NO HOLDS BARRED Margaret McCartney

Daily drug shortages place avoidable pressure on primary care

There's no clobetasone, ferrous fumarate, gentisone ear drops, metoprolol, valsartan, or mefenamic acid. These are not rare, esoteric drugs but workhorses of daily prescribing. Every day work is interrupted by news of what's not available. Pharmacists with no stock phone the practice receptionists to tell them that patients need alternative prescriptions.

The prescription for the unavailable drug must be destroyed and an alternative generated for the next best drug. Pharmacies have different stockists, so a pharmacy further away might have what is lacking on shelves nearby. Is it fair to make patients traipse around several outlets looking for something that may not exist?

Everyone knows about the pressure on primary care. Instability of basic drug supplies is an avoidable pressure, one being absorbed (as usual) by general practice. A combined total of 5% of my latest day on call was spent trying to fix prescription supply problems, one by tedious one.

A report from the parliamentary All-Party Pharmacy Group in 2012 found that the problem had existed for four years. It partly blamed "parallel trading," where cheap stock intended for UK markets ended up sold for greater profit in Europe. This, the group reported, was not helped by speculative behaviour. To me it simply looks like the failure of the free market to provide a stable service. The report noted an "air of resignation amongst those responsible" and challenged the government to place the interests of UK patients above European Union law on the free movement of goods.[1] The *Drug and Therapeutics Bulletin* meanwhile has ascribed blame to centralised, inflexible manufacturing. It also claims that 10-15% of UK community pharmacies use wholesalers' licences to export drugs to mainland Europe.[2]

Drug shortages harm patients directly—and indirectly because this inefficiency leaves doctors less time for other tasks. So why isn't it being sorted out? The All-Party Pharmacy Group wants the new government to act in its first 100 days to make drug shortages "never events."[3]

The All-Party Pharmacy Group wants the new government to act in its first 100 days to make drug shortages "never events"

This is not only a UK problem. Exactly the same thing is going on in the United States,[4 5] Canada,[6] and many of the eastern European countries supposedly benefiting from free EU trade.[7] This global problem needs a global solution. A stable supply of (usually) cheap useful drugs should be an international priority, and if free markets can't manage it then we need a system that can.

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BLOG Samir Dawlatly

Letter to the education secretary

Dear Nicky Morgan
Congratulations on being appointed education secretary. I would normally find myself writing to your cabinet colleague, Jeremy Hunt, the reason being that I am a GP. This is not a very fashionable profession these days, especially as up to a third of training places are unfilled and many GPs plan to retire early, or emigrate, or retrain as plumbers. I'm joking about the last one, although there is this scheme to assess patients' boilers. But I digress.

The reason I am writing to you is to ask if you wouldn't mind opening my children's primary school on Saturdays and Sundays for routine education. Quite what "routine" education means is anyone's guess, but I thought I would start bandying that word about too. You see, it would just be so convenient to have the school open on days that it seems I am expected to work, to provide routine care for my patients. Did you see what I did there?

I don't expect you will be able to pay the teachers any extra money, so I suggest that you simply unilaterally alter their contracts. About three months' notice should be sufficient. Alternatively, you sack a teacher or two, replace them with several teaching assistants of whatever educational standard you like, and then you would have more bodies on the ground to spread as thinly as you want. Simple really.

I'm sure that the prospect of working at the weekend will do wonders for your recruitment of the best graduates to train as teachers. Who doesn't want to work at the weekend, providing care that could be given at any other time of the week? I'm also sure that this exciting prospect will convince many of your more experienced workers to hang on in there just a little bit longer, in the job that they love; to work that little bit harder for no extra pay instead of retiring early. They would be mad not to.

I'm sure that the prospect of working at the weekend will do wonders for your recruitment of the best graduates. Who doesn't want to work at the weekend?

The irony is that when I have to work at the weekend (if I can't find anyone to do it for me) I'll be seeing the children who are my patients who couldn't come to see me in my afternoon surgery, which runs from 3 30pm to 6 30pm. Except, perhaps I won't, because they will be at weekend school. This hasn't really been well thought out, has it?

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Psychedelic drugs should be legally reclassified

Trials of physiologically safe and non-addictive drugs such as LSD, which may have therapeutic potential, are almost impossible, writes **James J H Rucker**

Psychedelic drugs, especially lysergic acid diethylamide (LSD) and psilocybin, which is found in the *Psilocybe* genus of "magic" mushrooms that grow throughout the United Kingdom, were extensively used and researched in clinical psychiatry before their prohibition in 1967. Hundreds of papers, involving tens of thousands of patients, presented evidence for their use as psychotherapeutic catalysts of mentally beneficial change in many psychiatric disorders, problems of personality development, recidivistic behaviour, and existential anxiety.[1]

