

## Support students in need of work experience

From Mr B. Shooter, MRPharmS

In order for students to maximise the benefit of the pharmacy practice modules of the undergraduate course at the School of Pharmacy, London University, each of the 600 or so undergraduates needs to be exposed to the different facets of the profession by undertaking work experience.

As far as community pharmacy is concerned the multiples participate fully, offering students paid work experience at weekends and during the vacations. This arrangement is mutually beneficial, fulfilling the students' educational needs and furthering the employers' human resource management strategy.

However, students have some difficulty obtaining experience in independent community pharmacies, mainly, I suspect, because they find it uncomfortable "cold calling" pharmacies asking for work.

I have been approached while on duty at the school and I am able to take on some students, but with only four pharmacies I cannot in any way satisfy the demand.

I would be happy to draw up and circulate a list of pharmacists willing to be involved. The advantages for small groups of pharmacies and individual pharmacists are the same as for the multiples. They include the possibility of eventual new pharmacist recruits, a foretaste of what it might be like

to be a preregistration tutor, employing an intelligent young person and, of course, the vain attempt to turn the clock back to relive our own student days!

May I invite any pharmacists who have premises in a Greater London borough and who are prepared to offer paid work experience to a pharmacy student to get in touch with me, preferably by e-mail, with all their contact details.

The students also prefer to use e-mail as their initial means of communication. The multiples pay around £5 per hour.

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## DISPENSING

## No wonder patients get confused

From Mr J. Blake, MRPharmS

Ask 100 patients at random how many days there are in a month. Most will reply 30, or 31, but how many would venture 28 — unless you asked the question in February? From this arises the problem that we have as pharmacists in convincing patients that a "patient pack" of 28 tablets constitutes a month's supply.

This is even more difficult when the medicine comes from a container of 500 or 1,000 tablets,

and is dispensed loose into a bottle, when their prescription was for a 30-day supply. Patient packs would have been a good idea if they had been introduced as had been intended and, indeed, as they have been on the continent of Europe. Our continental partners laugh at us, spending so much time using scissors.

The problem is exacerbated by those generic manufacturers that still insist on marketing two pack sizes — one of 28 and one of 30. If all this were not enough to make the physical side of dispensing so ambiguous, we also have to fight our way through a range of patient packs that are devoid of variation in colour and styles of text.

There have been numerous occasions where I have selected items such as atenolol and thyroxine tablets off the shelf to find these two particular generics muddled together. Different strengths of the same drug also pose potential problems where patient safety could be compromised.

No wonder patients get confused. At one recent pharmacy I encountered eight different brands of metformin 850mg in the dispensary, and I was forced to dispense using four different brands on a single prescription.

There are further complications when we are forced to remove expiry dates and batch numbers when we snip away with our scissors. So what is the greater crime the pharmacist can perpetrate here? Should he not supply the prescribed quantity or should he dispense without the details printed on the end of the patient pack?

Please can someone put some common sense into this ongoing saga.

**John Blake**  
Nerja, Spain

## CHILDHOOD VACCINATION

## Single vaccines could be for society's benefit

Mrs J. L. Westbury, MRPharmS

In his letter (*PJ*, 27 April, p570) Anthony Cox rightly pointed out that vaccination should be seen as a social responsibility and that for an individual to decide not to vaccinate is not morally justifiable given the risk brought upon the wider society in which they live.

However, the majority of parents of infants with concerns about the measles, mumps, rubella vaccine want to vaccinate their children. They want to protect their offspring from potentially fatal diseases. Yet, because they have a belief that the MMR vaccine has been implicated in causing autism, they are reluctant to do so. That is their dilemma.

A few weeks ago, a young mother came into my pharmacy to seek advice about the MMR vaccine. This mother wanted her child to be protected from the measles virus. However, she was concerned about immunising her infant because when her niece was immunised with MMR vaccine, the family believed that the child's development had stalled. The niece was later diagnosed with "queried autism".

I told the mother that the Department of Health believed that there was no link between autism and the MMR vaccine and informed her of the many studies conducted around the world, which ruled out any association. I also gave the mother a DoH "MMR — the facts" leaflet. After counselling, it was evident that this parent still had strong reservations so I advised her to discuss the matter with her general practitioner. A few days later the GP contacted me to ask if I could obtain a single measles vaccine. He, too, had failed to convince this mother.

In this case, the parent, the GP and the pharmacist all wanted to vaccinate. However, this mother had strong concerns that the combined MMR could affect her child. She opted in the end not to vaccinate. Do we now say to her that her strongly felt individual concerns should be set aside for the good of society?

