

LETTERS

MODERNISATION

Council should act upon the views of the members

From Mr G. A. Miller,
MRPharmS

I read with immense interest the report of the special general meeting held in London on 1 June (*PJ*, 7 June, pp802–807).

During the proposing speech for the motion “this meeting instructs the Council to arrange for a referendum of the entire membership to be held to establish the level of support for any proposed new Charter once the details of any such proposal(s) have been finalised,” an important point was made that was not included in the *PJ* report.

Historically, the Council has set a precedent in changing policy based on the outcome of an SGM. The last time a majority of those members attending an SGM voted against Council policy was in 1989. Following this SGM, the Council of the time reversed policy that had previously been set, acting upon the views of the membership.

I hope that the current Council will follow this precedent, and act upon the views of the membership, which were clearly expressed at the first SGM of 2003.

Gavin Miller
London W6

Look to others to determine best way to proceed

From Mr A. P. Griffin,
MRPharmS

As a pharmacist registered in both the United Kingdom and Australia, I wonder if the Royal Pharmaceutical Society has looked for inspiration as to its future composition and function in other countries that have similar systems of regulation and representation of the profession.

In the various states of Australia, regulation of the profession is usually handled by a government board comprising pharmacists, representatives of the major professional bodies, as well as industry, legal, government and consumer representatives. This

board also deals with disciplinary matters, and usually has the stated aim of ensuring that the public interest is served by maintaining an extremely high standard of professional practice.

On a separate matter, representation of the profession is advanced by several bodies, representing either specific groups (ie, hospital pharmacists, pharmacy owners, etc), or the whole profession. This representation includes everything from publishing professional journals and continuing professional education to lobbying government and negotiating contracts.

Since these two functions are separated, members of a particular body may voice their disapproval with how their professional body represents them (or not, as the case may be), by declining to renew their membership, while remaining able to practise pharmacy. This results in each body (by and large) doing what its members want. One wonders how many pharmacists in the UK would financially support the Society if it were not necessary to do so to go to work each day. Is this one reason why control of our professional body may be wrested from us by non-pharmacists?

I would be interested (as may some fellow members) to learn of how the profession of pharmacy is regulated and represented in other countries with similar health-care systems. Perhaps by examining the way others handle these two very different and often contrary roles may we determine the best way to proceed.

Andrew Griffin
Bristol

TECHNICIANS

Dual registration as pharmacist and technician

From Ms J. L. Flint,
MRPharmS

Your report of the June Council meeting (*PJ*, 14 June, p839–41) included some of the policy decisions that the Council has made regarding eligibility for dual registration as both a pharmacy technician and as a pharmacist (subject to the Society proceeding to regulate technicians). Although the report is correct, I am writing to provide further clarification on some of the issues.

- That a requirement to demonstrate continuing fitness to practise as a pharmacy technician through participation in continuing professional development is likely to be required for all registered pharmacy technicians — including those with dual registration
- That pharmacy technicians who go on, or have gone on, to train as a pharmacist will be able to remain on the pharmacy technician register — in addition to the pharmacist register if they so wish
- That separate registration fees will apply for each register and that there will be no reduction in registration fees for anyone considering dual registration
- That we anticipate only a very small number of people,

if any, wanting dual registration as both a pharmacist and a pharmacy technician

Janet Flint
Project Manager, Support Staff
Regulation,
Royal Pharmaceutical Society

Misconduct results in removal from both registers

From Mr D. Leech

I write as both president of the Association of Pharmacy Technicians UK and a member of the Society's steering group on the regulation of support staff. In your report of the Council meeting (*PJ*, 14 June, p839) you said that the Council has made some policy decisions regarding eligibility for dual registration as both a pharmacy technician and as a pharmacist (subject to the Society proceeding to regulate technicians).

At the Association of Pharmacy Technicians UK annual conference in April 2003, it was made clear that the association fully supported the proposal. However, the overwhelming view of our members and executive committee is that anyone removed from one register because of proven misconduct should also, automatically, be removed from the other. The suggestion that a pharmacist removed from the register because of proven misconduct could still practise as a pharmacy technician, is clearly unacceptable. The association is pleased to note that the Society's Council decision reflects this view.

Darren Leech
President
Association of Pharmacy Technicians
UK

OMEPRAZOLE

Need for a new legal category of medicines

From Mr P. Brettle, RGN

Normally the application to classify omeprazole as a pharmacy medicine (*PJ*, 24 May, p709) would raise little concern. The efficacy of omeprazole (and

ADVICE FOR CORRESPONDENTS

Letters for publication can be posted, faxed, or sent by e-mail to letters@pharmj.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.

other proton pump inhibitors) in relieving the symptoms of heartburn and acid regurgitation is widely acknowledged, as is its enviable safety record. However, it is precisely because of this efficacy that there are concerns that omeprazole use might mask the development of serious gastro-oesophageal conditions.

