

■ STATIN SWITCH

## Pharmacy is willing, but participation must be on realistic terms

From Mr P. Jenkins, FRPharmS

The latest large public health initiative involves the reclassification of simvastatin from prescription-only supply to pharmacy (*PJ*, 3/10 January, p8). Just taking a tablet is not enough, however, because healthy lifestyles must be embraced, and that is what public health is all about.

It is intended that pharmacists will be widely involved in the initiative. They are to be part of the induction process, then help in monitoring for compliance because it is essential that patients be motivated to persist with the treatment. They will also supply the statins.

This is a unique initiative and can give indications of pharmacy's possible future role in the NHS, since the Government's real intentions towards the profession can be determined from how this project is presented.

The pharmacist's induction and monitoring roles will have to be funded — and funded at a proper level, not on the cheap but out of new money like the new roles for GPs. Another question arises over who will pay for the drugs each month. Making them P indicates patients will be expected to pay. Patients told they need long-term medication that they will have to pay for themselves might think twice, especially as the less affluent will probably have no tradition of paying for prescriptions. Will the pharmacist be expected to talk them into, and check on,

long-term monthly purchases? And what will be the cost? What is a realistic charge to the patient for medicine and back-up?

Pharmacy is willing to participate and contribute, as ever, but it must be on realistic terms. Our negotiators know what is required and although this year's offer indicates little goodwill by the Government the position with a new project is different. We could say "no" to the whole thing if terms are not acceptable and make it clear that, like the doctors, we value ourselves — and so, too, must the DoH, if it really wants the plan to succeed.

**Peter Jenkins**  
Cardiff

■ DISPENSING

## The dangers of open plan dispensaries

From Mr D. P. Phillips, MRPharmS

I wish to express my concerns about organisations adopting open plan dispensaries (*PJ*, 15 November 2003, p667). I agree with Susan Coyle (*PJ*, 6 December 2003, p774) but would go further and suggest that some open plan dispensaries are not just distracting but potentially dangerous. Staff working in such dispensaries can be put under unnecessary stress and in my opinion become more prone to making mistakes.

Clearly the more mistakes that are made, the greater the chance of a pharmacist or checking technician missing one. Indeed some stressful situations are generated specifically because of a lack of privacy and confidentiality (*PJ*, 22 November 2003, p709).

Let me share some of my experiences of an open plan pharmacy:

- In high-volume, longer-waiting-time situations, "crowding" of technicians by patients can occur, possibly in an attempt to see what is happening to their prescription or almost to intimidate and push them to work faster. Tutting, audible sighs, drumming of fingers and plain verbal abuse all help to coax the situation along.
- Patients sometimes attempt to correct technicians if they think they are dispensing their medicines.
- Patients comment on what they mistakenly believe to be their medicines but which are, in fact, someone else's.
- Technician work flow is constantly stopped to answer queries because patients believe they have immediate access to the pharmacist and technicians regardless of what they are doing.
- Technicians under training are put under pressure with patients staring and literally breathing down their necks. This can be off-putting for experienced staff but for those in training, in my opinion, it can have a negative impact on confidence and performance.
- Difficult situations arise from seeking to correct dispensing errors in front of the patient; unsurprisingly this can give rise to lack of public confidence and poor public perception.
- Discussions about medication with colleagues, or over the telephone, are overheard by the public and this has led to problems. Also, half-heard conversations between staff can be misinterpreted by the public.
- Security of the dispensing bench is compromised.
- Aggression by difficult patients is hard to defuse because there is nowhere to go. In addition, discussion has to take place with an audience.

This list is not exhaustive. However, what has been of interest is that the company involved redesigned its open plan pharmacy and screened off a large part of the dispensing area. Since the redesign there has been a dramatic reduction in near misses.

**David Phillips**  
Market Drayton,  
Shropshire

## Prescriptions by appointment

From Mr D. P. O'Sullivan,  
MRPharmS

I recently had the opportunity to observe what I believe is now called "the dynamic" between a community pharmacist colleague and a client/customer/service user/patient.

