

■ WHICH? REPORT

We cannot shift responsibility away from the pharmacist

From Ms G. Ames, MRPharmS

I was surprised to read your leading article "Which? hunt" (*PJ*, 7 February, p142). The suggestion that if the patient is known to his or her local pharmacist, the quality of service provided would be higher is rubbish. That statement is a weak excuse for incompetence. The whole concept of community pharmacy is our easy availability to the public. Anyone should be able to walk into our pharmacies and obtain good advice.

Our pharmacy assistants are supposed to be trained to ask patients the initial, relevant questions and to refer them to the pharmacist when necessary. However, your article would have us believe that the onus of responsibility for imparting that information lies with the patient, not with the pharmacy staff. Are we to understand that the general public have somehow educated themselves to a degree that they can now comprehend their condition sufficiently well as to apprise the medical profession without being prompted? My training and that of the counter assistants has always been that we are to be proactive and thorough in our questions to the patient in order to understand the condition described. On numerous occasions I have questioned patients who, for example, emphatically deny taking any other medicines. However, after the third or fourth time of asking (in different ways), a realisation dawns and the patient

states: "Oh yes, I am taking some of those. Is that what you mean?"

Yes, patients do have a degree of responsibility to impart the information sought but we cannot shift the onus of responsibility away from the professional, who knows what questions to ask and appreciates the significance of the answers.

It is clear from the *Which?* report that the pharmaceutical profession is not ready to embark on all the new initiatives that the Royal Pharmaceutical Society and the Government are keen we should. High dispensing levels and often cramped conditions in our retail premises has put enormous pressure on pharmacists. I accept that the profession must move ahead into new areas, but it should not be at the expense of essential services currently available.

Geraldine Ames*Stroud,
Gloucestershire***Let us move away from the blame culture**

From Dr M. C. Watson, MRPharmS

The Royal Pharmaceutical Society has asked *Which?* to identify the pharmacies that were visited for their recent report "Can your pharmacist cope?", their purpose being to "help the pharmacies visited" not for "punitive" reasons (*PJ*, 14 February, p198). Although it makes uncomfortable reading to learn about the inappropriate outcomes of the covert visits made during the study, the Society's reaction in wishing to seek out these pharmacies is cause for even greater discomfort and suggests that it is missing the point. The

problem will not be resolved at a pharmacy-level: organisational changes are required.

Currently, within the NHS there is an increasing focus on risk management and improved patient safety. A key theme of enhancing safety and minimising risk in high risk activities such as the provision of health care in general, and the supply of non-prescription medicines in particular is the emphasis on the process that generates the risk or error, not the individual.¹ In this case, it is the process of supplying non-prescription medicines in general and not the individual pharmacy or member of staff with whom the *Which?* "patient" consulted.

In order to progress, we need to move away from blame culture and to start looking at the bigger picture. If the public is to have confidence in the supply of non-prescription medicines and advice from pharmacies we need to think about radical changes in the activities of community pharmacists and their staff. Time and again we hear of pharmacists remaining in the dispensary while the least-trained members of staff are involved in the riskiest activity, ie, supplying the medicines. Either pharmacists need to move out to the counter or the people behind the counter need further training to equip them with the skills and knowledge necessary to ensure the safe and effective supply of non-prescription medicines. Organisational changes are required to provide pharmacy support staff with regular ongoing training to ensure that they are equipped to deal with customer requests and needs.

Training solely to enhance knowledge is not enough.^{2,3} There are many barriers, other than lack of knowledge, to the supply of non-prescription medicines from pharmacies: inadequate communication skills, lack of protocols (eg, which patients, products and symptoms to refer to the pharmacist or GP), and adverse customer/patient response all reduce the likelihood of achieving ideal outcomes with consultations.

The Society's time would be better spent addressing these issues rather than trying to identify the pharmacies that generated the less than favourable outcomes.

I am currently investigating these issues as part of an MRC fellowship: "Identifying optimal strategies to promote the evidence-based supply of non-prescription medicines from community pharmacy". I would welcome comments or suggestions from

community pharmacists and their staff or, indeed, the Society on possible solutions to the problems discussed above.

