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CPD

Proposals strike at the Society's foundation

From Dr R. C. Moreton, MRPharmS

The Royal Pharmaceutical Society's continuing professional development proposals strike at the very foundation of our Society and its institutions. Besides losing members, as I believe we will, we could see the demise of the British Pharmaceutical Conference and the demise of the academic pharmacist. I would even venture to suggest that it may cause problems for those members who work for the Society at Lambeth.

The BPC appears to be disproportionately supported by attendees from the industrial sector and academia through the relationship with the Academy of Pharmaceutical Sciences. If industrial pharmacists leave the Society in numbers, will there be pressure on the academy to sever the link with the conference? Without the support of the academy, how viable is the conference?

If the Society is going to be a two-tiered membership, with community and hospital pharmacists making the active members and then the rest becoming second class citizens, as it were, what is the point of industrial pharmacists like myself remaining members? Some will try to meet the requirements, but many of us living overseas will find it difficult. Will academic pharmacists suffer the same fate? What does this mean for the future of pharmacy training, especially with the new schools that are to open? Where will we find the pharmacists for the courses that are mandated to be given or supervised by pharmacists? I do not think that community and hospital pharmacists working on a part-time basis is a long-term solution.

And then we have the pharmacists working at Society headquarters. Will they be able to meet the requirements for membership of the register of active members? Our Secretary and Registrar was for many years a hospital pharmacist, but not now. The Society can always engineer the rules to accommodate certain groups, but too many accommodations may lead to legal action by other groups to try to obtain the same kinds of accommodation.

There is an old saying that a camel is a horse designed by a committee. Sadly, I believe the new proposals inspire neither myself, nor many of my colleagues. I think we need to throw out these divisive proposals and start again. Being a pharmacist is both about our academic training and about an attitude of mind that the patient comes first and that we are there to provide a service for patients. I am a pharmacist who works in industry. I believe I serve the patient just as much as the next pharmacist. I know that I engage in CPD almost daily; I would not have survived in industry without continuing to learn and develop myself professionally. If, as I believe under the proposals, we will see the end of the industrial pharmacist as a member of our Society, then I think the Society and the membership will be the long-term losers. United we stand; divided we fall.

Chris Moreton
Waltham, Massachusetts, United States

Dr ROBERT DEWDNEY, head of education, Royal Pharmaceutical Society, replies: Perhaps Dr Moreton has not read the original proposals paper (*PJ*, 8 February) or the outcome of the consultation with the membership (*PJ*, 29 March, pp456–7) or the report of Council and the accompanying frequently asked questions (*PJ*, 17 May, pp699–703). Pharmacist academics and pharmacists in the industry will be regarded just as much practising pharmacists as anyone else on the practising part of the future register.

I would repeat my words in response to K. M. Youings letter of last week (*PJ*, 7 June, p793): Dr Moreton "is 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."

MODERNISATION

Where is that bogeyman?

From Mr H. R. Patel, FRPharmS

I write both as a member of the Royal Pharmaceutical Society's Council and its Modernisation Steering Group who is keen to secure support from members of the Society on a fundamentally important issue that was omitted from the paper on the subject previously circulated by the Society. I support the view that the Society's Charter should retain, without qualification, the object "to maintain the honour and safeguard and promote the interests of the members in their exercise of the profession of pharmacy" and that this object is restricted to pharmacist members.

The members' support should be expressed at the roadshows in a clear and forceful way so that the vote is clear and unequivocal. We must remember that what is being challenged is the concept of an organisation for pharmacists, run by pharmacists.

I have no problem with having three Privy Council nominees, but I share the concerns of the past presidents (*PJ*, 6 July 2002, p15 and 15 February 2003, p231), about a diluted Council with a remit that takes away the main reason for the formation of the Society over 160 years ago.

Winning the argument may be tough but it is not the "David and Goliath battle" that it has been made out to be. There are implied suggestions that the bogeyman will get us if we do not conform. I hear the membership saying: "Where is that bogeyman? Let us see him."

The least the members can bear in mind when discussing the issue at the roadshows is that the vote in support of retaining the object at the special general meeting was unanimous.

Please vote to retain the current Charter object without qualification and to restrict the object to pharmacist members only.

Hemant Patel
Brentwood, Essex

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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.

