



ISSN 0111-6258

Department of Health,
P.O. Box 5013,
Wellington.

5 June 1984

CLINICAL SERVICES LETTER NO. 227

To Medical Practitioners

(Copy to Proprietors of Retail Pharmacies)

“SPECIALIST RESTRICTED” MEDICINES

Although frustrating at times, the “specialist restriction” contained in the Drug Tariff allows the free supply of many medicines at an earlier time than would otherwise be the case. It also allows the supply of some medicines which might otherwise never be listed in the Drug Tariff.

It is an important feature of the Drug Tariff and places a certain onus on both the general practitioner and the specialist. It is important that both the general practitioner and the specialist should keep a record of all therapy recommended in this way. This record should include the date of recommendation whether given in writing or orally. In recommending such treatment, the specialist carries a definite responsibility.

This responsibility attaches to specialists employed by hospital boards as much as it does to those in private practice. Possibly one of the most frustrating aspects of the system for general practitioners and pharmacists is when correspondence from hospitals fails to identify the name of the specialist responsible for recommending the treatment to be continued.

The Drug Tariff is specific in that specialists are recognised for the purposes of the Tariff only to the extent of the specialty in which they are recognised or registered. For example, it is not appropriate for any specialist other than an eye specialist to be prescribing or recommending treatment with “specialist restricted” medicines which are for use in the eye if payment is to be made from public funds.

Certain medicines carry this restriction because the Pharmacology and Therapeutics Advisory Committee is of the opinion that specialist expertise is required for their proper use. A general surgeon, for example, is not considered to have the detailed knowledge of dermatological conditions and treatments possessed by a dermatologist.

General practitioners sometimes indicate that they find the need to seek specialist recommendation to be demeaning. No such implication is involved or intended because it is expected that anyone recognised as a specialist will have a more detailed knowledge of the use of medicines within the limited confines of that specialty.

OXYPHENBUTAZONE AND PHENYLBUTAZONE

Recently the Pharmacology and Therapeutics Advisory Committee reviewed the availability of these two medicines under the Drug Tariff.

Their use has also recently been reviewed in many other countries and steps taken to control their continued use. These two medicines are considered to be particularly hazardous and there are many alternatives which are as effective in the majority of cases.

The Pharmacology and Therapeutics Advisory Committee is of the opinion that the only remaining indication for phenylbutazone which is now acceptable is for the treatment of ankylosing spondylitis and that there is no place for oxyphenbutazone.

From 1 August 1984, phenylbutazone and oxyphenbutazone will no longer be available under the Drug Tariff. Approval will be given for the free supply of phenylbutazone for ankylosing spondylitis as a supplementary pharmaceutical benefit if application is made to this Division on behalf of the patient. Supplies will then be available from hospital pharmacies. This is the only indication for which free supplies will be authorised.

Approval will not be given for free supplies of oxyphenbutazone.

FAMILY MEDICINE TRAINING PROGRAMME

The Government has now approved the transfer of the administration of the Family Medicine Training Programme from the New Zealand Council for Postgraduate Medical Education to the Royal New Zealand College of General Practitioners.

This change will become effective on 1 December 1984 and will coincide with other changes to the programme which were notified in Clinical Services Letter No. 224.

AZATHIOPRINE

Thioprine (a new brand of azathioprine marketed by Pacific Pharmaceuticals Ltd) was withdrawn from the market on 13 December 1983 pending further investigation of a report that use of this medicine had rapidly caused severe leucopenia in two patients.

Although the Department of Health had already assessed this medicine and was holding adequate in-vivo bio-availability data, this allegation coming from a senior physician was regarded as sufficiently serious to warrant the immediate withdrawal of Thioprine. Investigation has been time consuming but has now finally revealed that the report was incorrect in both cases. In one case severe leucopenia did occur but the patient had not taken Thioprine; in the other case, when Thioprine had been used, no severe leucopenia had occurred.

The temporary restriction on the distribution of Thioprine has now been withdrawn.

RECOVERY OF FEES

A recent case of refusal of credit after the provision of medical services has drawn attention to Section 98 of the Social Security Act 1964.