Margaret Watson*Department of General Practice and
Primary Care,
University of Aberdeen
(e-mail m.c.watson@abdn.ac.uk)***References**

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Society should have called for Government investment

From Mr J. Andrews

As a preregistration trainee I am disappointed with the Royal Pharmaceutical Society over its inadequate reaction to the *Which?* report, the findings of which are a blow at a time when the profession should be seen as a source of excellent service and reliable advice concerning all aspects of health care.

Calling for proper support and investment from the Government, and stressing that the results were not a clear representation of the profession as a whole would have been a good start for the Society. Now the opportunity has gone.

James Andrews*Guildford, Surrey*

■ COMMUNITY PHARMACY

Treat all customers professionally

From Ms W. A. Stone, MRPharmS

I strongly disagree with J. S. Bowman (*PJ*, 14 February, p184) who would keep drug misusers out of community pharmacies. I am ashamed of his attitude towards drug-dependent patients. Does he include nicotine-dependent patients or are they acceptable to him?

He complains of hassles of storage, checking for accuracy of prescriptions and incredibly, "necessary book-keeping

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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.

involved". Does he also complain when recording a supply of morphine to a patient in severe pain?

Perhaps in his role as a locum pharmacist he does not have the chance to get to know the patients and establish a rapport with them.

We aim to treat all our patients and customers in the same professional manner and most respond accordingly. When a patient does not conform to expected behaviour, then is the time to consider withdrawal of service. I agree that some patients can be abusive, threatening, demanding and intimidating but this behaviour is by no means exclusive to drug-dependent patients.

Contrary to Mr Bowman's view, I see every reason to treat drug-dependent patients in the community as another step towards their rehabilitation.

Wendy Stone
Bristol

Patients are grateful for drug misuser services

From Mr M. C. Harvey, MRPharmS, and Ms M. Saunders

In response to the letter from J. S. Bowman (*PJ*, February 14, p184), we are concerned about the generalisations and lack of professional understanding he shows. We have worked in many pharmacies that provide services to the drug misusers whom Mr Bowman wants to eject from community pharmacy.

First and foremost, they are patients and need treatment. Secondly, we are professional health care providers in the community. Since these patients belong to the community, it is the pharmacist's role to assist them. If we are looking for enhanced pharmacy roles why turn them away?

Community-based patients are not all of the personality type Mr Bowman describes. Many are grateful for the service and thankful to see any glimpse of a helpful attitude to their plight. Indeed a positive attitude to the care of these patients may well contribute greatly to their rehabilitation.

M. C. Harvey
Chichester,
West Sussex

Michelle Saunders
Final-year Pharmacy Student
University of Portsmouth

Pharmacists can build a supportive relationship with drug misusers

From Miss E. R. Mills, MRPharmS

I was saddened by J. S. Bowman's views on the treatment of drug misusers in community pharmacies (*PJ*, 14 February, p184). I work for a drug and alcohol service co-ordinating a supervised administration of methadone scheme from community pharmacies. Providing a service to drug misusers can be rewarding, and not just because of the payment received each month.

Department of Health guidelines have emphasised the importance of community pharmacists in the care of drug misusers as part of shared care arrangements.¹ Much work has been done to ascertain pharmacists' views on, and involvement in, the care of drug misusers. A questionnaire to community pharmacists showed that 69 per cent of pharmacists were interested in supervised methadone consumption and 67 per cent in shared care arrangements.² Another study looked at the opinions of pharmacy support staff. Positive attitudes were associated with service provision; over half of all staff were happy to be involved in service provision and two thirds believed the pharmacy was an appropriate place for providing these services.³

I agree that drug misusers can be a security risk to the store and that staff can feel threatened and intimidated. Shoplifting and dealing with intoxicated users is a common problem — whether providing a service to drug misusers or not. Clients in a treatment programme are generally well behaved. They have a lot to lose if they are withdrawn from the programme. Pharmacists involved in supervised administration of methadone report few serious incidents and contact with the police does not change significantly after the introduction of the service.⁴ So surely we should be supporting such programmes to encourage drug misusers to seek help and minimise the problem of intoxicated clients in our pharmacies?

