

SPECIAL GENERAL MEETING

Clear indictment of a lack of coherency

From Mr R. Norton, MRPharmS

In the past I have been guilty of a *laissez-faire* attitude when it has come to the internal affairs of the Royal Pharmaceutical Society. Having attended the special general meeting on 1 June, I now realise this was a serious mistake. I feel compelled to write to express my dismay about the leadership of our Society and the future direction in which it appears to be moving.

A large part of my previous indifference to the Society's workings has been based on a naive belief that the Council, elected by the Society's members, represents the views and interests of pharmacists. The SGM clearly confirmed how wrong I have been. In fact, the President's remarks showed that the Society leadership seems more concerned about keeping the Government on side than serving the interests of grassroots pharmacists. The membership appears to be paying its subscription fees to fund a quango.

The Council's apparent willingness to accept large-scale lay representation and the move to charitable status appear to have been recommended purely to pacify the Government and protect the Society's regulatory role. The passionate opposition to the Council's proposals at the SGM are a clear indictment of the lack of coherency between them and the membership as a whole.

Maybe it is time to start afresh. Clearly many of us have lost confidence in our Society's leadership. If we were in a public limited company, the shareholders would surely move to a vote of no confidence.

Richard Norton
Guildford, Surrey

I do hope the Society will listen

From Mr D. Sbarpe, FRPharmS

I attended the special general meeting of members of the Royal Pharmaceutical Society on 1 June at which the current Council proposals for a new Charter were put to the test. Speaker after speaker demolished the Society's arguments and the Council was overwhelmingly defeated on each vote.

I am not and never have been a member of the Young Pharmacists Group but it is the YPG that led the opposition to the Council's attempt to change the fundamental nature of our Society, and I admire them for all the work they have so successfully done to make members aware of the threat we all face.

Every pharmacist should be grateful to the YPG for campaigning to prevent the Council pursuing its policies. Hundreds of pharmacists were there: young and old, politically active and not, present and former members of the Society staff, industrial pharmacists, community pharmacists and pharmacists employed directly by the National Health Service. They were not

a vociferous minority of rabble-rousers; they were conciliatory, constructive, well-informed and articulate. They came with a legal adviser, a solicitor specialising in the field.

I hope the Society will, belatedly, listen and take heed. If so, future generations of pharmacists will owe the YPG a huge debt.

David Sbarpe
Past President of the Royal
Pharmaceutical Society
London NW11

NEW CHARTER

Proposed charter fails to recognise Scotland's needs

From Mr F. J. Owens,
MRPharmS, and Mr R. A. Shiels,
MRPharmS

It is an indication of the robustness of the Royal Pharmaceutical Society's 1953 Charter that it is only now, 50 years later, we are examining whether it continues to meet the needs of the profession. Much has changed in the intervening years. It is therefore right that Council now addresses this issue. Clearly, any new Charter should aspire to achieve a level of robustness similar to that of its predecessor and reflect the delicate balance required in providing for the Society's dual role as both a professional and regulatory body.

The re-establishment of the Scottish Parliament on 1 July 1999 fundamentally changed the political and administrative face of Scotland. The National Health Service across the United Kingdom is currently undergoing rapid change. It is likely that each of the four health administrations will develop in different ways. In particular, through the Scottish Parliament, there is a clear desire to adopt Scottish solutions to Scottish problems.

The Society's Scottish Department is currently established by way of Article 16 of the 1953 Charter, and the Scottish Executive, its democratically elected body, by existing Byelaw. Article 6(4) of the proposed Charter falls short of that required to meet the needs of the profession in Scotland, where responsibilities for health, community care and social justice are all devolved to the Scottish Parliament. It is essential that the Society continues to recognise a

separate need for a suitable Scottish structure within any new Charter.

Although similarities exist across the various UK pharmacy plans, there are significant differences in both emphasis and priority. In meeting the health care needs of the Scottish population, it will be essential that Parliament and the Scottish Executive Health Department are able to draw on local expertise and benefit from proactive advice. We believe that effective responsibility must be delegated to the Scottish Department's governing body, the Scottish Executive. Failure to do so will not serve the needs of the Society's members in Scotland and will result in missed opportunities for pharmacy.