Pharmaceutical Society in New Zealand "reborn"

From Mr A. J. Leigh, MRPharmS

Having viewed from a distance the Council's approach to being both a regulator and an advocate in one, I consider it flawed. The Royal Pharmaceutical Society should be there to support good pharmacy practice and to be an advocate of all pharmacists. To regulate, as well as do this, means that it either neglects the members of the Society or appears to those outside the Society to be favouring the members.

A far better approach would be to spin off the membership part with its publishing arm and leave regulation to a subset of the Society with non-pharmacist involvement and prerequisite "paper walls" between it and the membership part.

In the near future the New Zealand Pharmaceutical Society is to do just this. There will be an external element to regulate the profession and the PSNZ will be "reborn" as a membership based society with no regulatory function. This will make for a stronger society rather than a weaker one.

Andrew Leigh
Auckland, New Zealand

SGM

An illusion of progress

From Mr D. R. Thomas, MRPharmS

I attended the special general meeting of the Royal Pharmaceutical Society on 1 June and found the debate and discussions interesting, in particular the concern by some members regarding outside interference in the status quo of our Society and the consequences arising. I attach therefore the following quotation usually entitled "They also had their problems":

"We trained hard, but it seemed that every time we were beginning to form up into teams we would be reorganised. I was to learn later in life that we tend to meet any new situation by reorganising and a wonderful method it can be for creating an illusion of progress, while producing confusion, inefficiency and demoralisation." Petronius Arbiter 210 BC.

David Thomas
Feltham, Middlesex

TITLES

Title "doctor" would confuse public

From Dr M. E. King, MRPharmS

As a "proper" doctor with a PhD, I disagree with Roger Dawson's solution for differentiating between practising and non-practising pharmacists (*PJ*, 31 May, p749). Having spent four years at university in order to complete my thesis, I would be most upset if the Royal Pharmaceutical Society started handing out this title on payment of a full-time fee. I believe that it would lead to more confusion from the public's perspective since medical practitioners already have the title, mostly as a courtesy. I cannot begin to count the number of times I have been asked which medical school I attended.

Martin King
Cardiff

Let us be proud of our profession

From Mr C. J. Little, MRPharmS

I would like to comment on the recent letters (*PJ*, 10 May, p648 and 31 May, p749) claiming that pharmacists should be given the title "Doctor". Many pharmacists working in community and hospital practice possess PhDs and I am sure that they are not so insecure as to feel the need to impress with a title that would serve only to confuse patients — so why should any of us?

If you want to be called doctor in the health service then perhaps it is time to go and graduate from medical school and accept the responsibility and pressure that accompanies the title. Let us be proud of our profession and avoid being distracted by the transparent spin that "doctor", an embarrassingly unearned and ultimately purely self-gratifying title, provides.

Christopher Little
Southport, Merseyside

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THE REGISTER

Will certificates be recalled?

From Mr M. Crane, MRPharmS

In *The Journal* of 17 May (p702), we were told that the "Annual Register of Pharmaceutical Chemists" is to be known as the "Annual Register of Pharmacists". No reasons were given for the change and it could be presumed that with the removal of chemistry from the object clauses in the draft Royal Charter the term "pharmaceutical chemist" could be an embarrassment.

Although the registration certificate, at present, uses the term "pharmaceutical chemist", the holder's name would appear in a Register of Pharmacists, which seems to be inconsistent.

Is the Royal Pharmaceutical Society intending to recall the registration certificates of all the members and issue amended certificates?

The President assured members that this was not removing the restricted title of "pharmaceutical chemist". The title will continue — but will it be used by the Society?

Malcolm Crane
Rye, East Sussex

ANN LEWIS, Secretary and Registrar, Royal Pharmaceutical Society, states: The change in Register title reflects the description which is now most frequently in use and most likely to be helpful to members of the public wishing to look for the Register. There is no suggestion that the title "pharmaceutical chemist" should be removed from the list of protected titles and there would be no need to reissue certificates carrying this title.

PATIENT PACKS

Additional measures will minimise wastage

From Mrs P. L. Sneddon, MRPharmS

From my 14 years' experience in hospital pharmacy I can only endorse the view that patient pack dispensing has to be the safest option for the future. I am disappointed that the scissors are still snipping and that change can be so slow. Cutting foil strips can result in loss of vital printed information. Sharp corners of foil can cut the fingers of pharmacy staff and patients, and cause difficulties in handling uneven portions of foil pack.

