

Practice must go beyond supervision

From Mrs H. St C. Remington,
FRPharmS

Graham Phillips writes in *Broad Spectrum* (P7, 30 March, p430) on supervision and skill mix and on the adjacent page in the same issue Sittal Patel writes a letter about the contrasting role of nurses and pharmacists in provision of necessary medicines. She wants role development and the facility to deliver best care to patients. Mr Phillips describes doing the same. I believe the message from Lambeth is in support of both their wishes.

The Royal Pharmaceutical Society supports the pharmacist in the community in the delivery of medicines management services. This is not some magical divide between prescription products and over-the-counter medicines. The law does, however, do that to us and so we are striving to achieve the public, Government and professional agenda in a new way of working, with new rules, and potentially new remuneration models.

As a secondary care pharmacist, I agree with the differential Mr Phillips poses, that we have little to do in the way of self care advice for the inpatient stay. Medicines management takes many forms and we all work clinically when we ensure that the patient gets the optimum treatment. The difficulty identified by Mr Phillips is how do we retain the best of the past and yet move on. There are doubtless many models that could work. Skill mixing work is one of them.

In the hospital service we employ one or two pharmacists within a whole team approach in the dispensary. The economies and efficiencies of scale clearly have a place. One way of working may well be to address this in the community, too. Where newly qualified staff team up with experienced pharmacists perhaps Mr Phillips and Ms Patel could both achieve the best solution. Time out of the premises would allow some of the new roles to be achieved or indeed practised in the community pharmacy, with clinics and chronic medication review, and, soon, supplementary prescribing. Staying alone, practising in the traditional manner will carry on in many places, too.

I disagree that Lambeth is divorced from practice. However, it has a responsibility to offer leadership and vision of how pharmacy may achieve its core purpose of medicines management within the new National Health Service. The debate needs to be about how local pharmaceutical services can be moulded to deliver for the patient and for all the highly clinically qualified pharmacists coming out of pre-registration training and becoming disaffected with "licking, sticking and pouring".

Ms Patel wants to have the facility and framework to do even more than the scenarios described by Mr Phillips, not less or even the same. In Lambeth, we have a responsibility to forge the means of meeting the old and the new. Both are still medicines management. I understand some, but I agree not all, of the pressures of immediacy, and limited released time from employing a skill mixed workforce. I suspect that mergers and changed service models must be embraced to move on. The Pharmaceutical Services Negotiating Committee has the responsibility for negotiating new ways of remunerating for changed models of working, and we need to learn how to make LPS work for everyone. Local PCTs have the opportunity to address these agendas and if we do not meet these challenges and find solutions then there is a risk that "supply" rather than "pharmaceutical care" will emerge, with real damage to patients' safe and increased access to medicines.

Pharmacy technicians have developed clinical work models in the hospital sector. Their role goes far beyond the supply role, too. Dispensing assistants, trained to the equivalent of NVQ 2 are now employed for assembly and associated supply duties. Many clinical technicians are employed in the primary care trusts, too. A team approach needs developing in all settings.

The Council of the Society recognises the accountability of the pharmacist in the process of medicines management. Supervision as a concept is only part of this, and today we must go beyond it if we are to achieve clinical governance in a real sense for patients.

Helen Remington
Chief Pharmacist, Addenbrooke's
Hospital, Cambridge, and
Member of Council, Royal
Pharmaceutical Society

Members' skills must not be eroded

From Mr I. C. Strachan,
MRPharmS

The recent *Broad Spectrum* article by Graham Phillips (P7, 30 March, p430) questioned the Royal Pharmaceutical Society's position on skill mix at the expense of our traditional roles. To propose change is simple; to sustain it, however, demands commitment and a following from others. But is our leadership in danger of playing fast and loose with a network that has earned public confidence for decades? Extending our roles is, of course, a sensible and natural aspiration, but not through eroding our status. It seems we are endeavouring to redefine our role in order to release time for medicines management, local pharmaceutical services and other collaborative initiatives. Why is the job I have undertaken for 15 years suddenly open to such condemnation?

I strongly oppose the protagonists who feel it appropriate to relax supervision as a currency for more corroborative integration with other health professionals. I acknowledge pharmacists are demoralised and demotivated, yet the only latitude we should exercise is to encourage delegation and refraining from the mechanics of dispensing. When additional roles are undertaken then the funding should be sought for locum cover.

