

## A responsibility, not a burden

From A. J. Marshall, MRPharmS

What is it that the older generation of pharmacists have against ensuring a high standard within the profession? I read with disbelief the letter from P. I. Herman (*PJ*, 2 March, p287) regarding the subject of continuing professional development.

It is not a burden; it is a responsibility. If pharmacists wish to be competent dispensers, all very well and good, but they do not need a degree in pharmacy to do it. Accurately dispensing tablets, creams, suppositories etc, is not a difficult job, but the professional input to ensure correct doses and to avoid interactions with other drugs is.

Pharmacy is not about dispensing accurately. If it were, we could have been replaced by machines many years ago. Pharmacy is about ensuring safe use and supply of medicines. I do not like dispensing myself and am more than happy to let somebody else do this onerous task for me so that I can do what I trained for: to provide the public with good advice and ensure safe supply of medicines. This does not mean I have to dispense each item personally. However I do believe I need to supervise the process and assess each and every prescription.

I accept that experience has great value but I believe that the public have a right to expect that our profession knows what it is doing. How can pharmacists expect to do their jobs without CPD? Surely they read *The Journal*, or manufacturers' information when a new drug is launched, or the British National Formulary when they come across a product they do not recognise. All of this is CPD, so, despite what some pharmacists appear to think, it is no great burden simply to jot down a quick note of this and keep it in an envelope in case they are asked to prove it.

I do wish people would stop whingeing about CPD and just accept that, as a profession, to do our jobs properly we have to undertake CPD. Also, all this threatening of the "older" pharmacists "not bothering with CPD" and leaving, is really no threat at all. If they are not prepared to keep their knowledge

base up to date then the profession can, and should, do without them. This will ensure that those of us who take our professional role seriously (regardless of age) and wish to ensure the public get the level of competence in our professional knowledge they have a right to expect, will be in greater demand and will be able to earn a more professional wage.

A. Marshall  
Penkridge, Stafford

## CPD is what members want

From Mr A. Nathan, FRPharmS

I have read P. I. Herman's letter (*PJ*, 2 March, p287), but must disagree totally with his sentiments. He seems to think that mandatory continuing professional development is being introduced on a whim of the Royal Pharmaceutical Society as just another stick with which to beat members.

However, CPD is what members have said that they want. In the original Pharmacy in a New Age consultation more than three-quarters of respondents gave mandatory continuing education (as it was known then) as their first priority for the future of the profession. This view was endorsed in a consultation specifically on CPD a year ago. Even if the Society was not introducing it on its own initiative, the Government would be requiring it to do so, as it is currently for all health professions.

Mr Herman considers CPD as a restraint on trade and not enforceable under European Union law. I cannot see that an action to oppose a measure introduced to improve safety — which is ultimately what CPD is meant to do — and therefore in the public interest, would be looked on with much favour by any court, British or European.

Mr Herman seems to think that CPD is an imposition. I would have thought that any self-respecting professional would consider that keeping their knowledge up to date and maintaining their competence was a personal professional obligation. They should already be doing it, not complaining that they should not be made to.

Alan Nathan  
London N21

## Time the Society faced reality?

From P. N. Olswang, MRPharmS

I write in full support of P. I. Herman (*PJ*, 2 March, p287). Have the "brains" behind continuing professional development really thought it out? Do they realise the dramatic fall that will occur in the number of members at present doing locum work? Do they not know that there is already a shortage of pharmacists in both hospital and general practice? Do they not see the devastation it will cause to the profession and that the consequent fall in the number of pharmacies will mean hardship for the general public?

Kirsty Newton (*PJ*, 2 March, p287) describes the traumas of working as a newly qualified pharmacist in a community pharmacy. I and many other proprietors, left community pharmacy for these very reasons. If we are forced into CPD, we will simply opt out.

It is time the Royal Pharmaceutical Society and its officers faced reality.

