

STATINS

## Patients and people are different

From Dr J. Blenkinsopp, MBChB, MRPharmS

Your cover on 22 November 2003 poses the rhetorical question "are OTC statins good for pharmacy and for patients?". The answer to the first part of that question will depend on a clear understanding of the pharmacy role in tackling coronary heart disease and using the word "patient" may not help in this. The intention of the reclassification of simvastatin 10mg is to focus on people who are currently well, but at moderately raised risk of CHD. This is more than a semantic distinction: these people are not CHD patients currently and this underlines the role that the pharmacist could play in reaching them.

CHD is such a common disease (the lifetime risk of developing it at age 40 years is 1 in 3 for a woman and 1 in 2 for a man) that some have advocated a population-based approach with a "polypill" to achieve the maximum reduction in its toll.<sup>1</sup> In contrast, the sheer size of the problem means that the NHS has had to prioritise treatment to those at the greatest risk, including those that have already suffered a heart attack and those (eg, with diabetes) at extremely high risk of a first event. The role of self-care in reducing moderately raised CHD risk in the population sits strategically between these two approaches and is informed by both. Pharmacists should be reassured that in occupying this ground they are supported by the evidence and expert opinion. In the publication that launched the joint British guidelines on the treatment of CHD the authors commented: "There is now evidence from randomised controlled trials that for some risk factors intervention with drugs significantly reduces the risk of CHD events, and all cause mortality, in individuals with a risk as low as 6 per cent of such events over the next 10 years." In this context, the target population for pharmacy self-care is likely to have a 10-year risk of a first coronary event (CHD death or a non-fatal myocardial infarction) of 10–15 per cent; if we included softer but meaningful endpoints such as unstable angina their risk would be substantially greater.

The distinction between "patient" and "person" has other implications: what may be the

right management strategy for the high-risk "patient" may not be optimal for the moderate risk "person". Until quite recently the 10mg strength of simvastatin was widely prescribed by GPs. Following a wealth of evidence in high-risk populations — including the ground-breaking Heart Protection Study in 20,000 Britons — there has been a move to recommend the higher doses (eg, 40mg only in HPS) used in these studies. This is entirely logical since for many of these patients achieving the maximum reduction in low density lipoprotein cholesterol (LDL-C) represents their best chance of significantly reducing their CHD risk. But why should we adopt the same approach for individuals whose moderate risk is derived primarily from their age and, for example, a modifiable risk factor such as being overweight? In these people weight loss and an increase in aerobic exercise can have a significant effect on their risk proportionately much greater than that available to high risk patients.

In adopting the more "holistic" model where 10mg of simvastatin is one part of the programme of interventions offered, pharmacists should not think that they are pharmacologically short-changing their customers. The relationship between simvastatin dose and LDL-C reduction is log-linear: a doubling of dose from 10mg to 20mg increases the relative reduction of LDL-C from around 27 per cent to 32 per cent and doubling the dose again to 40mg produces a further 5 per cent incremental improvement. The absolute reduction of LDL-C achievable with 10mg simvastatin, if sustained, will produce around a 30 per cent relative reduction in CHD risk. This will produce a valuable absolute risk reduction in those at moderate risk and if the individual also modifies risk behaviours the benefits will be considerable.

In an essentially normal population it is reasonable to use the lowest effective dose to achieve the proportionately greatest benefit. The rare adverse events (eg, myositis) associated with statin use are dose-related and linked in many cases to drug-drug interactions that increase statin effects. The risk of such events with simvastatin 10mg is very low and

therefore the risk to benefit ratio for the self-medicating individual is extremely favourable at this dose.

Advising "people" at risk of CHD in their efforts to remain well and to help prevent them becoming CHD "patients" will be a new role for pharmacists but one that they are well placed to play.