For the record, I wish to remain in my pharmacy, offering

advice to my patients, supplying medicines more effectively by means of positive steps to move POM to P. It is a role I relish, enjoy and, contrary to the view, find intellectually fulfilling. More importantly however, it offers a job description my customers respect and appreciate. Any future strategy for change must not commence by eroding the skills of its members, but through building strengths the community network has delivered.

Ian Strachan
Bury, Lancashire

Is the pharmacist legally responsible?

From Mr D. P. Phillips,
MRPharmS

Has Andy Murdock hit the nail on the head (P7, 6 April, p468)? Are there accountability differences between a superintendent pharmacist and a pharmacist? He obviously thinks not, but clearly in a court of law there is a difference. The tragic "peppermint water" case (P7, 16 February, p228) highlighted this difference by the fact that the focus of attention was on the pharmacist and preregistration trainee rather than on the superintendent pharmacist. The superintendent, I presume, was not judged responsible because he was miles away at a different location and therefore not directly involved.

What if a similar fatal error occurred with a checking techni-

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cin? The Royal Pharmaceutical Society says that the pharmacist is legally responsible. This may be so, but could not the pharmacist have a strong case in mitigation? The error would have occurred regardless of whether the pharmacist was present or not. Indeed he might just as well have been playing golf 50 miles away with the superintendent. Could not the pharmacist in defence question whether he is any more to blame than the superintendent? If this in anyway holds true, would not the focus of attention play heavily on the checking technician? A precedent has been set for this possibility in the "peppermint water" case.

Community pharmacists know they live in a blame culture and are keenly aware of litigation with regard to practice. I am not a legal expert but the issue of accountability and responsibility may not be clear cut. It is in the interests of both checking technicians and pharmacists to know where they stand. The letter from Mr Murdock, in my opinion, has done little to clarify the situation.

David Phillips
Market Drayton,
Shropshire

CHECKING TECHNICIANS

Technicians have legitimate aspirations

From Mr T. Delaney

Philip Trafford is off the mark (*PJ*, 6 April, p468) when he compares using accredited checking technicians in the dispensing process with allowing a stewardess to fly an aeroplane. Stewardesses do not regularly fly

aeroplanes under pilot supervision, but pharmaceutical technicians dispense the vast majority of prescriptions in hospital under pharmacist supervision.

In recent years, pharmacy practice has moved away from dispensing and focused more on so-called clinical pharmaceutical activities. This shift, which has been acknowledged recently by the Audit Commission as being in the interests of patients, could not have happened had pharmaceutical technicians not taken over the bulk of dispensing work. We have reached the point where many supervising hospital pharmacists have far less practical exposure to the skill of dispensing prescriptions accurately than pharmaceutical technicians. The cognitive professional check is still done by the pharmacist, but the skill-based activity of dispensing an approved prescription accurately is the responsibility of the technician.

In cognitive terms, dispensing prescriptions accurately is skill-based. There is no reason to expect that pharmacists will be any less susceptible to human error in the skill-based activity than technicians. It is arrogant to presume that pharmacists are better than technicians at this activity. What is important is that a second, independent dispensing accuracy check is done by a competent individual.

Recently we have allowed nurses to administer drugs in most hospitals without the benefit of an independent accuracy check. This development was an expedient because of staff shortages in nursing and, so far as I am aware, has never been supported by research demonstrating that it is safe to eliminate the check. Yet some pharmacists are reluctant to allow checking by accredited technicians in the dispensary. Far better to have a technician check-

ing another technician, than to have a pharmacist dispensing unchecked.

Pharmacy technicians are developing their skills and have a right to expect that their roles and responsibilities will develop in tandem. Many influential doctors still do not accept the expertise of the clinical pharmacist, despite the great improvements in training and knowledge in our profession. We all have experience of how frustrating this has been and is for pharmacists, and how damaging it can be for patients. We should think of this when considering the legitimate aspirations of hospital pharmacy technicians to develop their role in medicines management. How much better the quality of medicines management would be now, if all doctors embraced and acknowledged the role of clinical pharmacists. How much better the dispensing process will be if we do the same for our technician colleagues.