P. N. Olswang  
Salford,  
Lancashire

## Resigned despair

From Mr C. Payne, MRPharmS

I read with resigned despair the latest news (*PJ*, 16 February, p223) from the Royal Pharmaceutical Society concerning continuing professional development, "Society to roll out new CPD framework to 5,000 pharmacies". Will the unfortunate pharmacists invited to participate in this exercise have the option to decline, and will those who participate be paid for the time and work involved?

Conrad Payne  
Haddenham,  
Cambridgeshire

### BADDY CHEMISTS

## Individualised trials possible

From Dr B. L. Furman,  
FRPharmS

There is nothing like a debate on homoeopathy to stimulate me to write to the *The Journal*.

Although homoeopathy, like other complementary approaches, is a system based on a holistic approach, this does not place homoeopathic preparations beyond evaluation by the gold standard: a randomised, double-blind, placebo controlled trial.

Patients could be subjected to a normal consultation with a homoeopathic practitioner who would then write an individualised prescription. A second,

### TELEPHONE NUMBER

It would be helpful if all correspondents would supply a daytime telephone number.

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independent person would then randomly allocate the patients to receive the prescribed item as written or a placebo. The patients and the physicians who assess the patients would be blind to the treatments. Thus, all patients would be assessed and treated holistically and the only difference would be that one group received one of a number of individualised homeopathic remedies for their particular condition, whereas the other group received placebo. The null hypothesis then would be, "There is no difference between placebo and the homeopathic treatment regimen".

As with any clinical trial there would be defined inclusion and exclusion criteria. Patients would continue with their usual medication and, of course, the trial would have to be sufficiently powered to detect the desired differences.

The role of the holistic approach per se in treatment effectiveness is much more difficult to evaluate scientifically and, as suggested by Professor Ernst (*PfJ*, 9 March, p325), the "placebo effect" may contribute to the success of conventional therapy as well as to that of complementary therapy. In a study of the credibility of various acupuncture techniques Choi and Tweed<sup>1</sup> found that the holistic acupuncturist was rated significantly more attractive, expert and trustworthy compared with non-holistic practitioners. Cassell<sup>2</sup> stated that "suffering is experienced by persons, not merely by bodies, and has its source in challenges that threaten the intactness of the person as a complex social and psychological entity". In the same article Cassell also states that "physicians' failure to understand the nature of suffering can result in medical intervention that (though technically adequate) not only fails to relieve suffering but becomes a source of suffering itself".

**Brian Furman**  
Glasgow

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## Amusing but in places wrong

*From Professor E. Ernst, FRCP*

I would like to thank Simon Whitaker for his most amusing piece on "quack cures" (*PfJ*, 2 March, p288). It was amusing but in several aspects wrong. He states for instance that "herbal preparations . . . lack any credible evidence base". Little does he know that there are hundreds of good quality randomised controlled trials demonstrating the efficacy of some (not all) herbal medicinal products. Many are even backed up by positive systematic reviews or meta-analyses of RCTs.<sup>1</sup> I agree with Mr Whitaker that health care professionals have a "responsibility for giving correct and appropriate advice". But surely this also includes a responsibility for being adequately informed.

**Edzard Ernst**  
*Department of Complementary Medicine, University of Exeter*

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## Valuable babies thrown out with the bathwater

*From Professor P. J. Houghton, FRPPharmS*

I agree with the general thrust of Simon Whitaker's remarks (*PfJ*, 2 March, p288) about the lamentable triumph of commercial over scientific considerations in much community pharmacy. However, I fear that he has thrown out some valuable babies with the bathwater in dismissing herbal remedies as quackery and lacking scientific evidence.

I would admit that there is much to be done in establishing a sound evidence base for some herbal remedies. I would also stress that, for many common herbal remedies now available, there is an increasing volume of pharmacological and clinical studies that confirm their tradi-

tional uses. The recent draft directive from the European Union proposing a new category of licensing for "medicines with a traditional use" emphasises that these products are viewed as having some value.

The department of pharmacy at King's College London is proud of its heritage of the scientific study of plant-based medicines and of its pharmacognosy courses. We strive to give our students the basic tools to be able to evaluate the scientific credentials of the herbs about which they will be asked questions in their later professional lives.