### John Blenkinsopp

Principal Research Fellow  
School of Pharmacy,  
University of Bradford  
(and chairman of the J&J/MSD  
Pharmacy Advisory Panel for the  
proposed switch of Zocor Heart-Pro  
from POM to P)

### Reference

1. Wald NJ, Law MR. A strategy to reduce cardiovascular disease by more than 80%. *BMJ* 2003;326:1419–23.

## Adverse effect on coenzyme Q10 levels

From Professor V. Preedy, FRCPath, and Dr D. Mantle, FRCPath

Recent items in *The Pharmaceutical Journal* have highlighted moves by the manufacturers of simvastatin (Johnson & Johnson/MSD), together with Government agencies, to reclassify statin drugs from prescription-only to pharmacy over-the-counter supply within six months (*PJ*, 22 November 2003, p699 and p705). Statins are potent inhibitors of 3-hydroxy-3-methylglutaryl coenzyme A reductase and the rate-limiting enzyme in cholesterol biosynthesis. This action is not selective, resulting in the inhibition of several non-sterol isoprenoid end products, including coenzyme Q10. The effect of statins in lowering coenzyme Q10 levels is well documented and should be a matter of concern to clinicians and other health care professionals, in addition to their better-known adverse effects (eg, myalgia, liver dysfunction, polyneuropathy). Many of the adverse effects resulting from statin use can be rationalised in terms of concomitant coenzyme Q10 depletion.

Coenzyme Q10 is a vitamin-like substance that plays a key role in normal cell functioning, in cellular energy transduction (as an electron carrier in mitochondrial oxidative phosphorylation), as a lipid-soluble free radical scavenging antioxidant, and as a stabiliser of cell membranes. Because of the continual high requirement for energy, coenzyme Q10 is particularly important in

the human cardiovascular system, as well as in the normal function of the immune system. Coenzyme Q10 is obtained partially from the diet, and partially via synthesis within the body; levels decline with age, and are depleted in a number of disorders, particularly cardiovascular disease.

Although coenzyme Q10 depletion may be tolerated in younger patients, particularly in the short term, with the trend to use statins in higher doses or in longer term treatment regimens, individuals are increasingly at risk from the effects of statin induced coenzyme Q10 depletion (particularly the elderly and those with chronic cardiovascular disease). Current prescribing information for statins gives no specific warnings or guidelines regarding coenzyme Q10 supplementation, although the pharmaceutical industry is well aware of this problem (Merck has held two patents dating from 1990 relating to co-administration of statins and coenzyme Q10). However, statin-induced coenzyme Q10 depletion is currently the subject of a citizen's petition to the US Food and Drug Administration, requiring manufacturers to change the labelling of all statin drugs to recommend the use of coenzyme Q10 supplementation. In addition, the marketing of statins in Canada requires labelling warning of coenzyme Q10 depletion, and the possibility that this "could lead to impaired cardiac function in patients with borderline congestive heart failure". It is possible that the true therapeutic potential of statin drugs is being partially negated by reduced coenzyme Q10 levels, and that co-administration of both substances would lead to an even greater reduction in cardiovascular morbidity and mortality. Oral supplementation of coenzyme Q10 would be necessary, as the latter is not available from the diet in sufficient amounts to compensate for the depletion in levels induced by statins. Thus the statin induced depletion of coenzyme Q10 could be completely prevented by co-administration of coenzyme Q10 supplements, with no adverse effects on statin cholesterol lowering or anti-inflammatory properties.

### Victor Preedy

Department of Nutrition and Dietetics,  
King's College London

### D. Mantle

School of Biology,  
University of Newcastle

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

## ■ OSELTAMIVIR

### A patient group direction in London

From Mr J. Mason, MRPharmS, and Mr R. Radia, MRPharmS

We noted the article (*PJ*, 13 December 2003, p805) describing the development of a patient group direction for oseltamivir (Tamiflu) by Roche.

In City and Hackney Teaching Primary Care Trust, the local pharmaceutical committee and the PCT have jointly developed a PGD authorising suitably trained community pharmacists to supply oseltamivir to at-risk patients who either present with symptoms of influenza or who have been exposed to somebody with suspected flu. The at-risk groups are those aged 65 years or older, or adults or children who have chronic respiratory disease (including asthma and chronic obstructive pulmonary disease), have significant cardiovascular disease (excludes people with hypertension only), have chronic renal disease, are immunocompromised due to disease or treatment, have diabetes mellitus, or live in a residential care establishment or are otherwise household.

