

## A transparent, democratic consultation is needed

From Mr R. Dickinson,  
FRPharmS, and others

We welcome the assurance that the Royal Pharmaceutical Society's Council is to follow the advice of the Privy Council and consult widely on a new Charter and that the new Charter will "safeguard and strengthen the (Society's) professional role" (*P7*, 15 March, p377). The key issue in relation to the "professional role" will, of course, be any proposed replacement of the Object in the current Charter "to maintain the honour and promote and safeguard the interests of the members in their exercise of the profession of pharmacy".

Another important issue will be how the results of the wide consultation exercise are dealt with and reported to the members. A transparent democratic process would involve:

- Ensuring that the consultation exercise is not subject to impossibly short time constraints
- Publishing a report of the major points made during the consultation, how often they were raised, accompanied by a statement of which have been accepted and which rejected and, in each case, an explanation of why
- Putting the text of the new Charter as proposed following the consultation to a general meeting of members

There is nothing new in the Council publishing a report of

the kind suggested, ie, on the outcome of a consultation exercise, on topics much less fundamental to the structure of the Society than a proposal for a new Charter. For example, whenever a new Code of Ethics and Statement of Professional Standards is proposed, there is wide consultation with the branches and the members generally. A final proposal is then put to an annual general meeting with an indication of the changes made to the original based on comments received during the consultation. If necessary, an explanation is also given of why the Council considers one or more suggested changes would not be appropriate. The members at the AGM are then asked to approve the new text section by section. The text finally adopted then has the added legitimacy of being the consensus of the membership, rather than something imposed by the Council.

Surely a lesser standard of democratic process is not justifiable for a proposal that could

change the very nature of the Society. After all, as *The Journal* report makes clear, if the Council were proposing amendments to the Supplemental Charter of 1953, it would be required to put the proposed amendments to a special general meeting and would require to achieve a majority of three-fourths of the members present and voting. The suggestion is made that a general meeting might not give a true picture of the views of the majority. Would that not depend on the number of members present and how much their views coincided with the major points made repeatedly in the consultation? If objections did indeed come from a small and vocal minority, that would be clear but we are convinced that is unlikely to be the case.

There is nothing new, either, in proceeding along the legislative and Charter paths simultaneously. After all, the 1953 Supplemental Charter was negotiated at the same time as the Pharmacy Act 1954 was within the parliamentary process.

For the avoidance of any doubt, let us assure you that none of us is among the band said by you to be likely to be "spluttering into their porridge or cappuccinos." We recognise and accept the need for some change. However, we do have serious concerns about, among other things, the proposal that the Society should become a charity, bearing in mind no one knows what that would mean in the medium term. According to press reports, charity law is to be changed and the nature of such changes needs to be known before the Society takes such an important step. For example, we could find that, as a charity, it would be impossible for the Society to undertake a professional representative role. That would, in our view, be unacceptable to the great majority of members.

### Raymond Dickinson

Assistant Secretary 1967-75,  
Deputy Secretary 1975-94

### John Ferguson

Assistant Secretary 1968-75,  
Secretary and Registrar  
1985-1998

### Bruce Rhodes

Senior Administrative Assistant  
1975-77, Assistant Secretary  
1977-90

### Douglas Simpson

Editor, *The Pharmaceutical  
Journal* 1987-2000

### Sydney Southwell

Senior Administrative Assistant  
1976-94, Secretary to the Welsh  
Executive 1979-94

#### ADVICE FOR CORRESPONDENTS

Letters for publication can be posted, faxed, or sent by e-mail to [letters@pbarmj.org.uk](mailto:letters@pbarmj.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. 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, including electronic media, 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 will usually 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.

#### TELEPHONE NUMBER

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

## A new Charter will not end the Society's misery

From Mr M. Koziol, MRPharmS

A series of stark and revelational admissions appeared in the "Fit for the future" pullout which came with *The Pharmaceutical Journal* of 15 March. The Royal Pharmaceutical Society now clearly admits that it would not succeed in securing the constitutional backing of the membership for its proposed changes. The pullout in essence is an admission that the Society is in great difficulty.

However, the Society has found itself in a mess for one simple reason: in planning a future it has strongly advocated a Society which is primarily regulatory, whereas those opposed to this plan have advocated a Society which gives equal prominence to both the regulatory and membership activities. The ideas that have been put forward by the members have secured widespread support.