Although I cannot vouch for the infallibility of my memory, I cannot remember Simon Whitaker as one of our undergraduates. His apparent lack of knowledge of the current "state of play" regarding the scientific base of herbal remedies is therefore excusable. It is to be hoped that the new indicative syllabus will give every pharmacy student in the United Kingdom the benefits that graduates of King's enjoy.

**Peter Houghton**  
*Professor of Pharmacognosy King's College London*

## The Society's position on homeopathy is quite clear

*From Mr J. R. Sharp, HonMRPharmS*

Predictably, Simon Whitaker's article on quack cures and "Baddy Chemists" (*PfJ*, 2 March, p288) has brought forth the standard outraged cries from the proponents of homeopathy (letters, *PfJ*, 9 March). Just as predictably, none of your correspondents is able to present any real scientific evidence for the efficacy of homeopathic "remedies". It is difficult, for example, to believe that Lawrence Collin's citing of a 1900 report of the treatment of cholera "using camphor homeopathically" in Russia in 1830 is a significant result derived from a properly controlled scientific trial.

It is just as difficult to understand the persistence of this argument that continues, from time to time, to rear its hoary head in your columns. The Royal Pharmaceutical Society's policy on

this issue is quite clear, and should surely be the final word on this subject. It is:

"The Council of the Pharmaceutical Society of Great Britain recognises that the essence of homeopathy involves a thorough and lengthy consultation with a homeopathic practitioner, which takes into the account the whole condition of the patient. There are many reports that such consultations are beneficial. The consultation may include, in addition to advice, the prescription of a homeopathic remedy.

"With regard to the actual composition of the "homeopathic remedies, there is no scientific evidence for their efficacy, only anecdotal and subjective reports.

"It is unlikely that the benefits attributed to homeopathy could extend to over-the-counter recommendation or self-selection sale.

"The Council of the Society therefore recommends members to inform any persons seeking advice on homeopathic products that there is no scientific evidence for their efficacy, beyond that to be expected from a placebo response." (*PfJ*, 14 June 1986, p770.)

If, however, I may be permitted a postscript, it is interesting to note that in the same issue in which the pro-homeopathy letters were published there appeared a report of a controlled trial which demonstrated that "homeopathic potencies of house dust mite" were ineffective against asthma (*PfJ*, 9 March, p313). The homeopath's riposte to this finding is, apparently, that the treatment was not "individualised" and this "individualisation" is "the hallmark of homeopathy". This is a very neat response, since "individualisation" would render invalid any attempt at a double-blind cross-over clinical trial. It does, however, call into question how "individualised" are all the hundreds (thousands even) of homeopathic "remedies" that are freely available, self-select and self-serve, in pharmacies across the country.

And, can anyone tell me, please, how does one go about diluting a house dust mite?

**John Sharp**  
*Woodley, Berkshire*

## Is the sale of homeopathic products ethical?

From Mr W. J. Pugh, MRPharmS

Predictably, poor old Simon Whitaker (*PJ*, 2 March, p288) has incurred the wrath of the homeopaths (letters, *PJ*, 9 March, pp325–326). What he has to realise is that, to its disciples, homeopathy has many characteristics of a religion. The fact that it is undisprovable is the bedrock of their belief. I once knew someone who believed that Jesus's father was an astronaut from deep space. "You prove I'm wrong" was the reply to anyone questioning this conclusion. Why bother? The underlying question is "Is the sale of homeopathic products ethical?" There are (at least) two answers to this. If the pharmacist truly believes in homeopathy then the answer is "yes". He is no more a quack than the vicar who promotes belief in God. Whether he is a nitwit is a separate question. If he does not, he has all the ethical standing of Donald Duck. It is, of course, difficult for the Royal Pharmaceutical Society to distinguish motive, and it seems to lack the motivation — although I recall the Statutory Committee warned that pharmacists who promoted Spagyric therapy could expect to be struck off (*PJ*, 16 August 1997, p250).

