add a touch of arrogance, the area manager’s target sheet carried the message “if you don’t reach these targets I will want to know why”.

On my raising the obvious issue of the pressures on pharmacists when they finish an MUR, the incredible response was that staff could bring prescriptions in for checking while a pharmacist is conducting an MUR. In my view, this destroys the whole confidential ethos of this service, as well as contravening the primary care trust’s service specification.

It is sad when commercial considerations try to override professional requirements and I, too, hope that issues such as this will be given careful and timely consideration by the new professional body.

Lawrence Collin
Westcliff on Sea, Essex

John D’Arcy, commercial director, Rowlands Pharmacy, responds: MURs became part of the pharmacists’ contract and thus formally part of pharmacists’ professional role in April 2005. Since that time, there has been a relatively slow but steady progress with MURs to the extent that there is still ground to be made up if pharmacies are to hit the target of 400 per pharmacy.

It is essential that we embrace MURs and get them done. They are a core component of the pharmacy contract in England and Wales. They are seen by the government and primary care organisations as a proxy for engagment and there are a number of examples of new contract decisions being based around the level of MURs being undertaken by existing contractors.

Rowlands Pharmacy is committed to pharmacists’ professional role and, as part of this, we are doing all we can to increase our delivery of MURs. This includes a considerable investment in training and development to help pharmacists in the delivery of MURs alongside other professional activities. We see MURs as pivotal to building a pharmacy role fit for the future.

From a patient perspective, MURs are also a key component of ensuring the safe and effective use of medicines. So we make no apology for setting and pushing MUR targets at branch level. And a target of five per pharmacy per week — 250 per year — is hardly excessive when compared with the national target of 400 per year.

More importantly, we believe that pharmacists should want to get behind MURs as a means of securing their professional future.

Pharmacy’s future is predicated on our delivering on all aspects of the contract. If we fail to deliver on MURs, we are squandering a huge opportunity and turning our backs on our professional future.

The good, the bad and the ugly

From Mr S. J. Riley, MRPharmS

I write in support of the letter around the subject of medicines use reviews from James Andrews (PJ, 27 March 2010, p315). After working for several years as a community pharmacist manager, I, too, now mainly work in primary care. But from my past experiences, it is clear we are in the situation of the good, the bad and the ugly.

The good is the potential pharmacy services have for the public, including MURs, minor ailment schemes, emergency hormonal contraception and others. But this is only if the necessary support is available (eg, trained staff, double pharmacist cover).

The bad is the situation we have been forced into as employees and locum pharmacists. Employee pharmacists are hounded by area managers, often non-pharmacists, for not meeting business targets set on professional services. As Mr Andrews mentioned, they have no interest in our professional obligations or service specifications, especially where MURs are concerned. Locum pharmacists are told that if they do not do MURs and other services, they will not be booked in future. But there has never been any negotiation over payments for these extra services and no extra support to provide them correctly.

The ugly is the general situation we are now in. No notice is taken of our ethical obligation to put patient interest above financial targets and, as the responsible pharmacist, it is our duty to determine what services are provided to ensure the pharmacy is run in a safe manner with the level of support available. Sometimes staff have not been trained to an adequate level for their roles and we have an unreasonable workload with various targets over us. Then, if and when errors are made or substantive service levels are provided to the public, as the responsible pharmacist, it falls at our feet.

Surely this must be made a priority for the new professional body. If it has an active voice in this area for frontline pharmacists, then it will certainly win more support. We should also lobby the General Pharmaceutical Council to set mandatory levels of staffing and maximum workloads, so contractors and management figures can be taken to task if we are prevented from meeting our responsible pharmacist and ethical responsibilities (rather than current “guidance” that says we should just use professional judgement). If these points were actioned, we could provide a better pharmacy service and provide greater value for money for the NHS. One or two colleagues have wondered if Panorama or Tonight be interested in how we are pushed into doing these inappropriate “quick-win” MURs and how they cost the taxpayer £28 a time?

Most importantly, if the GPhC and the professional body act on these points, we will have a safer service for patients.

Stephen Riley
Liverpool