Could the DoH provide the single measles vaccine on a named patient basis for cases such as these? Before agreeing to administer the single vaccine, the GP could outline the strong evidence in defence of the MMR vaccine and discuss the implications of this option, ie, having to give three injections on separate occasions and the lengthy delay required to complete the schedule.

Changing the DoH policy to allow for the supply of the single vaccine on a limited basis would not be for short-term political gain. It could be for society's benefit so that more children would be immunised and "herd immunity" achieved.

**Juanita Westbury**  
Nantwich, Cheshire

## ADVICE FOR CORRESPONDENTS

Letters for publication can be posted, faxed, or sent by e-mail to [letters@pharmj.org.uk](mailto:letters@pharmj.org.uk) and should not normally be of more than 400 words. The Journal reserves the right to abridge letters and to edit them for clarity and style. Pharmacist correspondents should supply their membership numbers and a contact telephone number should always be given. As a result of changes to the Annual Register of Pharmaceutical Chemists, women correspondents should specify a preferred title otherwise "Ms" will be used.

Letters are accepted for publication on the understanding that they have not appeared anywhere previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform The Journal at the time.

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication may be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

## Why we need to improve support for patients on oxygen

From Mr M. Bennett, MRPharmS

I was pleased to read the recommendations made by Guy Thompson in his article "Prescribing of long-term oxygen therapy — striking a balance?" (*PJ*, 4 May, p619). However, I believe that these need to go further and encompass the key role that community pharmacists can play in supporting oxygen patients and how this role can be developed.

Following the review of oxygen therapy instituted by the NHS Executive (*PJ*, 1 April 2000, p500), a group of pharmacists in Sheffield undertook a survey of pharmacists and patients. Because of the need to obtain data quickly in order to respond to the review, the sample was small (10 community pharmacists, 26 patients, and an analysis of prescriptions for 39 patients).

The survey showed that:

- 1 89 per cent of patients were over 60 years old (mean age=71)
- 1 62 per cent of patients received additional services (eg, liaising with the surgery about prescriptions, collecting prescriptions, delivery of other medicines, supplying medicines in special containers to aid compliance and reviewing medication needs)
- 1 Over 80 per cent rated the service as "excellent"
- 1 For 17 per cent of the respondents, it appeared to be more economic if a concentrator had been installed
- 1 35 per cent of patients were using oxygen when away from their home
- 1 83 per cent were taking three or more medicines
- 1 89 per cent had initially been prescribed oxygen through a hospital

Overall the survey showed the important role currently played by community pharmacists and highlighted how this could be enhanced under a system in which the initial prescribing was undertaken by a respiratory consultant with the community pharmacist becoming a dependent prescriber, adjusting

the dose and type of equipment to match clinical needs, social requirements and prescribing costs, alongside regular feedback to the initial prescriber.

The evidence we obtained illustrated that the current service provided by community pharmacists is much appreciated by patients. However, there is a need to build on this foundation to provide a pharmaceutical care package at a new level. Currently this is limited by:

- 1 The contractual agreement with primary care trusts
- 1 The inability (and financial disincentive) for pharmacists to institute a move from cylinders to concentrators where this is acceptable to the patient and would make economic sense
- 1 The limitations of the prescribable equipment, as illustrated by Mr Thompson
- 1 The lack of any input from prescribers — it is most unusual to be given any details of flow rate or length of time to be administered on form FP10

Finally, may I make a plea to look at the overall package of care? It is easy, when viewing the cost of the current service, to see potential savings but to miss potential additional costs. The delivery fees came from the global sum for pharmacy. Currently they help to support many additional services provided alongside oxygen delivery. Community pharmacies are under severe financial pressure and the removal of any sources of funding can have major implications on the viability of pharmacy services and in some cases the whole pharmacy.

Martin Bennett  
Sheffield

### SUPERVISION

## Has anyone asked the public?

From Mr A. C. Gush, MRPharmS

In reply to Helen Remington (*PJ*, 20 April, p532) may I comment to her an article by Darrin Baines in *Chemist & Druggist* of 16 March. Dr Baines suggests that the profession's leaders have failed us because they have devalued the achievements of the past (rather than building upon them)

en route to the future. Mrs Remington, while admitting only a limited understanding of community pharmacy, still feels qualified to lecture her community colleagues upon pharmacy mergers, service reconfiguration and skill mixing — while apparently recognising no value in community pharmacy as it is currently practised — in short, she has fallen into precisely the trap that Dr Baines describes.

