

## LETTERS

### SIGN LANGUAGE

## More effective communication

From Mrs M. Y. Sharma Kapoor,  
MRPharmS

I have always prided myself on having good communication skills when it comes to working with patients. However, during a recent locum I encountered a couple of deaf patients and found myself having to resort to a "speech to text" method of communication. I felt unsatisfied at not being able to communicate with these patients more effectively — resorting to writing down what I wanted to ask felt too primitive.

There are an estimated 9 million deaf and hard of hearing people in the United Kingdom, and the numbers are likely to grow since the population of over-60s is increasing (presbycusis being the commonest type of deafness). The Disability Discrimination Act 1995 says that if you provide goods and services to the general public it is unlawful for you to refuse to serve a deaf person, or to provide a service of a lower standard or on worse terms to a deaf person. You must also take steps to make your services more accessible to deaf people.

Bearing this in mind, I have enrolled on a British sign language course. Although it will be time-consuming and hard work, I am sure it will enable me to communicate more effectively with the deaf and hard of hearing population. The Royal Pharmaceutical Society defines continuing professional development as "everything that you learn which makes you better able to do your job". I am pleased that I have found a more unusual approach to CPD.

Monica Sharma Kapoor  
Leeds

### TABLET CRUSHING

## A pragmatic approach recommended

From Ms J. A. Smyth,  
MRPharmS, and Mr S. Keeling,  
MRPharmS

We echo Rebecca White's comment (P7, 9 August, p174) that patients must not be

denied essential drug therapy by preventing the crushing of tablets. The guidance from the British Association for Parenteral and Enteral Nutrition is a useful "how-to" guide covering methods of drug administration via enteral feeding tubes, and the main pharmaceutical and pharmacological problems associated with this. However, it is impossible to provide details of all the exceptions to the basic rules in such a concise guide.

At Wrexham Maelor Hospital we have developed a guide, now in its third edition, to the administration of drugs in patients with swallowing difficulties or enteral feeding tubes. As well as covering methods of administration, it contains monographs for over 180 drugs, with specific advice on dosage alterations, drug and route alternatives, drug-feed gaps and side effects related to enteral tube and crushed tablet administration.

The guide is available to nursing and medical staff on the wards as an A4 booklet, and to ward pharmacists as an A5 pocket book or Palm file.

We would recommend this pragmatic approach over a simple "do not do", since in our experience this rarely works in practice.

Jennifer Smyth  
Intensive Care Pharmacist and  
Editor of Drug Administration  
via Enteral Tubes Guidelines  
Wrexham Maelor Hospital

Steve Keeling  
Principal Pharmacist, Clinical  
Services.  
Wrexham Maelor Hospital

### 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.

### CPD

## Pensioners below the poverty line

From Mr A. R. Korsner,  
MRPharmS

I endorse what Andy Potheary writes in his letter (P7, 9 August, p175). I wonder also whether the powers-that-be have considered the extreme hardship that could potentially befall pharmacists reaching retirement age in the near future. In recent conversations with such pharmacists, it appears that many have factored into their retirement plans their ability to do the odd locum to supplement their pensions.

Unlike doctors and other health care professionals, more than 30 years of working in the National Health Service has gained pharmacists nothing in terms of an NHS pension. Most (especially employee pharmacists without the sale of a business as a financial cushion), through no fault of their own, will now face the possibility of falling into a poverty trap with this movement of the goal posts.

I for one do not relish seeing my professional colleagues in this position. Having worked a lifetime as unsung, unrecognised heroes of the NHS, we now face the ignominy of retirement on a shoestring, tending our daffodils, while our doctor friends whistle around the world spending their superannuation.

There has to be a way of registering semi-retired pharmacists so that they can work and carry out certain tasks of a non-

clinical nature without the necessity to fulfil the full continuing professional development requirements. With all due respect to the excellent academic achievements of recently qualified pharmacists, there is nothing that can be taught at university that can supplement the experience and confidence of a lifetime of work.

Is our Society prepared to sit back and witness the possibility of ex-pharmacists moving, in desperation, to "health food stores", advising and giving credibility to these ungoverned organisations?

If the Society is hell bent on this level of compulsory CPD then it needs to give much more thought to the needs of those pharmacists for whom the income from a little work is essential to keep both body and mind together.

It must also boost up and publicise the Benevolent Fund to take into account the considerable extra numbers who may, sadly, need to avail themselves of it.

There is currently great, unspoken, fear and uncertainty at grass roots.

Adrian Korsner  
London N20

### COMMUNITY PHARMACY

## Enhancing professional relations

From Mr B. N. I. Bloom,  
MRPharmS

I fail to see how leaving a patient in pain is "acting in the patient's best interest". I would suggest an alternative approach to that described by Paul Radnan (P7, 2 August, p146).

I would have contacted the patient's general practitioner and explained the difficulty and suggested the addition of ranitidine together with, perhaps, changing the diclofenac tablets to a modified-release preparation.

I would then have advised the patient to take the antacid before the anti-inflammatory, which should then be taken with food.

The result would have been that the patient's pain could have been reduced or eliminated, the patient would think that her local friendly pharmacist was terrific, and pharmacist-GP professional relations could have been enhanced.

Everyone is a winner. Such a situation is real and works.

Unless this kind of approach is taken we will all be replaced by "standard operating procedures".

**Bryan Bloom**  
Leeds

## JUNK MAIL

## How to reduce unwanted post

From Mr A. G. Paul,  
MRPharmS

The problem of junk mail posed by "Onlooker" (*PJ*, 2 August, p160) is easily remedied by registering with the Mailing Preference Service. The service can be contacted by telephone (020 7291 3310) or by e-mail (mps@dma.org.uk).