Practitioners are reminded that, in the case of general medical services or pharmaceutical requirements or any specialist medical services that may be the subject of payments from the Department in accordance with Part II of the Social Security Act 1964, no medical practitioner is entitled to recover any fees or charges until the expiration of one month after an account signed by him and showing particulars of the services provided has been delivered to the person chargeable.

This is interpreted to mean that a practitioner may ASK for cash payment but cannot insist and cannot take legal steps for recovery within the stated time. There is an exception provided, but only on application to a judge, where there is a reason to believe the person concerned may be leaving the country.

ULTRASONIC THERAPY LICENCES

Medical practitioners are reminded of the need for a licence to use ultrasonic therapy apparatus for the treatment of the human body. Under section 3 of the Physiotherapy Amendment Act 1953 such a licence may be granted by the Registrar of the Physiotherapy Board only to a registered medical practitioner or a registered physiotherapist. This provision is because of the significant risks and specified contra-indications associated with the high energy outputs used in ultrasonic therapy.

Application for such a licence should be made to the Registrar of the Physiotherapy Board on the form provided for the purpose. An applicant is required under section 4 (4) of the same Act to satisfy the Registrar that his knowledge and qualifications are such that he is a fit and proper person to use such apparatus. In practice, licences are granted when a minimum number of hours of approved tuition and training has been given by instructors with suitably approved licences. A short examination is also required. The Registrar will, on application, supply the names of those physiotherapists holding instructor/examiner licences.

Offences against the Act may result in a fine not exceeding \$1,000 and forfeiture of the ultrasonic therapy apparatus.

NEW ZEALAND INSTITUTE OF MEDICAL REPRESENTATIVES (N.Z.I.M.R.)

In 1975 the Director-General of Health wrote an introduction to the first handbook of Medical Representatives' Education. From this early beginning, has evolved a 2-year training course requiring written examinations with graduates achieving membership status of the New Zealand Institute of Medical Representatives (N.Z.I.M.R.). The Examination Board which sets the standards to be achieved includes a representative from the New Zealand Medical Association, the School of Pharmacy, the Pharmaceutical Manufacturers' Association and the Department of Health.

Stage I of the course comprises an introduction to the pharmaceutical industry, the function and responsibilities of the Clinical Services Division

of the Department of Health, and an introduction to the procedures involved in registration of medicines and their distribution in New Zealand. Also included is the Marketing Code of Conduct drawn up by the Pharmaceutical Manufacturers Association.

Stage II covers general anatomy, physiology and knowledge of the body and disease states. Upon successful completion of Stage I and II, medical representatives advance to a Stage III examination course covering basic pharmacology, action and interactions of medicines and aspects of disease and related treatment.

The Department of Health considers that the Institute of Medical Representatives represents a positive step towards ensuring that information provided by manufacturers' representatives is factual and reliable and is presented to the doctor in a knowledgeable manner. New Zealand practitioners may also consider acknowledging this development by noting those medical representatives who are undertaking the training course or who have graduated from the Institute of Medical Representatives. Graduates of the Institute of Medical Representatives may identify themselves by having the letters M.N.Z.I.M.R. after their names.

INTENSIFIED ADVERSE DRUG REACTION REPORTING SCHEME

Enalapril (Renitec) is to be added to the scheme. Enalapril is the pro-drug form of enalaprilat which is an angiotensin-converting enzyme inhibitor and is indicated for use in hypertension and congestive heart failure. After oral administration, bio-transformation occurs in the liver to the bio-active form. The pattern of adverse reactions differs from that associated with the other ACE inhibitor captopril, which remains in the scheme.

The following medicines are now included in the scheme:

- Aciclovir (Zovirax)
- Amiodarone hydrochloride (Cordarone-X)
- Captopril (Capoten)
- Enalapril (Renitec)
- Mianserin hydrochloride (Tolvon)
- Nifedipine (Adalat)
- Tocainide hydrochloride (Tonocard)



J. S. Phillips,
Director.



G. R. Boyd
Deputy Director

Divison of Clinical Services.