We chose oseltamivir rather than zanamivir, for several reasons:

- It is orally administered, so patients do not have to learn how to use a new device
- It can be used in children
- It can be safely used in people with respiratory disorders
- It can be used during pregnancy and breast-feeding (although we have specified these as exclusion criteria in our PGD)
- It can be used for both treatment and post-exposure prophylaxis

The scheme is designed to relieve pressure on GP practices should there be a flu outbreak. The PGD will come into operation if and when the Health Protection Agency's Communicable Disease Surveillance Centre weekly reports indicate that consultations for flu-like illness have exceeded higher than normal seasonal activity levels.

All pharmacists in City and Hackney TPCT have been invited to participate and those interested in taking part in the scheme will receive training in the operation of the PGD.

The LPC and the TPCT are committed to increasing the contribution that pharmacy can make to improving public health.

This scheme will help to increase awareness within the TPCT of community pharmacy's valuable public health role. This is also an example of how community pharmacy can improve access for patients and deliver new and cost-effective services, thereby helping the TPCT achieve its access targets.

In addition, by linking a new service development to training we are helping to improve the knowledge base of community pharmacists, and assisting in their continuing professional development.

#### Jonathan Mason

Head of Prescribing and Pharmacy City and Hackney TPCT

#### Raj Radia

Committee Member, North East London Local Pharmaceutical Committee, and Chairman, City and Hackney Community Pharmacy Forum

## ■ DIABETES

### Good management does not depend on self-monitoring

From Mr P. Burrill, MRPharmS

Further to my article in which I explored the evidence base for regular self-monitoring of blood glucose in those with type 2 diabetes (*PJ*, 15 June 2002, p847), I would like to share what has been happening in North Derbyshire.

After much discussion and debate, and several drafts, we have introduced a local guideline on self-monitoring in type 2 diabetes. A key aspect is that the need and frequency of testing should be determined by answering the

question, "how is this test going to alter what I do?". One GP practice (five partners), which was already composed of relatively low prescribers of testing strips, implemented the guideline a year ago and has recently completed an audit to assess changes in practice. In a year it has reduced the prescribing of blood glucose testing strips in type 2 diabetes by 82 per cent.

The process was easier than the partners expected and feedback was generally good; patients were relieved at not having to self-test. Some resistance occurred if the new arrangement conflicted with previous advice given but it still provided an opportunity for review. The diabetes nurse has been able to devote more time to other areas of patient management and the GPs have focused on HbA<sub>1c</sub> results. In a year, the percentage of patients with a HbA<sub>1c</sub> level <7.5 has increased from 67 to 81 per cent. The percentage of patients with a blood pressure <140/80 has increased from 55 to 76 per cent and those with a cholesterol <5 from 62 to 66 per cent.

This is one small audit but it does suggest that good management of type 2 diabetes does not necessarily depend on self-monitoring of blood glucose. Reducing the use of self-monitoring is possible in general practice and acceptable to both patients and staff, and can divert resources to improve the quality of diabetes care.

Readers who would like more information can contact me at peter.burrill@chesterfieldpct.nhs.uk.

#### Peter Burrill

Specialist in Pharmaceutical Public Health North Derbyshire Public Health Network

## ■ PACKAGING

### One manufacturer is on our side over size

From Mr J. C. Berrill, MRPharmS

I agree with Peter Beckley (*PJ*, 13 December 2003, p812) that packs are getting bigger, unnecessarily. However, one manufacturer seems to be on our side, helping those of us working with limited shelf space.

Karib Kemi-Pharm Ltd has produced a range of generics in small, neat packs that are about 70 per cent of the bulk of most other offerings. Its pack of 14 trimethoprim 200mg tablets is a gem. Perhaps our wholesalers could help us to use more packs similar to these.