What is notable throughout is that she talks of professional aspirations not patients. Has anyone bothered to enquire whether pharmacies without pharmacists is what the public wants? Whether then community pharmacists' public health role? Is the true agenda one of patient focus or has this become obscured by professional arrogance and personal ambition?

I am aware that the chief pharmaceutical officer for England is soon to publish a paper on the skill mix and supervision issue. For the sake of community pharmacists and the public, let us hope that he is talking to the people who actually provide the service in developing his ideas.

Andrew Gush  
Porthcawl, Wales

### THE PROFESSION

## Reasons why labels should not be abandoned

From Mr J. M. Allan, MRPharmS

David Kaye asks "Why do we label everything?" (*PJ*, 4 May, p612). Although I have never been impressed by the instructions "Take as directed" or "As before", the following reasons may be sufficiently relevant for us to retain this apparently quaint British practice.

It identifies the patient for whom the preparation has been prescribed. This is surely not unimportant in a household occupied by more than one person, in residential homes and in schools. It also identifies the supplier and gives the date of supply, both potentially important in any audit trail.

The dosage indicated serves as a reminder to those with less than total memory recall and provides printed evidence in the event of incorrect administration of any medicament. Verbal instructions given in either the

consulting room or pharmacy, when the patient may be under stress, can be misinterpreted and may not be retained for more than a short time. The person collecting the prescribed items may not be the patient. To discuss treatment with anyone other than the patient without his or her consent would be a breach of confidentiality. Even with the agreement of the patient there could be no guarantee that the verbal directions would be accurately conveyed to the patient. When travelling abroad, the fact that medicines are clearly labelled gives some indication that they have been prescribed for the specific individual.

While on the subject of labelling, a plea to prescribers to express dosage in terms of intervals of hours rather than "times per day", thus eliminating the ambiguity of the waking day as opposed to the 24-hour day.

By all means emphasise and clarify written instructions, where appropriate, through effective verbal communication. However to abandon labels, I suspect, would result in our keeping not a few lawyers in comfort for some time, while conversely providing discomfort to patients and pharmacists alike.

Malcolm Allan  
Glasgow

## Suffering from a "reality complex"

From Mr P. Williams

I would like to reassure Chi Icheung (*PJ*, 11 May, p648) that I do not suffer from an "inferiority complex" regarding the pharmacy profession, nor did I wish to offend community pharmacists or community pharmacy in my letter (*PJ*, 27 April, p572).

Perhaps, however, I suffer from a "reality complex" regarding the profession, a complex fuelled by numerous letters published in *The Journal* from practising pharmacists week in week out. Flanking Mr Cheung's letter was a letter entitled "driving nails into community pharmacy's coffin", in which Steve Bullock believes "our Society has in recent years sat back and watched as nail after nail was driven into community pharmacy's coffin" (*PJ*, 11 May, p648). John Macmillan (*PJ*, 13 April, p495) asks "when will I ever start my extended role?", a role that Mr

Cheung suggests all pharmacy students find "mouth-watering".

These letters, and the views of Sittal Patel (*PJ*, 30 March, p431), reinforce fears that my chosen career, a career that has forced students into thousands of pounds of debt, may not ride the waves of time, unless we act today to ask "for more now before it is too late". I hope that community pharmacy is a stable career base for Mr Cheung and me, so that we can participate in the proposed changes that, apparently, lie ahead. But forgive me if my mouth is decidedly dry at this moment in time and I am asking where is the pharmacy voice fighting for our survival?

**Paul Williams**

*Final Year Pharmacy Student  
University of Nottingham*

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THE SOCIETY

## Help for preregistration tutors

*From Dr A. Shallal, MRPharmS*

I read with interest the article by Steve Howard on the role of preregistration tutors (*PJ*, 13 April, p504). He advised single pharmacists who wanted to get started to "obtain plenty of help and advice" through the Royal Pharmaceutical Society's education division. I contacted the division recently and was referred to the National Pharmaceutical Association. That really was plenty of help and advice!

**Asaad Shallal**  
*London NW9*

VIRGINIA WYKES, education development officer. Royal Pharmaceutical Society, replies: I do not know the nature of Mr Shallal's query but conclude from his letter that it related to the development of a preregistration training programme. In the preregistration section of the education division we provide advice and assistance in response to the vast majority of queries that we receive, covering a wide range of issues, but occasionally we have to refer the caller elsewhere because the query is beyond our expertise.

