

CONCORDANCE

## We need to define concordance for ourselves

From Mr B. Shooter, MRPPharmS

With how many patients do I have concordant discussions, asked the last line of your editorial last week (11 October p480) in your preview of the series of papers that you published on this subject. Not many I thought. My family criticise my paternalism; overall my staff enjoy it. But what about my patients?

When I returned to your question I realised that we community pharmacists needed to define concordance for ourselves and then reflect upon our practice. As progress has been made over the years, with the advent of computerised patient medical records and prescriptions, both pharmacist and patient have now joined the prescriber and the industry: together we make up the team whose functioning is responsible for at least some of the health gain that the population of this country has experienced over the last couple of decades.

My pharmacist managers and myself have little evidence of non-compliance but I am sure this indicates that more and relevant practice research is required to help us understand the problem from other perspectives.

I will define concordance in community pharmacy as “the facilitating of the sharing of information by both pharmacists and their patients”.

In other words providing an atmosphere conducive to either party asking questions of the other for the benefit of the health improvement of the patient.

If that is the case we have begun to have concordant discussions with our patients but we are only at the start of this important process.

Barry Shooter  
Romford, Essex

## Concordance and “failures”

From Mrs I. Gummerson,  
MRPPharmS

The case of Mrs D mentioned in the article “Compliance, concordance and respect for the

patient’s agenda” (P7, 11 October, pp498–500), illustrates where current practice (in this case, of a general practitioner) can fail the patient. The author, Paul Bissell, is a medical sociologist who interviewed a 40-year-old Asian woman diagnosed with type 2 diabetes.

It is the well-meaning health care professionals that make her feel she is a failure, because she cannot adhere to the diet. “They are blaming me,” she says.

What else could have been done by the health care professionals involved?

I was surprised that metformin had caused “episodes of hypoglycaemia, losing consciousness on several occasions”, since metformin does not usually cause this. I wonder whether she was also on a sulphonylurea.

It would have been interesting for her blood to be tested at these “hypo” times, to get the true picture. People who get genuine hypos should be taught about the warning signs and how to deal with them. A blood glucose meter is useful to detect blood glucose fluctuations through the day, for targeting a regular meal or snack.

The hypos need investigating, Mrs D needs to understand what they mean and her medication adjusted if necessary. She needs to be “hypo-free” without running high glucose levels.

Dr Bissell did not mention whether she said she regularly took her medicines. The benefits of taking her medicines regularly should be reinforced. It may be useful to discuss ways of remembering to take daily doses if this is an issue. Adherence could be reinforced at each meeting. It

could be a win-win situation — being easier to carry out than trying to lose a lot of weight.

Mrs D needs help in adhering to the medication; the health professional should talk to her about staying healthier.

Her depression needs assessing, and the appropriate treatment giving. A depressed person is less likely to adhere to health care advice and medication.

This patient has already had a bruising experience with lifestyle advice. Perhaps agreeing on a small, sustainable weight loss at each meeting, would give her an easier target. She could get together with a support group — look at new ways of cooking, have a gossip and some fun (after all, she is only 40).

At a recent meeting a diabetologist was illustrating a “failure” patient who had been referred to him from a GP practice. This person was not reaching the primary care trust health targets. Boxes could not be ticked for targets of blood pressure, blood glucose, cholesterol, etc, so she was deemed a failure.

However the specialist showed us that over a 10-year period since she had been diagnosed, her weight had decreased by 5kg (although she was still obese), her BP and cholesterol had gone down somewhat, but the targets had still not been reached. He emphasised that, if she had followed no advice and taken none of her medication over the 10 years, she would have been much worse by now. She was in fact a success but had not reached the targets.

That is the point I hope that medication review and supplementary prescribing pharmacists

keep in mind: be positive; acknowledge all successes and help people to change in small manageable ways.

Irene Gummerson  
Wakefield, West Yorkshire

THE PROFESSION

## An outsider’s view of our profession

From Mr P. Penson

I was amused by a recent conversation I had on a chance encounter with an old acquaintance who asked me if I was still studying alchemy.

Was this an honest mistake or by a student of journalism, or does it represent an outsider’s view of our profession?

Peter Penson  
Fourth Year Student  
Welsh School of Pharmacy,  
Cardiff

REMUNERATION

## Fixed remuneration package needed

From Mr A. Sidbu, MRPPharmS

When is our profession going to move away from a profit-driven service to a patient-driven service? Community pharmacy, in general, only exists to make a profit. Why do we not get a fixed remuneration package for providing services to the community with the number of high street pharmacies allowed in one primary care trust linked to the average number of items dispensed in any given PCT area?

This way the issue of contract limitation can rectify itself by the opening of new pharmacies where needed, and each pharmacy will take a fair share of the item workload for that area. This should avoid the issue of having a number of pharmacies in one locality, with one pharmacy dispensing the majority of items.

With pharmacies dispensing the same number of items there would be an equal distribution of resources and remuneration.