Tim Delaney
Head of Pharmacy, Adelaide and
Meath Hospital, Dublin

Short-termism versus professionalism

From Mr P. D. Brassington,
MRPharmS

I read with interest Andy Murdock's defence of the use of accredited checking technicians (*PJ*, 6 April, p468). I can appreciate the commercial interest such a move generates for his organisation. I have spoken to many pharmacist colleagues; we are of the opinion that this can only produce short-term results. With the use of ACTs, the same conclusion would be derived as was

with parallel imports: there is a long-term danger that this provides the Department of Health with a reason to reduce our professional fees, and weakens the Pharmaceutical Services Negotiating Committee's negotiating stance forever.

The profession of pharmacy needs to be strengthened through more use of second pharmacists (which interestingly is what Mr Murdock espoused before his current change of heart) and continued training, not by abdication of our primary duties.

Paul Brassington
Sedgley, West Midlands

DRUG-HERB INTERACTIONS

Information not easy to find

From Dr I. H. Stockley,
FRPharmS

I agree with the motion passed at the British Pharmaceutical Students Association conference in Glasgow (*PJ*, 30 March, p422) about the need for more information about drug-herb interactions. That is why the next edition of 'Drug interactions' will have more information about herbal preparations than the current one, and why my module of drug interaction alerts on NDC's "Pharmacy Manager" software also carries an increasing amount of drug-herb data. The task is more than usually time consuming because there is so much guesswork and speculation about herbs which means that reliable information about clinically relevant interactions is not easy to find.

Ivan Stockley
Willoughby-on-the-Wolds,
Leicestershire

Advertisement

Without pharmacists, primary care would collapse

From Mrs A. Morant, MRPharmS

As a pharmacist, with a certificate of competence to practise from the Royal Pharmaceutical Society, I fail to understand why I am required to register with a primary care trust if I wish to continue to work for a contractor to the National Health Service — or indeed to work at all.

Having looked at the Department of Health website, I see reference to clinical governance which is defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish”. I also note a whole list of pharmacy-related PCT actions are required by April 2002 although I understand that this date has slipped.

One of the items listed is to “develop a strategy for the local implementation of community pharmacy clinical governance, within a multidisciplinary framework, ensuring that people are identified to carry the work forward into 2002–03”. Unfortunately, I could not see any details of what were the specific goals or what were the benchmarks along the way.

Furthermore, the document also stated that a national training programme for community pharmacy clinical governance facilitators will be developed in 2002 drawing on the experience of the national clinical governance support team to ensure a multidisciplinary approach that fits with the general clinical governance picture.

Assuming that the training will be assessed, does this mean that the Government is surreptitiously aiming to withdraw the Society's function as a qualifying body and thus debase it? Another possibility is that it is going to allow PCTs to impose closed-shops which will only allow its approved pharmacists to work. This would contravene our rights — both human and business.

Finally, as a locum pharmacist who could, theoretically, be

free to work in any part of the country, will I be required to be “approved” by each of the 300 or more PCTs around the country? If so, will locums have any time for health care after doing all the paperwork? In fact, will it become more important to have the right piece of paper than to care for patients?

The underlying reality is that pharmacy and pharmacists have already been debased and have become factory workers tied to the bench churning out prescriptions at an ever-reducing piece-rate per item. If this is to remain the sole role of the community pharmacist, there is no point in continuing professional development. After all, drug interactions will be indicated automatically by the dispensary's computer system if not previously flagged by the GP's computer when the prescription was generated.

We all know that much of the advice we give is no more than reassurance or the recommendation of simple remedies. However, what must not be overlooked is that, in some instances, the situation will be different and the recommendation will be to go to the GP or hospital without delay. This is not a road down which we can travel if pharmacists are to continue to have a vital role in health care and to be able to provide that first-line advice.

The profession and the patients (not to mention the health service budget) will only really benefit when we receive appropriate remuneration for our professional services. After all, if you see your lawyer, you expect to pay for the advice received. If we ceased to provide advice, with the result that patients would have to go their nearest accident and emergency department (if they can find one), telephone NHS Direct (which would then no longer have the option of directing the caller to a pharmacy) or make an appointment to see their GP, the entire primary care sector would collapse under the additional burden.

Annette Morant
Edgware,
Middlesex

E-MAIL

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What happened to Pharmacy in a New Age?

