

SUPERVISION

What is left for pharmacists?

From Ms J. R. Skepper,
MRPharmS

Community pharmacists are notorious for being cynical luddites but on the subject of supervision I would ask all hospital pharmacist to consider joining the cynics.

The use of dispensing technicians to fill the role of junior pharmacists can only alleviate the shortage of staff in the short term. Who is going to fill the grade C posts in three to five years time as the vacancies for grade A/B posts diminish? In *The Journal* of 5 October there were five A/B posts advertised compared with 27 C/D posts and 23 technicians posts. Where are hospitals going to find sufficient numbers of experienced young pharmacists to fill these grade C/D positions? Perhaps the Government will solve the problem by promoting technicians further up the hierarchy and they may well decide that, after all, hospital pharmacists are surplus to requirements.

In *The Journal*, technicians are offered a wide variety of roles, including medicines management, clinical services and support, dispensary manager, instructors and even prescribing technicians so what is left for pharmacists to do?

The Royal Pharmaceutical Society has failed miserably to promote the interests of its members but at least we can draw some satisfaction in the knowledge that when we are all unemployed, the Council will be too.

J. R. Skepper
Chesham, Buckinghamshire

CPD

Need to establish a non-practising register

From Mrs H. Levy, MRPharmS

I would assume that there are hundreds of pharmacists who, like myself, are not retired neither live nor work abroad and who work outside the profession yet, perhaps for nostalgic reasons, maintain their registration. I have been following the progress of

continuing professional development through the various stages and note with some degree of bemusement and concern that what will happen to us, with regard to remaining on the register without fulfilling the obligation of CPD, is a question yet to be addressed (*PJ*, 5 October, p508).

I would be most upset if I were to be forced to relinquish my hard-earned membership of the Royal Pharmaceutical Society. Might I suggest that a non-practising register is established for those members who sign the necessary declaration and pay the requisite fee. I understand that there would need to be a process for those who may want to switch between registers, possibly with a maximum length of time that one can remain on the non-practising register before it becomes impractical to transfer without significant retraining; but I am sure that these matters can be resolved.

I would urge the Society to issue a statement in the near future as to its intent so that this issue can be fully debated.

Helen Levy
Pinner, Middlesex

Older members dealt an insult

From Mr J. R. Martin,
MRPharmS

In his article on continuing professional development (*PJ*, 5 October, pp508-9), I believe Dr Wilson has dealt older members of our profession an insult. The question posed regarding older members does not assume that older pharmacists are out of date. My understanding of the concerns raised regarding older members, who will leave the profession rather than engage in CPD, does not involve any slight on their competence, but rather the disproportionate load the requirements will place upon them compared with the amount of professional work they do. Many, if not most, of these people are already semi-retired; they do the occasional day's locum for pleasure and to cover real emergencies; maybe one or two days every week or two.

It is perfectly understandable that they should be as up-to-date as any other pharmacist and that this will have to be demonstrable. However, it is also understandable that the extra work load with

CPD may tip the balance from the occasional day being pleasurable to do, towards the requirements to stay on the register being more effort than the work itself.

I suspect that as well as weeding out a tiny number of unprofessional, out-of-date pharmacists (of any age), the community workforce will lose a large pool of competent, experienced, knowledgeable and up-to-date older pharmacists who are already doing CPD but will find that recording it is simply not worth the time and energy.

J. Martin
Wallingford, Oxfordshire

Training should be for all who sell medicines

From Mrs D. Drury, MRPharmS

I believe that training should be made available to all those who sell medicines, not just pharmacists. I have therefore decided to send my continuing professional development video to the chief pharmacist's office. I trust the generosity of other pharmacists to do the same so that redistribution via our chief pharmacist can be made. Training would then be mandatory at garages, sweet shops and cafés, thus ensuring that Marshall Davies will have complete confidence in purchasing his cimetidine, ibuprofen and hydrocortisone from his local car boot sale.

Dorothy Drury
Bridlington, North Humberside

SOCIOLOGY

Brutal and unjustified criticism

From Dr P. J. Bates, MRPharmS

I believe that the criticism laid on the social context of pharmacy (*PJ*, 12 October, p525) was rather brutal and unjustified and I for one would like to convey to the authors of the article that I found it neither incomprehensible nor irrelevant. I appreciate that some language in sociology is difficult to grasp for the scientifically-trained mind, but once the concepts are understood the relevance to pharmacy becomes apparent. As pharmacists, we are socially engaged with the public and we need to understand their behaviour and attitudes towards health and illness, otherwise we are merely dispensing robots. In health promotion and practice research it helps to understand the sociological forces that are at work and this discipline can be approached in a scientific manner.