There are hassles associated with dispensing methadone. However any Controlled Drug prescription can be written incorrectly. In my experience, drug misusers are much more understanding about the inconvenience caused by an incorrectly written prescription, than, for example, a relative collecting morphine for a palliative

care patient. We should be liaising with GPs to ensure they understand the importance of the CD prescription regulations, not withholding services from patients.

A separate clinic prescribing and dispensing for drug misusers is not, in my opinion, a viable option. Many clients are prescribed for by their GP, and these numbers will increase as shared care agreements are implemented. One of the strengths of community pharmacy is its accessibility. Most clients pick up their methadone daily. This provides stability and routine for the client trying to get some order back into his or her life. It offers an opportunity for a brief assessment of their physical and mental well being, and reduces the risk of leakage of methadone on to the streets and the risk of accidental overdose. Many clients do not live near a clinic and visiting one may involve an hour's journey each way. This is not practical on a daily basis, especially if the client wishes to start work, and is likely to demotivate the client and risk them leaving treatment.

Drug misusers are the only patient group that pharmacists will see daily and such contact allows them to build a supportive relationship with clients. Once in treatment, the improvement in a client's physical, mental and social well-being can be dramatic and being part of that process is extremely rewarding.

Elizabeth Mills
London NW3

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Broad Spectrum

The Broad Spectrum feature is open to any reader. Contributions of around 1,100 words commenting on topical issues should be sent to graeme.smith@pharmj.org.uk

Give respect to gain respect

From Miss R. E. Hossack, MRPharmS

I disagree with J. S. Bowman (*PJ*, 14 February, p184) about drug-dependent patients. I have worked in a busy city centre store in Edinburgh with a large number of methadone patients and needle exchange users and I believe that a community pharmacy is undoubtedly a suitable setting for dealing with their needs. Often drug misuse clinics are understaffed and under-resourced, sometimes only opening for short periods. Community pharmacies, however, are easily accessible and increasingly open longer hours, catering, for example, for those patients in full- or part-time employment. There is the opportunity for patients to access information and advice from pharmacists and other pharmacy staff with regard to other aspects of both their own and their families' health. Pharmacies also allow patients to be included in community life and to build relationships with people outwith their usual circle, and to be treated like a human being rather than "the least desirable members of the public".

I accept that problems can arise but these can be managed by simple measures to allow these patients to have access to the health care advice and services that I and my colleagues give to all our patients. A written contract (with photograph attached for identification) between the pharmacy and user stating times convenient to the business at which the patient can attend is a valuable tool. Simple guidelines can be included as to how all patients are expected to behave with a statement that the pharmacist has the right to discontinue dispensing the prescription if bad behaviour occurs. With clear boundaries, the vast majority of patients behave in an acceptable and often exemplary manner and those who do not are dealt with swiftly.

In my experience, it is frequently the way in which any patient is treated or spoken to that dictates their response and I have always found that by giving respect I gain respect. I look forward greatly to the day when these patients are treated without prejudice in the community sector.

R. E. Hossack
Bathgate,
West Lothian

■ COMMUNITY PHARMACY

Mutual respect is key

From Miss A. R. Hudson,
MRPharmS

When I first qualified, as a young woman in charge of a pharmacy I admit I was apprehensive about dispensing methadone. I was unsure of how I would deal with any potential problems with drug misusers. I had heard horror stories similar to those mentioned by J. S. Bowman (*PJ*, 14 February, p184).

However, I have since found the majority of patients collecting methadone to be courteous to me, the pharmacy staff and other customers. They are polite while waiting for prescriptions and generally appreciative of the service offered. In return, I always ensure methadone is dispensed first thing in the morning to allow swift collection by the patient, and that I am friendly and professional towards each patient. Mutual respect is the key to a successful patient-pharmacist relationship.

Of course, I have experienced an occasional drug misuser who causes disruption. However I have also had "challenging" patients from all sections of the community, young and old.

The provision of needle exchange or methadone services is a good way for community pharmacists to be involved in the rehabilitation of patients who misuse drugs, and is one way the patient can feel normal and not sidelined into a "special" clinic.