Patient pack dispensing should only operate alongside the following measures to minimise wastage:

- Seamless patient care (eg, community to hospital to community)
- Regular repeat prescription review (at least annually)
- Annual compliance check for all patients taking more than three medicines (compliance has been shown to decrease dramatically for four or more items)

Penny Sneddon
Northwich, Cheshire

GOOD CLINICAL PRACTICE

New legislation

From Mr J. J. Gilroy, MRPharmS

Dr Robin Harman is to be commended for his detailed review, "The concept and implementation of good clinical practice in trials" (*PJ*, 10 May, p653). It is unfortunate that there is no mention of the European Union directive on clinical trials (2001/20/EC), part of which refers to good clinical practice (GCP). Also there is no mention of the consequent draft Statutory Instrument (SI) which transposes the provisions of the directive into United Kingdom legislation which takes effect from 1 May 2004. The period for consultation of the draft SI closed on 16 May. In addition, of note in this draft is the fact that a National Health Service trust is to be regarded as a sponsor and that there is to be a new UK Ethics Committee Authority responsible for the establishment and monitoring of ethics committees. This authority is in addition to the existing Central Office for Research Ethics Committees.

Dr Harman also refers to manufacturing and packaging of the investigated product but does not refer to labelling. This is an issue with which pharmacy clinical trial personnel not infrequently experience difficulty because there is no requirement of the regulatory authority to approve the label as it would for marketed products. Annex 13 to the Guide to Good Manufacturing Practice states what should appear on the label but not its clarity. None the less, Dr Harman's article is a useful review of the subject of GCP.

J. J. Gilroy
Chairman,
Pharmacy Subcommittee,
Institute of Clinical Research

MOUTH ULCERS

Sodium lauryl sulphate may be a culprit

From Mr R. W. Selfe, MRPharmS

I refer to your recent article on oral hygiene (*PJ*, 3 May, p619). Although I appreciate that this was primarily concerned with dental care, there was some correspondence from readers about mouth ulcers in Dr James le Fanu's medical column in *The Daily Telegraph* some time ago which might be of interest to others who like myself have been plagued with these in the past. It was suggested that choosing a toothpaste which did not contain sodium lauryl sulphate could considerably reduce the incidence of this condition. Having followed this advice for at least two years now, I can say that it works for me. The few that still occur are usually short-lived and respond well to application of proprietary gels.

Most toothpastes contain sodium lauryl sulphate, but some do not and these are the ones I now use. They are well worth a try to avoid a condition which can make eating a misery, even though I cannot suggest an explanation.

Reg Selfe
Benfleet, Essex

PREGNANCY

New screening test available

From Mrs H. N. James, MRPharmS

Following your recent series of continuing professional development articles on pregnancy, I would like to bring your attention to a new screening test that was not mentioned.

Group B streptococcus (GBS) is a common bacterium carried naturally by one third of the adult population. To adults it rarely causes a problem but to a newborn baby the effects can be fatal. It is the most common cause of bacterial infection in newborn babies in the United Kingdom. Around 700 babies each year become infected, although recent research[1] suggests the true incidence may be three times higher than this. Of the 700, approximately 100 die and 40 are left with long-term effects.

In the UK, GBS is not currently routinely screened for (the NHS test available is not accurate) and there is no national plan for dealing with GBS-carrying women. There are excellent evidence-based guidelines for dealing with known carriers and those deemed to be at risk during labour. Intravenous antibiotics given during labour can significantly reduce the risk to the newborn baby.

In May 2003, a laboratory in the UK (www.omnilabs.co.uk) became the first to offer the much more accurate gold standard screening test that is routinely used in the United States, Canada and Australia. The test is only available privately and costs £18.

A national charity, Group B Strep Support (www.gbss.org.uk), and its members are campaigning to raise awareness of GBS and the new screening test and have had national television and press exposure over recent weeks. In addition, the MP for Whitney, David Cameron, has recently tabled an Early Day Motion in Parliament, which at least 97 MPs are supporting. With this increased publicity, I hope the general public will start asking more questions about GBS and it may be pharmacists that they turn to.

Helen James
Sheffield

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1. Luck S, Torny M, d'Agapeyeff K, Pitt A, Heath P, Breathnach A et al. Estimated early onset group B streptococcal neonatal disease. Lancet 2003;361:1953–4.

STATIN THERAPY

Some groups of patients that could benefit are neglected

From Mr P. D. Burrill, MRPharmS

In their interesting article on cholesterol management (*PJ*, 17 May, p688), Helen Williams and Mel Stevens seem to be neglecting some groups of patients who could benefit from statin therapy. I am concerned that readers may misinterpret this.