Article 3 of the draft Charter allows the Council to dispose of property whatsoever or whosoever situated, with Article 6(2) permitting that any such actions which require a special general meeting are set out in regulation. We consider that any sales or purchases in Scotland as proposed by the Council should only be made with the approval of the Scottish Executive of the Scottish Department.

We believe the current draft Charter fails to recognise fully the needs of the profession in Scotland. It will be important that Scottish concerns are acknowledged in any revisions, and that we be provided further opportunity to comment on those revisions as and when they are made.

Frank Owens
Falkirk, Stirlingshire

Ron Shiels
Culloden, Inverness-shire

Let us hear it for the pharmacist!

From Mr P. Jenkins, FRPharmS

Most of us are unfamiliar with the rules of construction of Royal Charters. As the *PJ* has said, "a charter is an enabling document and the objects and powers contained within it should be as broad and high level as possible", so those with access to specialised advice are in a position to argue that detailed suggestions for inclusion are out of place and should be reworded or even dropped.

However there are two subjects that I feel strongly enough

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about to stick my neck out and say should be spelt out as obviously as possible in any final document. One is the status of the Welsh Executive and the other is the protection of pharmacists.

The first is covered by article 16 in the existing charter, revised as article 6(4) in the draft new version (*PJ*, 22 March, pull-out section). But why not be specific in the cases of the Scottish Department and the Welsh Executive in the new version? These are important bodies working with and to rules that are different from those that apply in Westminster. By all means leave the door open for the setting up of new "departments on a geographical basis" but if it was acceptable to name Scotland in the existing Charter then it must be acceptable to name both in the new version. A precedent has been set so why break it?

My second, not so parochial, concern relates to the replacement of article 4 of the existing charter, which says the Society must "promote the interests of members in their exercise of the profession of pharmacy", by article 3(1) in the new version. Although we do regularly consid-

er the "public benefit" as pharmacists, a strong profession backed by a strong headquarters is also important for the public's long term good. So let us hear it for the pharmacist. If this was acceptable as an object before, what has changed to make it superfluous now? At this time we need the stated, perhaps even blatant, support of all our organisations.

We support our Society. Let us see it support us.

Peter Jenkins
Cardiff

CD PRESCRIBING

An opportunity to reduce hassle

From Dr C. F. Green, MRPharmS

I note with interest that the legalities of Controlled Drugs prescription requirements are under review, albeit with a specific agenda (*PJ*, 31 May, p739). However, I have every confidence that the Council of the Royal Pharmaceutical Society has already spotted this opportu-

nity to add to the review, and discussed how it could benefit pharmacists.

From a hospital pharmacy perspective (and I am sure that community pharmacists have similar problems) there are two key areas where the Council should push for change. The first is that hospital pharmacists should be able to write discharge prescriptions for CDs; it is ridiculous that they cannot. Secondly, where doctors fail to understand the nuances of dosage form design and prescribe, for example, MST 50mg tablets (rather than writing out the correct number of 10mg and 30mg tablets), instead of harassing the doctor to change it and waste his time and ours, pharmacists should be able to supply the appropriate strength of tablets under their own authority. I would also like to see the abolition of writing requirements for hospital discharge prescriptions since, provided pharmacists have the inpatient prescription, it is possible for them to verify the authenticity of CD prescriptions on the spot. However, this is probably a little politically sensitive, so I will

happily settle for the first two for now.

I am not suggesting a free-for-all with CDs, but with appropriate documentation or legal guidance, these long-standing and irritating problems could be eradicated without any loss of benefit to patients and at the same time, relieve pharmacists and doctors of unnecessary hassle.

Chris Green
Assistant Director of Pharmacy,
Royal Liverpool and Broadgreen
University Hospital

ASTHMA

Life and death

From Dr D. Cairns, MRPharmS

Your headline (*PJ*, 31 May, p742) states: "First year of life critical in asthma." It might be worth pointing out that the last year of life can be pretty critical too.