#### Julian Berrill

Ringwood, Dorset

## ■ PRODUCT NAMES

### Phenytoin rope!

From Mr C. Goalen, MRPharmS

I fear that Arthur Williams's novel solution for naming new drugs (*PJ*, 20/27 December 2003, p841) has a poor prognosis. It is, you might say, a "road map" for bringing some sanity to the complexities of pharmaceutical nomenclature. Alas, recent trials of this genre in the world have not proved fruitful. However, I hope he will take heart on hearing that, as was suggested some 45 summers ago when we both worked at the Manchester Royal Infirmary, I keep a phenytoin rope in my boot in case the car goes in fits and starts.

#### Clive Goalen

Harrogate, North Yorkshire

## ■ ALCOHOL METABOLISM

### Dizzy and delightful to danger of death

From Dr I. ab I. Davies, MRPharmS

While reading Pamela Mason's article on alcohol misuse (*PJ*, 6 December 2003, p777), I was reminded of Gaddum's description<sup>1</sup> of the four stages of alcohol intoxication, which he described as an aide-memoir as "dizzy and delightful, drunk and disorderly, dead drunk and danger of death" equating to blood alcohol concentrations of 100, 200, 300, and 400mg/100ml, respectively. I

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noted from the article that only two stages were considered equating to blood-alcohol concentrations of less than 50mg/100ml and of 100–500mg/100ml and above. I wonder whether, over the intervening 50 years, man has become tolerant to the effects of alcohol.

The difference in blood-alcohol concentrations between men and women has been attributed to different proportions of body water to body fat between the sexes. Although women tend to have a lower body mass than men and therefore blood volume, which is proportional to body mass, will be smaller, a difference in blood-alcohol concentration is not apparent when an equivalent dose of alcohol is administered intravenously. Neither of these facts adequately explains the difference in blood-alcohol concentrations between the sexes after oral intake of an equivalent dose of alcohol.

The difference in blood-alcohol concentration after oral administration could be due to the marked difference in the mass of liver between the sexes. On average the liver in women weighs 1.2–1.4kg and in men 1.4–1.8kg — a difference of approximately 25 per cent. Of an oral dose of alcohol absorbed and equilibrated in the liver during a first pass, 25 per cent more free alcohol would pass into a woman's blood stream compared with a man's. Also because a greater amount of alcohol is retained in the male liver, more alcohol will be metabolised making less available for later diffusion into the bloodstream.

**I. ab I. Davies**

*Ballygowan, Co Down*

#### Reference

- Gaddum JH. *Pharmacology* (4th ed). London: Oxford University Press; 1953.

#### DECISION SUPPORT

### Choosing between a rock and a hard place

From Mr R. Glasspoole, MRPharmS, and Ms H. Judd, MRPharmS

Following the recent **Broad spectrum**, "Crying wolf" (*PJ*, 22 November 2003, p708), and the ensuing correspondence (*PJ*, 6 December 2003, p773) from a number of readers I thought it would be valuable to give the perspective of a supplier of computerised drug interactions. With clinical decision support you

are damned if you do and damned if you don't. Decision support can be considered analogous to pharmacy practice in that no matter how many positive interventions you make you tend to be judged only by the errors that have been missed. What has not been mentioned is that computerised interaction alerts have provided valuable warnings to health care professionals in identifying "overlooked" interactions of sufficient clinical importance to require alternative treatment.

First DataBank (FDB), the suppliers of the Multilex Drug Data File used by a number of pharmacy system suppliers, is acutely aware of the need to cut down "background noise" to reduce information overload. This is one of our biggest challenges because no two health care practitioners agree on the need for an alert — if it is known to them, it is "noise"; if not, the alert is required. Therefore this challenge affects not only suppliers of health care applications but also individual health care professionals.

