

Only winners will be general practitioners

From R. A. Parekh, MRPharmS

After reading parts of the Office of Fair Trading report, I cannot help thinking that John Vickers, Director General of Fair Trading, made up his mind right from the beginning that control of entry must go. Instead of looking at things objectively, he spent the past 18 months building up a case to present to the Government in order to justify his decision.

However, before our supermarket colleagues start celebrating, they need to give some thought to the long-term effect that deregulation would have on their own pharmacies. The biggest threat to a properly regulated and funded pharmaceutical service would come from doctors, not from other pharmacists or supermarkets.

What will happen when doctors start opening pharmacies within their own surgeries? By my calculations any GP practice with three or more partners would find it profitable to open an in-surgery pharmacy. Taking into account the costs of employing a pharmacist and perhaps a dispensary technician, most doctors would still enjoy a substantial additional income to their practices.

I estimate that almost 70 per cent of the prescriptions generated in the surgery would be dispensed by a pharmacy on site. That would leave about 30 per cent of the prescriptions to be dispensed elsewhere. I wonder how

many of these would eventually reach an out-of-town supermarket? I expect that it would be very few.

As for young pharmacists, whose cause Asda seems to be championing (*PJ*, 25 January, p110), there would be no suitable site for them to open a new pharmacy because they would eventually be "leapfrogged" by their local GPs.

So it seems that if the Government accepts the OFT recommendation there would be no winners; not supermarkets, not young pharmacists and certainly not patients. The only winners that would emerge out of this would be doctors.

R. A. Parekh
Cheadle, Cheshire

Politicians and economists need educating

From Mr J. C. McClellan,
MRPharmS

I am not that surprised at the Office of Fair Trading report proposing deregulation of control of entry. Once again, it reveals politicians' and civil servants' ignorance and low opinion of pharmacists.

This attitude goes back to Margaret Thatcher's era. She instigated today's climate by instilling in the minds of the public that profit is the be-all and end-all of progress, to the exclusion of skilled dedication in any occupation, be it as butcher, baker or candlestick-maker. It is the rejection of the tenet "to each his

or her trade or profession", and the implication that anyone can do anyone else's job.

This is exemplified on the high street: building societies providing banking services, petrol-stations selling food and over-the-counter medicines, and so on. But worst of all are the supermarkets, which have grasped nearly all the products of other businesses and the associated profits. The public now has no real choice or personal service.

In the area where I have lived for 49 years most small shops have closed, including two pharmacies. A shopping mall has opened about a mile away, which is owned by Asda; it has resulted in the closure of three businesses and pushed the sole pharmacy into smaller premises. Now, the OFT implies that pharmacy is a monopoly.

It is time these politicians and economists were educated.

J. McClellan
Leeds

A welcome from potential proprietors

From Mr G. J. Weeks,
MRPharmS

Once again the noise of the vested interests in our profession are rendering inaudible the voices of those who would benefit from deregulation of community pharmacy. Pharmacists who aspire to move from employee status to that of proprietor seem to have been totally ignored. They will welcome the removal of a restraint on freedom.

Then there is Joe Public, who has not been well served by the restriction. Take Greenford, for example, where it has resulted in the loss of a local pharmacy, where the people are. The contract was bought by a multiple in the new shopping centre, where the people are not. It all goes to illustrate the adage that the professions are a conspiracy against the laity.

However, it remains to be seen if this Government will act in the public interest. Perhaps Tony Blair could, in this, prove to favour market forces more than Margaret Thatcher did.

Graham Weeks
Greenford, Middlesex

How did the Society react?

From Mr I. M. Caldwell,
FRPharmS

Being idle and retired gives one the freedom to read the papers. I read three newspapers on Saturday 18 January and two on Sunday 19 January, both tabloid and broadsheet. All reported with varying degrees of accuracy on the proposals of the Office of Fair Trading regarding deregulation of the National Health Service contract. Nowhere was there comment from our Society although I understand that there was comment from the President in one broadsheet. Since the report has been expected since last May, were there no scenario-based outline responses on the stocks ready for instant release? Do we still have staff who have a public relations function?