Donald Cairns
Pharmacy School,
University of Sunderland

Advertisement

CFC-FREE INHALERS

Remind patients to wash their MDI devices

From Ms E. Gilchrist and others

We write to raise awareness of a problem with chlorofluorocarbon-free salbutamol metered dose inhaler devices which, although recognised by manufacturers, is poorly communicated to patients.

Manufacturers of CFC-free MDIs recommend regular washing of the devices to ensure continued reliable performance, and this information is conveyed in the patient information leaflets supplied with these products.

Anecdotal evidence from patients presenting at respiratory outpatient clinics and from inpatients at the Chelsea and Westminster hospital, suggests that CFC-free salbutamol MDI devices frequently "seize up" or "become blocked", despite an adequate reservoir of drug in the pressurised canister. These observations indicated a potential problem with the performance and reliability of the devices, prompting further inquiry. A subsequent telephone call to the then Medical Devices Agency elicited an acknowledgement of the problem but no immediate plans for further investigation or action.

Results from a preliminary questionnaire-based audit of Chelsea and Westminster patients suggest that up to 80 per cent of patients using CFC-free salbutamol MDIs may experience problems with their device malfunctioning. The findings appear to be independent of the brand of inhaler. In our experience, these data reflect poor adherence to manufacturers' instructions regarding regular device washing. This seems to be due to a combination of lack of awareness of the advice regarding regular washing of MDI devices, with patients often neglecting to read the PIL, and a failure to appreciate the importance of this advice, given the potentially serious consequences of device malfunction during an exacerbation of airways disease. The majority of patients questioned, favoured direct counselling from a health care professional as the most effective way to deliver this message regarding the importance of regular washing of the MDI devices.

Further studies are under way to evaluate the extent of the problem and this may result in a call for boxed warnings on the outer packaging of these devices. We would strongly encourage all practising pharmacists to take a moment to counsel patients using CFC-free salbutamol MDIs to reinforce the information in the PIL for these devices, clearly demonstrating how to wash the device and how often.

Emma Gilchrist
Preregistration Trainee

Kieran Hand
Clinical Pharmacist

Katey Wilkins
Preregistration Trainee
Co-ordinator
Chelsea and Westminster Hospital
London SW10

Inhalers containing CFCs are to be withdrawn from the end of June (see p783).—EDITOR.

REMUNERATION

Pharmacists are so timid

From Mr M. Samson, MRPharmS

To anybody who cares to peruse the appointments pages of any national newspaper, it would be clear that a salary of £50,000 per annum is commonplace among the professional classes. Solicitors, accountants, dentists, doctors and so many others whose qualifications are in the same category as those of pharmacists enjoy an income commensurate with their qualifications. They are not embarrassed by their incomes and neither should any professional be who has studied so hard to qualify. It therefore seems strange to me that only pharmacists are content to accept far less than their due, encouraged, of course, by multinational companies whose directors are answerable to nobody when it comes to salary and share options. They pay themselves what they like and ignore their shareholders. To earn £1,000 a week saving lives is, of course, hardly comparable to the £10,000 a week an international footballer earns, but it is in fact an average pay packet for our peers. This translates as £25 an hour assuming a 40-hour week. Why therefore do so many locums accept £17 to £18.50 an

hour? Are they so browbeaten and timid, that they are not worth their salt? Employers need them even more than they need employers. They are essential to their viability.

Michael Samson
Worthing,
West Sussex

BRANDING

There should be one brand name for one drug

From Mr R. A. Lowe, MRPharmS

I refer to the advertisement on the back of *The Pharmaceutical Journal* of 17 May for the latest over-the-counter medicines from Pfizer Consumer Healthcare. It appears that the Benadryl brand name is the most important piece of information on the packaging. If one looks closely, one can see that Benadryl Allergy Relief capsules contain acrivastine, whereas Benadryl Allergy oral solution contains cetirizine.

Surely one brand name should be associated with the approved name of only one particular drug?

