

Readers' letters

Strength in unity

The recent opinion article by Philip Brown (*BJ Clin Pharm* 2009;2:30) was up to his usual thought-provoking standards. He suggests that the professional needs of hospital and advanced clinical pharmacists would be better met by an independent and dedicated organisation such as the Guild of Healthcare Pharmacists (GHP), rather than coming under the umbrella of the new Professional Leadership Body (PLB).

The GHP currently takes the position that it would like to be focused primarily on terms and conditions and directly associated professional issues. The PLB on the other hand, will be focused on practice issues and the wider professional leadership and support that members require. Consequently, we have been working to establish the most effective interface between the PLB and the GHP. We intend to work with the PLB to ensure that it provides a relevant package of services and true professional leadership for pharmacists working in the managed sector. There is strength in recognising and maintaining the diversity of views and practice in professional, but inclusive, leadership, to deliver the best outcomes for patients and pharmacists through the unity of one voice.

The GHP acknowledges that there has been a gap in the support provided to NHS pharmacists by the Royal Pharmaceutical Society and we hope that things will not go on as before. We believe the wider profession wants an organisation that is confident, forward-looking and inspirational, freeing and supporting pharmacists to deliver a common agenda of innovative change. This will raise the standards of practice and safety throughout the whole medication pathway.

On a personal level, I wholeheartedly agree with Dr Brown's call for a broader base to pharmacists' education (*BJ Clin Pharm* 2009;1:351). I believe pharmacists are trained to think in terms of 'black and white', when in fact there should be less focus on the right answer and more on the best answer. This involves teaching them to deal with the real 'grey' world and requires not just teaching of the pure sciences, but increased training in the social sciences, including communication and psychological issues.

Perhaps to illustrate I could draw on the creative and lateral thinker Edward De Bono, who suggests assigning a number of different coloured 'hats' to different thought states.¹ Similarly, pharmacy needs to teach its students to assume a number of different roles, or 'hats'. Hence, pharmacists may need their 'black hat' (the logic applied to identifying errors or mismatch) for a final check in the dispensary, but for other aspects of pharmaceutical care they might be better placed wearing a 'red' (gut instinct), 'yellow' (logic applied to identifying benefits), or 'green' (statements of provocation or investigation) hat.

I do wonder if we over-teach pharmacists to be comfortable constantly wearing the black hat of logic and negativity. Consequently pharmacists can continue to hang on to traditional ways of working, and traditional roles and functions, becoming afraid of risk and change.

David Miller

President, Guild of Healthcare Pharmacists

Reference

1. De Bono, Edward. *Six thinking hats: An essential approach to business management*. Boston: Little, Brown, & Company;1985.

Local practice forums

In an earlier letter to *The British Journal of Clinical Pharmacy* (2009;1:190) a correspondent described the role of local practice forums (LPFs). Hospital, community and academic pharmacists are now starting to use their LPFs to network and share best practice, in a way that is very different to the former branch meetings.

An example of this is an interactive presentation I gave at the recent LPF meeting in Huddersfield. My presentation illustrated two separate models used in the treatment of opioid dependency: oral methadone or buprenorphine, and injectable diamorphine.

The first of these models was based upon a study that was conducted in Canada last year.¹ Injectable diamorphine was compared with oral methadone maintenance treatment in patients who were refractory to treatment, having not benefited from at least two treatment attempts (including at least one methadone treatment). The primary outcomes were retention in the treatment programme or drug free status, and a reduction in illicit drug use or other illegal activity, assessed at 12 months. Rates of retention were much higher in the diamorphine group than the methadone group, and rates of illicit drug use or illegal activity were much lower.

The second model concerned the use of injectable opioid treatment (IOT), which has been declining in Britain over recent years. Reasons for this include the rise of oral methadone treatment and a shortage of doctors who are licensed to prescribe IOT. There is also reluctance to prescribe IOT because of concerns over the lack of arrangements for supervision, lack of resources, and perceived limited evidence base for its effectiveness.²

Following the presentation, small groups discussed four options for the treatment of opioid dependency in community pharmacies: supervised diamorphine injection; diamorphine injection for the patient to take home and inject unsupervised; oral methadone or buprenorphine maintenance treatment; and any other suitable ideas.

Following considerable debate, few participants thought that oral maintenance therapy was the best model of treatment, despite it being the most commonly used model in the UK. Supervised administration of injectable diamorphine in the clinic in which it is prescribed was a more popular choice.

Other ideas for the treatment of opioid dependency that were discussed included psychosocial counselling and the design of differing formulations of diamorphine to enable single daily dosing.

As can be seen from the above discussion, LPFs allow more freedom to discuss such controversial matters and also allow more room for debate than the traditional branch meeting.

Lawrence Daniels

Pharmacist teacher practitioner, University of Bradford and Airdale NHS Trust

References

1. Oviedo- Joakes E, Brissette S, Marsh DC, Lauzon P, Guh D, Anis A et al. Diacetylmorphine versus methadone for the treatment of opioid addiction. *N Eng J Med* 2009;361:777-86.
2. National Treatment Agency for Substance Misuse. *Injectable heroin (and injectable methadone) – potential roles in drug treatment*. London:NTA;2003.