**Alan Paul**  
Winchester, Hampshire

## PACKAGING

## Read the label!

From Mrs M. Carson,  
MRPharmS

In reply to Zvi Silver (*PJ*, 26 July, p117), putting the odd pack on the shelf upside down makes you look harder. Many packs look the same these days. Upside down means "read the label".

**Marie Carson**  
Aberdare,  
Mid Glamorgan

## PRESCRIBING

## Encourage generic prescribing

From Mr A. J. Young,  
MRPharmS

I read with interest the letter from M. D. A. Tomlin (*PJ*, 2 August, p147) regarding information on discharge letters. Although many hospitals are working on computer discharge letters we currently still rely on the clear writing of doctors and pharmacists.

We encourage generic prescribing owing to the increased number of errors that occur

when brand names are used. For example, Istin has been misread as ISMN, Lasix as Losec and Epilim as Epanutin. The list of examples goes on. To say that prescribing by brand leaves no room for error is simply incorrect.

**Anthony Young**  
Durham

## THE SOCIETY

## Members should reject new sample Charter

From Dr A. S. Hersom,  
FRPharmS

The Hull Branch Committee met recently to discuss the new sample Charter and questionnaire.

We believe that it is vitally important that members send a clear message to the Council that existing Charter Objective 3 (to maintain, honour, safeguard and promote the interests of the members in their exercise of the profession of pharmacy) must be retained and that members should reject the new sample Charter using the questionnaire (downloadable on [www.rpsgb.org.uk/pdfs/rpsgbfitforthefutureesrform.pdf](http://www.rpsgb.org.uk/pdfs/rpsgbfitforthefutureesrform.pdf)) by the end of August.

The number of people who gave up a Sunday in June to attend and overwhelmingly vote against the Council's modernisation proposals at the special general meeting significantly outnumbered all the people who attended the 12 regional roadshows. This demonstrates the depth of feeling against the new sample Charter.

**A. S. Hersom**  
Secretary,  
Hull and District Branch  
Royal Pharmaceutical Society

## Embracing devolution

From Mr C. Ranshaw, FRPharmS

As secretary and branch public relations officer to the Cardiff and Vale Branch with over 600 members, I receive regular mailings from the Royal Pharmaceutical Society headquarters in Lambeth.

Recently I have received "Better management of minor

ailments: using the pharmacist" with a supporting letter from the President commending the publication. Although the principle and generality of this publication is superb it fails abysmally on the detail. Throughout, reference is made to primary care trusts, which do not exist in Wales or Scotland.

The President has expressed her delight that Dr David Colin-Thomé has endorsed and written the forward to the publication. Again I have the greatest respect for Dr Colin-Thomé, but even he has only commended the publication to PCTs. Still, I would not expect any other endorsement from the national clinical director for primary care, Department of Health. The DoH is England only, PCTs are England only. We are the Royal Pharmaceutical Society of Great Britain, not England.

We are now put in the difficult position of having a good publication that is perceived to be irrelevant in Wales. I would be hard pressed to take this to the minister for health and social services in the National Assembly for Wales for her to endorse its adoption. It is just not credible to take forward an English-based document that completely ignores the NHS (Cymru) Wales structures.

It would have been so easy for the authors of this report to make it generic by referring, for example, to primary care organisations in all three home countries.

The latest publication I have received is "Beyond the baseline: the role of clinical facilitators working with community pharmacists", written by Catherine Dewsbury, clinical governance pharmacist, Royal Pharmaceutical Society. This is another document written with that prevailing culture, ie, the Royal Pharmaceutical Society of England. When will Lambeth become less anglocentric and realise that devolved government occurred in 1999 and, like it or not, Wales and Scotland are responsible for the NHS policies, strategies and administration in their own countries, not the DoH?

I would like all pharmacists to recognise that there are differences within the NHS in each of the three home countries and that we are moving at different rates and sometimes in different directions. However, what seems to be problematical is to get the Society to embrace devolution seriously.

It does concern me greatly that at this time, when we have had much debate about the dual role of the Society, two excellent examples of the professional activity of the Society will not be of use in Wales. The annual retention fees of all pharmacists are being used to produce these professional documents and they should therefore be in a form that will be applicable to all pharmacists in Great Britain.

**Colin Ranshaw**  
Secretary,  
Cardiff and the Vale Branch  
Royal Pharmaceutical Society

BEVERLEY PARKIN, director of public affairs and communications, Royal Pharmaceutical Society, replies: Colin Ranshaw highlights a feature of the growing reality of devolution, which is creating different priorities and developments in each country. Increasingly, the Society and other organisations are recognising the need to respond to this by identifying those generic issues that apply to the whole of Great Britain and those that are relevant in one or more of the individual countries.

In the latter case, this requires us to address country-specific issues with material that reflects the realities of increasingly devolved health service provision. The two documents to which Mr Ranshaw refers were both specifically designed to address audiences in England. With a foreword by the national director for primary care for England, the briefing on minor ailments aims to showcase emerging schemes to the primary care trusts in England. The clinical governance document was also designed for an English audience and was produced to meet the needs of community pharmacy clinical governance facilitators who are being recruited to PCTs across England.

To meet the specific needs of the circumstances in Wales and Scotland, the Society's Welsh and Scottish Departments have taken up the opportunity of producing appropriately worded and targeted documents for use in these respective countries. Such briefing papers have enjoyed considerable success with audiences in Wales and Scotland. In some circumstances, different approaches may be deemed more useful, depending on the issue, the prevailing political climate, the national policy implementation timetable and priorities in those countries.