My colleague had a number of prescriptions pending and had, unusually, persuaded the raptorial circle of patients to disperse and reassemble in about 20 minutes. A patient arrived in the seemingly quiet pharmacy and presented a prescription. It was a single item prescription to treat the dermatological testosterone flux indicator that was his face. My colleague advised the patient, gently, of the impossibility of instantaneous supply. The patient, as you may have anticipated, replied, "Why, what is the problem? It is only tablets." A further, more detailed, yet still gentle, explanation was given. The patient, apparently with an imminent appointment, said he could not wait and he would retain his prescription and departed with same and my colleague's blessing.

It may be asked why not allow the patient involved to "jump the queue" and indeed, it is a temptation. However it is axiomatic that as soon as one starts the "promoted" prescription, a member of the first circle returns and the mental health implications for all parties involved are beyond computation.

I have to ask myself, when did we allow our profession to become so harried and hurried? People will wait patiently (I omit the obvious pun) for cobblers and dry cleaners, and yet not for us. I am uninformed about the need for interaction checks and life-threatening events associated with holed soles and stained garments, yet we strive, it appears, to produce the results quicker than a scratch card. Is this irreversible?

My wish for the New Year?  
Prescriptions by appointment.

**Declan O'Sullivan**  
Dublin,  
Ireland

### Telephone number

All correspondents should supply a daytime telephone number, in case we need to contact them urgently

Letters for publication can be posted, faxed, or sent by e-mail to [letters@pharmj.org.uk](mailto: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.

## ■ PACKAGING

**From the perspective of an elderly carer**

From Mr A. G. Hopkins, MRPharmS

I have read many articles on medicines for the elderly, and a lot of them, possibly researched by younger people, seem to miss a vital point: consultation with the elderly consumer.

Having served four score years and ten, I am classed as the official carer of my 91-year-old wife who suffers many of the ailments of old age, such as disablement, glaucoma, deafness, etc. She has to have medication which I supervise. My main annoyance is the blister pack which, for the elderly, is a menace. I would suggest that a younger researcher dons a pair of heavy duty gardening gloves and then tries to open a blister pack.

There are other problems with blister packs: small tablets easily get lost because the pressure required to pop the blister often means the tablet ends up on the floor and cannot be found. I have solved this problem by carrying out the task over a basin.

The use of oversize blister packs containing minute tablets can be a problem because pressing the blister does not break the seal and we have to resort to scissors.

Blister packs may be manufacturers' answer to supply but the bottle is still best, in my view.

I often wonder how lonely old people without a knowledgeable carer manage. I am sure most medicines are wasted and the GP is often misled as to the efficacy of a particular regimen, often prescribed by a consultant.

**A. G. Hopkins***Aldershot, Hampshire***PJ Online**

The *Pharmaceutical Journal's* website, PJ Online, can be found on the internet at [www.pjonline.com](http://www.pjonline.com).

At the site, pharmacists can take advantage of a daily news services and can view the contents of the current weekly issue. The site also contains a searchable archive of *PJ* material and a searchable database of current job advertisements. There is also a feedback facility, whereby browsers can send e-mails to the editor and to the business development manager.

**Refuse to order outside packs for stock**

From Mr K. K. Upadhyaya, MRPharmS

Peter Beckley asks why packs are getting bigger (*PJ*, 13 December 2003, p812). Although parallel imports remain a problem, the solution for generics is quite simple: when ordering, simply specify that a particular brand should not be supplied. When the companies using outside packaging find that none of their stocks are being reordered, they may reconsider their packaging strategies.

I note with interest that, however large the packaging becomes, there still remains insufficient room to attach a normal sized dispensing label without obliterating important information.

**Kamlesh Upadhyaya***Elstree, Hertfordshire*

## ■ AMATEUR RADIO

**International group for pharmacists**

From Mr S. J. Gilbert, MRPharmS

Members who are amateur radio enthusiasts may wish to have a look at the International Pharmacists Ham Group website at [www.malpensa.it/iphg/index.htm](http://www.malpensa.it/iphg/index.htm). Started in March 2002 by two Italian pharmacists, it now has 181 members in 42 countries, and our membership continues to grow. The aim is to promote worldwide friendship for our members who work in all fields of pharmacy.