Fundamentally, drug knowledge base suppliers provide the core knowledge and rules. Computerised drug interactions cannot be considered in isolation without understanding a patient's physical condition and the clinicians' knowledge. An interaction considered of minor clinical importance can still have major therapeutic consequences, particularly in patient populations (consider the implications of one fit on a previously stable epileptic patient). An important interaction can still be overlooked by an experienced clinician as we were recently reminded by a director of pharmacy investigating a case where a consultant had overlooked a warfarin-azole interaction.

In order to resolve the issues with computerised drug interactions a user profile is required where the user can individualise the alerts that they want to see. We consider that it is impossible to produce centrally a set of rules that meets "one size fits all" criteria. The core rules provided by the decision support suppliers need to be able to be customised at various levels including by the individual users of the application. However there needs to be a full audit trail to ensure that it is recognised that clinical decision support information has been purposely filtered. One of the key requirements for "user friendly"

decision support is greater collaboration between the providers of clinical systems, purchasers of such systems and the health care professional.

This year FDB has been involved with three projects led by the National Patient Safety Agency looking at different issues with decision support. One of the projects involved the NPSA commissioning an academic research project to identify the drug-drug combinations that should generate "critical prescribing hazard alerts", which cannot be easily overridden by GPs using electronic prescribing systems in the UK. FDB supported this project by supplying information on nearly 200 drug interaction combinations that we consider to be the most clinically important for the panel to review. One important aspect of our collaboration is that the results from the study will help to specify future requirements for drug interaction functionality. This will enable the knowledge gained from the study being routinely available in the clinical environment.

Last month's announcement of the first contracts being awarded

for the National (NHS) Programme for Information Technology (*PJ*, 13 December 2003, p802) heralds the start of a new era where the everyday use of IT will be unavoidable and will probably have far greater impact on the practice of pharmacy than anything else.

Decision support based on an individual's full health record will become routine and a standard tool for improving patient safety and care. When the majority of the routine patient and clinical checks are automated a valuable opportunity is created for pharmacists to engage patients and physicians more readily in pharmaceutical care.

We would be pleased to hear from any reader with comments about decision support since these are invaluable in helping to develop functionality that meets clinical requirements.

**Robin Glasspoole**

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**Hillary Judd**

*Head of Knowledge Base Services,*  
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## ■ MODERNISATION

**I believe our profession has been weakened**

From Mr C. Martin,  
MRPharmS

I have watched from the sidelines with growing concern and feel strongly that I should now take the opportunity through your letters columns to voice my concerns regarding the new Charter for our profession and comment on the way our Council has seemed to ignore the views of some of our colleagues.

I took the opportunity to respond to the consultation and was grateful for the personal response received from modernisation project manager Christine Gray. I was specifically concerned regarding the process of consultation and the fact that in the absence of the S60 order we were being asked to decide on the future of our profession without all the facts. I understand that the Department of Health has been given proposals regarding the new legislation by the Council but, as usual, it is the Government that will ultimately

determine and have the final say on what appears in the draft Order.

The Charter should concern itself with representation and the Order should take care of the regulatory function. Both are inextricably linked and between them should form a robust framework that will secure our professional future.

I believe the process should have and could have been better co-ordinated by the Council. Therefore I cannot understand why there is such a great rush to sign off the new Charter and why in the face of some major opposition and concerns further consultation and dialogue has been ruled out. I have some sympathy with the Save Our Society campaigners and still cannot understand why a 1,000-name petition seems to have been ignored.

I am chairman of the primary care organisation (LHB) in Pembrokeshire and in a similar situation I would have been duty bound to respond to such a mark of discontent with the process. Lessons must be learnt from this. I am sure that support for their cause would be welcomed and this

apparent injustice should be addressed.

It is clear to me that during this time change it is essential that we have strong professional representation and leadership. I believe this has been a missed opportunity and strongly feel that our profession has been weakened by the whole process.