The National Pharmaceutical Association, Scottish Pharmaceutical Federation and the Scottish Pharmaceutical General Council were widely and extensively quoted in the press and on television. Was the Society's press release ignored by the media and, if so, have representations been made to the Press Complaints Commission and the Broadcasting Standards Authority about the omissions as instances of failure in balanced reporting?

If the recommendation in the OFT report is eventually implemented it will impact on the professional lives of the majority of pharmacists, be they proprietors, managers, employees or locums, community or hospital. Our Society is obliged to represent the interests of its members. Did I miss a lot during my media browsing or do we appear not to have done so on this occasion?

I. M. Caldwell
Larkhall,
Lanarkshire

JEAN-PIERRE MOSER, head of public relations and membership, Royal Pharmaceutical Society, replies: On the day of publication of the OFT report, the President wrote to David Lammy, Parliamentary Under-Secretary of State for Health, expressing the Society's concerns that patients should continue to have access to local pharmacy services. The President also

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expressed concerns about the potential impact of the proposal on local planning of pharmacy services and the pharmacy workforce. A news release was issued to the media and received coverage in national news media as well as in the pharmacy press.

This story has been reported in a balanced and fair way in the media, with many newspapers taking a pronouncedly pro-community pharmacy stance. The question of why the views of the Pharmaceutical Services Negotiating Committee and the National Pharmaceutical Association predominated in coverage over those of the Society and other bodies is for newspaper editors to answer but is most likely to be linked to the fact that these bodies speak for contractors and community pharmacy owners. The Society's role is to speak for the pharmacy profession in the patient interest and our views on this matter, as on all matters, were expressed with that clearly in mind.

Limitations of Society's proposed response

From Mr A. Matalia, MRPharmS

I fully support the Office of Fair Trading report on pharmacy and contract limitation. A free market economy is the fairest way forward.

Under the old system there was no free market. This was unfair because the OFT did not impose minimum salaries for pharmacists, which enabled employers to exploit pharmacists and pay them as little as possible. These pharmacists either had to work for low salaries or leave

pharmacy since most could not afford the high goodwill values of chemist shops.

Further, when contract limitation was introduced there was never a vote of the membership of the Royal Pharmaceutical Society.

The Society continues to support contract limitation even though it disadvantages the majority of its members.

The Department of Trade and Industry should prevent the Society supporting contract limitation without a vote of its membership.

*A. Matalia
Coventry*

ANN LEWIS, Secretary and Registrar, Royal Pharmaceutical Society, states: As the regulatory and professional organisation for pharmacists, the Society cannot be involved in commercial matters, including the terms of the contract to dispense National Health Service prescriptions. The Society does, however, have a remit to ensure that the public benefits from a safe and effective pharmacy service.

The Society has called on the Government to consider first and foremost the needs of patients when it frames its response to the OFT report. The Society has also expressed concerns about the potential effects of the OFT's proposal on the development of pharmacy services, local health care planning and the pharmacy workforce.

The Society is currently working on its detailed response to the OFT report. This will include concerns about the need to secure the public and patient interest but will not involve any view on the best contractual arrangements needed to achieve that end: that is a matter for others.

The more letters to the national press the better

From Mr B. Zatland, MRPharmS

I was delighted to see published in *The Times* (5 February) a clutch of letters from pharmacists and others concerning the recent report of the Office of Fair Trading. The more letters that are sent to the national press on these matters, alerting the public to the implications of government decisions, the better.

*Ben Zatland
Northwood, Middlesex*

Let us have a day of action

*From Mr C. J. McKendrick,
MRPharmS*

Following the Office of Fair Trading report, there is a 90-day consultation period during which all vested interests will make their representations to Ministers. I believe that actions speak louder than words and would call on the National Pharmaceutical Association to organise a "day of action" in London a week or so before Ministers pronounce on their deliberations. My customers have already started offering their support, and I would suggest that any motivated community pharmacist should hire a bus and recruit 20 or 30 customers to make the trip to London to voice their support to save the country's community pharmacy network.