The Society now believes that it can bypass the constitu-

tional safety net, which allows the members to vote on any proposed changes, by simply trying to force through a new Charter quickly and expediently without the need for a special general meeting. It believes instead that it will be allowed to get away with another pretence of a consultation — as before.

The Society's motivation is clear: it wants a new Charter to reflect the needs of the Government's regulatory agenda. Indeed, the pullout makes clear that the same Department of Health officials as have been involved in the drafting of the Section 60 (regulatory) order would be involved in the rewrite of the Charter.

I am surprised that the Society has not worked out that calling for a new Charter will not end its misery. I can only imagine that just as the current debate has already shown, two new Charter options will emerge:

- A regulatory Charter proposed by the Society and backed by the Government
- A members' Charter proposed and backed by the large majority of members

The only way that a new Charter can be installed is if it can be shown that it enjoys the broad support of pharmacists. As such, the Society can attempt to run away from the outcome of an SGM by changing the rules of the debate, but it will not be able to escape a simple logic.

Pharmacists will always want the Society to safeguard and promote the interests of the members in their exercise of the profession of pharmacy. A new Charter will merely provide an opportunity to emphasise this role and enable the Society to do it much better.

Mark Koziol  
Birmingham

## Is consultation a pointless exercise?

From Mr G. W. Watson,  
MRPharmS

I note that the Council of the Royal Pharmaceutical Society has wisely decided to avoid submitting its proposals for a new

Charter to a special general meeting and having to face a "small but vocal minority", which apparently includes every living past-president other than those currently on Council and the former editor of *The Pharmaceutical Journal*. Instead it has opted for consultation.

For some reason the words of Sir Winston Churchill come to mind: "One can always consult a man and ask whether he would like his head chopped off tomorrow but when he says he would prefer not, cut it off anyway."

G. Watson  
Barnard Castle, County Durham

## Charter should mention inactive pharmacists

From Miss H. C. Stanniland,  
MRPharmS

I read with interest the proposal for a new Royal Charter in last week's issue of *The Pharmaceutical Journal*. I approve of the aims of the proposal and most of the wording. However, in the recent

consultation on CPD, there was a proposal to create a second register for "inactive" pharmacists who would not be required to undertake CPD. If such a second register is created, then paragraph 5 of the Charter should make specific reference to such pharmacists, rather than including them in the "other persons in such categories" umbrella statement. This would give them the recognition that they deserve.

*Claire Stanniland*  
London SE8

## SUPERMARKET PHARMACY

## Proud to be a supermarket pharmacist

From Mr P. J. Banks, MRPharmS

I have read with growing annoyance the character assassinations by my fellow professionals in recent weeks and have decided that the time has come to put the record straight. I have been a supermarket pharmacist for the past six years. I chose this particular path because, unlike my colleagues in other sectors of community pharmacy who take responsibility for the non-pharmacy areas like shampoos and toiletries, I am allowed to concentrate on pharmacy services.

Quite apart from the image that has been portrayed in *The Journal* over the past few weeks the company I work for is committed to their patients, staff and pharmacists. In recent months my pharmacy has been involved in diabetic screening, a minor ailments scheme, medicines management campaigns and smoking cessation pilots, which have all taken place within my modern well-equipped pharmacy using a purpose-built consultation room. I have access to funding for locum cover to allow me to develop myself professionally, my pharmacy staff and my business. In recent months I have trained a preregistration trainee and I am currently in the process of helping my trainee dispenser through the NVQ level 3. The company also encourages and supports my participation in the local pharmacy development group and my membership of the local pharmaceutical committee.

In addition to all of this, the team of pharmacists in the pharmacy where I work serve around 2,000 customers a week, offering a full pharmaceutical service with

clinical governance at its core for 78 hours a week.

From those critical of supermarket pharmacy who do not believe that I am worthy of my place as a member of the profession, I would like to know what is so terrible about the service which I offer to my customers and patients.

*Philip Banks*  
Huntingdon,  
Cambridgeshire

## Local pharmacies will always be more accessible

From Mr R. W. Selfe,  
MRPharmS

I have never worked in a supermarket pharmacy but I think some comment is needed in reply to John Tapster's highly critical letter (*PJ*, 8 March, p332).

