Prescribing the best medicine for patients

GPs and pharmacists work in tandem says **Harry McQuillan**

I READ with interest recent mainstream media reports suggesting that an army of pharmacists would be descending upon GP surgeries to solve the current recruitment difficulties our medical colleagues are facing.

While I welcome the pharmacy profession being portrayed in a positive light, I remain to be convinced the answer lies with replacing some GP colleagues with pharmacist employees.

Greater collaboration between community pharmacies and GP surgeries can deliver better care for those accessing the NHS and also deliver efficiencies for those charged with delivering services.

Primary care in the NHS is built on the foundations of the contractor model. This covers pharmacy, general practice, dentistry and optometry. Most of us will find that we access pharmacy services the most, followed by the GP. Almost everyone will be familiar with attending a doctor appointment, having a treatment prescribed, followed by going to a pharmacy to have the item supplied. These two settings are where the majority of patients get professional support and advice.

Many out with the professions will find it surprising to learn that the infrastructure facilitating joint working between community pharmacy and general practice is often very limited. We need to enable closer working relationships between the professions through electronic communication channels. Streamlining referral of patients between both services would also aid care. Oddly, it is often easier for a pharmacy to refer a patient to the out of hours service than into general practice.

Health boards should also provide leadership to facilitate both pharmacists and doctors to engage with each other. This could be attending joint meetings or hosting clinics in the others premise. Community pharmacy practice has developed greatly over the past 15 years. I expect that to continue especially in light of the Scottish Government's pharmacy vision, Prescription for Excellence.

At CPS we have debated thoroughly community pharmacies future direction. We strongly believe that pharmacists cannot be expected to fulfil the role of a general practitioner. Just as it would not be appropriate for a doctor to take over the role of a pharmacist. Both professions require lengthy periods of undergraduate and postgraduate training. The skills developed are very different. Pharmacists are the experts in medicines while doctors remain the experts in diagnosis. The skills, although very different, are certainly complementary to patient care.

Despite synergy between the roles, I have reservations about pharmacists in the employment of either health boards or the GP surgeries themselves being the norm in medical surgeries across Scotland. In areas which have used this approach I have had feedback from pharmacists that the relationship between the surgeries and the community pharmacy has been diluted. This is mainly because the surgery will now seek advice from the practice-based pharmacist. As the patients ultimately rely on the GP and community pharmacist, anything that weakens the relationship between the two professionals is unlikely to benefit patient care. I remember earlier in my career. GP colleagues being regular visitors to my community pharmacy to discuss patients and seek advice. Sadly I doubt this is the norm in a number of areas across Scotland.

Supporting a greater working relationship between the two professions should be a priority for health boards, government and organisations like CPS. Facilitating a community pharmacist to provide GP support will almost certainly be more cost efficient for the NHS than recruiting large numbers of staff. Undoubtable NHS services are under more pressure than ever before as the Scottish population ages. More people are living longer, healthier lives often with long term conditions. This of course should be celebrated but we must also be innovative to keep the NHS fit for purpose.

However, when it comes to GP and pharmacist working relationships we can perhaps learn from the past. I hope Prescription for Excellence can bring us back to a situation where the community pharmacist and the GP are regulars in each other's workplace.

● *Harry McQuillan is chief executive of Community Pharmacy Scotland www.communitypharmacyscotland.org.uk*

It's hard to juggle with e-cigarettes

Vaping is helping addicts give up smoking, but legislation to ensure it doesn't create a new craving for the young is welcome, says **Sheila Duffy**

THE question of how we should respond to electronic cigarettes has divided the public health community. Passionate advocates on either side use the same information to conclude either that these devices could significantly reduce the smoking rate, or could undermine decades of progress in youth smoking prevention. Developing an appropriate response to e-cigarettes is a difficult balancing act.

Yet the rapid growth in e-cigarette use, coupled with the vast ongoing harm caused by tobacco, mean actions have to be taken despite the unknowns. With the Scottish Government soon to introduce its Public Health Bill to the Parliament, steps will be taken to develop a national regulatory framework.

On the one hand, nicotine is highly addictive and long experience tells us to be wary of commercial interests seeking to build a market in addictive products. We cannot expect e-cigarette producers and retailers will be content to service a declining market of existing smokers and refrain from targeting new generations. The big tobacco firms, the market leaders in putting profits before the health of their customers, have all bought into the e-cigarette market, but I am concerned that much of their emphasis is on devices which project the appearance of smoking and seem to be least effective in helping smokers quit. For "Big Tobacco", cigarettes remain the more profitable option and they will remain keen to sell both. On the other hand, the addictiveness of nicotine, and highly engineered cigarettes which are designed to maximise the nicotine hit, mean that despite much effort and significant progress in Scotland in recent decades, the tobacco companies are still getting their pound of flesh from more than a fifth of Scottish adults, the great majority of whom say that they want to quit.