**W. John Pugh**  
Welsh School of Pharmacy  
Cardiff

## PHARMACIST PRESCRIBING

## Do nurses know more about medicines?

From Mr I. C. Nock, MRPharmS

Emblazoned across the front cover of *The Pharmaceutical Journal* (23 February) was "How pharmacist prescribing is working now" and I was full of glee in the progress of pharmacy in the United Kingdom. It is the new millennium, after all.

In the same edition was an article on nurse prescribing (p233). After reading through and comparing, however, I found that pharmacists can prescribe such items as lactulose, loperamide, Dioralyte and paraceta-

mol whereas nurses can now prescribe nine oral antibiotics (and a further extensive list of potent medicines mentioned on the Department of Health website).

Did I read this wrongly? Do nurses know more about medicines than pharmacists? Why is this situation not the reverse?

**Ian C. Nock**  
Hong Kong

## MMR VACCINATION

## Public still needs to be convinced about safety

From Mr P. E. G. Shattock,  
MRPharmS

Your report (*PJ*, 2 March, p280) that the Department of Health is asking pharmacists to encourage patients to accept the combined measles, mumps and rubella (MMR) vaccine demonstrates, once again, a total failure on the part of the Department of Health to convince the public about the safety of this product. The implication, included in your report, that doubts about safety are being promulgated by parents purely to add weight to their legal claims is unworthy but typical of the Department's approach.

The Department continues to promote the deceit that the whole scientific basis for linkage rest upon the original 12 cases described by Wakefield.<sup>1</sup> It totally ignores the further 150 similar cases described by Furlano *et al.*<sup>2</sup> The finding of the genetic material (RNA) from measles virus in the intestines of 75 of 91 of these children has been publicised although formal publication is awaited<sup>3</sup> as has the finding of measles RNA in blood.<sup>4</sup> Additionally, antibodies to the measles virus have been detected in a proportion of children with autism<sup>5</sup> (which may be associated with brain auto-antibodies). The Department argues that all of these findings may have resulted from wild measles but, according to the parents, these children have not had measles except through the attenuated strains in the MMR vaccine.

Dr David Salisbury points out, correctly, that measles virus is extremely immunosuppressive and that giving the vaccines separately could mean that the child has a suppressed immune system when the other vaccines are given sequentially. Strangely, he feels

this principle does not apply when the vaccines are given in combination.

The Royal Pharmaceutical Society suggests that pharmacists are well placed to offer information and support to parents who are concerned about vaccinations. I would agree and would suggest that pharmacists follow the advice of Simon Whitaker (*PJ*, 2 March, p288) who, in his article on quack remedies quotes our Code of Ethics which requires that pharmacists should not recommend any therapy "where they have any reason to doubt its safety or quality".

If pharmacists have studied all the evidence, rather than merely read the Department's information sheets and still believe that this vaccine is safe, they can recommend it with a clear conscience. If they have not done that, such an action would be difficult to justify.

**Paul Shattock**  
Autism Research Unit,  
University of Sunderland

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## Putting patients' trust in jeopardy

From Mrs A. Morant, MRPharmS

As community pharmacists, we are asked by the Department of Health to support its line on MMR vaccination. Furthermore, the article "Pharmacists asked to spread positive message about MMR vaccine by DoH", (*PJ*, 2 March, p280) concludes with a statement that the Royal Pharmaceutical Society "continues to support the position held by the Department" and adds that pharmacists are well placed to offer information and support to parents and can "reassure" parents about the safety of MMR.

A tailpiece to the article refers us to the internet for further information. I have visited the site quoted and read the 50 or so pages of "information" much of which, unfortunately, reads like hurriedly cobbled together hype aimed at promoting a weak case. To cite one example, while one document states that MMR vaccination has been in use for nearly 30 years in the United States there is no reference to the increase in autism over a number of years. I feel that I need reassurances that there is no correlation between the two, before I can endorse MMR in any way. After all, giving three live viruses at the same time to an infant with an undeveloped immune system might not be such a good thing.

I encourage all pharmacists to read this article carefully, even if they do not study the information on the internet. They will see that the DoH opposition to the single vaccines is because "it would give credibility to the shadow of doubt being cast over MMR".