These are not new concerns, and they underlie the post-marketing surveillance of omeprazole. These concerns are acknowledged by Galpharm's proposals to provide training for pharmacists on diagnosis and referral for gastro-oesophageal reflux disease. Unfortunately, such measures are doomed to be ineffective.

Patients may be reluctant to visit their general practitioner with their symptoms for a num-

ber of reasons, and an appreciable number of these — because they are reluctant to confront a feared diagnosis or because they have a dread of clinicians — will simply circumvent the proposed measures by presenting to a new pharmacy each time they need more medication.

If it is believed that omeprazole is pharmacologically safe enough to be available from pharmacies but there are concerns that its use should be monitored for good clinical reasons, perhaps there is a need for a new legal category of drugs whereby a condition of the supply is that the NHS number of the patient is recorded. These details could then be fed back to the patient's GP to allow monitoring of drug use. There are other drugs, eg, insulin, which might be appropriate for inclusion in this category if it were created.

Although this would be a nightmare with a paper-based system, it would become far less onerous as the IT links within the NHS become progressively more integrated.

Paul Brettle
Senior Information Analyst
Walsall Primary Care NHS Trust

PAROXETINE

Alternate day regimen unhelpful

From Mr S. G. Bleakley,
MRPharmS

The recent advice from the Medicines and Healthcare products Regulatory Agency concerning paroxetine in children (*PJ*, 14 June, p813) suggests that paroxetine should not be stopped suddenly but tapered slowly then taken on alternate days. Although I would concur with much of this advice, it is our experience that an alternate day regimen in paroxetine withdrawal is unhelpful.

Paroxetine has been associated with a greater number of discontinuation reports than other selective serotonin reuptake inhibitors.¹ This may be due to its short half-life (24 hours) and its ability to inhibit its own metabolism via a concentration-dependent effect. Consequently withdrawal symptoms may appear after one day of abrupt cessation.

With alternate day dosing patients can experience withdrawal symptoms on one day but not the next. A more patient friendly approach is a slow tapering of the dose, using the liquid if required, over at least four weeks but continuing with a daily dose.

Stephen Bleakley
Medicines Information Pharmacist
National Psychiatry Medicines
Information Centre,
Maudsley Hospital, London

REFERENCES

1. Olver J, Burrows G, Norman T. Discontinuation syndromes with selective serotonin reuptake inhibitors. Are there clinically relevant differences? *CNS Drugs* 1999;12:171-7.

LETTERS@...

Letters intended for publication in *The Pharmaceutical Journal* can be e-mailed to letters@pharmj.org.uk. E-mail correspondents should include a postal address or registration number and a daytime telephone number.

SEARCH THE JOURNAL

The Pharmaceutical Journal's website, *PJ Online*, contains a fully searchable archive. Visit www.pjonline.com to see how easy it is to use. The archive starts from August 1999.

DRUG TARIFF

Not obliged to make a loss

From Mr M. K. Amin,
MRPharmS

Christian Thimbleby writes to complain about the severity of the monetary penalty enforced upon him by the dispensing of a single dressing, and his inability to claim broken bulk from a packet of five (*PJ*, 21 June, p860). He also states it is "something I am contractually obliged to do."

I would say that he is not obliged, contractually or otherwise, to make a loss from the dispensing of a prescription. He is foolish to have dispensed the item at a future loss and if a complaint had been made about his contractual obligations then I would suggest that he stand up for himself (and the profession) and challenge such an argument in front of a primary care trust panel. If this fails then surely no court of law could ever entertain the idea of a supplier being forced to make such a deliberate loss.

Milan Amin
Sutton,
Surrey

PENICILLIN

The true chain of events

From Mrs A. Morant,
MRPharmS

I do not think that anyone disputes Alexander Fleming's claim to the discovery of penicillin to which Mr K. A. Lees refers to in his letter (*PJ*, 7 June, p793). However, without the subsequent work by Florey and Chain (in which many others were involved) Fleming's 1929 paper on *Penicillium notatum* could well have languished on some bookshelf gathering dust to this day.

Even though Fleming suspected that this bacterium might be useful as an antiseptic, he was defeated by its instability. It was only in the late 1930s that, while carrying out a literature search on more than 200 antibacterial substances, Chain came across Fleming's paper. Subsequently, Florey and he undertook their penicillin study. In due course,

the first clinical trials were carried out between February and June 1941 in the Radcliffe Infirmary, Oxford.