Total deregulation will lead to pharmacy closures in the most vulnerable communities, leaving thousands of people without easy access to a local community phar-

macy. Compared with this, all the other pharmacy issues put together do not amount to a row of beans. If local community pharmacists do not make a stand here they can kiss goodbye to it all.

So come on NPA, let us have a little bit of direct action, and come on pharmacists, e-mail the NPA (npa@npa.co.uk) and offer your support.

*Chris McKendrick
Swindon, Wiltshire*

SUPERMARKET PHARMACY

Equal treatment

From Mr B. Shooter, MRPharmS

Owners of supermarkets consistently take advantage of the regulations that allow them to register with the Royal Pharmaceutical Society only that part of their premises that they wish to designate as a pharmacy. Other owners of pharmacy premises invariably register the whole of their premises as pharmacies.

By not registering the whole store, supermarket owners must cause their pharmacist employees many professional paradoxes.

The privilege of owning a pharmacy is accompanied by professional responsibility except in the case of supermarkets where pharmacies share premises from which ethically unacceptable products are sold.

With the probability of an increase in the number of supermarket pharmacies it would seem only fair and reasonably simple for the Royal Pharmaceutical Society to treat all premises registrations on the same practical basis from now on.

*Barry Shooter
Romford,
Essex*

A body with no muscle

From Mr D. H. Patel,
MRPharmS

I was proud when I first bought my pharmacy in 1971. In those days, the Chemists Contractors Committee was our negotiating body and it rarely succeeded in getting a decent remuneration for the contractors. When it was superseded by the Pharmaceutical Services Negotiating Committee I thought my luck had changed for good. But had it? No!

Almost every year the PSNC made noises about what they were looking for from the Department of Health. Every year it has come back with nothing but breadcrumbs with which to run my business and feed my family. Things just got worse as the years went by. I had to work harder and harder to earn the same amount of money from one year to the next.

Having got fed up with the PSNC, which just could not

negotiate, and the Department of Health, who was always on the look out for "over-payments", I sold my business in 1999. I now am happy that I do not have to put up with the nonsense from either of them.

In my view, the PSNC is a hopeless body with no muscle and it is a waste of one's hard earned money to finance its existence. We should have formed a trades union or joined a scientific and managerial union in the 1970s.

D. H. Patel
Luton,
Bedfordshire

SUE SHARPE, chief executive, Pharmaceutical Services Negotiating Committee, replies: Whether a decision to join a trade union in the 1970s would have resulted in better outcomes for pharmacy contractors is hard to judge. The greatest problem for the PSNC, then and today, is legislation that allows the Secretary of State to determine remuneration. To that extent the PSNC does not have muscle; it never has and nor would a trade union.

Mr Patel sold his pharmacy in 1999. Current contractors face some major threats and few would have any illusions that it is easy to get a satisfactory outcome to them. At present the PSNC is working on three national priority issues: the future of control of entry, negotiating a new contract and securing acceptable systems for generics remuneration. These are not simple, but they are vital for the future of community pharmacy, and it is essential that contractors' interests are represented at national level.

The PSNC has always worked to represent pharmacy contractors; its members are community pharmacists who share the interests and frustrations of all pharmacy owners. Local pharmaceutical committees work hard at local level to build opportunities for contractors, and a major role for the PSNC is to provide support and services for them as well as information and advice to contractors. As the Government devolves funds to local level, the role of LPCs will become even more important, and we would urge contractors to support their local LPC.