Some smokers find it easier to quit successfully than expected. Some, often supported by Scotland's free national stop smoking services and with nicotine replacement products when needed, are able to ease out of their dependency on smoking. But there are some smokers for whom e-cigarettes match the smoking experience closely enough to make these devices an acceptable alternative to lit, smoked tobacco. I've heard many anecdotal stories of heavily addicted smokers using e-cigarettes to quit cigarettes, and I am excited by the possibility that these devices could play a role in saving lives.

Our lungs are very sensitive and e-cigarette users inhale more than just water vapour. I cannot see that using an e-cigarette over an extended period will not result in some level of harm. But the toxic cocktail of chemicals in tobacco smoke is so highly damaging that we can be confident that for most people, moving completely from tobacco use to e-cigarettes should bring significant health benefits. Dual use of tobacco and e-cigarettes is less certain, though – even low levels of continued smoking are disproportionately harmful.

The tightrope that legislators must walk in determining how to regulate e-cigarettes is how to stop them being promoted to non-smokers while encouraging existing smokers to give them a try. I believe that the proposals expected in the Public Health Bill can take us some way forward. The Scottish Government proposes a ban on the sale of e-cigarettes to under-18s, supported by a ban on unstaffed vending machine sales, and on adults buying the devices for children. These are important , justified measures with widespread support.

Conversely, the Scottish Government does not propose to ban the use of e-cigarettes in enclosed public spaces. The smoking ban legislation was underpinned by a wealth of evidence of harm to others, evidence which is not there with regards to indoor e-cigarette use. Some forms of advertising, such as on TV or in newspapers, will be banned under a European directive from May 2016. It seems the government has signalled an intention to take powers to regulate local advertising, such as shop windows and billboards, but will consider further before using these powers. Again, this seems like a good balance.

I am concerned at the ubiquitous presentation of e-cigarettes, but appreciate the need to leave space for encouraging existing smokers to switch. It may be that the places tobacco is currently sold are the places stop-smoking advice and products, and e-cigarettes, should be promoted. Perhaps we should be looking at further restrictions on the sale of the more lethal product, tobacco.

I am glad we are finally taking steps towards an appropriate regulation of e-cigarettes, but am aware how much more learning, thinking and discussion we still have to do. As with Scotland's legislation on smoking, our main aim should be to protect people's health and to create better choices and environments for our children to grow up in.

● *Sheila Duffy is chief executive, ASH Scotland, www.ashscotland.org.uk*

So far, vaping has not been proven to be a significant risk to the health of people around e-cigarette users Picture: Phil Wilkinson

> I am excited by the possibility that e-cigarettes could play a role in saving lives

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Empowering he individual is the key to all our actions, from MPs to social workers

Some lose out daily, not just on election night, says Lesslie Young

THE scenario is that your job is up for grabs in a re-organisation and you are going to have to apply for it.

You've been doing this job or similar most of your adult life, for decades. You have jumped through all the hoops to get there, working your way up and you have a fair grasp of what you're doing. You are at the very least competent. You apply. You are trumped by another candidate half your age who is still in college. That's bound to dent your sense of personal agency in the world.

Who would be a politician? As a politician up for re-election, the interview process is not as most people experience one. For starters, you don't have the opportunity to answer all of the questions entirely yourself. Your responses are dictated for you by that darned manifesto which you may or may not agree with in entirety. Also you only attend for part of the interview. Your fellow party candidates are answering some questions too, and some of them may have landed you in it.

Not to mention the most important proxy, your party leader.

Less an interview, more like asking someone else to sit your driving test for you, and history tells us that some party leaders don't much value practising emergency stops or three point turns.

Another difference from normal recruitment is that, when the decision is announced, it happens up on stage, in front of a crowd, and televised. Even if the successful candidate turns down the offer because a better one has come along, everyone will know you were not first choice. It is in the nature of politics, democratic politics at any rate, that you might be a terrifically talented representative for your locality, you might have spent years crafting your debating skills, building a reputation for being effective, gaining experience and knowledge in different disciplines, honing your offer to the electorate but still end up in the wrong party at the wrong time.