Robert Lowe
Wymondham, Norfolk

PHARMACY CLOSURES

Has action against closures been taken?

From Mr M. E. Q. James,
FRPharmS

There has been much discussion recently, both in your columns and elsewhere, of the increasing practice of pharmacies shutting at short notice, particularly on Saturdays. Non-availability of locums is usually cited as the reason.

Naturally this inconveniences patients, especially those who are expecting to be able to collect prescriptions, and consequently neighbouring pharmacists who then have to try and sort things out. I had occasion a few months ago to advise a pharmacist that he should provide evidence of failure of an agency to provide an agreed locum in order to prevent a "breach of terms of service" hearing.

I have now been made aware of a case where a primary care trust has warned a contractor that, should they persist in this practice (and they have a branch where apparently this is a regular occurrence), and the PCT can obtain evidence of locums being available, then the PCT would consider bringing a service committee case.

I would be interested to know if this action is being considered elsewhere, or indeed, if such action has already been taken.

Miall James
Colchester,
Essex

YELLOW CARDS

If in doubt, fill one out!

From Mr J. M. Fallon,
MRPharmS

Following the recent transmission of Channel 4's "Dying for drugs" and BBC1's *Panorama* "Seroxat: e-mails from the edge", I am writing to express my concern over the lack of effective pharmacovigilance and post-marketing surveillance that, as pharmacists, we are in a prime position to undertake and promote to the general public.

Pharmacists are entitled to report adverse drug reactions (ADRs) using the yellow card system. Unfortunately, I do not believe this has materialised into common enough practice such that the general public readily identifies it as an activity we can undertake for them independently and impartially. What does it matter?

Well, declaration was made on the BBC documentary that the system was "considered to be desperately inadequate" and criticism was made that the Medicines and Healthcare products Regulatory Agency does not take such reports directly from the public. The rational conclusion is that we would be leapfrogged from offering a potentially rewarding service if such reports were accepted. Time definitely is not in our favour. Can we justifiably wait for major shifts in how we practise to occur until we routinely undertake such activity? In the face of pressure groups that may follow the lead of *Panorama* and lobby the authority with its own reporting system, I doubt it.

In fact, NHS Direct has now come on board offering this service too (*PJ*, 3 May, p608).

Pragmatically, reimbursement for service provision is an issue. Ethically, we are duty bound to act in the best interest of the patient and the public at large, such that we should already be actively promoting awareness and readily reporting potential ADRs. If we delay much longer for monetary reasons and we are leapfrogged, at least we cannot argue that we were blind to such an outcome. For those of us willing to act positively following recent adverse publicity, let us follow a conclusion reached in the documentary: "If in doubt about an ADR, fill a yellow card out".

John Fallon
Brighton

PATIENT PACKS

I am ashamed for the profession of pharmacy

From Ms D. S. Fine, MRPharmS

As a "non-practising" pharmacist who is on long-term thyroxine medication, I have my prescriptions dispensed at a local pharmacy.

I am ashamed for the profession when I receive snapped packs of tablets. Sometimes the pack has sharp edges; sometimes there are two tablets at the bottom of the box. When the pack has been "snipped", it looks as though the pharmacist is acting totally unprofessionally. Patients who are not pharmacists may make all sorts of assumptions — that the pharmacist is financially as well as literally cutting corners, that inferior medicines are being dispensed, or that someone else's used drugs are being recycled.

I can think of no other modern, professional transaction in which a product would change hands in such a furtive, shameful fashion. Each time I receive my tablets in this state, I am forcefully reminded of the expression, "Would you buy a used car from this man?"

I am only pleased that I am the recipient and not the perpetrator of this unacceptable practice.