Community pharmacists are trusted by the public. Over the years we, as a result of professionalism and regard for the interests of our customers, have become regarded as a source of reliable advice and information. Now the DoH wants us to wave the flag and promote MMR vaccination. This is all very well as long as MMR is safe. How can we do it if there is any degree of doubt?

Why should we, who have no part in the administration of MMR, be required to back it, except for the fact that the public trusts us? Furthermore, what immunity from legal action will the DoH give pharmacists (let alone parents and children) in the event of anything going wrong?

In addition, will there be an opt-out for those of us who do not have blind faith in the MMR, like there is for Roman Catholic pharmacists and contraception?

These are all fundamental issues. The Government and the DoH recognise the trust that the public have in the profession without which GP surgeries and hospital accident and emergency departments would grind to a halt due to overload.

No one involved in health care can afford to put this trust in jeopardy.

**Annette Morant**  
Edgware,  
Middlesex

## NATIONAL HEALTH SERVICE

## No need for pharmacists?

From Mrs S. J. L. Barrow,  
MRPharmS

The NHS Plan promised that over the next few years there would be 7,500 more consultants, 2,000 more general practitioners, 20,000 more nurses and 6,500 more therapists working in the National Health Service. The February 2002 edition of the NHS Magazine includes an article about allied health professionals (AHPs), who make up the 6,500 extra therapists required by the NHS. The article talks about improved status and training, expanding career options and therapist consultants, a seven per cent pay rise for 2002, and a 50 per cent increase in on-call allowances. This sounds excellent.

The list of AHPs, however, is as follows: art therapists, drama therapists, music therapists, chiropodists/podiatrists, dietitians, occupational therapists, orthoptists, orthotists, prosthetists, paramedics, physiotherapists, diagnostic radiographers, therapeutic radiographers, and speech and language therapists.

The NHS of the future apparently does not need pharmacists, cardiographers, or laboratory and pathology staff, or, probably, some other professions that do not come under the heading of doctors and nurses.

At least we now know exactly where we stand.

**Sara Barrow**  
Senior Pharmacist  
Royal Hampshire County Hospital,  
Winchester

## PHARMACOGENOMICS

## Are pharmacists to be replaced by the microchip?

From Miss L. Martin

Professor Akhtar's article on pharmacogenomics (*PJ*, 2 March, p296), was intriguing but raises a few questions in my mind as to the real role of pharmacists in this futuristic scenario.

If the decision as to appropriate prescribing is to be performed by a computer programme, does this mean that the practitioner of the future is to be a microchip? Surely this potentially puts pharmacists back to dispensers as could be extrapolated from the comment "pharmacists are likely to be key players in the dispensing of drugs based on an individual's gene profile".

The anxiety of many pharmacists could then certainly be fulfilled with regard to the world takeover by pharmacy technicians, as pharmacists would be redundant, replaced by the chip.

The other scenario is that we no longer study pharmacy but all move to becoming computer programmers.

**Lynn Martin**  
Third Year Pharmacy Student  
University of Brighton

## THE INDUSTRY

## Grab those opportunities!

From Mr R. J. Kantaria,  
MRPharmS

In their letters, Tabassum Jafri (*PJ*, 23 February, p244) and Geoff Trew (*PJ*, 2 March, p286) refer to their struggle with obtaining training places within the pharmaceutical industry. Unlike the experience of Mr Trew, the industry did visit my peers and me at university during our final year to give a presentation on the opportunities offered. This was in addition to receiving the usual presentations from the community and hospital sector. However, this may not be the case nationwide and more could be made of the preregistration "milk-round".

Having recently entered the industry from hospital pharmacy I have faced many new interesting and diverse challenges and

used many of the skills gained at university and through my role as a hospital pharmacist. Just the other day I used my knowledge of pharmacokinetics to influence a promotional piece and my pharmaceutical knowledge to answer a complicated medical information enquiry. As Dr John Hunt states (*PJ*, 2 March, p286) there are many opportunities available in the industry and pharmacists possess a unique blend of skills and knowledge that would help them in any sector of the industry.