From Mr W. N. P. Chapman,
FRPharmS

Graham Phillips's concerns, as expressed in his Broad Spectrum article (*PJ*, 30 March, p430), are relevant. He strongly supports the value of dispensing technicians; so do I. They are a necessary part of the community pharmacy team. He points out, however, that the free time that they make available is not in usable “chunks” — he is right.

Members of the Royal Pharmaceutical Society's Council and community pharmacists should remind themselves of the Council's response in September 1996 to “Pharmacy in a New Age — the New Horizon”. In the executive summary the Council wrote: “Finally, three structural changes were identified as preconditions: a reformed remuneration system, rationalisation of the distribution of community pharmacies and at least two pharmacists per pharmacy.”

I work within a group of four pharmacies with superb supporting staff. But in only one of these pharmacies, since earlier this year, have we had the privilege of two full-time pharmacists. Now we know how extra time can be made available.

The approaching Council election affords us the opportunity to vote to influence the shape of the new Council, which may then be able to revive and act upon the grand words from 1996.

W. N. P. Chapman
Consett, Co Durham

Lockers could be an area for errors

From Ms J. Szewc, MRPharmS

My colleagues and I were interested to read of the Wirral Hospitals pharmacists' findings that giving medicines from patient lockers leads to fewer medicine administration errors by nurses (*PJ*, 2 March, p274).

In North Durham, we also operate a system using patient medicines lockers and patients'

own drugs and, like the Wirral pharmacists, we believe that administration errors have been reduced when compared with the traditional medicines trolley system.

However, we have encountered problems resulting from nursing staff not completely emptying the lockers when patients are transferred to other wards. Although we are not yet aware of a patient receiving the previous occupant's medicines, this is a potential area for increasing administration errors.

We would be interested to hear if anyone else has found similar problems, and how they were solved.

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Let us have electronic prescribing for outpatients

From Mr A. P. Gledhill,
MRPharmS

I agree with Noel Baumber (*PJ*, 6 April, p466) and John Pickup (*PJ*, 13 April, p495) that the current usage of hospital FP10(HP) prescription forms is unacceptable. Not only are the problems of patient safety important, but the hospital loses control of what its doctors are prescribing and loses sight of the cost implications because the Prescription Pricing Authority cost reports are not available for four to five months. Usage of FP10(HP) forms seems to be on the increase as hospitals focus their limited staff resources on more acutely ill inpatients.

In my dreams I envisage the hospital doctor electronically prescribing from an approved hospital formulary list (using decision support software to check doses, drug interactions etc). The patient is then asked which community pharmacy they would like their prescription electronically transferred to via the NHSnet. A link between the hospital drug database and that used by the community pharmacy using the freely available eDrugID (www.fist.dta.abank.co.uk) would make the rekeying of

data unnecessary. The patient would simply turn up at their local pharmacy with some sort of authorisation form. An electronic record of the prescription would be automatically downloaded into the local health EPR (electronic patient record) which can be accessed at any time by GPs and other authorised NHS staff. Assuming the NHS drug costs are available from the hospital drug database and that the prescription is dispensed in the community then the costs of these prescriptions would be immediately available to the hospital.

The technology to do this is available now but I suspect that we will first have to print a paper copy of the prescription. I would encourage all my hospital colleagues involved with electronic prescribing projects to contact the relevant person in the Department of Health and press for computer printer compatible FP10(HP) forms to be made available and work closely with their software suppliers to introduce electronic prescribing for outpatients.

Andrew Gledhill
Burnley, Lancashire

Good practice must be recognised

From Miss D. I. Tait, MRPharmS

As a pharmacist working for HM Prison Service since 1993 I was pleased to see the news feature (*PJ*, 30 March, p427) that focused on the positive aspects of prison pharmacy service developments in Scotland and Northern Ireland. The article implied that the current review of pharmacy services in prisons in England and Wales by the Prison Service and the Department of Health might have much to learn from these models.

The Scottish Prison Service has indeed made good progress since February 2000 when the Moss contract for pharmaceutical services became operational. However, it should be noted that at this time the Prison Service in England and Wales had been implementing similar models for some 10 years. Following critical reports from the Chief Inspector

of Prisons in 1988 and 1991 a rapid workforce expansion and much innovation led to the services currently operating in many Welsh and English prisons. Steve Crago at HMP Bristol outlined these in the article.