Amandip Sidbu  
Pinner,  
Middlesex

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## CONSULTANTS

## Generic job functions already in existence

From Mr P. J. Maltby, MRPharmS, and Dr B. L. Ellis, MRPharmS

We note the proposals by Hebron *et al* (*PJ*, 30 August, p261) and the ensuing correspondence from Webb *et al* (*PJ*, 27 September, p404) for creating the role of a consultant clinical pharmacist from the functions described in HSC 1999/217, and fully support them.

We would like to make pharmacists aware that the UK Radiopharmacy Group has proposed a generic series of job functions for consultant radiopharmacists (or radiopharmaceutical scientists) that closely correspond to the existing consultant clinical scientist grade C post. The latter's role has already been defined in the job evaluation profile section of "Agenda for change" published by the Department of Health, with the level of responsibility and expertise being recognised as being equal to that of a medical consultant.

The proposed consultant radiopharmacist or radiopharmaceutical scientist post has the support of the Guild of Healthcare Pharmacists because hospital pharmacists and hospital clinical health care scientists are being seen in the same light by the DoH for human resource planning in the future. The DoH has further recognised that radiopharmacy is a function of the health care scientist workforce in the NHS, by including it in the development of a national occupational standards exercise currently being undertaken nationwide. These standards will, in the next few months be linked to competencies, and thus ultimately ensure that the skill mix and qualifications of staff are correct for each defined job function.

We would therefore urge our fellow senior technical specialist pharmacists, especially those in "early implementer" sites to work closely with their GHP representatives and consider wording their job evaluation profiles in conjunction with their local "matching panels" to suit the term "consultant".

It would be iniquitous for technical pharmacists not to be

recognised as "consultants" in their own right when clinical pharmacists in the hospital setting and in the primary care setting (eg, Boots) already are.

**Paul Maltby**  
Principal Radiopharmacist  
Radiopharmacy Department,  
Royal Liverpool University Hospital

**Beverley Ellis**  
Department of Nuclear Medicine,  
Manchester Royal Infirmary

## MODERNISATION

## Make your views known

From Mr A. Tanna, FRPharmS

The Council of the Royal Pharmaceutical Society has spent a lot of time thinking through the implications for pharmacy of the modernisation of health professional regulation and strengthening its professional leadership role by developing a new Royal Charter, since retaining the status quo is not an option. Later this year the Government plans to publish the regulatory legislation governing the Society, in the form of a draft Section 60 Order. If the Society wishes to retain the benefits of chartered status, it needs to ensure that any new Charter is compatible with the Section 60 Order, otherwise the Charter will be overshadowed by the legislation.

At this year's British Pharmaceutical Conference, it was explicitly stated that the Society's Council would revisit the objects in the draft charter following feedback from members over the summer. The omission of the third object in the existing Charter was one of the main anxieties raised in the consultation. ("To maintain the honour and promote and safeguard the interest of members in their exercise of the profession of pharmacy.")

It was originally proposed by the Society that this particular object should be relegated to a power in the new Charter. However, this option proved to be very unpopular with the members and played a significant part in the debate at the special general meeting in June.

Members resolved that the Society's Charter should retain the object without qualification — carried unanimously by those present at the meeting.

Following the SGM, the Council issued a statement acknowledging the strong support expressed by the members for this object and saying that it would take this fully into account when considering the new Charter. It was anticipated the Council would address those concerns by revising the objects in the draft Charter to give greater prominence to the Society's professional leadership and development role. At the June Council meeting, the Council also decided that it would not pursue charitable status for the present. But the possibility of charitable status still stands for some future time and, therefore, will not be closed off entirely.

At the September Council meeting, the revised draft Charter was presented to the Council members for discussion. Regrettably, there is no explicit statement in this revised Charter that states its prime object is to act in the interest of its members. I had my reservations concerning this and other sections of the revised draft Charter and I, therefore, with some of my colleagues voted against it.

Section 2 of the revised draft Charter states: "The objects of the Society (hereinafter referred to as "the objects") shall be for the public benefit." Although sub-section 3 states "To safeguard, maintain the honour, and promote the effectiveness and interests of the profession of pharmacy" and although it may look the same as Article 4 in the old Charter, it is not. And it is not the same as the membership decided at the SGM.

Since this object does not state explicitly that it is in the interest of its members, it would be compatible with charitable status if any future Council desired to seek it.

It seems to me that the Council is turning the Society into a regulator — with the option of seeking charitable status in the future — at the expense of its professional function. It is my understanding that Object 4 of the existing Charter, if reinstated in the revised draft Charter, would be compatible with the Section 60 Order.

The Council is now seeking the views of the membership of the revised draft Charter. It is therefore in your interest to feed your views to the Society and how you feel about these changes.

**Asbwin Tanna**  
Member of Council,  
Royal Pharmaceutical Society

## Not holding a referendum is not an option

From Mr H. Argomandkhab, MRPharmS

At the special general meeting of the Royal Pharmaceutical Society in June, a motion that the Council should hold a referendum of the membership to establish the level of support for any proposed new Charter was carried unanimously (*PJ*, 7 June, p807). However this week's report of the Council meeting in October 2003 dismisses the referendum out of hand.