He appears to suggest that the proportion of all prescriptions which are sorted into the "miscellaneous doctors" category can be used as a criterion of customer loyalty and, by inference, whether or not a pharmacy is in a proper environment. Where does that leave those of us who, like myself, spent many years in areas like Central London, even in premises within station concourses, dealing almost entirely with passing commuter trade? There were, however, a few regular prescription customers and before the days of electronic records our memories had to be the only prompt if an unexpected change of treatment arose.

Mr Tapster is understandably nostalgic about his village practice where, no doubt, he could greet by name most of those

approaching his counter and derive much satisfaction from his work, gaining the deserved appreciation of those he helped. But for every person who likes to linger for a friendly chat, how many are there waiting behind who just wish to be served and move on? I would suggest that supermarket customers mostly, but not always, fall into this category and it is perfectly proper and desirable that there should be pharmacists who choose to work in such an environment.

Despite worries about the Office of Fair Trading recommendation, a report from Mintel (*PJ*, 15 March, p360) says that a convenient location is the major factor in terms of where people buy health care products. Now being a full-time customer myself, I believe that for those on foot the local pharmacy will always be more accessible, and I fully agree with Geoff Laidlaw, (*ibid*, p365) that if the service offered there is so superior to that of supermarkets, then what is there to fear?

*Reg Selfe*  
Benfleet,  
Essex

## Failed by greedy generation of proprietors

From Mr C. R. Hackett,  
MRPharmS

I must respond to the letters of John Tapster (*PJ*, 8 March, p332) and Richard Johns (*PJ*, 22 March, p399). I find the arguments regarding pharmacists who work in supermarkets rude, insulting and ill-conceived.

The supermarket provides an excellent environment in which to practise pharmacy. I have been a supermarket pharmacy manager for two years and in that time have developed several initiatives. I have also obtained an oxygen contract and only the other night I was asked by the on-call doctor to deliver oxygen to a patient at 9pm. I would also deliver antibiotics to a child at night if asked to do so.

Members of Mr Johns and Mr Tapster's generation seem to want to have their cake and eat it. There were a lot more independents when they were first qualified, which people presumably took over from previous owners. However this chain was broken by the greed of the next generation of owners who sold their

## E-MAIL

E-mail correspondents are asked to give a postal address or membership number.

pharmacies to the multiples (who were able to pay more for them). Future independent pharmacists like myself were squeezed out of the market. These chains have now become so big that they are not able to maintain their NHS contracts. Surely opening up the market place will allow pharmacists to challenge these chains in certain localities on customer service grounds.

The real argument for pharmacy is with the Medicines Control Agency because of the number of products that are now on the general sale list, eg, Imodium, Calpol sachets, Nurofen, Colpermin and various nicotine replacement therapies. The relentless switch of medicines to GSL is the biggest drain on pharmacies' income and would prevent me seriously looking at setting up my own community pharmacy. I will stick to pursuing my career in supermarket pharmacy, which I enjoy, and wonder what might have happened if the previous generation of pharmacists had given us a chance at ownership.

*Colin Hackett*  
Bristol

## PACKAGING

## Look and read, don't glance

From Mr K. C. Stead,  
FRPharmS

There are two mentions of the remark by Lord Hunt about indentifying "at a glance the information to make sure that the medicine can be used safely" (*PJ*, 8 March, p320 and 321). A glance may be sufficient for instance to identify a pictorial sign on our roads but it is inadequate to apply to a medicine when we must look and read. The advice should always be to look at and read the label, however clear or large the type. This advice cannot be repeated too often to patients, carers and health professionals.

*Keith Stead*  
Southall,  
Middlesex

## PJ ONLINE

**The Pharmaceutical Journal's website, *PJ Online*, can be found on the internet at [www.pjonline.com](http://www.pjonline.com). At the site, pharmacists can take advantage of a daily news services and can view the contents of the current weekly issue.**

**The site also contains a searchable archive of PJ material and a searchable database of current job advertisements. There is also a feedback facility, whereby browsers can send e-mails to the editor and to the advertisement manager.**

## Decriminalising drugs of addiction may benefit society

From Mr J. B. Price,  
MRPharmS

In the early hours of Monday 19 February, an athletic drug addict gained entry to our pharmacy through the roof. He took all of our stocks of diazepam and dihydrocodeine to sell on the streets and thus perpetuate one of the most lucrative pyramid systems ever devised.