An irony

From Mr A. E. J. Sterry,
MRPharmS

It seems ironic that we now have to satisfy the Department of Health of our competence to practise when that same Department issues rules to the Prescription Pricing Authority that prevent a pharmacist from deciding how many paracetamol tablets a patient might need to cover a two-month period of treatment. I believed I had developed sufficiently as a "professional" to decide that 200 would suffice but the prescription was returned to me so I could send it back to the consultant for him to make the decision. Since a second item on the prescription was worth nearly £600, I did not bother.

I just hope that in future pharmacists will have proved themselves sufficiently professionally developed to be able to make such a simple decision and get it through the pricing circus.

Alan Sterry
Chipping Sodbury, Gloucestershire

A need for lessons in psychology

From Mrs M. S. Kapoor,
MRPharmS

I read with interest an article entitled "Influences on GPs' decision to prescribe new drugs — the importance of who says what" (*Family Practice* 2003;20: 61–8). Unsurprisingly, medical representatives featured highly, with the conclusion that decisions to initiate new drugs were "heavily influenced by 'who says what', in particular the pharmaceutical industry, hospital consultants and patients".

As I read through the study my heart sank at the lack of mention of pharmacists working as prescribing advisers or prescribing support pharmacists. However, a couple of pages on, my yearning eyes were greeted with the snippet "Primary care groups and their prescribing advisers seemed to be emerging as influences, especially in relation to drug costs".

Is that it? After several years of pharmacists being attached to GP practices we merely appear to be useful sources of independent drug information. Where are we going wrong? Are we not convincing enough? Are we not persuasive enough?

Perhaps the answer lies in the way we are presented to GP practices. If I were a GP who was presented with a young whipper-snapper of a pharmacist whose function was to "sort my prescribing out" I would be pretty indignant at the concept. After all, no one wants to be told that what they are doing is wrong.

Practice pharmacists employed by primary care trusts have to cover several GP practices in one week. This means that they are not readily available at any one practice; if there were one pharmacist per practice, the scenario where a medical representative would see both GPs and the practice pharmacist together would be the norm rather than the exception.

The pharmaceutical industry spends a colossal amount of money in training medical representatives, with lessons in psychology playing an important part.

Pharmacy students do not attend courses in the psychology involved in influencing and

negotiating so their lack of training, compared with the in-depth psychoanalytical skills of medical representatives, puts them at a disadvantage.

Most GPs (at least the ones that I have encountered) believe that a pharmacist on their team is a valuable asset. However, for us to reach the point where we are seen as one of the top influential factors on GP prescribing, we need some good marketing, fewer practices to look after per pharmacist and some lessons in psychology.

Monica Sharma Kapoor
Prescribing Support Pharmacist
Doncaster West Primary Care
Trust

Extemporaneous dispensing may not be cost-effective

From Ms F. Cruickshank,
MRPharmS

In response to the letter from Christopher Wragg (*PJ*, 8 February, p188) regarding preparation of simple formulae, I do not believe it is beyond the current generation of pharmacists to carry out extemporaneous dispensing.

It is a skill still taught during the undergraduate degree course. However what has to be evaluated is whether such an activity is cost-effective and safe in general practice today.

In the case of copper and zinc sulphates lotion BPC, the process of making the preparation is straightforward but the following points should be considered:

- Do procedures for extemporaneous dispensing comply with Health and Safety legislation, eg, COSHH Regulations?
- Is the equipment used dedicated to products for external use to avoid cross contamination?
- The concentrated camphor water BP must be made separately because it is no longer available
- Are the balances used to weigh the ingredients calibrated and accurate?
- How much time will be involved in sourcing the

materials, preparing the product and recording details of dispensing?

- The four principal ingredients cost approximately £100
- Pharmacists will only be reimbursed basic costs if they choose to prepare a product such as the lotion and this does not remunerate them adequately for the time involved
- The last edition of Martindale to carry the formula was the 28th, published in 1982. How many dispensaries have a copy of this?

There are pharmacists engaged in extemporaneous dispensing and manufacturing in licensed units both in hospitals and industry and they build on the skills taught as undergraduates.