Although I now only work occasionally in community pharmacy, I look forward to treating all members of the community on those days, whatever their needs.

I am sorry that Mr Bowman's experience has been so negative. Perhaps he could liaise with his local drug misuse treatment team to overcome some of the difficulties he has had in the past.

Allison Hudson
Wokingham, Berkshire

A most one-sided view of the treatment of drug misusers

From Ms C. S. Charlton, MRPharmS

J. S. Bowman (*PJ*, 14 February, p184) has presented a most one-sided view of the treatment of drug misusers in the community. Once a patient has been prescribed methadone or another treatment

for his or her problem, they are embarking on a pathway which, given the necessary support, may lead that person back to a useful and rewarding life. Community pharmacists are in an ideal position to offer support, with regular contact with the patients.

I do not expect Mr Bowman treats other categories of patients with such disdain. Like Mr Bowman, I work as a community pharmacist in the north east of England. My experiences are different. I have also been abused, threatened and met demanding and intimidating people in the course of my working life. Yet none of my methadone clients has ever been involved in these situations. Shoplifting is not to be tolerated, and in the shops where I work we make it clear to our patients that if it does happen they will no longer be able to have their methadone dispensed from our premises. Well-motivated people do not risk being thrown off a well-run scheme.

Drug misusers are people and should be treated as such, not excluded from our lives. If a family member of Mr Bowman's ever made a mistake which led to drug addiction, I wonder if he would then consider it correct to deny that person access to the type of health care which is the right of each and every one of us.

I am sure that Mr Bowman's belief that "no one believes that methadone or other treatments of drug-dependent patients should be dispensed from a community pharmacy" is wrong.

Carol Charlton
Darlington, Co. Durham

Complaints about drug misusers' behaviour are negligible

From Mrs H. L. Walker, MRPharmS

Although I can understand J. S. Bowman's discrimination (*PJ*, 14 February, p184) against drug misusers who are in treatment on the grounds that he may have had unpleasant experiences in the past, to justify it due to the problems arising from incorrect prescriptions, storage problems and book keeping difficulties seems wholly inappropriate.

A reason to support their treatment in the community is that there is extensive evidence that treatment reduces injecting behaviour and therefore the spread of HIV and hepatitis C.¹ It also reduces crime, and improves physical and psychological health.²

These benefits of methadone maintenance have now been demonstrated in primary care where pharmacists played the crucial role of supervising consumption.³

Surely to see any patient improving in so many aspects of their life should be incentive enough; the extra payment given is intended to cover the workload involved.

The difficulty of substance misusers can be greatly exaggerated and usually is done so by those who have a greater ignorance of the subject and who do not get involved. The Shared Care Scheme in East London covers nearly 900 patients treated by 150 GPs and 50 pharmacists and the number of complaints about patients' behaviour is negligible.

As health care professionals our duty of care is to help patients, not turn our backs because of a few isolated incidents.

H. L. Walker
*Shared Care Substance Misuse
Manager
Mile End Hospital, London E1*

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Last words

From Mr W. D. Fisher, MRPharmS

The final paragraph of Bob Dunkley's letter (*PJ*, 21 February, p215) puts me in mind of the following. About a decade ago, while I was still in Glasgow, two "methadonians" were quietly awaiting their turn to receive their supervised dose and were chatting about their respective stays in London, courtesy of Her Majesty, in Wormwood Scrubs. A dodgy character entered the pharmacy and they turned on him: "You! Out of here! No shoplifting! They look after you in here!"

Walter Fisher
Whitefield, Lancashire

Drug misuse services contribute to society

From Ms F. Donachie, MRPharmS

Since the 1960s when the two Brain Committee reports were published, the view of drug addiction in Britain has been considered to be a condition for which treatment could and should be provided. Over the years this has led to the development of specialist services. These services are run by a wide range of professionals who have contributed greatly to the well being of the clients they see and also to our society as a whole.

The UK government and the devolved Scottish Executive continue to take the view that this group of people should be actively helped with their addiction and just as importantly, with the wider social problems that they experience.

