



The patient comes first above all else

BY vigilantly sticking to professional standards, understanding your rights and responsibilities and, most important, always placing the health of the patient first above all else, pharmacists will rarely come foul of the law. Seems pretty cut and dry, but unfortunately it isn't always so.

PSE vs PE

Pharmacies around the country will have begun buying in new stock for the season of Winter ailments and, along with it, will need to consider what proportion of products containing pseudoephedrine (PSE) they'll order compared to those containing phenylephrine (PE).

The new restrictions on the availability of PSE products and the introduction by Pfizer of PE-based Sudafed products (with other manufacturers planning to follow suit) forced significant changes onto pharmacy in the way these products are managed, from both business planning and counselling perspectives.

In many ways, tougher restrictions on access to PSE products have exacerbated the potential for harm to pharmacy workers. I've heard numerous instances where pharmacists and staff were threatened by criminals frustrated at finding it increasingly difficult to purchase PSE products for illegal diversion.

In fact, the excellent Project Stop database, which has already triggered a number of arrests and now has federal funding to roll the program out nationally, includes a field for the pharmacist to record when staff safety is threatened.

This is one of the main reasons why PE products are so welcome. As well as bringing choice to the pharmacist and customer, it helps to underline the restrictions placed on PSE products and increased difficulty in obtaining them. Only when the drug runners learn that the PSE money tree has been chopped down will their efforts begin to wane. And even then desperation might lead to break-ins, or worse, if they believe there is a lot of PSE stock in the pharmacy. But

with the introduction of PE, pharmacists can more comfortably reduce their stock on hand of PSE products.

A potential problem is that no guidelines or treatment algorithms have been developed to assist pharmacies manage the new system from a customer treatment perspective and this is problematic. This means it is up to each pharmacy to develop their own set of guidelines for managing the customer interaction, whether it be symptom or product-related, based on their own customer profile. This is an important factor when considering the time pressures which often exist in pharmacies during winter.

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One thing is certain: assistants will need appropriate training to ensure they are properly qualified to advise customers and answer their questions. As assistants are now legally able to manage recommendations on PE products, it might be tempting for pharmacists to focus on other issues such as dispensing during busy periods. Unless the assistants are properly trained to best advise on appropriate use of PE, the pharmacist will have abrogated their responsibility to the customer. Remember, always place the health of the patient first above all else.

When a generic is not a generic

A case has been brought to my attention where the issue of brand 'evergreening' has the potential to cause confusion and misinterpretation between the pharmacist, doctor and patient. A branded prescription product was able to gain a new indication just before the end of its patent life. This meant that newly registered generic brands, while being acknowledged as being bioequivalent to the originator brand, are not technically considered generic equivalents.

My concern is that pharmacists will be unknowingly placed in a dispensing situation where they don't have all the relevant information.

If a patient presents with a script for the originator brand and the 'no substitution' box is not ticked, many pharmacists will exercise their right to offer their patient a more affordable generic substitute.

However, if the patient's doctor has prescribed the originator brand for the indication not allowed for use by the generic equivalents, then the pharmacist may unwittingly offer the patient a generic which was wrongfully considered a substitute, simply because they have no idea what indication the doctor has prescribed the medication for.

Fortunately, I have received legal advice which says that pharmacists who do substitute the originator brand unwittingly while complying with all other conditions will not have committed an offence.

However, the issue remains that these evergreening practices may well increase and similar examples such as this may occur in the future. I hope this is simply an anomaly that the Canberra bureaucrats can correct by providing the pharmacist with more information. It also helps underline the importance of shared information between the prescriber and the dispenser. How can a pharmacist hope to place the best interests of the patient above all else without all the relevant information? ■