I do not believe that extemporaneous dispensing is a dying skill and those of us actively engaged in this area continue to develop this branch of pharmacy, and thoroughly enjoy it.

Fiona Cruickshank
Prudhoe,
Northumberland

Locums are the hospital's responsibility

From Ms J. Bayley

Having read R. Isap's letter (*PJ*, 25 January, p115) about locum pharmacy technicians' earnings, I must point out the technician's side of the argument. In most hospital pharmacies, because of a shortage of qualified staff, departments would find it difficult to run without locum pharmacists and technicians. Any hospital that takes on "staff with little or no experience" takes responsibility for this type of recruitment, and I have never worked with locums who have been of low calibre.

Finally, since Ms Isap believes that her degree has not been worthwhile for £3 per hour extra, I would suggest she seeks an alternative career.

Jackie Bayley
Pharmacy Technician
Macclesfield District General
Hospital

Advertisement

Patients soon find their optimal injection technique

From Mr N. A. Caldwell,
MRPharmS

I welcome the contributions from Gavin Miller (*Pf*, 14 December 2002, p845) and Irene Gummerson (*Pf*, 11 January 2003, p50) to the debate on how we label insulin preparations. I can see great sense in both commentaries. However, I would suggest that specifying how to inject an insulin preparation in terms of "subcutaneous", or "just under the skin", would not make a blind bit of difference to a diabetes patient who administers his or her medicine using a learnt technique. As someone who has injected insulin for the past 30 years I can attest to the fact that we soon find out our own optimal injection technique. If you go too deep and hit a muscle it hurts excruciatingly. If you hit a blood vessel it hurts excruciatingly. It is really quite simple.

I also disagree with labelling certain insulins to be injected before food, while others should be injected before meals. When is a gastronomic extravaganza a small snack, and thus merely food, and when does it become a meal? All meals, generally, contain food, but not all food is a meal. Why, then, draw the distinction on the label?

In addition, a number of patients on basal bolus regimens take a long-acting insulin preparation before bed, and not before meals, without ill effect. Therefore, should we be instructing that it must be taken before food, when many patients do not, and have not, had a problem, such as nocturnal hypoglycaemia, with injecting before bed?

I would propose therefore that we label long-acting insulin preparations (eg, Insulatard) with "Inject the required dose once or twice daily as directed".

For short- and intermediate-acting insulins (eg, Actrapid, Mixtards and Humulins) label with "Inject the required dose 20 to 30 minutes before food, as directed".

For rapid-acting insulins (eg, Novorapid, Humalog, NovoMix and Humalog Mix) label with "Inject the required dose immediately before food as directed".

I would suggest that what we "write" on the label is often for our own benefit and not implemented by a typical insulin-dependent diabetes patient.

I propose therefore that we should stop specifying the dose, which everyone agrees is a variable entity, and thus is silly to specify on a cartridge that will be used for a couple of weeks. In addition I think we should consign "subcutaneous" to the dustbin.

Neil Caldwell
Deputy Chief Pharmacist, Clinical Services,
Wirral Hospital NHS Trust

Is IM diazepam suitable for use in emergencies?

From Mr K. R. Smith,
MRPharmS

Dental emergency boxes in our trust used to contain diazepam rectal solution. The proposal now is that that should be changed to diazepam intramuscular injection. But dentists are not considered adequately trained to give Diazemuls intravenously so that is not an option. The rectal solution has apparently raised concerns over potential accusations of abuse, following its use in an emergency situation.

The intramuscular injection seems a practical proposition, except that, as far as I am aware, it precipitates in the muscle and diazepam reaches the general circulation slowly, and presumably in relatively lower concentrations. This would seem to make it entirely unsuitable for use in an emergency.

Can anyone shed any light on what is happening in their areas, and whether my concern is justified, or can a pharmacology expert tell me that although onset of action is slow IM diazepam would be effective?