**Chris Martin**  
*Chairman, Pembrokeshire LHB*

ANN LEWIS, Secretary and Registrar, Royal Pharmaceutical Society, replies: As Mr Martin says, the Council's proposals for the S60 Order are now with the Government. Ultimately, the terms of both the Order and the Charter are in the hands of Government ministers, since it is Government ministers who take Privy Council decisions. It is also right that the Charter and legislation are inextricably linked. If decisions on the Charter had been delayed until the draft legislation was ready, the Government might not then have been willing to alter it to fit in with what the Council wanted to see in the Charter. The Council could then have been restricted to producing a Charter to fit with the legislation as drafted.

The Council's intention is certainly not to ignore the views of pharmacists, which have informed and strengthened the draft Charter. The Council's purpose in petitioning the Privy Council at this time is to ensure that the Government will prepare its S60 Order in the clear knowledge of the Council's wishes for both the legislation and the Charter. This provides the best means of making certain that, between them, they form a robust framework that will secure the broad remit of the Society and reinforce the key roles of professional leadership and development.

**Member of silent majority speaks out**

From Mrs P. K. Sandhu, MRPharmS

After reading letters in *The Pharmaceutical Journal* and postings on the Private-Rx website, this former member of the silent majority has been moved to write. I find the wording of the Charter impossibly difficult to decipher, and agree with Tony Watson's sentiments (*PJ*, December 20/27 2003, p840). I thought we lived in a world where plain English was the gold standard, or maybe I am a naive idealist.

I have always put trust in the champions who I know do understand such technical details to thrash it out and work towards a just outcome. It appears, however, that the Royal Pharmaceutical Society is following the culture of the current Government: ignoring the wishes and concerns of the majority in order to pursue its own strategy relentlessly. I urge everyone who, like me, has so far not got personally involved to read whatever they can: get out those old copies of the *PJ* (or just hit the search button on the website), visit the Save Our Society website pages and make up your mind which side you support. Then do something about it.

After more than 20 years in a profession which I believe has always been "world-class" but poorly represented by its gatekeepers, this pharmacist is going to raise her head above the parapet and risk being counted (or shot down).

**Paramjit Sandhu**  
*Southall,  
Middlesex*

ANN LEWIS, Secretary and Registrar, Royal Pharmaceutical Society, replies: The recital, or introduction, of the Charter certainly sounds old-fashioned but this is still the required form for such documents.

In updating the Charter, the Council is seeking to secure the Society's integrated nature as a regulatory and professional body, which is what the majority of pharmacists who responded said that they want.

The Council has taken full account of the views expressed in two consultations on the Charter and in more than 50 meetings held around Britain.

The new Charter, if granted, will allow us to retain the flexibility and autonomy that chartered status provides and will support the development of the profession well into the future.

## ■ PRESIDENT'S MESSAGE

**Laudable altruism**

From Mr M. J. Lee, MRPharmS

Gill Hawksworth's message (*PJ*, 20/27 December 2003, p849) indicates a laudable altruism but I think that it would be wrong to suggest that others, rather lacking in this quality, could not, or should not, do the job of being a

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pharmacist. For my own case, I get few complaints from customers to whom I believe I offer a proficient service, carried out in the manner befitting of an English gentleman, which means I will only do it for money.

**Michael Lee**  
Birmingham

#### ■ FELLOWSHIPS

### Why community pharmacists are in short supply as fellows

From Mr J. P. Bannerman,  
FRPharmS

I wholeheartedly applaud and support the letter from Monty Goldin (*PJ*, 20/27 December 2003, p841). The letter is one of congratulations to those who have been designated fellows, while putting forward the challenging question, "are there no community pharmacists worthy of such an honour?"

Bearing in mind the numbers of our colleagues involved in delivering high-quality, innovative patient care, along with those who

have moved forward the boundaries of the profession's role in the community setting, there can be but one positive response. With the preponderance of our members engaged in the community, and the quality of the work done there, I believe that it is almost an embarrassment to the profession that we have not been able to include in the recent announcement any community pharmacist who has "attained the distinction in the science, practice, profession or history of pharmacy".

However, it has to be stated that the Royal Pharmaceutical Society is entirely dependent on fellows and members putting forward the names of suitable candidates for fellowship. This is a challenge for us all in that the overall number of fellows is diminishing at a time when the standard of pharmacy practice has never been higher.

