

SPECIAL GENERAL MEETING

Why members should attend

From Mr R. Blyth, FRPharmS,
and Mr D. Simpson, FRPharmS

Why should pharmacists attend the special general meeting of the Royal Pharmaceutical Society on 1 June? Because the Society's Council is well on the way to surrendering to the Government the Society's autonomy. So, if pharmacists want to preserve the Society as their own essential representative body, they should make an effort to be present at the SGM.

Disliked as an SGM may be by the Council, the fact is that, short of a referendum, it is the final and democratic forum by which pharmacists can exert pressure to mend its ways upon a Council characterised, so far as the membership is concerned, by dictatorial dogmatism.

For 162 years, the Society has served the public interest by advancing pharmacy as a knowledge-based profession. Pharmacists' reward, the furtherance of

which has been aided and abetted by the present Council, is to have our freedom as a liberal profession to govern ourselves removed and for us to be ruled according to the whims of government and the effortless superiority of the denizens of Whitehall. As the Spectator said (February 8): "The dead hand of the managerial state must be removed from professions such as medicine and teaching." And, let us add, "pharmacy".

Britain has long been regarded as a free country. Not any more. The free country has become the "nanny state". Politicians and Whitehall know best.

The Council does not take kindly to criticism, blaming the critics' aversion to change. But the critics are not opposed to change, only to wrong-headed change.

In fact, they desperately desire change of the Council's current policy of supinely abject surrender to government edict. They want the Society to retain its sovereignty as the representative association of pharmacists, with, if necessary, a regulatory arm independent of the Council, as is the present Statutory Committee.

Let the Council say to the Government: "We shall meet your demands, but let us do it our way with the least damage to the proud traditions of the Royal Pharmaceutical Society."

The first stage in this process must be a resounding vote in favour of the motions that will be debated at the SGM.

Finally, we do not want a wild dash towards a new Royal

Charter and the seeking of charitable status that may inhibit future activities and could well be inimical to the interests of the Society in its historic role as the professional representative body of all pharmacists.

Robert Blyth
Douglas Simpson

Former Editors

The Pharmaceutical Journal

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The Society will become the DoH's poodle

From Mr G. S. Phillips,
MRPharmS

For me the most significant aspect of the Royal Pharmaceutical Society's annual general meeting was not the moving of the goalposts (apparently, the purpose of the AGM is not to approve the annual report or the accounts). Nor was it the fact that the President undertook merely to "note" the successful motion instructing Council to undertake a referendum of the membership before pursuing charitable status for the Society. (After all, this kind of Machiavellian manipulation has become *de rigueur* at Lambeth and should surprise no one.)

Most significant was the discussion on the proposed new Royal Charter. One of the current charter objects is "to maintain the honour and safeguard and promote the interests of the members in their exercise of the profession of pharmacy".

When asked why there was no such provision in the proposed new Charter, the Society's legal expert Robert Bulling said that only high level objectives should be reflected in the charter "objects". So there we have it. The Society claims for itself the joint roles (and all the finance that goes with it) of regulation and professional representation. Various members of Council repeat weekly their claims that both roles will be strengthened, and the Society's independent legal expert lets the cat out of the bag. Representation of the profession's interests is no longer a key objective. The so-called "dual role" will migrate, by stealth, to a single statutory role leaving our professional body as little more than a poodle of the Department of Health.

Graham Phillips
St Albans, Hertfordshire

Must Council members be on the "active" register?

Ms A. Farrelly, MRPharmS

Will it be a requirement that all pharmacist members of the Royal Pharmaceutical Society's Council be on the "active" register?

Ann Farrelly
Wallington,
Surrey

We have been advised by the Society's education division that the answer to Ms Farrelly's question is "yes".—EDITOR.

There is better practice carried out in breweries

From Mr J. Sharp,
HonMRPharmS

The advantages of patient pack dispensing are too obvious to need restating. It should have been fully in place long ago, and, but for (on all sides) a considerable deal of stupidity and not a little intransigence, would have been. However, the three articles which you published last week (*PJ*, 17 May, pp683–687) all, directly or by implication, perpetuate a fallacy.

For example, Kailas Mahadevaiah and Trevor Jones, respectively, state that patient packs "allow patients to recognise their medicines more easily" and "clearly identify the name of the medicine, where and by whom it was made". This is just not so.

In current practice, the use of patient packs only serves further to confuse patients as to the nature and origins of their medicines, thus:

- The doctor prescribes using a generic name
- The pharmacist dispenses a patient pack, which in all probability has, printed on the manufacturer's pack, a different (and quite possibly not English) name for the medicine (indeed, if the dispensing pharmacy uses a variety of sources of parallel-imported products, the name on the pack could well differ with each repeat prescription)
- The pharmacist then sticks the (generic) dispensing label on the pack, usually over the manufacturer's name for the product, for all the world as if the object is to obscure it

This does nothing to clarify things for the patient; rather, the reverse. But it does not end there. On opening the carton, the patient is likely to find strips printed in a language other than English, over which yet another not entirely comprehensible label has been affixed — quite possibly with yet another name for the product, and giving a different manufacturer's name.

Good manufacturing and dispensing practice? They do it better in breweries.

John Sharp
Woodley,
Berkshire

Snipping is dangerous and should stop

From Mr C. Anton

You asked for pharmacists' views on patient packs (*PJ*, 17 May, p670), but here are my views as a patient.

I recently collected some doxycycline capsules from the pharmacy attached to my general practitioner's surgery. They came in a box and there was one complete strip of 25 capsules and a part strip of three capsules of a different brand. The part strip of three had no expiry date and the

box only contained the patient information leaflet for the strip of 25 and not the part strip of three. Such practice is profoundly dangerous, illegal and should stop.