Kevin Smith
Brecon, Powys

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ADVERTISING

The role of the PMCPA

From Mrs H. Simmonds

I refer to recent correspondence regarding pharmaceutical advertising from Anthony Cox of the West Midlands Centre for Adverse Drug Reaction Reporting (*PJ*, 1 February, p154) who was responding to Professor Trevor Jones, Director General of the Association of the British Pharmaceutical Industry (*PJ*, 25 January, p116).

The Prescription Medicines Code of Practice Authority (PMCPA) was established by the ABPI to deal with all matters relating to the Code of Practice for the pharmaceutical industry at a distance from the ABPI itself. The code covers the promotion of medicines for prescribing to health professionals. It reflects and extends beyond United Kingdom legal requirements.

The industry strongly supports self-regulation, which is permitted by UK and European law and supported by the Medi-

cines Control Agency. Inter-company complaints are a means of reinforcing self-regulation as companies keep a close eye on each other. Health professionals concerned about advertising should consider submitting complaints to the PMCPA for consideration under the code. One of the major differences between self-regulation and MCA statutory control is that under the code a complainant is given full details of the outcome, including the opportunity to appeal if no breach is ruled at the initial stage. Further, full details of cases considered are published in the quarterly *Code of Practice Review* which is available on request. Detailed information is neither provided to the complainant nor published by the MCA.

Mr Cox is wrong to state that the use of data on file is not open to scrutiny. Companies which refer to data on file in their advertising must provide the relevant part of that data on request. All claims, etc, must be based on an up-to-date evaluation of the evidence and reflect that evidence clearly. They must be

capable of substantiation and such substantiation must be provided on request.

One of the roles of the PMCPA is to provide training on the code and occasionally presentations are made to groups of health professionals using examples from completed cases. The PMCPA is happy to consider any request for a presentation on the code.

Heather Simmonds
Director,
Prescription Medicines Code of
Practice Authority

LOCUM PAY

Preregistration trainees will be reaching for the monkey-wrench

From Mr R. Harris,
MRPharmS

Stephen Taylor (*PJ*, 8 February, p188) states that locum rates of £25 per hour and allowance for travel time are

unreasonable. I contend that these rates are becoming more popular because, as professionals, we are beginning to demand rates that reflect our true worth. It is interesting that Mr Taylor does not contest that plumbers are worth £30 per hour. From this it can be argued that Mr Taylor believes that as "hard working, caring" professionals we are worth less than two thirds the value of a plumber.

The year 2002 was not a year of money grabbing as Mr Taylor claims but rather the awakening of pharmacists as to their true value. Such attitudes that would have us pay more to a plumber than a hard working, caring health professional dedicated to trying to provide excellent health service and error-free dispensing will have many preregistration trainees reaching for the monkey-wrench.

I hope we will see a sensible conclusion to the ongoing problem of variation in locum rates, and pharmacists (locum and employee) remunerated and respected appropriately.

Richard Harris
Birmingham

Advertisement

Illegibility problems with computer prescriptions

From Mr W. D. Fisher,
MRPharmS

I see that Sir Liam Donaldson has written to doctors alerting them to the dangers of illegible handwriting (*PJ*, 8 February, p178).

However, he does not appear to have addressed the problem of illegible or near illegible prescriptions caused by the use of worn out computer ribbons and misaligned patient details, medicines and doses, which often do not show over the printing on the National Health Service prescription forms.

How many "near misses" — or worse — have these caused?