I know that I am speaking for my colleagues on the Panel of Fellows when I say that while we must all maintain the standards of distinction pertaining to fellowship, it is encouraging that the Council has reduced the qualifying time to 12 years. In

addition, the Council has announced that it intends to introduce next year, a second route to fellowship based on self-nomination. I hope that this, along with Mr Goldin's letter will encourage many more recommendations for designation by the membership.

**Jim Bannerman**  
Glasgow

#### ■ RETENTION FEE

### A totalitarian and bureaucratic Society

From Mr R. Blyth, FRPharmS

Any pharmacist who thinks that the Save Our Society campaign is unnecessarily alarmist should think again after reading the following statement that accompanied the retention fee form for 2004.

It reads: "Late payers will not be treated as leniently as they have been in the past. Members who do not settle their fees on time risk erasure from the Register."

This is the language, not of a professional body, but of George Orwell's prophetic book 'Nineteen

eighty four': "Authority, totalitarian and bureaucratic, has you under its observation from which there is no escape."

**Robert Blyth**  
Milton Keynes,  
Buckinghamshire

### Is this a plot to trim down the register?

From Mr C. J. Richardson,  
MRPharmS

I have received my annual retention fee form for 2004. I noted with interest the inclusion of many stern warnings that the law requires payment by 1 January 2004 and that failure to pay promptly will be treated less leniently than in previous years.

The warnings would have been more effective if the form had not arrived on 3 January.

My hope is that this is run-of-the-mill inefficiency rather than a sinister plot to trim down the register.

**Chris Richardson**  
Raynes Park,  
London

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## ■ RETENTION FEE

**If the form is late how can we pay in time?**

From Mr N. K. K. Aling, MRPharmS

I received the Royal Pharmaceutical Society's letter to inform me that I should pay the 2004 annual retention fee, which is due by 1 January 2004, on 3 January.

In the letter, it says: "Under the Pharmacy Act 1954, section 2(3), payment is due by 01 January 2004. Failure to make payment by this date will be treated less leniently than in previous years. Members who do not make payment on time risk erasure from the register, and those who continue to practise following erasure risk prosecution."

If we receive the annual retention fee form late, how can we possibly pay in time?

Lucky for me, I am not at risk because I pay by direct debit.

**Nicholas Aling**  
London SW4

**Demand could have been less patronising**

From Mr C. Smith, MRPharmS

It is rare indeed for me to voice my feelings towards the Royal Pharmaceutical Society. I have just returned from holiday to find the "Pharmacist's Annual Retention Form 2004" informing me that under the Pharmacy Act 1954, section 2(3), "payment is due by 01 January 2004. Failure to make payment by this date will be treated less leniently than in previous years. Members who do not make payment on time risk erasure."

I do understand the answers that, no doubt, justify issuing such a demand for payment. However, perhaps a less patronising use of "less lenient" might have been less disagreeable.

I would hope future letters sent out by the Society may be written in a more acceptable style. I would add that threatening people with immediate erasure and then asking for charity is not usually the best way to get money out of them.

**Chris Smith**  
London E4

**E-mail**

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**Musings**

From Mr D. C. Shenton, MRPharmS

Musings followed receipt of the retention fee papers on Christmas Eve, with their intimidating approach requiring my attention within the hour so as to have a small hope of not contravening the law.

1. Lambeth must have data showing that no members are away from home during December or, nowadays, up to their eyes in work.
2. The threat in paragraph three of the covering letter is empty.
3. If (2) is mistaken (in which case, woe is me), what series of events will commence on 2 January? What will they cost?
4. Presumably the Council gave approval to this debt-collector's approach.
5. The exacting provisions of the Pharmacy Act can only justly be used to beat us if the mailing arrives each year in late November, if not sooner.