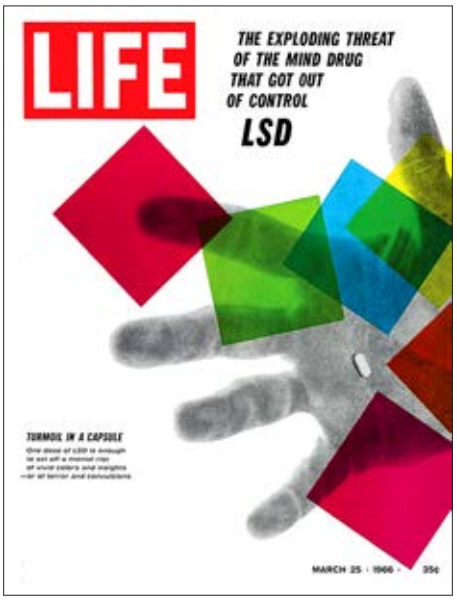
This research abruptly ended after 1967, when psychedelics were legally classified as schedule 1 drugs under the UK Misuse of Drugs Regulations and as class A drugs under the UK Misuse of Drugs Act 1971. This classification denoted psychedelic drugs as having no accepted medical use and the greatest potential for harm, despite the existence of research evidence to the contrary.

Indeed, in 1992 John Ehrlichman, former assistant to Richard Nixon—the US president who intensified the "war on drugs" in the 1970s—notoriously admitted that the administration had lied about the harmful effects of drugs and had manipulated media coverage of them for political advantage.[3]

Nearly 50 years later psychedelic drugs remain more legally restricted than heroin and cocaine, which are schedule 2, class A in the UK. But no evidence shows that psychedelic drugs are habit forming; little evidence shows that they are harmful in controlled settings; and much historical evidence has shown that they could have use in common psychiatric disorders. A growing number of organisations, most recently in Norway, are questioning the need for such draconian restrictions.[4]

Where's the harm?

Psychedelic drugs do not induce dependence.[5] A 1984 review of adverse reactions to psychedelics found little evidence of harm in controlled settings.[6] Furthermore, in 2010,



an analysis of harms caused to recreational users and to society by a range of psychotropic substances ranked LSD and psilocybin among the safest of all those studied.[7] The therapeutic index (toxic dose as a ratio of standard dose) for LSD and psilocybin is about 1000; for cocaine it is 15, for heroin it is 6, and for alcohol it is 10.[8] The belief that psychedelics induce homicidal or suicidal behaviour was inculcated by the politically driven and media led condemnation of LSD in the 1960s.[9]

To hold a schedule 1 drug, institutions require a licence costing about £5000. Only four hospitals currently hold such licences, which come with regular police inspections and onerous rules on storage and transport

In a population study of 130 152 respondents to the US National Survey on Drug Use and Health (NSDUH) from 2001 to 2004, a history of reported psychedelic use was associated with lower reported levels of serious psychological distress, the need for mental health treatment, and psychiatric medicine.[10] Researchers found no association with psychosis.

Evidence for medical use

Many of the clinical trials of psychedelics published in the 1950s and '60s, before prohibition, fell short of modern standards; however, several good quality, controlled trials were performed. Using data from six such trials in alcoholism, a recent meta-analysis that compared treatment with LSD against controls in 536 people found that LSD treatment was favoured in terms of objectively measured improvements in alcohol misuse.[13] Recent pilot studies outside the UK have shown clinical efficacy in anxiety associated with advanced cancer,[14] obsessive compulsive disorder,[15] tobacco addiction,[16] alcohol addiction,[17] and cluster headaches.[18]

However, larger clinical studies are almost impossible throughout the Western world because of the practical, financial, and bureaucratic obstacles imposed by schedule 1 classification or its equivalent.[19] For example, because of the burden of compliance with the UN's schedule I, only one manufacturer in the world produces psilocybin at sufficient quality, quoting our group a prohibitive £100 000 for 1 g (50 doses).

In the UK, to hold a schedule 1 drug, institutions require a licence costing about £5000. Only four hospitals currently hold such licences, which come with regular police inspections and onerous rules on storage and transport. Prescribers of a schedule 1 substance also must hold a licence, which costs £3000.

These restrictions, and the accompanying bureaucracy, mean that the cost of clinical research using psychedelics is 5-10 times that of research into less restricted (but more harmful) drugs such as heroin—with no prospect that the benefits can be translated into wider medical practice. The self reinforcing cycle of stigma generated by UN schedule I classification means that almost all grant funders are uncomfortable funding research into psychedelics, and similar problems are encountered with ethics committees.

Legal prohibition of some psychotropic substances continues to be a condition of UN membership, stigmatising a facet of behaviour and arguably causing more harm than it prevents.[20]

We call on the UK Advisory Council on the Misuse of Drugs and the 2016 UN General Assembly Special Session on Drugs to recommend that psychedelics be reclassified as schedule 2 compounds to enable a comprehensive, evidence based assessment of their therapeutic potential.

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