My advice to Mr Trew and anybody else interested in entering the industry is not to give up. Maybe the industry should be more proactive in recruiting pharmacists but at the same time I would encourage students and pharmacists alike to explore the opportunities available.

**Rakesh Kantaria**  
Luton,  
Bedfordshire

## Opportunities are out there

From Miss S.-W. Yee

I have read the letters from various correspondents regarding careers in industry and there are a few points that I would like to add.

Obtaining a preregistration placement in industry has become more difficult due to limited places. In my opinion, this could be for two possible reasons. First, the contents and information in the new preregistration trainee workbook are mainly about hospital and community pharmacy practices. This could have discouraged the industry to take in preregistration trainees. Secondly, preregistration trainees have to take a number of days off work to take part in study days, therefore, can only spend a limited time in industry within their six-month placement. This may have discouraged the industry to take on preregistration trainees as opposed to full-time pharmaceutical scientists.

I hope the Royal Pharmaceutical Society, the Industrial Pharmacists Group and pharmaceutical companies can come together to discuss this issue. I have experienced many opportunities and challenges in various areas of the pharmaceutical

industry during my six months and hope that future preregistration trainees can obtain placements in industry more easily.

There are many opportunities for pharmacists within the industry because of the vast number of departments and areas in which pharmacists can use their skills. It is a rewarding career with lots of new challenges together with good training.

We should not think that industry only wants people with a higher degree. I believe that if you are enthusiastic and persistent, the opportunities are out there.

**Sook-Wab Yee**  
Preregistration Trainee  
Bristol-Myers Squibb and Wirral  
and Whiston Hospital

## MDS

## Full and proper payment

From Mr P. R. Rodwell,  
MRPharmS

I read with interest that another multiple is to charge for the supply of monitored dosage systems (*PJ*, 9 March, p318), and I applaud the move. However I would like to ask the following:

How did they arrive at the figure of £3 per patient per week? I ask this because at pharmacist locum rates (£20/hour) this equates to packing a one week MDS in nine minutes excluding any cost for equipment. Surely this still means the job is being done at a loss.

Have the multiples in question simply come up with a figure to get the question of funding out into the open, or have they assumed minimum pharmacist input to the process? I do realise that packing of MDSs is a role suited to technicians, but we do need to keep in mind that not all pharmacies have such staff. If primary care trusts and others adopt the figure of £3 we may well find that not all pharmacies will be able to afford to offer an MDS service thereby leading to an inequity of service provision.

If we are to take on roles and expect payment, I think we should argue for full and proper payment and not fall into the trap of doing someone else a favour again.

**Paul Rodwell**  
Wallingford,  
Oxfordshire

## PACKAGING

## You are the weakest link, goodbye!

From Mrs M. F. Black,  
MRPharmS

Last Christmas we were given a family game entitled "The weakest link", issued by the BBC. This contained a small gadget (5cm x 7cm x 8mm) with a red button which, when pressed, says "You are the weakest link, goodbye".

With the wonders of modern technology it might be possible to create a smaller device which could be attached to a medicine container to tell a blind patient the name of a medicine and when to take it, as an adjunct to the more detailed label. I suppose that such an item would not be expensive.

M. Black  
London W5

## PSNC ELECTIONS

## Three issues for debate

From Mr N. Baumber, FRPharmS

As the retiring regional representative, I must congratulate Peter Cattee on his winning of the Pharmaceutical Services Negotiating Committee election in the Trent region. We have seen in his recent articles and the formation of the AIMp that he has many talents and attributes, which I hope he will use for the greater good of community pharmacy.

My letter on "The aim of AIMp" (*PJ*, 16 February, p209) was not as negative about the new organisation as he suggests (*PJ*, 2 March, p285). I invited readers to consider for themselves the issue as to whether a small number of pharmacy owners needed special recognition on the reconstituted PSNC.

Incidentally, I would never question his fundamental right to stand for election to the PSNC on whichever platform he cares to stand. I welcome a healthy democracy that thrives on well-contested elections and gives the opportunity to voters to think hard about the policies, achievements and intentions of the candidates. This has only happened

in three out of 15 regions on this occasion, which raises the first issue of whether we would see a better debate on contract politics and the people behind them through national elections to the PSNC. Combining all the votes of the two independent candidates (147), would not have changed the result in Trent region. Peter (191) won by 44 votes.