Doreen Fine
Pinner,
Middlesex

Putting money before patients

From Ms J. M. Evans, MRPharmS

I recently took part in an experiment where I was asked to take a white blank tablet without knowing what it was. I, of course, would not. This is how patients must feel, even when they are given patient packs. If they are presented with lots of cut up strips this will further compound their concern. Recent media attention has made patients wary of the medical profession. As a group, health professionals should be trying to regain their trust. Patients will not trust pharmacists who give them a variety of colours and shapes of tablets in one box and claim they are the same. Cost is not a reason to jeopardise patients' health. Unfortunately, however, pharmacists do have to think of cost. If the Department of Health were to make patient pack dispensing compulsory, pharmacists would not need to put money before the patient.

Janice Evans
London W2

PENICILLIN

The results of a rogue infection

From Mr K. A. Lees, FRPharmS

For the sake of accuracy, I write to say that penicillin was not discovered at Oxford (*PJ*, 17 May, p703) but by Fleming at St Mary's Hospital in London. He used a small Petri dish, about four inches in diameter, and *Penicillium notatum* turned up as a rogue infection on his plate on which, I believe, he was researching lysosyme. The development work was carried out at Oxford and this formed the basis of the industrial production of penicillin by four commercial operators, of which Glaxo was the ultimate survivor. This undoubtedly formed the foundation for the development of the pharmaceutical giant we know today. A significant step in the whole procedure was made by Merck, I believe, who discovered the beneficial effect of the use of corn steep liquor in the growth medium for the *Penicillium* species.

K. A. Lees
Bath

THE SOCIETY

Council members and CPD

From Mr. K. M. Youings, MRPharmS

The response from the education division to the question of whether Council members must be on the active register (*PJ*, 24 May, p719) suggests that the changes envisaged at the Royal Pharmaceutical Society go much further than has been published to date, and is increasingly disturbing. Does it follow that those on the inactive register, who will lose representation rights, also lose their voting rights? It seems improbable that a group of members could have voting rights and yet be restricted as to whom they could vote for, especially as none of the candidates for election to Council need have the slightest interest in anything other than "active" members.

Already we know that the register is to be split. How long will it be before the Society only represents community practice and some hospital pharmacists? Perhaps this is what is behind the need to have a new Charter. Under the present one, the Society has to work for the benefit of all pharmacists, including industrial, academic, agricultural and veterinary etc. These are seen as branches of the profession, with their own special interest groups.

It is surely time for the full truth to be told. So please, Council, put your cards on the table and tell the membership the whole truth instead of the modern "tell a bit, leak a bit, deny a bit" approach. If there is a future for the "inactive pharmacist" as a member of the Society, what is it? There is no CPD that counts for us other than the weekly articles in the *PJ* (and, since that may not fit into our individual CPD plans, even that probably does not count) or other private study. The *PJ* is available online. So apart from wanting our money, why would the Society wish to retain members on an "inactive" register?

K. M. Youings
Romford, Essex

Dr ROBERT DEWDNEY, head of education, Royal Pharmaceutical Society, replies: Any pharmacist member of Council will, by their work in Council and committee meetings, be active in

the broad practice and science of pharmacy and thereby subject to the envisaged CPD-submission requirement. He or she would not be able to sustain a statement that he is not so active, in order to move to the non-practising part of the Register.

On the final point in the letter, "Why have an inactive register?", the Council has sought to preserve a way for long-time members of the Society to remain so if they wish, even though they may have retired from all paid or voluntary work in or related to pharmacy. Putting these pieces together, a pharmacist on the non-practising register could stand for Council and receive votes from pharmacists on the non-practising register as well as from pharmacists on the practising register but if he were elected to Council, given the nature of the work involved, he would have to, with some alacrity, move to the practising register and become subject to the CPD requirement.

By his general tenor, Mr Youings appears to be under a misapprehension that someone at the Society has made a policy distinction between patient care (community and hospital) and other forms of pharmacy practice and science. In fact, as has been clearly and repeatedly stated in the *PJ*, the Council has consciously eschewed such a distinction.

It is worth pointing out that all the Council's proposals on CPD enjoyed strong support within the recent consultation with the membership (*PJ*, 29 March, p456).

Finally, readers might be interested to note that Council members were among the first to whom CPD was rolled out in October last year and that they will be among the first to submit records when CPD becomes mandatory.

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