We dispense daily doses of methadone in our pharmacy and have got to know these consumers quite well. (The intruder mentioned above was not one of "ours" — most of our clients' behaviour is exemplary). However, over the past three years we know of one who has died from an overdose of heroin not far from the shop, another who has committed suicide and more than three who have suffered severe beatings from drug pushers.

I was addicted to tobacco for 30 years and, although I am not an alcoholic, drink my fair share of beer and wine. These two drugs have always been legally available at a reasonable price in the United Kingdom and therefore I have never had to resort to criminal acts to satisfy my wants and in the case of nicotine, my cravings.

Do any other pharmacists believe it possible that, if the sale and possession of all addictive drugs were decriminalised and these substances were made freely available at an affordable price, a huge number of crimes, tragedies and other problems would vanish overnight? The drug barons would simply go out of business, our children would be safe from pushers because there would be no money to be made and the savings in terms of police and legal system workload would be massive. Moreover, the tax revenue available to the Government from the sale of legalised drugs would benefit everybody.

**Brian Price**  
Aberdare,  
Mid Glamorgan

## Doctors need more training on prescribing

From Mrs Y. Haarboff,  
MRPharmS, and Mr J. P.  
Anthistle, MRPharmS

*The Pharmaceutical Journal* (4 January) reported major changes in pharmacy practice: the right to prescribe. Although we read the articles with great interest, there are aspects that need urgent attention.

Medical practitioners have had the legal right to prescribe since the 1858 Medical Act. This right has never been questioned; instead, it has always been assumed that doctors are trained in the act of prescribing and as a result are expected to be competent. The decision to appoint doctors to supervise and train nurses in prescribing was probably based on this assumption, which clearly has also been accepted by the Royal Pharmaceutical Society and applied in this new scenario of pharmacist training for prescribing.

The reality is unfortunately quite the opposite. Medical students in the United Kingdom are taught clinical therapeutics, which includes the selection of drugs for specific indications. Unfortunately, little or no formal practical prescribing training or application of their prescribing ability takes place during their years at university. These skills are normally acquired during their year as a preregistration house officer.

The National Prescribing Centre has identified clear competencies for nurse prescribers. The same competencies acted as a basis for determining the competencies required by potential pharmacist prescribers. Training programmes have been designed around these competencies and have already commenced for future nurse prescribers. The supplementary prescriber must demonstrate these competencies before they will be allowed to prescribe. In stark contrast, no competencies exist to use as a basis for training or assessing the prescribing ability of medical students, or medical practitioners. Yet, according to the Royal Pharmaceutical Society, it is the

latter group that will be required to act as trainers and supervisors of supplementary prescribers.

One would think that a proactive view on practical prescribing as part of medical education should be of utmost importance. The General Medical Council has identified this possibility by stating clearly in its document "Tomorrow's doctor" (June 2003) that medical students must be able to perform accurate drug calculations and to write prescription for analgesics and antibiotics. The GMC further requires these two competencies to be signed off before doctors' full registration, but no standardised assessment exists to ascertain and evaluate achievement against these competencies.

In some trusts the prescribing ability of preregistration house officers is assessed. In the majority of these cases, the pharmacy department carries out these competence assessments — that in itself is ironic.

With the current focus on medication errors, the cost to the NHS in additional hospital days due to medication errors, the establishment of the National Patient Safety Agency and the goal of the Department of Health to reduce medication errors by 40 per cent by 2005, the importance of training and actively teaching practical prescribing in the undergraduate medical course becomes an issue of national importance. Competencies need to be agreed and assessment of the prescribing ability of preregistration house officers should be a prerequisite to their full registration.

**Yolinda Haarhoff**  
Pharmacist Teacher Practitioner  
Cambridge Graduate Course for  
Medicine

**John Anthistle**  
Chief Pharmacist  
West Suffolk Hospital

#### HOSPITAL PHARMACY

## Technicians could be hospital pharmacists

From Mr M. Brown

The impact of university top-up fees is a controversial subject that could have a profound influence on National Health Service pharmacy. A recent news feature (P7, 1 Febru-

ary, p145) raised the question of whether top-up fees will act as a deterrent toward people embarking on a career in pharmacy; views appear to be mixed.

The "fallow year" and the NHS plan had a diverse impact on the roles within pharmacy, forcing the profession to search for answers to combat any expected shortfall in staffing numbers. To this end, the roles of pharmacists and technicians have become blended and a better skill mix obtained.