The second issue, which should interest single pharmacy owners everywhere, is whether this reflects the current ownership split (excluding Company Chemists Association and Co-op pharmacies). The organised votes of a few members of AIMp for one candidate in any region could well outweigh all the other independent votes; in which case, the balance of political and financial interests ranged against the thousands of single pharmacy owners is formidable. If regional elections remain as the only way for independents to be elected to the PSNC, then the AIMp should have special recognition and its members should opt out of contractor elections.

The third issue that contractors (and not the PSNC) need to resolve is whether single pharmacy owners ought to meet under a new political banner now that the National Pharmaceutical Association has broadened its membership and wields historical precedent rather than a political mandate.

Noel Baumber  
Grantham,  
Lincolnshire

## MEP GUIDE

## Is the guide missing vital information?

From Mr K. Khan

As a preregistration trainee I am eager to expand my pharmaceutical knowledge in order to provide the best possible health care I can to patients. In order to do this I need to have the most appropriate and up-to-date material available, including the "Medicines, ethics and practice" guide.

Since pharmacy as a profession seems to be moving forward, I find it strange that I have to look up information regarding such issues as what medicines require storage at low tempera-

ture, the ethics regarding the emergency supply of medicines and issues regarding pregnancy testing in the pharmacy in previous editions of the MEP. The latest edition of the MEP seems to be missing a lot of vital information. As I mentioned to one of the Royal Pharmaceutical Society's inspectors recently, to her agreement, I believe that the latest copy of the MEP needs some serious amendments, because what was once a useful reference source seems now to be collecting dust on the shelves of many pharmacies.

Khorrum Khan  
Rugby

HELEN DARRACOTT (head of professional standards, Royal Pharmaceutical Society) replies: The most recent edition of "Medicines, ethics and practice" (number 25; July 2001) does not include some information that appeared in earlier editions, for a number of reasons. In the case of the areas referred to above, any special storage requirements for a medicine will be those stated on the product packaging, or in the summary of product characteristics. The new Code of Ethics (May 2001) does not contain any guidance — all guidance is now in the "Practice guidance" section of "Medicines, ethics and practice" and on the Royal Pharmaceutical Society's website. Advice on pregnancy testing was being rewritten at the time of going to press, and revised guidance has been available on the Society's website since September 2001.

Pharmacists must ensure that they only use information sources that are current, and use their own judgement in deciding how to act. No publication can or should be used as a substitute for professional judgement.

## BPC

## The Council should reverse its decision

From Mr G. A. Largue,  
MRPharmS, and Mr M. R.  
Hickey, MRPharmS

The Moray and Banff branch has come to a similar conclusion as the Dorset branch (*PJ*, 9 March, p327), in that once the funding of delegates to the British Pharmaceutical Confer-

ence is stopped, there will be few representatives sent from this branch.

As one of the smaller and also one of the more northern branches of the Royal Pharmaceutical Society, we get a grant of only approximately £600, and out of this we manage to organise at least eight meetings (one joint with the Northern Scottish branch) and carry out some public relation exercises, eg, having a meal with an MP. In fact, if it were not for sponsorship of meetings we would not be able to organise as many as we do, because each meeting costs between £150 to £200 depending on numbers — we usually get between 20 and 25 per cent of members attending, with most members travelling at least 15 miles.

If we were to fund someone to attend the BPC in Manchester this year it would cost about £350 for flights or about £176 for a return second class train fare. There would also be accommodation, meals and the registration fees for the conference over and above the mentioned costs. So, to send two delegates, which we would previously have been able to do, could cost more than our branch grant. This cost would always be similar because the BPC is usually held in England and any delegates sent from this branch would nearly always have to travel the furthest distances.

The branch has submitted a motion to the branch representatives' meeting on this subject and hopes that the Council decides to reverse its decision so we have as much of a chance of participating in the BPC as any other branch.

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Secretary

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## PJ ONLINE

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