From the report (*PJ*, 11 October, pp521–523), Marshall Davies said that some of the developments that would take place during the next 20 to 30 years would be beyond members' comprehension today. In addition Dr Gill Hawksworth said that "the Council does not want to restrict this consultation to any single question", and Andrew Burr saw other reasons to rule out a referendum as the "time scale and the complexity of the issue."

If this is not treating the membership with contempt, I do not know what is. The membership is made up of highly intelligent and qualified pharmacists, many of whom are better qualified than the current Council. If the Council believes that we may not understand these complex issues, then it has admitted its failure to explain these to us in easily digestible language.

As for the timescale, again it is the Council that has been in charge of that and after the SGM of 1 June it knew that the members had unanimously voted for a referendum and it must build that into its time scale. More importantly, at the SGM, immediately before the vote was taken, I repeated the members' demand: "Hassan Argomandkhab said that the Council needed to go back to the drawing board, produce a draft Charter that it broadly supported, then seek the members' comments and then hold a referendum. That was the order." (*PJ*, 7 June, p807).

The referendum comes after the Council has agreed the final document. So far it has produced a revised draft Charter and is seeking the members' comments, what is left is to hold a referendum after they have finalised the document in December. Not holding a referendum is simply

not an option because you are not sure of the outcome. A proper referendum will have its own explanatory notes and balanced "yes" and "no" campaigns.

The issue here is more fundamental than whether I or any other member supports or rejects the new Charter; the fundamental issue is about erosion of our democratic rights as ordinary members of the Society.

I, and many other so-called ordinary members, will not be prepared to stand on the side while our Council deliberately casts aside our democratic rights and ignores our wishes through its own failures.

**Hassan Argomandkbab**  
*Halewood, Liverpool*

## Representation fails to appear once

*From Mr G. S. Phillips,  
MRPharmS*

In the unattributed "Fit for the future" paper on professional leadership and development of our profession, (*PJ*, 27 September, insert) the word "representation" fails to appear once. Is this significant?

**Grabam Phillips**  
*St Albans, Hertfordshire*

### WORKFORCE CENSUS

## Are documents that important?

*From Ms J. A. Appleton  
MRPharmS*

I returned from holiday to a large brown envelope from the Royal Pharmaceutical Society with the words "Very important documents inside" in large bold print. I wondered what was so very important. I opened it to find the pharmacy workforce census inside.

Is it really that important? Let us have some sense of perspective. Were these words put on the envelope to persuade more people to return the completed questionnaire? My guess is they would have the opposite effect.

**Janet Appleton**  
*Edinburgh*

### SOPS

## Writing SOPs — a chore or a challenge?

*From Mr T. H. Spence,  
MRPharmS*

Think in pictures — Kodak once used this slogan to promote popular photography.

What an opportunity for the present day procedure-writer. Armed with a digital camera, a mild analytical talent and a modest computer he or she will be able to create an illustrated database which would more than cover the immediate requirements of the Royal Pharmaceutical Society (*PJ*, 4 October, p443).

Moreover it will form a foundation for linking future standard operating procedures, recording updates and documenting deviations which inevitably occur; staff-training, too. The scope is tremendous.

Writing SOPs can indeed be fun. Try compiling procedures which address the domestic scene!

**Thomas Spence**  
*Llanfairfechan,  
Gwynedd*

## Writing SOPs is not fun

*From Mr T. Maddison,  
MRPharmS*

Ten things to enjoy this weekend:

1. A long walk across the lake-land fells
2. A nice bottle of wine
3. The last mowing of the lawn this year
4. Listening to Charlie Mingus
5. A meal at the local bistro
6. A clear autumnal morning
7. Watching England beat South Africa at rugby
8. Working off the week's frustrations at the gym

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### THE SOCIETY

## "Emeritus pharmacist" could be used for retired members

*From Mr D. J. Savage,  
MRPharmS*

I am greatly annoyed after spending all my working life as a pharmacist to hear that there are those in the profession who would deny me calling myself a pharmacist just because I have retired.

It might sound like using a sledge hammer to crack a nut, but I feel that the Council could show a measure of gratitude for past services to the profession from all retired pharmacists if it encouraged the use of the title "Emeritus pharmacist".

This title would be in line with the definition of emeritus given in the 'Concise Oxford Dictionary': "Emeritus: having retired but allowed to retain a title as an honour."

**D. J. Savage**  
*York*

9. Watching the sunset over the hills
10. Writing standard operating procedures

Thanks for the final suggestion, *PJ*, but I don't think so!

**T. G. Maddison**  
*Lancaster, Lancashire*

### SPECIALS

## Will we end up as pseudo-medics?

*From Mrs M. R. West, FRPharmS*

How have we got to the position where pharmacists cannot make simple ointments (*PJ*, 11 October, p491)? I fear for the future of the profession if modern pharmacists are to end up as pseudo-medics.

We were always prepared to advise patients on their medication but we should not discard our basic pharmaceutical skills while doing this.

**M. R. West**  
*Bristol*

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