

NEW CONTRACT

## Back to basics

From Mr I. C. Strachan,  
MRPharmS

From last week's announcement of a new vision for pharmacy and new contract negotiations has finally emerged a menu of services we can all begin to comprehend (*PJ*, 19 July, p73). I give a few words of caution, however, not to undermine the basic or minimum dispensing service as phrased by our politicians. It is after all the one activity which patients have valued and understand. Basic dispensing was pivotal to mobilising through the National Pharmaceutical Association's successful petition campaign. The illustration of this national endorsement by the public at large diffused the wrath from the Department of Trade and Industry and Treasury to introduce total deregulation.

Offering a safe, efficient dispensing service should not be sacrificed at the expense of a vision without additional resources.

**Ian Strachan**  
Board Member  
National Pharmaceutical  
Association

## Solid foundations?

From Mr A. G. W. Paul,  
MRPharmS

Trust the choice of front cover image (*PJ*, July 19) does not convey a hidden message, and that the tiers of the pharmacy contract are being built on a more solid foundation!

**Alan Paul**  
Winchester, Hampshire

PATIENT INFORMATION

## Personalised leaflets are available

From Mr M. P. J. Hadley,  
MRPharmS

Lorraine Sherr said that information has relevance to patients only if it is personalised (*PJ*, 12 July, p61).

This was well demonstrated by John Urquhart MD in a paper

E-MAIL

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

("Cost-benefit assessment of patient education") he presented to an open conference on patient information at Bethesda, Maryland, in 1992 (organised by the United States Pharmacopeia).

He gave medicines to four groups of patients in Clic-Loc containers with a microchip to record compliance. One group received counselling, a second received patient information leaflets and a third received neither. He could detect no difference in the level of compliance, which was around 43 per cent. The fourth group received both a leaflet and counselling drawing the patient's attention to some point in the leaflet. The compliance in this group was about 78 per cent.

A number of computer suppliers can now produce patient information leaflets that are personalised. Using these with counselling may achieve a level of concordance in line with these studies.

**Mike Hadley**  
Guernsey, Channel Islands

PACKAGING

## Don't place packs upside down

From Mr Z. Silver, MRPharmS

In your meeting report (*PJ*, 12 July, p62), patient safety was considered, accompanied by a photograph of packs of amiodarone and amitriptyline tablets. The amitriptyline packs featured are marketed by Alpharma Ltd. I am familiar with its packaging, and consider it to be well designed and thought through.

The 10mg strength of amitriptyline shows "10mg" on a white background; the 25mg strength on a pink background and the 50mg strength on a red background. This is, to my mind, a sensible scale — the lighter the colour, the weaker the tablet; the darker the colour, the stronger it is.

If you look at the picture accompanying the article you can see the pack of amitriptyline 10mg (in the stack behind the opened pack with a cross) is

upside down on the shelf. Similarly, the top pack of the 50mg strength (on the right) has also been placed on the shelf upside down.

Surely the single, initial, most important check when dispensing is to read the label on the pack and ensure that you have selected the right box. If the packs are placed on the shelf

upside down it makes reading the label that much harder.

I was told many years ago not to place packs on the shelf upside down — it gives them a headache. How much of a headache does a pharmacist get if he supplies the wrong item?

**Zvi Silver**  
Edgware, Middlesex

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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.

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## DRUG ADMINISTRATION

## The practicality of oral syringes

From Mr H. P. Radnan,  
MRPharmS

The report in *The Pharmaceutical Journal* (5 July, p33) of an overdose administered by a mother to her child (age not specified) highlights three problems.

First, the choice of the preparation by the prescriber — a suspension containing 50mg/5ml to give a daily dose of 3mg — could be considered inappropriate. To try to administer accurately a volume of 0.3ml from a standard 5ml oral syringe is well-nigh impossible. Perhaps a more proactive approach would have persuaded the doctor to change the prescription to the more appropriate

5mg/5ml suspension, which is also readily available, in which case the infant's mother would not have to change the administration procedure to which she was accustomed.

The second point is that there are available oral syringes of a more appropriate size for measuring small amounts. Baxa manufactures a range of suitable oral syringes starting from 0.5ml. Furthermore, it also supplies marker dose labels. These are clear, self-adhesive strips with a black line. The label can be positioned along the barrel of the syringe so that the black line acts as a marker to which the plunger head is to be withdrawn, thus enabling the exact required volume (0.3ml in this case) to be obtained.

The third point is never to assume that the patient, mother or carer is adept with an oral syringe. Pharmacists should consider

keeping a bottle/syringe assembly behind the counter so that their staff can demonstrate its use.