A more imposing problem will be derived from the following question: "If you were a newly qualified pharmacist with debts of £25,000 or greater, where would you be drawn, hospital pharmacy or the comparative riches of community care?" For pure hard cash, there can be only one winner, and many newly qualified students may well choose the community path. This would raise a more malignant and insidious problem than the "fallow year".

The career structure for many pharmacy technicians currently ends at senior level, by which time they have gained invaluable experience and, in many cases, qualifications. However, much of this knowledge is wasted due to legislative restrictions. Currently technicians qualified at HNC (NVQ4) level have undergone a minimum of four years accredited training. Would it not be more appropriate to allow suitable and willing, qualified technicians the chance to pursue a modular system of study over three to six years on a day release basis? The end result would be a specialist pharmacy degree only valid in the hospital environment. The introduction of such a scheme would produce a pool of highly experienced specialist hospital pharmacists constantly available to the NHS. Staff unable to continue training at any period could have modules in the bank and, depending upon the level of accreditation, achieve diploma or certificate standard.

The pharmacy community has a golden opportunity to seize the initiative and move with the times. The scheme would provide a dedicated career pathway for technicians to attain specialist degrees, negate any shortfall in pharmacist numbers and provide the NHS with a constant dedicated workforce.

**Matt Brown**  
Senior Pharmacy Technician  
Royal Shrewsbury Hospital

#### PRESCRIPTION CHARGES

## Easier to turn a blind eye

From Mr P. M. Brown,  
MRPharmS

Adrian Korsner (P7, 22 March, p401) is not the only person to see that a small levy on prescriptions would lead to simplified administration, reduced waste of medicines and improved health care for those who are currently having to decide which of their prescribed medicines they cannot afford.

So how much will a £1 levy per item raise in comparison with the current prescription charges? This must be a relatively easy question to answer. The more difficult problem will be to find politicians brave enough to charge the levy on pensioners, those on benefits and those with a chronic illness. In the meantime it is easier for the Government to increase prescription charges every year and turn a blind eye to everything else.

**Peter Brown**  
Croydon, Surrey

## £1 levy is not political sense

From Reverend G. J. Weeks,  
MRPharmS

Adrian Korsner (P7, 22 March, p401) does not tell us the purpose of the levy as he perceives it. To me it is merely a fiscal measure. As such, if it were to be levied on all prescriptions, I think 60p per item would bring in the same revenue as at present.

However, no government will do this. The only popular taxes are the ones other people pay. A levy for all would be just as fair as the late community charge and just as popular.

Yes it makes pharmaceutical sense, but not political sense.

**Grabam Weeks**  
Greenford, Middlesex

#### SEARCH THE JOURNAL

The Journal's website, P7 Online, contains a fully searchable archive. Visit [www.pjonline.com](http://www.pjonline.com) to see how easy it is to use. The archive starts from August 1999.

#### CPD

## The profession will be poorer

From Mr W. T. Brookes,  
FRPharmS

Bruce Rhodes expresses so elegantly (P7, 22 March, p400) what many of us think about suggestions that anyone no longer practising should be removed from the Register.

I would also take issue with those who would like to take away the right to use the title of pharmacist. Mr Rhodes and many others, although no longer in practice, are still active in the profession and I believe contribute much to its wellbeing. Take away such activists and the profession will be all the poorer.

Incidentally, am I no longer to be allowed to use the letters FRPharmS? I note that applicants to be members of the panel of fellows "must still be active in the profession". If that debars those like, for example, Bruce Rhodes, it precludes a large number who would be invaluable to the panel.

Martyrdom holds little attraction for me but I, too, intend to carry my title to the grave.

**W. T. Brookes**  
Stoke-on-Trent, Staffordshire

## A comparison with the legal profession

From Mr J. A. Tweed, MRPharmS

With regard to the use of the title "pharmacist", it may be interesting to compare the situation in the legal profession and use of the title "solicitor".

Having been registered as a solicitor with the Law Society one needs a "practising certificate", renewable every year, in order to practise, as well as performing 16 hours of "continuing professional development". If, for some reason, one does not take out the certificate then one does not cease to be a solicitor, although one cannot practise. Similarly, one should not cease to be a pharmacist, having put so much work into qualifying, just because one does not wish to practise actively.

**J. A. Tweed**  
Burton Joyce, Nottingham