In 1999 the "Orange Guide" (Drug Misuse and Dependence — Guideline on Clinical Management) was published throughout the UK and in Chapter 1 it states: "Drug misusers have the same entitlement as other patients to the services provided by the NHS." I mention specifically "other patients" because this is one of the points which J. S. Bowman (*PJ*, 14 February, p184) fails to appreciate.

Various papers have shown that many community pharmacists want to engage actively with this group of patients and that their work benefits the individual and society as a whole. The idea of a central clinic for all clients is not an appropriate way forward for the service or the client — it is expensive, isolating for staff and client and, most importantly, stigmatises a group of people who are an easy target.

I agree that this group of patients is not an easy group to deal with at times. However, work has been carried out which shows that, with appropriate training and support, pharmacists can and do provide a valuable service to their communities.

I would suggest to Mr Bowman that he should contact his local addictions service for advice and assistance. There are also training and coaching packages available that may help when dealing with any patient who may have specific difficulties.

Frances Donachie
*Specialist Pharmacist in Substance
Misuse,
Ayrshire & Arran Primary Care
NHS Trust*

■ BRANDED GENERICS

Cost implications are enormous

From Mr I. Bell, MRPharmS

I support Paul Kirby in his condemnation of branded generics (*PJ*, 21 February, p215). Primary care trusts in general do not support such prescribing. This is because the PCTs are aware of the long-term detrimental effects this will have on overall prescribing costs, patient compliance and pharmacists' goodwill — especially so if a trend is set of changing prescribing habits every time a different branded generic becomes flavour of the month.

As Mr Kirby rightly points out, the cost implications to pharmacy contractors are enormous. Indeed my accountant has frequently pointed out to me that I would be bankrupt if I relied upon my professional fees plus practice allowance to provide the pharmaceutical services that I do.

It is common knowledge that it is pharmacy contractors' business skills that keep down generic prices through open market competition between suppliers. Prescribing of branded generics will destroy this equilibrium, which will ultimately drive up the price of drugs to the NHS. I sit on my local PCT prescribing subcommittee, which is unanimously against the use of branded generics as a short-term fix to an individual practice's prescribing budget, and is acutely aware of the implications that such a switch would have in the long term.

I would therefore urge other pharmacists, especially those in the same PCT as Mr Kirby, to support him, and if necessary boycott any meetings called (in pharmacists' own time) to discuss future PCT projects, unless they start to engage local pharmacists in open

discussion before implementing such schemes which could jeopardise the PCT, pharmacists' remuneration and, most of all, compromise the consistent supply of medicines for patients.

Ian Bell
Middlesbrough, Cleveland

■ OPEN-PLAN DISPENSING

Lack of confidentiality is a slippery slope to oblivion?

From Ms D. A. Allen, MRPharmS

Patient confidentiality is a cornerstone of any profession. So, by making pharmacists compromise patient confidentiality through open-plan dispensaries, are some companies undermining pharmacy as a profession?

Can community pharmacists really engage with other members of the primary health care team if they cannot guarantee the confidentiality of their own customers? In my view, compromise on patient confidentiality is the slippery slope towards professional oblivion.

Deborah Allen
Stourbridge, West Midlands

■ VALUE ADDED TAX

No VAT please, we're pharmacists!

From Mr G. A. Boorman, MRPharmS, and Mr H. R. Patel, FRPharmS

Your coverage (*PJ*, 24 January, p77) of a commercially motivated campaign over reduction in VAT on non-prescription medicines brought to mind the professionally

motivated submission of the North-East London Local Pharmaceutical Committee to the Government in June 2000, during its National Plan for NHS consultations. The LPC said at the time that over-the-counter medicines that are of proven efficacy in priority areas of health promotion and children's medicines should be zero-rated for VAT.

Pharmacists already provide a health promotion and disease prevention role as part of their current contract. However, this role could be significantly extended and made more relevant to the particular needs of the local population. Pharmacists can provide a valuable role in relation to primary prevention (such as healthy lifestyles and smoking cessation) and secondary prevention (for example, provision of aspirin and blood pressure/cholesterol monitoring post myocardial infarction).