I would think that a considerable proportion of the *PJ*'s readership is involved in professional activities that incorporate some sociology. As a community pharmacist with only a basic training in sociology, I have found this series of articles to be of value and I am keeping them for future reference. Such articles may open the narrow minds of some pharmacists, if only they are willing.

Philip Bates
Bassett,
Southampton

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PARKINSON'S DISEASE

Selegiline has a valuable role

From Dr D. MacMahon, MB BS, FRCP, and Dr J. R. Playfer, MD, FRCP

We read with interest the news item 'Patients with Parkinson's disease should not be started on selegiline' (*PJ*, 3 August, p150). The headline was reminiscent of the style of journalism that surrounded selegiline in 1995 when Lees *et al* published their interim mortality data, since when the debate over the safety of selegiline has continued in the medical press.

Your news item referred to a review published in the French journal, *Prescrire*, which attempted to review the data surrounding the use of selegiline in the treatment of Parkinson's disease. The article itself presented some of the published data on selegiline, but failed to pick up some important publications surrounding the issue of mortality – this was the driver behind the above title, which we

believe to be inaccurate on two grounds.

The authors highlight the only study that has ever shown a statistically significant increase in mortality, the UKPDRG published in 1995.¹ Unfortunately, the authors fail to recognise that the results from this open trial have never been supported by results of other numerous controlled studies that have been published since. Notably, a meta-analysis of five long-term, prospective, controlled studies showed no increase in mortality associated with selegiline with or without concurrent use of levodopa. In a further six studies not included in the meta-analysis, there was also no evidence for increased mortality. The Medicines Control Agency sponsored an analysis from the General Practice Database and this showed no increase in mortality with selegiline.³ Indeed when the UKPDRG reported the results of their 10-year follow up last year they commented: 'We concur that there is no proven causal link between selegiline and increased mortality in patients with PD.'⁴

The authors of the *Prescrire* article also highlight that there are some concerns that selegiline is metabolised to amphetamine and other amphetamine metabolites and this may cause adverse symptoms (particularly insomnia) or contribute to toxicity. This is an avoidable problem. A buccally absorbed preparation (Zelapar) is available, which has been demonstrated to have a more predictable pharmacokinetic and pharmacodynamic profile than generic selegiline. Zelapar 1.25mg by buccal absorption has equal efficacy to 10mg generic selegiline and shows a highly significant reduction in amphetamine metabolites by avoiding liver metabolism.⁵

Used appropriately, selegiline has a simple but sometimes valuable role to play in the management of Parkinson's disease, both in monotherapy and as an adjunct to levodopa.⁶ There is consensus that treatment of this disease must be individualised and it is now widely agreed that selegiline should be avoided in the presence of postural hypotension, dementia or psychosis, and in general frailer patients with concurrent diseases.⁷ However, despite these cautions, there is considerably more evidence in favour of its safety than there is against it.

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MODERNISATION

Opportunity to ensure a better balance missed

From Dr W. Dawson, FRPharmS

I read with interest the debate in Council and the subsequent decisions on the composition of a future – or was it reformed – Council (*PJ*, 12 October, pp545-8). I am bitterly disappointed that the opportunity was missed to ensure a better balance of representation among the pharmacist members of the future Council. I understand from the President's presentation at the British Pharmaceutical Conference in Manchester (*PJ*, 28 September, p445-6) that professional advisory boards would be used to provide suitable advice to Council where this is seen as useful by either Council or the board. To me this misses the point that, in debate within the Council chamber broad professional experience should be brought to bear on all matters for debate and decision. We cannot allow the only breadth in discussion to be provided by the lay members of the Council and, with great respect, the evidence to date does not suggest that our democratic process provides such breadth within our current Council members.

It also seems illogical, having had no distinctions on residence, region or professional specialism for Council membership since the Society began, we can now allow regional nomination for

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both lay and pharmacist members but no sectoral qualifications. It may be politically correct but it does not seem to ensure functional effectiveness. Assuming the logic of Scottish and Welsh reserved places, then sectoral representation should be equally valid and I see no issues in creating a structure where representation is by election but within a defined structure of Council places. If four pharmacist places were reserved in such a way ó perhaps Scotland, Wales, and two from education, industry or science ó I think Council would be the better for it.

My only hope in the debate is the comment from Dr Evans (*PJ*, 12 Oct, p548) who notes that the constant drip of decision making is, in a sense, interim and that the submission of the total process will require the package to show integration and functionality. Perhaps a more effective consultation process might inform Council members as they move towards the final vote and I encourage the President and Council to try to achieve this. It is clear that neither questionnaires in *The Journal* nor requests to write to the modernisation steering group stimulate a wide response but the meeting at BPC showed that there was tremendous interest in active dialogue between membership and Council.