As the 1945 Nobel Prize for physiology and medicine was awarded jointly to Fleming, Florey and Chain, the latter two scientists must surely have done appreciably more than just "the development work" at Oxford.

Jean Medawar and David Pyke do much to debunk the mythology surrounding the discovery of penicillin in their book 'Hitler's gift: scientists who fled nazi Germany' and give credit where it is due:

"... In 1942 a friend of Alexander Fleming's was close to death in St Mary's Hospital, London, and the scientist asked Florey for a supply of the rare substance to save him. The 'wonder drug' did indeed work, and on 30 August its success was reported in The Times, followed next day by a letter from St Mary's which also claimed credit. The story went largely uncorrected by Florey, who unlike Fleming, was publicity-shy, and multiplied into a shoal of wildly inaccurate reports which claimed, among other things, that the first clinical trials had been held at St Mary's using penicillin sent in churns from Oxford. Florey, Chain and the William Dunn School of Pathology had vanished from the equation; and no amount of subsequent corrections managed to revise the generally recognized version, which became a popular myth."

This is a demonstration of the importance of setting the record straight, even if it means blowing one's own trumpet, if we are to maintain an accurate record of events. Hence, it is not a new phenomenon that spin, all too often, wins out over the truth.

Annette Morant
Edgware,
Middlesex

Heatley improvised production methods

From Mr K. Brown

Further to the letter from Mr K. A. Lees (*PJ*, 7 June, p793) I write to confirm that penicillin was indeed discovered by Alexander Fleming at St Mary's Hospital in September 1928. However,

there are other matters on which I must correct him. Fleming was not working on his earlier discovery lysozyme at that time, but was studying staphylococcal variation when one of his culture plates became contaminated by the fungus *Penicillium notatum*. It was not until 1941 that penicillin first came into systemic clinical use as a result of the work of a team at Oxford led by Howard Florey and including the biochemist Ernst Chain. The production methods improvised by Norman Heatley formed the foundation of British surface culture of penicillin throughout the 1939-45 war.

However, after the war, British pharmaceutical companies began to produce penicillin using fermentation techniques pioneered in the United States. These methods and the use of corn steep liquor as the best growth medium for penicillin-producing *Penicillium* species were developed at the US Department of Agriculture Northern Regional Research Laboratories at Peoria, Illinois, where Heatley went to work with Andrew Moyer. Heatley went on to work for Merck, but it was Pfizer that built the first fermentation plant at Brooklyn. Merck, however, did lead the way with the scale-up of streptomycin production in partnership with its discoverer Selman Waksman.

Kevin Brown
Trust Archivist and Alexander
Fleming Laboratory Museum
Curator

ONLOOKER

Is Onlooker appropriate?

From Mr P. A. Hardy,
MRPharmS

I wish more people would read Onlooker, then perhaps more people would want to write in and complain about it. My latest irritation comes from his or her piece "Making a habit" (*PJ*, 14 June, p838). Onlooker decries the modern "habit" of two working parents in a household. He or she goes on to describe this practice as a parental "shortcoming." Since these comments appear in the final paragraph, perhaps Onlooker shares my instinct about his or her readers and their endurance.

Perhaps Onlooker should imagine a pharmacist in "modern society", starting a career with a young family, still shouldering debt from student loans, and trying to gain a toehold in the housing market. Would Onlooker then think maintaining two wages was a capricious "habit"?

My last paragraph shows that I assume Onlooker is older than me. If I am wrong I do not apologise — in spirit, if not in fact, Onlooker is middle-aged.

The two big questions I would like to ask are who is Onlooker and what is his or her remit? Is this "roving brief" with a tenuous scientific link appropriate in the news organ of pharmacy? I realise a broader view on life than just pharmacy is essential. To paraphrase C. L. R. James (Onlooker always enjoys a quotation), "What does he know of pharmacy, who only pharmacy knows?" But Onlooker's view is not broad; it is narrow, self-satisfied, and rather patrician. The column's themes — arcane prose, classical allusions, concern for rural England, a suspicion of working mothers, distaste for political correctness, etc — root it in "Middle England" territory.

The time has come to reconsider this column's place in *The Journal*. Although reliably providing a page of copy for the editorial team, it does not hold a grip on the membership. On the other hand, this section is probably more accessible to the casual, non-pharmacist reader than almost any other. Is this really how we want the rest of society to see us?

P. A. Hardy
Wakefield,
West Yorkshire

Occupation not liberation

From Ms S. Tibi,
MRPharmS

Although I often turn straight to the Onlooker page for the fascinating bits of information it contains, I do take objection to reference to the "liberation" of Iraq (*PJ*, 7 June, p800) when what has taken place is no more nor less than occupation.

Selma Tibi
Oxford