Given the marked differences in the demographic distribution of disease, effective prevention policies are a vital component in the drive to address health inequalities. Community pharmacy services can be an essential tool in this endeavour. As has been noted, the use of pharmacy services is associated with deprivation as is the mean dispensing volume per population. Thus, local pharmacies are a particular resource for deprived populations. Studies suggest that convenience of access is an important determinant for pharmacy use and a third of patients arrive by foot — the need for pharmaceutical services therefore may be higher in areas where car ownership is lowest. This underlines the need to ensure that the distribution of pharmacies is maintained in deprived areas of London and other cities.

Many OTC medicines are of proven effectiveness in addressing

the health priorities of the Government. For example:

- Nicotine replacement therapy to counter coronary heart disease and cancer
- Aspirin 75mg for secondary prevention of heart disease
- Folic acid supplements for pregnant women
- Liquid paracetamol to relieve fever and pain in infants and young children

The costs of such treatments, however, can be prohibitive, particularly for those on low incomes. For example, NRT may cost £15 per week. (Although this is cheaper than cigarettes it provides little incentive to smokers to address their addiction.) Reducing the price of these treatments may play a significant part in encouraging their appropriate use, with consequent health benefits.

As part of a targeted health promotion strategy we recommend that the Government designates these (and other selected OTC medicines) as zero-rated for VAT. Glucose monitoring kits and nebulisers are already VAT-exempt if a patient fills in an appropriate claim form. Similarly, all children's medicines must be zero-rated in line with current policy on shoes and clothes.

It is not too late, with a general election looming in around 18 months, for the profession to collectively back the campaign and be seen as a champion of the common man. But, whether community pharmacy seizes the opportunity to lobby on professional grounds remains to be seen.

Gary Boorman
Chairman

Hemant Patel
Secretary, North East London Local Pharmaceutical Committee

Advertisement

■ CPD

Website problem identified

From Ms K. Johnson, MRPharmS

I recently received my box of continuing professional development materials from the Royal Pharmaceutical Society. I immediately read the text, loaded the CD-ROM and accessed the website. On attempting to make my first entry of CPD I could not enter the date and I could not get any choices from the choose boxes on the reflection page.

I telephoned the helpdesk (whose number is in the manual). It was able to identify the problem: I had a pop-up killer on my computer. However, it was unable to tell me how to disable this.

I then telephoned a computer-literate friend who advised me how to cure the problem. I have Norton security on my machine which provides an option to block advertisements and pop-ups. I switched these off and was then able to complete my CPD entry. However I can now expect vast amounts of advertisements to appear when I am online.

Perhaps it might have been useful if those who trialled the system could have let members know of this problem. Perhaps I can enter this technical experience as a CPD entry!

I understand from my friend (who designs websites) that this blocking of pop-up menus indicates a cheap website and that the problem could have been avoided by some java script being written.

Karen Johnson

Redhill,
Surrey

FRED AYLING, CPD officer, Royal Pharmaceutical Society, responds: I am sorry to hear of Ms Johnson's experience. The website does indeed use pop-ups. Pop-ups are a legitimate technology widely used by many websites. However they have gained a negative reputation because they are commonly used for advertisements. At the time when the website was developed pop-up killers were not in wide use. The settings on pop-up killers can be adjusted to permit pop-ups from legitimate sources, including www.uptodate.org.uk. I use the same pop-up killer as Ms Johnson and have changed its settings to allow pop-ups from www.uptodate.org.uk. This is a

straightforward procedure which takes a minute or two. Instruction can be found in the manual that comes with Norton Internet Security (NIS), to which I would ask Ms Johnson to refer. The advice that she received from her expert friend would seem to be to switch off her pop-up killer altogether which would mean that she continues to receive advertisements from other sites. We do not recommend that she do this.

There are at the very least some 170 different pop-up killers on the market. It is unreasonable to expect the technical helpdesk to know how to change the settings on all of these programs. It is, however, reasonable to expect those who choose to install a pop-up killer to know how to use it effectively. The helpdesk correctly identified the problem and advised Ms Johnson that she needed to adjust the settings on her pop-up killer. If she does not have the NIS manual, a search of the internet should find locations where one may be downloaded. Alternatively, advice is available from the publisher's website at www.symantec.com.