Politicians sign up for this type of employment. Most of the rest of us don't. It is difficult to imagine a more stark contrast when your desire is to achieve power than the potential outcome for failure being absence of power. How much is your psyche diminished when all of your work is for nothing? Perhaps that is why so often there is party infighting following a defeat. That power-seeking gene has to hook up to a target even if it happens to be in a smaller pool.

Politicians seek power to a purpose. The proportionate allocation of that purpose towards self-interest, the interests of similar people, and the interests of the population as a whole will vary from politician to politician. I would suggest that for we non-politicians achieving power with a small "p" over just our own life is goal enough.

The purpose of social care is, at base, empowerment. The proper role of any worker in social care is to empower. The helping role exists to support someone because that person needs skills or knowledge to compensate for those they do not have to the same degree and to complement those that they do.

The best of the social care workforce recognise that they are in a relationship with individuals they support in which the power is not balanced. The worker has much of the power. The best are also the ones who seek to give that power away. Where social care goes wrong is when a worker is unaware of their power or, much more culpably, when they are only too well aware of it and abuse it.

Do spare a thought for those politicians who woke up recently with a sinking feeling because they had been stripped of power the day before.

Bear in mind too those who will wake up every working day for whom the challenge is not to deal with having their power taken from them but how to give it away.

● *Lesslie Young is chief executive of Epilepsy Scotland www.epilepsyscotland.org.uk*

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A chance to Share in vital medical research

But read the small print before opting in says **Calum MacKellar**

SINCE 2012, the Scottish Health Research Register (Share) has been inviting everyone, aged 16 or over, in Scotland to indicate whether they would be prepared to take part in biomedical studies to develop new treatments.

Individuals registering with Share, part of the NHS, give permission for their medical data, from various NHS computer records in hospitals and GP surgeries, to be checked to see whether they might be suitable to participate in research projects. If they are, Share staff will then invite these individuals to take part in the study. But there are no obligations.

The health information used by Share is usually coded so that it can be routinely used without any identifying information about a patient. However, if necessary and in exceptional circumstance, this secure code can be retrieved so that the person can be identified.

More than 55,000 people have already signed up to the register in Scotland which aims to recruit 100,000 people before the end of 2015.

One of the reasons Share is very much an improvement on the previous system is that patients have consented, beforehand, to be invited directly by NHS staff on to a medical study. This has a number of advantages.

For example, in the past, when a healthcare professional involved in the care of patients wanted to invite them on to a research project, he or she was never sure whether even inviting them would cause distress or upset.

Moreover, it is illegal for a researcher not involved in the care of patients to access any of their identifying details without their consent making it impossible for him or her to invite these patients onto a study project. In the past, this meant the researcher having to ask, instead, healthcare professionals, who were involved in the care of the patients, whether they could invite them to participate in the study which took up a lot of these carers' precious time.

Share participants can also decide whether any of their leftover blood samples taken for standard clinical tests by their GP or in hospital can be stored indefinitely in a biological sample bank for future use in medical research.

Before registering with Share or accepting to donate surplus blood it is, however, crucial for potential participants to read the small print.

For instance, it is important to be aware that scientists will be able to use, in a coded form, a patient's blood samples and NHS data for research which could take place both in and outside the UK with different partners such as pharmaceutical companies and could include genetic studies. This may even involve the deciphering of the patient's entire genetic code.

Furthermore, it is essential to remember that appropriate consent is not a one-off decision which is given in perpetuity but a continual process that lasts the lifetime of an individual. This is addressed, to some extent, by Share in that a person can leave the register at any time without having to give a reason at which point his or her samples will be destroyed and data removed from the register.

Obtaining appropriate consent from participants, however, may mean that still further clarifications are provided by Share. For example, at the moment it is indicated that blood samples can be stored indefinitely for future research. But does this then imply that the cells in the blood of the patient could be stored for hundreds of years in the future and then used in research that could be seen as offensive to the original patient? For example, could the stored cells be used to create new reproductive cells for the creation of new kinds of persons?

A person registering with Share should also be made aware that there are some situations where their anonymity could be lifted even when assurances are given that this would not happen. For instance, a judge would be able to let a police investigation override guarantees of confidentiality by the researchers.

But overall the development of Share should very much be welcomed in seeking to develop appropriate procedures for biomedical research which could eventually save lives. It just needs to make sure that a robust system of continuous consent is established including taking persons off the register when their lives eventually come to an end.

● *Dr Calum MacKellar, director of research of the Scottish Council on Human Bioethics, 15 North Bank Street, Edinburgh EH1 2LS. www.schb.org.uk You can register with Share by going to: www.registerforShare.org*