Christopher Anton
Administrative Co-ordinator,
West Midlands Centre for Adverse
Drug Reactions

Packs should be labelled in English

From Mr R. M. Hall, MRPharmS

It was with interest that I read the article on patient packs, in particular the patient pack principles and the four key benefits (*PJ*, 17 May, p684).

Now that I have reached the stage in my life where I am a consumer rather than a dispenser of medicines, I find it interesting to be made aware of the problems of compliance. I can just about cope with patient packs with the days of the week printed in Spanish but my latest prescription has completely floored me — the days of the week were abbreviated in Greek.

I have pursued this problem, arising from the dispensing of parallel imports, with the Medicines Control Agency as was, to no avail because it is simply not interested. I would therefore suggest that the requirement that the packs be labelled in English be added to the patient pack principles.

This whole subject is a good example of how we can spend thousands of pounds on bureaucracy without managing to implement what is generally agreed to be a desirable policy.

Richard Hall
Market Drayton, Shropshire

Use interdental brushes

From Ms E. Tilling, MIHPE

I was delighted to see your article on general oral health care by Derrick Garwood (*PJ*, 3 May, p619). As a dental hygienist I want to comment on the presentation of dental floss as seemingly the only method of interdental cleaning. Flossing is difficult for even the most motivated and dextrous of patients. An effective and atraumatic flossing technique is the gold standard for interdental cleaning but most patients cannot achieve it.

Another method of interdental cleaning that is being taught routinely in dental schools is the use of interdental brushes, which are matched to the size of the interdental spaces. This method is not only easier than flossing it is also highly effective, probably because patients use them more often than floss. There will, of course, be some sites that interdental brushes cannot fit into and floss is the only option, but for

most sites interdental brushes offer an easy and effective way to clean. A range of interdental brushes can be obtained from dental wholesalers and a limited number of pharmaceutical wholesalers.

Elaine Tilling
Education and Project Manager
Molar Ltd

THE INDUSTRY

A disappointing, one-sided debate

From Mrs S. I. Leverett,
MRPharmS

Lack of access to affordable drugs in the so called developing countries is a complex issue. It is neither simply due to the greed of pharmaceutical companies (as the Channel 4 documentary "Dying for drugs" indicated), nor to the corrupt and indebted regimes of developing countries (as suggested in your leading article of 3 May, p602).

It is true that access to clean water, better housing, etc, are

fundamental to better health. However, it is also a fact that many people suffer through being denied access to affordable drugs.

I have recently returned from southern Africa where I worked in a large acute hospital as a volunteer pharmacist. Patients were given paracetamol for herpes infections because aciclovir was not available. Terminally ill patients requiring opioid analgesics received morphine liquid. Controlled release morphine tablets are not an option, unless you can afford private health care. When there was a supply problem with the morphine powder used to prepare the solution (for several months), patients in many districts went without. There were no alternatives. As for anti-retroviral drugs, these are not a treatment option. However, this is not to say that the drug companies do not assist occasionally.

Many developing countries do lack infrastructure within their health care systems (or else people such as myself would not be required there) and tasks such as monitoring compliance and adverse effects require trained staff to carry them out. So there is a need for managed entry of drugs into the health service.

Your leading article also mentioned bad debts and corruption. The latter is not a phenomenon peculiar to developing countries and the former is something which has been exacerbated by the policies of the World Bank.

The upshot is that pharmaceutical companies do have a significant role to play in the access to drugs and the sooner people face up to this, the better. It is disappointing that all too often, this debate is one-sided, with the blame apportioned to a single party.

Sharon Leverett
Norwich

Such ill-informed blanket criticism is resented

From Mr R. B. A. Johns,
MRPharmS

I did not see the Channel 4 programme referred to by Patricia Armstrong (*PJ*, 17 May, p680) but I have read your comments (*PJ*, 3 May, p602) which she says she found even more appalling than the programme's content. I intend no disparagement of the

editorial in saying that if that was a defence of the pharmaceutical industry, as she claims, then a vastly more vigorous one could have been mounted, and having spent a considerable time in the industry I would like to do so. However, may I say first that Mrs Armstrong exhibits a certain naivety in believing everything that the media put before us; surely most of us realise that bad news and provocative journalism make good copy, or in this instance, good television.

One may reasonably wonder whether Mrs Armstrong offers anything other than her own prejudices in support of her several generalisations, the most glaring of which is to group all pharmaceutical manufacturers under the implied heading, "rapacious and cynical exploiters of the sick". I assume she is aware that there are companies, the true "me-too-ers", which undertake no original research at all but simply await the expiry of patent on a successful drug before producing a cheaper version. The profits of such companies may be huge in relation to their turnover, but do "we all know" it? I certainly do not.

Then there are those whose research is confined to molecular manipulation in the hope of producing a more effective variant or one with fewer side effects than the original. Again, the scale of their profits can only be guessed at but is presumably reduced by their failures.

Finally there are the truly innovative companies with research budgets which can indeed be described as "huge" but which often result in the "breakthrough" which Mrs Armstrong derides. Would she prefer that such research, financed out of profits, should cease? The company with which I was associated for 24 years was responsible for a number of genuine advances in therapy and hygiene — primidone, chlorhexidine, halothane, propranolol and tamoxifen are a few, and the number continues to grow — and incidentally retained on its list at least one unprofitable product to meet a small continuing demand from developing countries. I was proud to be associated with that company and cannot do other than resent the ill-informed blanket criticism of Mrs Armstrong and others of like mind.

Richard Johns
Boston,
Lincolnshire

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