Unfortunately, we did not have sight of Steve Howard's article before it was published but had we done so, we would have clarified that we have limited expertise in the education division to help

independent contractors develop training programmes. The tutor training packs and related information we produce describe the requirements and framework for preregistration training programmes, on which the training provider should base its own training programme. Suggestions are given in our materials as to the source of other training resources, study days for trainees, etc. However, employers need to formulate the detail of their programmes, to take into account the particular nature and scope of their pharmacy. Tutors in the hospital and community multiple sectors receive help and support from their regional education and training leads and company training managers, respectively, with whom we liaise closely. Independent community contractors can receive assistance in developing preregistration training programmes from the National Pharmaceutical Association's training department, with which we also liaise closely and to which we refer callers when it is necessary.

I would like to clarify one other aspect of Steve Howard's excellent article which appears to have caused some misunderstanding among readers. The article states that "tutors receive an honorarium". In fact, a payment to individual tutors is not universal. Community pharmacy contractors who employ preregistration trainees receive a training grant from the Department of Health to cover some of the costs of training, but a payment to individual tutors is a matter decided by the employer. Steve Howard's company, Lloydspharmacy, makes payments to its own tutors as described in his article.

## Jumping on the Shipman bandwagon

*From Mr H. Littler, MRPharmS*

Stuart Anderson (*PJ*, 11 May, p644) bases his case for a separate inspectorate on avoidance of media criticism in the event of an exceptional incident involving a caring, considerate but murderous pharmacist. He overlooks the fact that there have been many deaths involving pharmacy practice over the years, none of which has resulted in the headline writers' field day he predicts. He recommends the establishment of Pharmacy Inspection Authority (PIA) in order to secure pharmacy's

future. He says the time has come for a clear and total separation of the professional, regulatory and inspection functions but later concedes that "what might be considered 'professional functions' of the Society" would in fact fall to the new regulatory body.

"Can it [the present inspectorate] guarantee that there could never be a pharmaceutical Shipman?" he asks. Could the proposed new PIA? Would it deploy an army of inspectors to sift through pharmacists' records searching for evidence of supplies of slow acting poisons, or is its purpose just to take the flak?

Investigation of the activities of serial murderers is, and is likely to remain, a matter for the police with bodies such as the Society's inspectorate or the proposed PIA involved only marginally, if at all. Their activities are far more likely to come to light through information provided by pharmacy staff, other pharmacists, doctors, suppliers or agencies with whom the Society and its inspectorate have maintained informal contact for many years.

There may be a case for a separate inspectorate but this attempt to jump on the Shipman bandwagon does nothing to promote one.

**Henry Littler**

*Wigan, Lancashire*

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THE COUNCIL

## Might as well stay at home

*From Mr W. B. Rhodes, FRPharmS*

The letter from a previous editor of *The Pharmaceutical Journal*, Robert Blyth, warning of the dangers of limiting free speech by members of the Royal Pharmaceutical Society's Council should be reread and heeded by all the profession (*PJ*, 4 May, p612).

The Cheltenham and Gloucester Branch recently had a Council member to speak and he flatly refused to give his views in response to questions saying that if he did so he would be in breach of the code of conduct and would thus be denied papers for meetings and participation in Council affairs. Whether he was influenced by the presence of a "minder" from the PR department, to whom he constantly deferred, I cannot say.

If Council members are to be limited to telling us simply what we can read in *The Journal* then they might as well stay at home and so might we.

**Bruce Rhodes**

*Winchcombe, Gloucestershire*

## Smacks of totalitarianism

*From Dr G. B. Drummond, MRPharmS*

It is good to know that a committed crusader like Robert Blyth has decided not to let his sword sleep in his hand. His views, so well expressed in his recent letter (*PJ*, 4 May, p612), deserve the support of all members who value the principles of open and transparent governance. The increasing tendency, in so many directions, to muzzle the possible critics, smacks of totalitarianism and must be resisted.

I look forward to more members of Council refusing to accept the quite indefensible vow of silence.

**Gordon Drummond**

*Hull, North Humberside*

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THE JOURNAL

## Spanner in the works!

*From Mr M. Henderson, CEng*

The graphic on the front cover of your issue of 4 May has confirmed the long-standing argument in our house (my wife is a pharmacist, I am an engineer) that pharmacists struggle with the logic of mechanics and applied science.

It is unfortunate, but I am sure the irony of the mechanism is not lost on your readers, ie, the component sprockets around the centre (identify, plan, act, evaluate, record) will operate fine together as a group but when the central cog (officialdom?) is introduced, the whole system locks up! Is this the cunning plan?

**Malcolm Henderson**

*Chester*

Sometimes, for the purposes of illustration, artistic licence can be allowed to overrule pure functionality.—EDITOR.