**Stephen Gilbert***UK Co-ordinator International Pharmacists Ham Group*

## ■ RECIPROCITY

**Make it easier for overseas pharmacists to work in Britain**

From Mr V. M. Summers, MRPharmS

I read the section entitled "Reciprocal registration agreements" in the report of the October meeting of the Royal Pharmaceutical Society's Council (*PJ*, 11 October 2003, p524) with

some alarm. For many years the mainstay of locums available to the hospital pharmacy service (and probably to the community, too) in the UK have been pharmacists from Australia and New Zealand who wish to travel and work temporarily in the UK.

This ending of the reciprocal agreement is likely to have a significant impact on the number of pharmacists available as locums to hard-pressed hospital pharmacies. Have members of the Council really thought this through before approving it? We have had an acknowledged shortage of pharmacists in the UK for several years, which is even now affecting community pharmacy (*PJ*, 29 November 2003, p730). The new schools of pharmacy will have no impact on pharmacist numbers for several years and the profession has managed to steer itself high up the health agenda in the four health administrations, which will result in investment in pharmacy.

The Society should be looking at ways of making it easier for overseas pharmacists with equivalent qualifications to work in the UK, not harder. Even the Government has got this message by placing pharmacists on the list of shortage professions for the speedier awarding of work permits.

**Vince Summers***Chief Pharmacist Borders General Hospital, Melrose, Roxburghshire*

ANN LEWIS, Secretary and Registrar, Royal Pharmaceutical Society, replies: When this issue was considered, the Council recognised the importance not only of maintaining standards for entry to the register but also ensuring that the criteria are applied consistently for all applicants. The decision will not come into effect until the necessary regulations have been made and change in process agreed. Discussions are also to be held with relevant bodies in Australia and New Zealand.

## ■ ONLOOKER

**Islam and science**

From Dr A. M. Alam, MRPharmS

The "disturbing account of the state of scientific endeavour in Islamic countries" highlighted by **Onlooker** (*PJ*, 3/10 January, p34) is all the more tragic when one considers that from the 8th–15th centuries the Islamic world led the rest of the world in scientific

development. Islamic scientists excelled in numerous fields such as architecture, astronomy, geography, medicine and mathematics. Many crucial systems such as Arabic numerals, and the Indian concept of the zero, were transmitted to medieval Europe from the Muslim world. One has to only look at the origins of many commonly used words — alcohol, algebra, algorithm, cipher, elixir, chemistry — to realise that they are derived from Arabic.

In the mind of the historian Briffault, "science owes a great deal more to the Arab culture, it owes its existence". He further comments that "had it not been for such Muslim upsurge, modern European civilisation would never have arisen at all ('The making of humanity', London, George Unwin & Allen, 1928).

Historian George Sarton speaks of "the miracle of Arabic science, using the word miracle as a symbol of our inability to explain achievements which were almost incredible . . . unparalleled in the history of the world" ('Introduction to the history of science', Baltimore: Williams & Wilkins Co, 1927–48).

**A. M. Alam***Maidenhead, Berkshire*

## ■ THE CHARTER

**Questionable claim**

From Mr D. I. Simpson, FRPharmS

The Secretary and Registrar says that the Royal Pharmaceutical Society's Council has taken full account of the views expressed in two consultations on the Charter and in more than 50 meetings held around Britain (*PJ*, January 3/10, p16). If this were the case, the Charter object of promoting the interests of the members in their exercise of the profession of pharmacy — something about which members had expressed much concern — would be in the draft Charter sent to the Privy Council. It is not.

Furthermore, the motions passed at the special general meeting in June (*PJ*, 7 June 2003, p802) — one of these called for the preservation of the object to which I have already referred and another wanted a referendum on the Charter — have been essentially ignored.

