Letters

NEW PROFESSIONAL BODY
We can work together

From Mrs L. K. Gilpin, MPharm

I am writing in response to Robin Herbert's letter about the Channel Islands and Isle of Man pharmacists and the way in which they were disenfranchised at the last election (Pj, 19 June 2010, p607). This is absolutely not the way to start to have a relationship with potential members of the new professional body and I am sorry for it.

In the strange way that these things happen, the first discussion we had at the first English Pharmacy Board meeting after the election was about this situation in that one of our guests was from the Channel Islands.

The new professional body has concern for its members at its very core. Wherever those members are from and whatever there is need for representation to Government, this is what we will do and this is where we will go. This will happen whether the Government is at Westminster, Edinburgh, Cardiff, Douglas, St Helier, St Peter Port or Sark.

The boards, the shadow Assembly and the staff at the Royal Pharmaceutical Society all know we have a lot to prove. We are working to show just how good the new body can be. I do not want to lose one single potential member so please Mr Herbert, and others similarly affected, keep talking to us and let us see whether we can work together to make this the best thing that has ever happened in pharmacy.

Lindsey Gilpin
Chairman
English Pharmacy Board
lindseygilpin@hotmail.com

SPECIALS
Crushing tablets or opening capsules is sometimes necessary

From Mr T. R. Root, FRPharmS, and others

As contributors to the Royal Pharmaceutical Society's guidance document on the procurement and supply of pharmaceutical specials (Pharmacy Professional, June 2010, p27), we would like to make the following points in response to Caroline Wickworth's letter (Pj, 12 June 2010, p580).

We note her comments about off-label use and acknowledge that it presents issues significantly different from those associated with the use of medicines that are not the subject of any marketing authorisation (product licence).

We readily acknowledge there is a growing number of valuable information resources to inform management of patients for whom no licensed medicine is available. However, we must also point out that almost all are based on practical experience and not on scientific evidence of any sort. A list included in the guidance itself might quickly become outdated but we would encourage the Society to develop, publish and regularly update a separate list as an appendix.

The Society has received several other comments about a perceived conflict between this and the UK Medicines Information guidance (in which manipulating a licensed product (crushing tablets or opening capsules) is suggested for consideration before use of a special. Both this document and the UKM documents are guidance to inform situation-specific decisions by professional practitioners. They are not hard-and-fast rules and cannot account for the nuances of every possible set of circumstances.

We would suggest the fact the two documents are not identical is evidence of just that. Each clinical situation must be judged on its merits. For some drugs, there is empirical or other evidence to show that crushing tablets or opening capsules is safe and effective, and this may be the only option for a chemically unstable drug. For other drugs or in other situations where, for example, patients or their carers do not have the manual dexterity to crush tablets or open capsules, this clearly is not an option.

We believe that our hierarchy accurately describes the principles of best practice, but it is not intended for use in isolation. A pharmacist who has read the guidance and has an appropriate awareness of understanding of all the issues will be properly equipped to make an informed judgement about the course of action most appropriate to an individual patient.

As a general principle, it should always be our aim to provide patients with medicines that are ready to administer (ie, we should expect patients to crush tablets or open capsules only if it is not possible to provide a safe and effective ready-to-administer medicine when they need it).

However, we must recognise that there will be circumstances where we cannot provide medicines that are ready to administer (ie, where concerns about safety, efficacy or timely availability of a special cannot be resolved). In those circumstances, the balance of risks and uncertainties may favour crushing tablets or opening capsules, especially if there is evidence that this has previously been shown in practice to be safe and effective.

Moreover, it has to be clearly understood that there are often significant uncertainties associated with both options. The most often-voiced concern about crushing tablets or opening capsules is probably about a patient getting the right dose. In reality, many oral liquid specials should be of equal concern for exactly the same reason, and that they may also pose a risk of unexpected side effects due to chemical decomposition of unknown extent.

We fully accept the importance of cost as a factor to be considered when choosing an unlicensed medicine. We were, however, advised that it was inappropriate to discuss this in detail in the context of guidance from our professional body.

Finally, we welcome the interest in the guidance and want to take this opportunity to draw to the attention of all pharmacists who have yet to read it, and to encourage a wide continuing debate. They can participate at groups.rpharms.com/_forum/home.asp by clicking on the “specials” discussion group.