The background to these changes and details of current services were published in *Hospital Pharmacist* in April 1999.¹ As co-author of this article I expressed the hope that the (then current) review of prison health care would recognise the important roles of pharmacists and technicians within the multidisciplinary health care team and that professional representation for pharmacists be reinstated at policy level. This was not to be. The resulting report² made mention to pharmacy in only two paragraphs.

Since the former post of head pharmacist was lost in 1996 (not two years ago as stated in the *PJ* article) prison service pharmacists have been campaigning for service review and development.

I would like to hope that the latest review, about to be circulated for consultation, will at last recognise the good practice in many prisons and give prison ser-

vice pharmacists the proper mechanisms to standardise and develop services for prisoners throughout England and Wales.

Diana Tait
Cardiff

REFERENCES

1. Pawley E, Tait D. Prison pharmacy. *Hosp Pharm.* 1999;6:96-103.
2. HM Prison Service and NHS Executive. The future organisation of prison healthcare. London: Department of Health; 1999.

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An interesting, rewarding job

From Mr S. Vobra, MRPharmS

I am fed up of reading letters from disgruntled pharmacists like John Macmillan (*Pf*, 13 April, p495).

Not only are these letters instrumental in reducing the morale of the profession but they also have the effect of reducing undergraduates, preregistration trainees and new pharmacists to a state of gloom and doom about their chosen profession before they have had time fully to experience it for themselves. They also project an image of pharmacists as moaners and groaners who appear to be totally paralysed with regards to their own professional fate.

I have only this to say to these "colleagues" of mine: either put up and shut up or walk away. This is a free and democratic country; no one is forcing them to work where conditions are not to their liking.

It is about time that pharmacists who do not like what they do waved goodbye to the rest of us and walked out of the door never to look back. This will at least allow us to get on with a job that is highly interesting and rewarding.

Samir Vobra
Preston,
Lancashire

An attack on commercial freedom

From Mr D. Macarthur,
MRPharmS

British Association of Pharmaceutical Wholesalers chairman Stephen Simms was right to highlight the growing trend by multinational manufacturers to apply fixed quotas to supplies of some or all of their products to wholesalers when he spoke at the BAPW dinner (*Pf*, 6 April, p453). Under the guise of "supply chain management", this is merely another attempt to stifle parallel trade.

As well as being illegal under European Union competition law, quotas — which are sometimes

announced to long-standing customers with just a few weeks' notice and without any explanation as to their basis or as to how, when and if they may be subsequently revised — are a direct attack on the commercial freedom of wholesalers. New pharmacy accounts cannot be sought, expansionist plans have to be put on hold, promotions cannot be run, and even existing accounts may not be fully serviced in the event of a sudden surge in demand. Shortages inevitably occur, with consequent risks to patient health and extra demands placed on doctors and pharmacists.

Also speaking at the dinner, pharmacist Mike McConnell said that manufacturers have difficulty making up for a sudden fall in parallel trade usage as more packs in UK livery have to be supplied. He did not mention that in many cases these UK packs are made in the same overseas plants that supply the rest of Europe, and that shortages in the countries that supply parallel trade are directly engineered through quotas by the head offices of these same manufacturers.

In the UK, as in every other European country that enjoys incoming parallel trade, there are clear savings for the health care system and the public. The National Health Service gains in two ways. First, there is the discount clawback. New drugs also have virtually complete pricing freedom here, and with parallel trade providing the only form of price competition possible with patent-protected products, there are also significant dynamic effects. Together, both types of savings amount to hundreds of millions of pounds annually, with no sacrifice in product quality, and no measurable impact on the ability of industry to invest in research and development or to meet its profit expectations.

Runaway drug cost inflation is a constant threat to the NHS. Without parallel trade, some other cost containment tool, inevitably a more interventionist and market-distorting one, would have to be introduced. Is this what industry wants? Is it not time for it to stick at what it does best — the discovery, development and commercialisation of new cures — and stop interfering with the distribution chain for no other motive than profit?

Donald Macarthur
Secretary General
European Association of
Euro-Pharmaceutical Companies

Professional development does not end with registration

From Mr P. I. Herman,
MRPharmS

I must point out that in a letter I submitted to *The Journal* recently (*Pf*, 2 March, p287) the word "continuing" was substituted for "compulsory" before the words "professional development". Recent responses to that letter may have arisen as a result of this editorial error.