**Douglas Simpson***Member of Council Royal Pharmaceutical Society*

■ THE CHARTER

## Answers, please!

From Professor H. McNulty,  
FRPharmS

It gives me no pleasure to write this letter after I read about the procedural and governance issues surrounding the Council's acceptance of the new Charter for the Royal Pharmaceutical Society. The article from Sydney Holloway (*PJ*, 13 December 2003, p810) makes salutary reading on what might have been. The response to consultation (*PJ*, 20/27 December 2003, p848) is, on the other hand, rather disappointing and gives few clues about all the issues raised in the consultation process or the Council's views on these issues.

What debate was there on the matters raised by the Scottish Executive? There is no reference to any consideration of these points. While the resultant Charter is an improvement over previous versions, it was produced in haste with last-minute changes that were not agreed unanimously — a high-risk strategy with such an important document.

There are a number of questions to which I would like to have answers:

1. The Health Act was issued in 1999, so why did we find ourselves in a position of disunity and apparent panic at the last minute of the process over four years later?
2. When was the December 2003 deadline for the Charter first known? How was this taken into consideration in drawing up the consultation schedule?
3. How was the first Charter consultation paper issued by the Society without full prior discussion and approval by Council? (Whatever the answer to this, rules of Governance must be written to prevent this ever happening again.)
4. Why did the Council not withdraw the first draft Charter immediately after serious problems were identified? This could have given time for a proper consultation on a second version. (The intransigence of the leaders of the process who saw no difference between objects and powers or the need to accept early major changes is indefensible in hindsight.)
5. Why was the first draft not withdrawn immediately after the special general meeting or the June Council meeting, which finally accepted the need

for change? (This would have still given time for preparing and properly debating the second improved version within the December looming deadline.)

6. Why were special general meeting motions seen as undemocratic and then largely ignored by Council?
7. How could any Council members agree to sign off the Charter with less than 75 per cent majorities in a number of votes and when some members openly expressed concerns over lack of time for consideration?
8. Given the control the Charter exerts on professional activities, why was the consultation on the topic of professional leadership left until September and again a paper apparently largely devoid of anything but a cursory Council discussion then issued?

There seems to be a lack of appreciation of the nature of the challenge and the need to unify the profession in this process. Talk of wide consultation is nonsense — branches had no chance of responding in the few weeks allowed to agree the final Charter and there were few if any regional discussions with Officers on the final draft. The Council and Officers appear now to be exposed to public humiliation through court action. This will weaken our professional standing in the eyes of government and of other professions. What a sad end to such an exciting opportunity!

**Howard McNulty**  
*Glasgow*

ANN LEWIS, Secretary and Registrar, Royal Pharmaceutical Society, replies: Professor McNulty raises some important questions. I will address them in turn.

1. Even after a lengthy process of consultation and policy development, those charged with taking final decisions will feel conscious of their responsibilities. So it was for the Council in December but there was no last-minute panic. Following consideration of the Health Act in 1999, the Council established a working party to develop proposals for reform. The Health Act Working Party sought views on and produced recommendations for the Society's fitness to practise machinery and mandatory continuing professional development. Proposals were

submitted to the Department of Health. At this stage, the Council recognised that these proposals were not necessarily a long-term solution but could provide a way of achieving much-needed improvements until it became clear whether more far-reaching reform was needed. Since then, the external context has changed significantly. We have seen further legislation, the reform of other health professional regulators, the establishment of an overarching council of health regulators, and the much broader interpretation of regulation set out in the Kennedy report. In response, the Council initiated a further programme of reform in October 2001. Pharmacists and others have been consulted on a broad range of issues to inform the new legislation and the new Charter. Decisions have now been taken on the Charter but there is much still to be done before the reform programme is completed.