W. Dawson
Alton, Hampshire

Changing the Charter

From Mr D. Simpson, FRPharmS

Just for the record, Ashwin Tanna did not quite get his fractions right when he raised the question in the Council meeting about the majorities required to change the Charter and thereby the number of elected members on the Society's Council (*PJ*, 12 October, p548).

A motion in the Council would require a majority of three-quarters (not two-thirds) of members present and voting. This, as Mr Tanna correctly suggests, must be confirmed by a special general meeting of members convened for the purpose by a majority of the same order. This was fully explained by John Ferguson, the Society's former secretary and registrar, in his letter published on 5 October (p484).

The current Secretary and Registrar, Ann Lewis, suggested in response to Mr Tanna that the now intended changes might be effected by an Order under Section 60 of the Health Act 1999. But the wording of Section 60 makes it clear that such an Order can only be made for the purpose of regulation of the profession. Thus an Order can only be used in connection with the Society's regulatory duties, and not its representational and association functions.

It is my opinion that the changes in the composition of the Council that are now envisaged go beyond regulation and would require a change in the Charter, which would require a motion of the Council with a three-quarters majority followed by a special general meeting. I do not see how these steps can be avoided. The Council will, thus, have no option but to provide a

forum at which the members can make their views known and vote on the proposals that have now been made to alter the size of the Council and greatly increase the number of lay members (*PJ*, 28 September, p463).

Douglas Simpson
Beckenham,
Kent

Will fees be halved?

From Ms A. Farrelly, MRPharmS

No taxation without representation! If the numbers of pharmacists represented on the Council are halved will our fees also be halved?

Ann Farrelly
Wallington, Surrey

Ignore ethnic origin question

From Miss P. C. Eaton,
MRPharmS

I want to add my voice to the pharmacists who object to, or are uncomfortable with, the ethnic origin question in the Pharmacy Workforce Census.

It would be nice to think that if there are enough of us who ignore that part of the census in future, the Royal Pharmaceutical Society will get the message that no amount of explaining, reassuring or justifying will ever make this question acceptable to many of us.

Pam Eaton
Southsea,
Portsmouth

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EYE DROPS

Review eye drop prescribing and purchasing

From Mr N. V. Morley, MRPharmS

It may be of interest to readers that Harold Shipman was not the first doctor to unlawfully kill people by the use of morphine. One of the first recorded medical practitioners to do so, Dr Robert Buchanan, was executed in July 1895 for the murder of his second wife. It is claimed he was inspired by the case of Carlyle Harris, a medical student, who had been convicted of a similar crime the same year.

An interesting aspect of the Buchanan case was that he masked one of the symptoms of morphine poisoning, ie, contracted pupils, by putting belladonna eye drops into the victim's eyes. Belladonna, of course, has the effect of dilating pupils.

Although the symptoms of morphine poisoning are well known and have been fully detailed at the trial of Shipman and the subsequent Judicial

Inquiry, it might be interesting to review the prescribing or purchasing of the other modern equivalents of belladonna eye drops, such as atropine eye drops.

Nigel Morley
Blisworth, Northampton

DIVERTICULAR DISEASE

Rethink indicated for diverticular disease

From Dr M. Griffiths,
MRPharmS

The keynote address by Professor Tom Kirkwood at the British Pharmaceutical Conference (*PJ*, 5 October, p488) presented the equation that recognition as a specific disease equals a decrease in stigma, increased recognition of carers, the prospect of a cure, more research and increased interest from the pharmaceutical industry. Alzheimer's disease was the example used.

I wonder if Professor Kirkwood realises that for another disease, which affects 50 per cent of people in the same age group, the equation is in reverse.

There is no cure for colonic diverticular disease, research is minimal in this country and interest from the pharmaceutical industry is negligible. The disease is recognised but the effects on patients' lives are not. The dietary fibre theory on the cause, prevention and treatment of diverticular disease cannot be sustained by closer examination¹ or by 30 years experience,² nor can it be supported by changing epidemiology, which has, however, always indicated an environmental cause.

A rethink is definitely indicated, but patients are now being told that diverticular disease is an inevitable and normal part of ageing and that because so many people are afflicted, it is questionable whether it should be called a disease (meeting of the Digestive Disorders Foundation, June 2000).

A number of problem attitudes towards ageing were mentioned during the Conference keynote address. I would suggest that diverticular disease is a good

example of this and changes are needed with some urgency in these supposedly enlightened times.

Mary Griffiths
Macclesfield

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