I stress that I do not believe that professional development ends or should end with acceptance on to the Register of Pharmaceutical Chemists.

Peter Herman
London W1

Undertaking CPD is easier than you think

From Mr A. Nathan,
FRPharmS

Peter Jenkins (*Pf*, 6 April, p465) demonstrates a complete misconception of what continuing professional development is but at the same time provides perfect illustrations of it. Your title for his letter — "Fit the courses to the horses" — encapsulates his argument that pharmacists need to tailor their learning to their specific job or role, and that knowledge is often acquired from sources and by means other than the formal learning that is normally regarded as continuing education, and he is quite correct in saying this.

He is also right to say that the knowledge required by a community pharmacist differs from that of a pharmaceutical adviser, and in so doing is illustrating one of the principles of CPD — that learning is tailored by the individual to their specific needs. He is wrong, however, in thinking that pharmacists who "attend all possible events on almost any subject" are examples of best practice. In fact they may be just the opposite if they are not reflecting on what their educational and developmental needs are, and are just doing anything and everything that comes their way.

Mr Jenkins appears to understand what CPD is about without realising it, and I am sure that there are many pharmacists like him.

CPD is simply a process of formal recognition and recording of what most pharmacists probably already do intuitively to keep their knowledge up to date and maintain their competence. And, once the Royal Pharmaceutical Society's scheme is up and running and they have joined it, I am sure that they will find it easier than they think.

Alan Nathan
London N21

No more outmoded traditions

From Mr B. Shooter,
MRPharmS

The pharmacy manpower crisis to which Graham Phillips refers in his Broad Spectrum article (*Pf*, 30 March, p430) will be eased to some extent this summer when a thousand or so newly registered pharmacists start seeking employment.

One of my roles at present is to have the privilege of working with pharmacy students at the School of Pharmacy, London University. These highly motivated, intelligent, hard-working and well-trained young people will have no problem in delegating the technical aspects of the dispensing process to their technicians.

I hope they will then be free to take on the pharmacist's true role which I describe as being "guardians of the nation's medicines", advising members of their communities and their fellow health care professionals on all aspects of drug usage.

Attempts to keep pharmacists, especially those recently qualified, tied to the dispensing bench will be met with increasing frustration and hostility.

Employers, in particular, have a duty to ensure that systems are in place to facilitate the practice of the profession by pharmacists in accordance with their training rather than following outmoded traditions.

Barry Shooter
Romford,
Essex

DISPENSING

Who owns private scripts?

From Mr L. David, MRPharmS

I was surprised to read the Law and Ethics Bulletin concerning the retention of private prescriptions by community pharmacists (*PJ*, 23 March, p414). A private prescription is the property of the patient and the patient should be able to keep the prescription until the requirements therein are fulfilled. This gives the patient the right to have it dispensed wherever he or she chooses.

I can imagine the destruction of good pharmacist-patient relations if the patient demands his prescription back and the request is refused. I also wonder, if someone took this matter to court, on which side the verdict would be.

May I suggest that the Royal Pharmaceutical Society has the law regarding this repealed so that sanity can return.

Leo David
Hounslow, Middlesex

THE SOCIETY

Alternative modernisation options

From Mr J. D. Khan, MRPharmS

It was refreshing to read Joy Wingfield's Broad Spectrum article "Getting to grips with modernisation" (*PJ*, 23 March, p396) which focused the debate on the key issues rather than the ambiguities emanating out of Lambeth. Although I endorse the sentiments of her article I do not subscribe to her notion that the College of Pharmacy Practice (for which she is a governor) can adequately fulfil the role of an "accrediting" body since, like the Royal Pharmaceutical Society, this organisation is also badly in need of updating and becoming a body of relevance to the practising professional. In both these organisations revolution rather than evolution is needed.

Although I have submitted my comments to the "ill composed" modernisation committee, I am still concerned at the narrow remit of options offered for the Society and enclosed comments which seem biased to the status quo position, and

worse still *The Journal's* woefully inadequate analysis of its snapshot survey. I get the feeling that the "hierarchy" already have a position on this issue, regardless of what the membership say. This is reminiscent of the spin in Tony Blair's Government.