Paul Radnan  
Salford

## RESEARCH GOVERNANCE

## Help is available

From Dr J. Silcock, MRPharmS

Tully and Cantrill provide a clear and practical guide to the research governance framework for health and social care (*P7*, 12 July, p51). I know from experience that guiding novice researchers and experienced practitioners through the new administrative maze is not always easy. Unfortunately, the application of the guidelines (eg, by different ethics committees) and

governance awareness of potential research collaborators may both be a little variable. This means individual researchers need a good working knowledge of the framework to deal with issues that may be identified, ensure high ethical standards and educate their peers.

Lone practitioners may find it particularly useful to know that there is an NHS-funded national research help line: RD Direct. Advice on any aspect of research can be obtained via the web ([www.rddirect.org.uk](http://www.rddirect.org.uk)) or telephone (0113 295 1122). Related services also offer advice on research funding ([www.rdinfo.org.uk](http://www.rdinfo.org.uk)) and research training ([www.rdlearning.org.uk](http://www.rdlearning.org.uk)).

Jon Silcock  
Research Practitioner  
University of Leeds and Leeds  
Teaching Hospitals NHS Trust

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## If you don't record it, it didn't happen

From Mr K. S. Donlon,  
MRPharmS

As pharmacists we develop skills and gain knowledge on a daily basis — why then should we have to write about it? There is a simple philosophy for those struggling with continuing professional development — if you do not record it, it did not happen.

You must realise this in its simplest form. Once you have learnt something, record it. If an opportunity passes you by then make sure you are ready for the next one. Do it once a week. Once you are on a roll it becomes

second nature and suddenly you are making time for yourself to learn.

Do not be in any doubt that unproven CPD will see you in the dock trying to explain why you were too busy to be professional.

**Kieron Donlon**  
Wigan,  
Lancashire

## Unnecessarily worried

From Mr B. Shooter, MRPharmS

It seems that Dr Norman Harris is unnecessarily worried about the bureaucracy of continuing professional development (*PJ*, 12 July, p48). In his letter, he outlines his current activities,

which clearly fulfil much more than the minimum CPD commitment. Surely, his letter is all that is required as part of his CPD portfolio.

**Barry Shooter**  
Romford, Essex

## Can we have factual guidance?

From Ms A. Farrelly, MRPharmS

I would think that most pharmacists would agree that completing continuing education courses should be followed by applying this knowledge to practice.

However, most pharmacists have all too little free time and the prospect of reams of paper or hours spent on expensive internet connections discourages all

but the academics. Can we have some factual guidance with examples as to the requirements before we all resign?

**Ann Farrelly**  
Wallington,  
Surrey

Dr ROBERT DEWDNEY, head of education, Royal Pharmaceutical Society, replies: Internet connection at home and at work is increasingly the norm. Indeed, we have a strong hint in paragraph 5.36 of "A vision for pharmacy in the new NHS" that it will soon be required in pharmacies.

The Society's "Plan and record" includes examples of recorded continuing professional development. It can be viewed at [www.rpsgb.org.uk/education](http://www.rpsgb.org.uk/education) for those who have not yet been reached by CPD roll out.

CPD

## Society should trust the professionalism of its members

From Mr S. R. Axon, FRPharmS

The reply from Robert Dewdney to David Shenton (*PJ*, 5 July, p13) illustrates the problem of inflexible rules and suggests that the “non-practising” pharmacist may well be better leaving the register completely.

Having practised for 30 years in a non-clinical capacity, like Mr Shenton, I recognise my professional limitations and would never give advice beyond my competency but my experience of both general practitioners and pharmacists is that they certainly read up on their own afflictions. As a member of a group of patients with heart disease no doubt Mr Shenton has read widely on his condition and is probably better qualified to speak to fellow patients on this than many practising pharmacists with up-to-date continuing professional development logbooks. In addition, pharmacists speaking from a standpoint of knowledge to such groups can only enhance the public esteem in which the profession is held.

In its determination to reduce everything to a set of intractable rules for Lambeth to administer, rather than to trust the professionalism of its members, Dr Dewdney confirms that the Royal Pharmaceutical Society proposals on CPD will prohibit non-practising pharmacists from offering advice in any circumstances. Is this really what the consultation supported or is it a convenient Society interpretation of that consultation?

As to the final question in Mr Shenton's letter — whether this is in the public interest — it seems to me that the Society's blanket prohibition of those on the inactive register giving voluntary health care advice is only serving this if the Society really believes that they will be so reckless and unprofessional as to speak on matters beyond their competence. Is this what the Society regards as being a modern regulator?