2. The Council decided in March 2003 that the new Charter should be developed alongside proposals for new legislation, in order to safeguard and strengthen the Society's integrated remit as a professional and regulatory body. The extensive consultation programme undertaken between March and September was designed with this in mind. At that time, we were aiming to complete the decisions to inform the legislation in August and for final decisions on the Charter to be taken in October. In the event, proposals for the S60 Order were completed in October and decisions on the Charter in December. This allowed the Council to publish a second draft Charter in October for any further comments before final decisions were taken.
3. This is simply wrong. The initial draft Charter was agreed by the Council to be issued as a basis for consultation — no more, no less. It was discussed by the Council but was not put forward as the Council's preferred draft (*PJ*, 15 March 2003, p378).
- 4–6. The SGM motions were considered by the Council in June 2003. The Council acknowledged the strong concerns expressed at the SGM but recognised that it would not be proper to take decisions

about the new Charter while a consultation was ongoing. It is quite wrong to suggest that the Council has not taken full account of members' views. Certainly, it could not incorporate every suggestion into the final draft Charter. This would never have been possible because the Council has to act in the best interests of the profession as a whole. The public, patients, government and other health professions also have vital interests in the future of the Society. The Council has taken full account of the views received, as shown by the important changes made to the draft Charter in response to that feedback. Members have played a real part in the development of the new Charter.

7. There was no requirement for approval of the final draft Charter by a specific percentage of Council members, other than by a majority. In the event, the final draft was approved by 70 per cent of Council members present and voting. The timescale was tight but there was sufficient time for consideration. Every Council member had the opportunity to speak on the draft Charter and to vote either for or against the final draft.
8. External timetables have meant that the initial emphasis has been on the Society's governance framework and its regulatory functions. But it is not right to suggest that no consideration was given to the Society's key functions of professional leadership and development before last September. In fact, the Council's decision to seek a new Charter provides the clearest demonstration of its commitment to maintaining and building upon the Society's professional role. The discussion paper published in September was to inform future work on describing credible and appropriate structures which, together with the governing Council, could support the full range of the Society's functions in the future.

This is a lengthy response but I hope it provides clarification. I agree that the new Charter represents an exciting opportunity. I also believe that the new Charter, together with the new legislation, will form a robust governance framework for the Society of the future.

■ THE CHARTER

## The Council may have exceeded its powers

From Mr M. Koziol, MRPharmS

If any pharmacist had any doubt whatsoever that some members of the Council were intent on turning the Royal Pharmaceutical Society into a regulator at the expense of the representative role, then they should simply study the front cover of *The Journal* of 13 December, which gives a detailed view of the Privy Council petition.

The petition claims that the Council believes that the Society should, for the public benefit, be more appropriately equipped to function as a regulator. It does not mention representation of pharmacists and there is no mention of promoting and safeguarding the members in their exercise of the profession of pharmacy.

But even as some of the Council and staff were busy congratulating themselves on what they consider to be tough and uncompromising leadership they were doubtless aware that this matter would not simply go away.

On the following day, I was in a meeting, surrounded by some of pharmacy's most eminent and senior personalities; the meeting was joined by Charter experts — two lawyers and a barrister.

It transpired that not a single rule or regulation could be found anywhere which could have given some members of the Council the authority to have done what they did without first securing a 75 per cent majority vote on the Council and then seeking the permission from the membership through a special general meeting. As we now know, they secured neither.

Leading counsel opinion is that they have exceeded the scope of their powers and they had no business or authority in petitioning the Privy Council in the way that they did.

The Society has been established as a membership organisation for over 160 years and its assets are conservatively worth more than £100,000,000 — surely the modernisers did not believe that the members would simply idly stand by and allow them to hand over these considerable assets to the government's regulatory agenda?

There is still time to overturn the decision taken by the last Council meeting, but to do this will require pharmacists to support financially proceedings in the High Court.

I appeal to all pharmacists to support the SOS campaign. The actions of the membership could still ensure that we have a professional membership body that we can be proud of and one that we can pass on to future generations of pharmacists.

**Mark Koziol**  
*Birmingham*

## The Journal is there to serve the members

From Mr R. Blyth, FRPharmS

In substituting your own headline "Totalitarian and bureaucratic" without even a question mark in place of my own "Save Our Society" over my letter (*PJ*, 3/10 January, p17), you may have inadvertently conveyed a wrong impression of my view of the Royal Pharmaceutical Society, damaging my credibility. I attached these words not to the Society, but to the language accompanying the retention fee form. It was to the language that I objected.

The main purpose of my letter was to support the work of the Save Our Society campaign and in particular to indicate how and where to send cheques needed for the campaign's legal fees. All that information was omitted from my letter as published.