Walter Fisher
Manchester

No reason to produce separate registers

From Dr J. A. Hunt, FRPharmS

Your leading article (*PJ*, 8 February, p176) poses some fundamental questions. The suggestion that pharmacists who work in academia, the pharmaceutical industry, pharmaceutical journalism or any aspect of the profession, other than individual patient care, might be designated "inactive pharmacists", is a worrying one. Such a description would be inaccurate, unacceptable and many hard-working pharmacists would regard it as insulting. As indicated by your correspondent Maurice Jackson (*PJ*, 8 February, p189) the media and, no doubt, uninformed members of the Government and the public, regard the pharmacist as the chemist in the corner shop or working in the supermarket. It should be part of the Royal Pharmaceutical Society's remit to correct this false impression and to support all members of the profession, regardless of the sphere of pharmacy in which they work. If Government officials think that "anyone holding themselves out to be a pharmacist" (*PJ*, 8

February, supplement) is necessarily someone who dispenses prescriptions, then they should be properly briefed and perhaps reminded that pharmaceuticals provide one of Britain's largest exporting industries, involving many pharmacists who travel widely or live overseas.

Pharmacy is a broad church, and can only provide the service that the Government and the public expect if all branches of the profession work in a harmonious and co-ordinated way. If it were not for pharmacists in the industry researching, developing, formulating, stability testing, analysing and authorising release of pharmaceutical products, and then supervising distribution and providing technical and medical information, there would be no products for "active pharmacists" to dispense. Without academic pharmacists there would be no new pharmacists and without pharmaceutical journalists we would all work in an uninformed vacuum. The profession provides an integrated whole, and to begin setting up invidious distinctions between pharmacists depending on their employment should not be countenanced by the Society.

The solution to the problem is a simple one for which there is already an established working precedent. In the industry, an individual who has satisfied certain official requirements, who is duly authorised and registered, and is responsible for supervision of production of pharmaceuticals, their quality assurance, the batch records and for authorising their release to the market is designated "the qualified person". In a similar way, a pharmacist working in individual patient care who has satisfied the requirements of CPD should be designated as "the authorised pharmacist" and hold a certificate to that effect. The designation could be recorded in the annual register of pharmacists by a letter "A", in the way that fellows are recorded with a letter "F". If thought appropriate, retired pharmacists paying the reduced subscription could be identified by letter "R". There is absolutely no reason to start producing separate registers and creating different sorts of pharmacists. Once a pharmacist, always a pharmacist, and we all work in our different ways for the health of the nation.

John Hunt
Weymouth,
Dorset

Still a lack of transparency in Council's proposals

From a group of past presidents of the Royal Pharmaceutical Society

Last summer we wrote to *The Pharmaceutical Journal* (6 July 2002, p15) to express our concerns about the Council's proposals for reform. We were pleased to be invited by the President to Lambeth to discuss our concerns.

In the course of that meeting we made clear our opposition to action that would weaken the ability of the Royal Pharmaceutical Society to act as the professional representative body for pharmacists and to discharge its chartered objects. We also expressed concerns about the processes by which proposals for fundamental change were being brought forward.

At the conclusion of what we believed to be a constructive meeting we expressed a hope that we would not need to reiterate our concerns. Sadly since that meeting there has been no improvement in the processes. In recent weeks we have learnt that the Council wishes to seek charitable status for the Society, and wants its publishing activities to be managed through a separate, wholly owned company. The members have not been advised of what the implications of charitable status are for the Charter, how services to the membership can be improved, and how a separate publishing company will generate income for the profession.

The Society is now considering the registration of pharmacy technicians. It remains unclear whether this is to include dispensing assistants but the total numbers involved could be substantial. If registered with the Society, such persons would be entitled to two reserved seats on the Council, which would not be "lay" places. If such persons were added to a reformed Council with the additional proposed composition of 30 to 40 per cent lay Council members, pharmacists themselves would lack any form of substantial overall majority. It is unlikely that such a Council would be properly able to promote the interests of members

in the exercise of their profession of pharmacy. Such particular concerns over technicians starkly illustrate our belief that a number of decisions have apparently been made in isolation which in themselves do not seem of great moment but which taken together could have momentous consequences.

In the *PJ* (4 January, p31), the President emphasised the unprecedented importance of the decisions to be taken about the future role of the Society. Transparency requires an understanding of the long-term vision so that the individual proposals can be understood. It is with great regret and concern that we write to record the lack of transparency in the processes adopted by the Council. It does no credit to the Council and we believe it is not in the interests of the membership.