My preferred option, which does not fall into the categories listed by the modernisation committee, is simple. There needs to be a single body that oversees registration and regulation of the profession and another single body that accredits pharmacists and pharmacist services encompassing standards, etc. There also needs to be a single body that oversees postgraduate education and continuing professional development and, most importantly, a single body that represents only pharmacists. This would be an umbrella organisation that had sections underneath it representing the various disciplines in pharmacy. Ideally all these bodies would be independent of one another but would work synergistically. The bodies at present that can best fulfil the above criteria and have the endorsement of the membership should slot into the positions dependent upon function.

I concur with the views expressed by Malcolm Almond in his Broad Spectrum article (*PJ*, 6 April, p464) that there are too many bodies that are unfocused and act on vested interests rather than promoting pharmacists. The current Council position pays lip service to the Government agenda and I believe that, rather than list short-term obstacles, the Council should concentrate on medium- to long-term goals.

Will the modernisation committee share with the membership alternative models to the ones in their questionnaire, such as the suggestion from Graeme Hall (*PJ*, 6 April, p468)? I think the Society should adopt the regulation/representation function because I do not believe it can represent pharmacists, especially if read in the context of Marshall Davies's interpretation of the word "membership" (*PJ*, 6 April, p482).

I hope this consultation exercise does not become another futile, bureaucratic exercise that yields nothing other than meeting the wishes and aspirations of the hierarchy at Lambeth in support of the status quo.

J. D. Khan
Rochdale, Lancashire

Wrong comparison

From Mr R. Blyth, FRPharmS, and others

You draw a false comparison in your recent leading article on changes in regulatory bodies (*PJ*, April 6, p452). The Royal Pharmaceutical Society is not the same type of body as the Nursing and Midwifery Council or the Health Professions Council. The latter two are regulatory bodies pure and simple, as were their forerunners, whereas the Society is a professional association as well as being a regulatory body. (It has an additional law enforcement role.) This invalidates the comments that you make.

You seem, like the Lambeth establishment generally, to be absolutely determined to drive hard down the regulatory route to the exclusion of the Society as the professional association of pharmacists. But there are ways of modernising the Society's regulatory function in the light of current demands from Government and elsewhere without wrecking it as a professional association. The Society itself has put forward a plan that would greatly increase lay participation in disciplinary procedures and in the auditing of competence to practise while retaining the present composition of the Council (*PJ*, 17 February 2001, p220).

Robert Blyth
Milton Keynes, Buckinghamshire

John Ferguson
Haywards Heath, West Sussex

Douglas Simpson
Beckenham, Kent

All fellows should be listed

From Mr W. G. Peberdy, FRPharmS

An abridged version of the Register of Pharmaceutical Chemists is now available online on the Royal Pharmaceutical Society's website. I looked at "Fellows" in the "Members and Fellows" section. Here there was the statement, "Fellowship of the Society is awarded to members who have made a distinguished contribution to the profession", and 496 names of such fellows were listed. However, anyone who

noticed (*PJ*, 30 March, p449) that there are currently 1,128 fellows is likely to wonder where the other 632 have got to. Under Section III of the Byelaws, it states that "all members registered as pharmaceutical chemists on or before the first day of February 1951 shall be designated fellows of the Society". So the description of fellows first given is incomplete.

I have no objection to awarding fellowships to those who have given good service to the profession but it must be borne in mind that many of those who became fellows under Byelaws Section III may also have given service worthy of recognition. But since they are already fellows they can hardly be proposed for election as fellows and be so recorded. If we are to list, as we have done, on the website, persons who are worthy of a fellowship award, we should at least distinguish all fellows in the web membership entry in some way, such as by the letter "F", as is done in the printed register and amend the entry in the members and fellows link briefly to explain this.

William Peberdy
Scarborough, North Yorkshire

Retention fee problem

From Mr V. A. Henderson, MRPharmS

On 4 March I sent a cheque to pay my retention fee. On 16 March I received a letter from the Society telling me that unless I pay my fees forthwith I will be struck from the register in six weeks' time. On 20 March I telephoned the registration section of the Royal Pharmaceutical Society and was informed that no mail will be attended to for the next several weeks, and that if I have not heard from them in five to six weeks' time to telephone again.

When I checked with my bank I found the cheque I sent had not been presented for payment. Is it not time that some of the vast amounts of fees that we are now being asked to pay be directed to increasing the staff in the registration department in order that they can keep up with their work?

In the meantime — from "limbo" — I am,

V. A. Henderson
Fakenham, Norfolk