**David Shenton**  
Staines,  
Middlesex

**Stop treating us like naughty children!**

From Mr P. J. Sealey, MRPharmS

If I were the Royal Pharmaceutical Society's Registrar, I would be going out today to buy a large eraser and some canes: the former to perform erasure of all those pharmacists' names who have not paid their retention fees by 1 January, and the latter to "apply less leniency to late payers", in the form of spanked bottoms presumably, if the tone of the letter is anything to go by.

Few pharmacists of my acquaintance pay their fees quickly, and I know of one or two who do not get their cheque books out until February or March. At Christmastime, I rarely open post which looks as though it might not contain glad tidings. Such envelopes are usually consigned to the sideboard drawer, at least until after Epiphany, apart from credit card statements, which have an absolute cut-off date, and those bills offering a discount for prompt payment.

So, here are some ideas: give us an absolute date after which we will surely be struck off (but not 1 January — have a heart), offer a modest discount for early payment

or monthly direct debit (you will be surprised how tempting the odd pound or two off will be), and, if you want results, stop treating us like naughty children.

**Philip J. Sealey**  
Warwick

*The Journal* has received several other letters in a vein similar to those published above. Retention fee forms were not sent out until mid December because the Society cannot act until approval for the fee increases has been granted by the Privy Council. Permission to increase the fees was granted on 1 December.

Retention fees have always been due on 1 January and the "less lenient" approach to late payers is being taken after concerns were raised at the 2003 annual general meeting (*PJ*, 24 May 2003, p732). — EDITOR.

## ■ CHRISTMAS MISCELLANY

**"Ikey pikey" pills**

From Mr J. E. Packham, MRPharmS

I was most interested to read the article on Taylor, Brawn & Flood by Roger Jacob (*PJ*, 20/27 December 2003, p871). In the article, reference is made to "hierapiera". I believe this to be "hierapicra" — aloes and canella powder, a powerful purgative with a dubious reputation as an abortifacient. In the early 1950s when I was an apprentice, I was warned to refer requests for "ikey pikey" pills to the pharmacist.

Another reference is to "Taylor's ready mixed mustard". When I returned to community pharmacy for a short time in the mid 1980s, I worked at Taylor's chemist in Newport Pagnell, near Bedford. Large jars of Taylor's Mustard were on sale and may still be available locally.

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**Memories**

From Mr J. Taylor, MRPharmS

Roger Jacob's article Taylor, Brawn & Flood of Bedford (*PJ*, 20/27 December 2003, p871) brought back memories, as I worked as manager of the Bromham Road branch (my first managerial post) for a short period in 1957 and 1958.

At that time the superintendent pharmacist of the company was a Mr Hanscombe — a pharmacist of the old school and a gentleman. But the managing director was Commander Newton, a somewhat intimidating ex-naval man. I think it was the commander who introduced the use of open pick-up trucks instead of vans for stock deliveries to the branches in order to reduce loading and unloading time — fine for mineral water perhaps, but less than ideal for pharmaceuticals.

The Bromham Road premises were old and had an interesting curved shop door, and what were probably the original fixtures and fittings, including an ancient cast iron gas heater. On the back of one of the showcases was an old coaching timetable. I even found some leaflets advertising Horse Balls.

The dispensary had a glass door opening on to a garden that was tended by TB&F's oldest employee, who lived in the flat over the shop. "Uncle", as everyone called him, was in his late 70s or early 80s and still working, having been employed by the firm as a dispenser as a young man. I was told that he arrived in Bedford to take up the position on the back of a horse-drawn farm cart, attracting attention because of his frock coat and top hat. Might it be possible, I wonder, that the young man so dressed in the watercolour could be "Uncle"?

In addition to the usual pharmaceutical lines, we sold the company's soft drinks and prepared mustard, and carried a range of photographic goods, although there was also a photographic department in separate premises just around the corner from the High Street branch.

I considered myself reasonably well paid on £15 per week. Incidentally, in spite of the name, I cannot claim to be related in any way to the John Taylor of Taylor, Brawn & Flood, although I may have gained a certain amount of (probably unwarranted) respect from a few customers who thought that I might have been.

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