I believe it is the duty of our *Journal* to provide such information to members. Perhaps the censoring of my letter is evidence of the dictatorial inclinations of the present Council. But the *PJ* is there to serve the members, not the dictates of the Council, and is, as well as being an official organ, an organ of a free press in a free society.

**Robert Blyth**  
*Milton Keynes, Buckinghamshire*

Mr Blyth's original letter was not censored; it was abridged in order to sit within a section of members' letters relating to the retention fee form, which we thought was the central point he was making.

Presumably, Mr Blyth, as a former editor of *The Pharmaceutical Journal*, had a similar relationship with the Council of the Royal Pharmaceutical Society as the current editor, who is accountable to the Council for the content of *The Journal*. However, *The Journal* has been put under no pressure by the Council to restrict the reporting of Save Our Society campaign activities. We have published several letters from members who object to the

Council's petition to the Privy Council. We covered the fact that the SOS campaign intends to go to law (*PJ*, 20/27 December 2003, p831) and we also pointed out that it was appealing for financial donations (*PJ*, 13 December 2003, p801). We will continue to report developments as they take place. Pharmacists interested in learning more about the SOS campaign and its appeal can visit its website at [www.saveoursociety.org.uk](http://www.saveoursociety.org.uk). —EDITOR.

■ THE JOURNAL

## Well done!

From Mr G. R. Ashdown, MRPharmS

I am impressed with the new layout and type face of *The Pharmaceutical Journal*. For the first time ever in my 30 years career as a pharmacist, the *PJ* now has a readable, easy-to-find format. It is a good improvement and long overdue.

I have always said that my wife's *Nursing Standard* was far more readable and more interesting to look at than the *PJ*. Consequently, most of my *PJs* were previously consigned to the waste bin unread or practically so, as the whole issue appeared uninteresting and boring. I could not be bothered to wade through them.

Now, at long last the *PJ* is on a par with such publications as the *Nursing Standard*, and has become eye-catching and readable. Well done!

**Graham Ashdown**  
*Chatham, Kent*

## Congratulations

From Mr G. Bryan, FRPharmS

Although someone past the end of his career, rather than a younger member for whom you say the redesigned *Journal* is primarily aimed, may I offer my congratulations to all concerned on its new appearance.

It seems to me that Peter Laws has done a splendid job in harnessing his typographical skills to the proper service of

improved readability, although I am aware that a designer can only be as good as his client in achieving that.

Also, am I not right in thinking that you have begun to use a less heavily coated paper? I certainly seem to spend less time squinting at **Onlooker** and more time reading him. Which brings me to my only criticism. My favourite page has the most recessive colour in its flagged solid rectangle; make an old man happy and persuade Mr Laws to choose a beefier one.

**Geoffrey Bryan**  
*Walton-on-Thames, Surrey*

## A most attractive new format

From Mr J. R. A. Baker, MRPharmS

Yes, most of us 45-years-plus readers are presbyopic (*PJ*, 3/10 January, p2). Why, therefore, are the letters printed in a smaller type face than the rest of the copy? I find them difficult to read with my +2.5 reading glasses. Otherwise, a most attractive new format.

**John Baker**  
*Bury St Edmunds, Suffolk*

## Do not lose clarity

From Mr R. G. Carter, MRPharmS

The typeface changes in *The Journal* do not seem, on a subjective basis, to have improved readability at all. Objective measurement of typeface size certainly confirms this impression with regard to that used in "Letters to the editor".

Additionally, the density of type seems to be reduced. This section of *The Journal* is one of the most interesting elements and it would be regrettable if it were accorded lesser importance than the rest of the editorial matter.

The rest of the "bottle" is quite acceptable but please do not allow the "wine" to lose clarity.

**R. G. Carter**  
*Hove, East Sussex*

We are sorry if some find the letters pages difficult to read. The type size on letters pages has for many years been marginally smaller than that in the rest of *The Pharmaceutical Journal* in order that we can fit in as many readers' comments as possible. However, the type size in our new-style letters pages is actually slightly larger than in our previous design. —EDITOR.

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