The authors recommend statin therapy is targeted at patients with established coronary heart disease (secondary prevention) and primary prevention in those with a 30 per cent or greater 10-year risk. They also mention that statin use is supported in people with diabetes and reference the Heart Protection study (HPS).[1]

HPS is the largest randomised trial of CHD prevention to date and should profoundly influence how statins are prescribed. Two key groups in the HPS study (as well as CHD patients and people with diabetes) were patients with established peripheral vascular disease (PVD) and patients with cerebrosvascular disease (CVD), both without CHD.

The patients with PVD were at the same five-year risk of a vascular event (30.5 per cent) as patients with a prior myocardial infarction (29.4 per cent). Most importantly, these three groups of patients, established CHD, PVD or CVD, all achieved similar benefit from simvastatin 40mg daily in terms of the number needed to treat (NNT) to prevent a vascular event over five years (range 17 to 20). People with diabetes aged over 40 but with no CHD also benefited to a remarkably similar degree (NNT of 21) and should now arguably be regarded as secondary prevention.

It is important that patients with established CHD, PVD or CVD, and people with diabetes aged over 40 are targeted for therapy with simvastatin 40mg daily with equal vigour. Ensuring that these groups receive this treatment will lead to substantial clinical and public health benefits.

Peter Burrill
Specialist in Pharmaceutical Public Health
North Derbyshire Public Health Network

REFERENCE

1. MRC/BHF heart protection study of cholesterol lowering with simvastatin is 20, 536 high-risk individuals: a randomised placebo — controlled trial. Lancet 2002; 360:7–22.

THE SOCIETY

Own goal on accounts

From Mr A. K. Mehta, MRPharmS

Your leader of 24 May (p708) is quite right to describe as an own goal the decision by the President and the Secretary and Registrar not to allow members a vote on the Royal Pharmaceutical Society's accounts at the recent annual general meeting.

It is all the more an own goal because, amid the concerns raised by members about the accounts at the AGM in 2002, I was asked during the meeting if I would assist the Council in improving the quality of the accounts. I replied that I would be happy to do so if there was a real intent on the part of the Officers of the Society to improve the accounts. Immediately after the meeting I was approached by the finance director of the Society with the same request.

I assume the fact that I have not been contacted subsequently means that the intent was not really there after all. The Officers of the Society could have chosen to improve the accuracy, clarity and disclosure of the accounts; there are still many matters in the accounts which, in my opinion, warrant greater disclosure to members. Instead they have chosen to issue accounts that do not allow members a full understanding of the Society's activities and existing risks, and as you rightly point out they have compounded this error by not allowing members to vote.

In the midst of a debate about modernising the Society and improving its governance, this was a peculiar and untimely decision.

Ash Mehta
Richmond,
Surrey

HUGH MITCHELL, director of finance and resources, Royal Pharmaceutical Society, comments: Mr Mehta was present at the 2002 annual general meeting and raised a number of questions on the 2001 financial statements, which were, I believe, comprehensively answered in my article in *The Pharmaceutical Journal* of 25 May 2002 (p745) entitled "Is the devil really in the detail?"

During the 2002 AGM, Mr Mehta made a critical assertion that an important disclosure had not been made which was, in fact, an erroneous statement on his behalf. Since the financial reporting standard he referred to, FRS13, was not available on the night, his statement could not be challenged and this led to significant confusion and misled the meeting.

The Society's financial statements are well presented and the quality of explanatory information has been significantly improved during the past two years, particularly within the "Annual review". The financial results are also published on the website in good time to allow constructive questions at the AGM.

The Honorary Auditors have complimented the finance team on the quality and transparency of the information supplied to them and also that contained in the financial statements and the "Annual review".

The Society has, as well as the Honorary Auditors, significant governance in place to ensure that members' interests are well served in the areas of accuracy, clarity and disclosure. It has made a significant investment in the areas of financial audit, has an active resource management committee and active audit committee overseeing financial and operational control procedures. This investment should give full comfort to the membership that all financial matters are well controlled and that risks are recognised and managed.

The 2002 financial results enabled a significant strengthening of the balance sheet and this was recognised by the members who attended the AGM on 14 May 2003.

In 2002, I agreed that any suggestions for improvements to the information presented would be considered. No suggestions were received, except from the Honorary Auditors.

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