Tim Root
Stephen Tomlin
Carol Roberts
Robert Lowe
Richard Bateman
Kevan Wind
Mark Dasgupta
Heidi Wright

Contributions to the good practice guidance on the procurement and supply of pharmaceutical specials

Letters are welcome from all readers. Letters for publication can be posted, faxed, or sent by e-mail to letters@rpharms.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 and registered pharmacy technician correspondents should supply their membership numbers, and a telephone number should always be given.

All letters are considered on their merits and are accepted for publication on the understanding that they have not appeared anywhere previously. This includes PJ Online. 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. Further to a recommendation by the Journal Oversight Board (Pj, 1 March 2008, p324), pharmacists and pharmacy technicians whose names appear on the non-practising part of the relevant register are asked to make their status known.

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 be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

Published letters will appear on PJ Online as a matter of course.

Letters and PJ Online

Published letters will appear on PJ Online as a matter of course.
Some pharmacies in remote areas pay high rates for locums just to stay open.

Locums do not provide

advanced and enhanced services

Locums cannot be properly trained (because the workforce is transient)

Locums can cause danger to the public due to travelling long distances, having unpredictable shift patterns and working long days

There is mounting evidence of poor health, which results in reduction in service quality

We argue that there is no evidence presented to validate these assertions. Moreover, most locums will find these arguments, at the minimum, grossly misleading.

The authors mention pharmacists are working under stress, although they do not specifically say these pharmacists are locums. They suggest that this is due to poor organisation and a failure to provide the correct mix of pharmacists, assistants and technicians. So this is not a locum issue and should not be included in the argument.

The article mentioned that locums provide a vital service in areas where recruitment is difficult. However, it fails to mention that locums provide an invaluable service to pharmacies, thus enabling them to continue and thrive. How else could businesses that need pharmacists, assistants and technicians be able to continue and thrive? How else could businesses that need locum pharmacists to fill all the jobs, and that there is no evidence of pharmacies being closed due to lack of pharmacists. However, the authors draw no conclusions.

They admit that it is not clear how flexible the locum workforce is, what training locums have undertaken, what qualifications they possess and how much support they provide beyond essential services, despite arguing that they cannot be trained adequately. They then talk about the need to keep costs down, but there is no attempt to analyse the relative costs of locums versus employees. It simply implies that locums cost more. But where is the proof?

Therefore, the conclusion must be that locums are key players in the delivery of pharmacy services to the public, despite the inexplicable resentment by some people in the industry.

Rebecca Midgley
Amy Midgley
Pharmacy Seekers Ltd

Evidence is being disregarded

In response to Susan Bewley’s comments that a pharmacist’s objection to the supply of emergency hormonal contraception would “contribute to more unwanted pregnancies and abortions” (PJ, 12 June 2010, p580), I would like to draw her attention to the following.

There is no evidence to demonstrate that increasing access to EHC leads to a reduction in unwanted pregnancies and abortions. Paton et al found that “irrespective of either the matching or the adjustment procedure, we find no evidence that over-the-counter emergency birth control schemes lead to lower teenage pregnancy rates”.

Raymond et al, in their systematic review, state that increased access to emergency contraceptive pills increases use, but has not been shown to reduce unintended pregnancy rates.

Indeed, a Cochrane systematic review concluded that the chance of pregnancy was similar regardless of whether or not women have emergency contraception on hand before unprotected sex, even though women who had a standby supply were more likely to use it, and to use it sooner after sex.

What conclusions can be drawn from this — that we should continue with this ineffective offer or look to alternatives? The summary of product characteristics for Levonelle 1500 states:

Levonelle 1500 is not recommended in children

There are very limited data available in women under 16 years of age.

However, we still persist in drawing up patient group directions for supply of EHC in the under 16s to be used by healthcare professionals without full access to patients’ medical records.

What safety issues are being missed when supplies of powerful sex hormones to young girls are not being communicated to GPs? When it comes to yellow card reporting, how would a GP know that a patient presenting symptoms may be related to use of EHC?

My concern is that, with regard to sexual health strategies, evidence is being disregarded in order to pursue this contraceptive mentality. Pharmacists’ objections to the supply of EHC are often questioned and ridiculed. Could it be that, based on the evidence, they are acting in the best interests of their patients?

Sean Mackey
Carnforth, Lancashire

References