If non-practising pharmacists resigned from the register they would be freed from the petty discipline of the Society and

restore to themselves the freedom to enter into discussions and offer opinion upon things that have interested them throughout their professional life. Against this the main advantages of remaining on the inactive register (post CPD) seem to be the professional status of calling oneself a pharmacist and receiving the *PJ*. When reading the letters pages, at times, the latter does nothing for my blood pressure.

**Stephen Axon**  
*Amersham, Buckinghamshire*

## Will overseas credits be acceptable?

From Dr J. Landau, MRPharmS

In my view, if one's name is on the Register of Pharmaceutical Chemists, one should fulfil the continuing professional development requirements whether actively in practice or not. It is as simple as it sounds. This way, we can all retain our appropriate title and full privileges. In turn, we should attempt to keep up to date especially if we are dispensing advice to friends, as has been said (*PJ*, 19 April, p548).

I have retained my name on the British register since qualifying at Bristol in 1960. As a full-time university faculty member at a college of pharmacy in New York, I am not required to be on the New York register but reinstatement is difficult. I therefore choose to maintain registration and fulfil the required hours of continued education (some of which are allowed by correspondence).

I do not believe that the plight of overseas members has been discussed. Will CPD credits be accepted from overseas?

**Janet Landau**  
*Associate Professor in Clinical Pharmacy*  
*Long Island University,*  
*New York*

Dr ROBERT DEWDNEY, head of education, Royal Pharmaceutical Society, replies: The situation of pharmacists registered in Great Britain and resident overseas has been specifically discussed and decided upon by the Council (*PJ*, 17 May, p703). There will be no distinction from the situation of GB-resident pharmacists and the roll-out of the CPD system will

encompass them in due course. Because this system is not credit-based, the acceptance of overseas credit-rated courses does not arise as an issue. I suggest Dr Landau looks at the CPD “Plan and record” to learn of the basis and the structure of the system. It can be found at [www.rpsgb.org.uk/education](http://www.rpsgb.org.uk/education).

### THE PRESIDENT

## A double act

From Mrs A. B. V. Chalmers,  
MRPharmS

Stuart Maconochie (*PJ*, 12 July, p46) is unsure that he can have confidence in the incoming President because she deferred to the Secretary and Registrar for response at the roadshow. I say, may they long continue as a double act. In contrast to what I thought was Dr Hawksworth's diffident oral delivery on 30 June, Ann Lewis was both audible and lucid. May the one listen, write and facilitate action, and the other speak to us all.

**Anthonia Chalmers**  
*London W6*

### THE SOCIETY

## Avant-garde streak is lacking

From Mr G. Burke

It is clear from your letters that many pharmacists are disgruntled and dissatisfied. This situation is by no means new and the problems with pharmacy today largely echo those that existed five years ago. To mention a few: limited roles in community pharmacy, under-used skills, the apparent low status of pharmacists and poor progress with existing innovations such as pharmacist prescribing.

Although I must be careful not to bite the feeding hand, I think that not enough is being done by the Royal Pharmaceutical Society to address these ongoing concerns and to champion the interests of pharmacists. The Society is well-placed to advance the status of the profession. However, it seems to lack an avant-garde streak to the detriment of its dutiful and increasingly melancholic members. Unless these issues and others are resolved, I

fear an increasing number of young pharmacists will leave the profession and use their pharmacy degree as a sign of aptitude to enter into other professions, graduate schemes and jobs.

Although I might appear to have a pessimistic view, I remain an apologist for pharmacy, and would like nothing more than to be proud of the profession and the Society (which I am, in part). However, I believe the body that represents pharmacy has to do right by its members' expectations.

**Gareth Burke**  
*Preregistration Trainee*  
*London*

## Should we drop the adjective “royal”?

From Mr E. P. Crabtree,  
MRPharmS

The Royal Pharmaceutical Society was not always “royal” (*PJ*, 12 July, p44). It became “royal” in 1988, not long before we celebrated the sesquicentenary of the Society. No one asked the members if they wanted this change, and as far as I remember this fait accompli was imposed after little if any discussion even in the Council. The net result of this has been, in my opinion, nil; neither the Society nor the individual members have gained any increase in prestige or anything else.

I suggest any change of name should drop the redundant adjective “royal”. We could follow the American example and become the British Pharmacists Association (except that pharmacists employed by Boots seem to have a prior claim to the initials BPA). Perhaps we could be the British Pharmacists Society or the Society of British Pharmacists. But any proposed name change should be ratified by a referendum of the membership.

**E. P. Crabtree**  
*Huddersfield*

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