John Balmford
Jim Bannerman
Arnold Beckett
Geoff Booth
Ian Caldwell
David Coleman
Bill Darling
Herbert Grainger
Colin Hitchings
Hopkin Maddock
David Sharpe
Nick Wood
Past Presidents
Royal Pharmaceutical Society

ANN LEWIS, Secretary and Registrar, Royal Pharmaceutical Society, replies: We did indeed have a thoroughly useful and constructive discussion when we met the past presidents in the summer. I am sorry if the past presidents are again in difficulty. I welcome this opportunity to reiterate the drivers that require the Society to modernise and the process for decision-making that the Council has adopted.

The Government has made it absolutely clear that it expects the Society to change its ways of working to include more lay members on our Council in order to become more accountable. This need to change is not negotiable but the positive message is that this is intended to strengthen, not detract from, the Society's role in providing professional leadership and advocacy, which the Government supports. Put starkly, the Society had two choices: engage in the modernisation programme and actively shape the profession's future, or cling to the past and have change

imposed on us. By choosing the former option, the Council has given the profession a say in its own future; to have chosen the latter would have done a disservice to the membership.

The process that the Council has adopted for making decisions on the Society's future has involved consultation on the direction of travel; informal Council discussion days to consider views and frame strategy; input from a steering group, including Council members and external experts, to shape proposals; and then decision-making by the Council at its formal meetings.

The proposal in principle to manage the publications operation within a wholly owned company was adopted in order to strengthen its management and governance and to allow the business to develop more effectively. The Council reaffirmed that it has no intention of divesting itself of any part of its publishing operation, which makes an important contribution to the Society's income and to the scientific and professional knowledge base. Detailed proposals are now being worked on for the Council to discuss.

The Council has decided that the Society should regulate pharmacy technicians. It follows, therefore, that there should be places on the Council for this group and the Council has decided that, should its plans to register technicians proceed, the number of places should be two.

The Council took the decision to seek charitable status for the Society because it will confer considerable benefits and advantages. We are now exploring how this might be done and have yet to analyse in detail the implications of this for the Charter or, indeed, any other element of our constitution or ways of working. However, given that the Society's functions as a regulatory, professional and benevolent organisation appear to be closely aligned with the criteria for charitable status, registration as a charity should bring clear benefits.

The issue of the Charter is, of course, one of the key questions that the Council will be considering when it decides on the most appropriate route to the reform of the Society. The Society is governed by both Charter and legislation, each of which confers a range of powers and duties. Potentially, reform

of the Society could be achieved solely through legislation or by the route of both Charter and legislation.

Many decisions have been made over the past year and there are many more still to be made. The timetable is tight — for some perhaps uncomfortably so — because the Government requires our proposals for regulatory change in the early part of this year. I do not expect that every pharmacist will agree with every decision that is taken but the past presidents will know, from their time on the Council, that difficult decisions cannot be shied away from on the grounds that they may be unpopular.

Reports, not promises, please

From Mr P. Jenkins, FRPharmS

Before each Royal Pharmaceutical Society Council election, we should be checking the record of Council members who want to stand again.

We could ask for their attendance records. We could ask about the positions they have taken on the main issues discussed during the time of their membership. We could try to find out how they have been able to pursue any promises they made in their election statement. These are all difficult but the last may be the most difficult. However, it would be the most illuminating, since election promises can backfire.

For example, the man who called himself H'Angus when he dressed himself up as a monkey to be the mascot for Hartlepool United Football Club, promised to give schoolchildren in the area a free banana every day if he were elected mayor. He got that job and the promise must have helped. However he found he could not fulfill his pledge because it would have cost around £400,000 in a full year.

I do not suggest that would-be members of Council offer blatant bribes but have their promises ever been costed and what became of them? It would be interesting to get a report instead of new promises and aspirations in this year's Council election statements.

Peter Jenkins
Cardiff