With regard to the use of java script as a solution to this problem, I am able to inform Ms Johnson that www.uptodate.org.uk already uses javascript. Indeed, pop-up windows cannot be created without it. Javascript is not a solution. The website is to be upgraded in the spring to include the use of Macromedia Flash technology. The primary reason for this upgrade is to create a smoother and more generally enhanced interface for users. One spin-off benefit is that it will do away with the use of pop-ups and their associated problems.

The CPD website now has close to 3,500 users. The helpdesk has taken in excess of 1,000 documented enquiries, the great majority of which have been dealt with quickly and effectively. The helpdesk is manned by members of the team who have developed the site, so callers will receive the best informed, expert advice. The helpdesk is committed to doing all it reasonably can to help users. To that end the helpdesk has written a set of instructions for making www.uptodate.org.uk a permitted site for pop-ups in NIS.

Telephone number

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

■ THE SOCIETY

Honorary members

From Mr S. W. F. Holloway

The President of the Royal Pharmaceutical Society is reported as saying that the first honorary member of the Society was elected in 1868 (*PJ*, 14 February, p200). In fact, honorary membership is as old as the presidency. Both categories are found in the original "Laws and Constitution of the Pharmaceutical Society of Great Britain", adopted by a general meeting on 1 June 1841. When the list of the founders of the Society was published in *The Pharmaceutical Journal* on 1 January 1842 (*PJ*, 1841/42, pp359-86) there were already 23 honorary members of the Society.

The Royal Charter of 1843 confirmed the Society's power to elect honorary members and to regulate, by Bye-law, their number, qualifications and privileges. Throughout the 19th century, honorary membership was restricted, by Bye-law, to "such scientific workers as have distinguished themselves in any of the branches of knowledge embraced in the educational objects of the Society". Honorary members were given all the privileges of membership of the Society except the right of being present at general meetings and of voting for the election of Auditors and the Council.

Sydney Holloway

Leicester

■ THE JOURNAL

Why the moratorium?

From Mr D. Simpson, FRPharmS

I would be glad if you would publish a rational explanation for the editorial decision to cease to publish further comment from members on the dispute about a petition for a new Royal Charter for the Royal Pharmaceutical Society (*PJ*, 21 February, p204).

As you acknowledge, there are at the present time no legal restraints on you publishing further comment, other than the normal ones concerning defamation. Accountability-wise, the Council has not asked you to call a halt to the debate. Is it that you just do not like argument. Surely not? It is the lifeblood of journalism in a civilised society.

Issues surrounding the possible granting of a new Charter have yet

to be resolved. There is much still to be discussed. So why have you decided that this discussion should not take place in *The Journal's* pages, and involve the Society's members?

A High Court case could be some way off, so your moratorium could last for a long time. I suspect that if you seek to persist, your position on it will become increasingly untenable.

It is, as you will know, the policy of the Council that *The Journal* "be produced in the interests of the members of the Society rather than the governing body" (*PJ*, 22 July, 1989, p110). The decision that you and your staff have taken is, in my opinion, against members' interests and arguably contrary to long-established Council policy.

Douglas Simpson

Beckenham, Kent

Member of the Royal Pharmaceutical Society's Council

We do not believe our decision is against members' interests. As we pointed out last week (*PJ*, 21 February, p204), nothing will be gained by publishing further comment on the issues until the case is heard in the High Court. Further debate in the pages of *The Journal* is likely to be repetitive and will have no impact on that decision. Moreover, we argued that issues are more likely to be muddied than clarified by further comment, which would not serve members' interests. In our view, any "issues surrounding the possible granting of a new Charter" can only be resolved after the High Court decision, and our pages will be open to include comment about developments thereafter. However, we are still reporting events as they occur (see p235).—EDITOR.

Hopes dashed again!

From Mr R. H. Higson, MRPharmS

I had a similar disappointment to Jim Rabbett (*PJ*, 21 February, p216) regarding POEMS. I was reminded of a poem my father regularly quoted:

*Johnny feeling life a bore drank some
H₂SO₄,
His father, an MD, gave him some
CaCO₃.
This neutralised him 'tis true,
But now he's full of CO₂!*

Ralph Higson

Wokingham,
Berkshire