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PHARMACY EDUCATION

Clinicians do not want pharmacists to be walking BNFs

From Professor A. T. Florence, FRPharmS

Duncan McRobbie fails to answer the question I posed in my letter to which he purportedly replies (*PJ*, 26 June, p802). The question was: "If science does not underpin clinical practice, what does?" One could ask a supplementary question: "What distinguishes a pharmacist's clinical opinion or knowledge from that of a physician or nurse?" He chooses instead to invoke a *reductio ad absurdum* in selecting a fragment of science that we teach, namely the synthesis of drugs. Pharmacists, he says, are never asked about how to synthesise drugs, therefore this topic is irrelevant. At least that is the interpretation he wishes readers to place on his piece of fun. Pharmacists may never be asked about the structure of DNA, either, but we believe that if they are to understand much about modern medicines or future medicines, they must.

The education of professionals requires a certain knowledge base, which is constantly being refined and extended. The criterion for inclusion of a subject in the MPharm programme cannot be what Mr McRobbie's pharmacist colleagues are asked on the wards today. There is an element of chicken and egg: if pharmacists are found wanting in extending the canon of knowledge through their own specialist understanding of matters outside the realm of their colleagues, then they will not be asked, at least not more than once.

If the object is to draw me into a debate about the particular topic he raised, then I would respond that we wish to impart something of the properties of drugs and to explain their reactivity and possible variability. So pharmacists might be asked about enantiomers and their behaviour, cross-reactivity in adverse reactions between different classes of drugs, hapten formation and metabolism, or if not asked might add something to the discussion about possibilities.[1] Could it be potential contaminants that cause this adverse reaction and not the drug? Why is it that biologics vary? And does it matter?

Senior medical clinicians that I have talked to do not want pharmacists to be walking BNFs but want them to have knowledge and understanding that they, themselves, do not have, namely pharmaceutical knowledge. They do not wish to see physicians *manqué*, but true pharmacists whose clinical understanding is underpinned by a different (but overlapping) subset of science from theirs.

We, here, certainly do not believe we have all the answers but through our academic pharmacy units and departments in hospitals, including the Centre for Paediatric Pharmacy Research at Great Ormond Street Hospital and the Institute of Child Health, we are gaining first-hand experience of what is uniquely required of pharmacists. We hope soon to appoint a Professor of Clinical Pharmaceutical Science jointly with University College London Hospitals, to pursue this vision of the future and to reinvigorate a research culture into practice, which might revive an interest in the fundamentals. Perhaps Mr McRobbie, who has published widely and is extremely knowledgeable on pharmaceutical competencies, can sit down with us to map out what the tree of pharmaceutical knowledge should look like, roots, warts and all.

A.T. Florence
Dean, The School of Pharmacy, University of London

Reference

1. Florence AT, Salole EG. Formulation factors in adverse reactions. London: Wright; 1990.

Practice — the appliance of science?

From Dr M. J. Norris, MRPharmS

I am distressed to read Duncan McRobbie's letter about the perceived inadequacies of the Master of Pharmacy degree courses offered by UK universities (*PJ*, 26 June, p802). I believe that it is important to reassure the profession that pharmacy academics do not just sit in ivory towers, completely divorced from the rest of the profession. I am just about to start a five-hour shift on a Sunday afternoon in a community pharmacy — the only one open within a radius of 40 miles!

Our courses are carefully constructed in consultation with all branches of the profession via employers' liaison groups. We also have both community and hospital teacher practitioners on the staff. The Master of Pharmacy degree courses are designed to give students a good understanding of the science underpinning pharmacy and to prepare them for continuing professional development upon graduation. To give but a single example, within pharmaceutics at Portsmouth, we try to teach the subject so that the students will have a good understanding about how formulation can be used to support clinical practice. For example, we would expect a student to understand the constraints on a formulation that should be administered by nasogastric tube rather than by simple oral administration.

Mr McRobbie mentions the inadequacies of recent graduates in undertaking simple patient counselling, providing routine health promotion or basic therapeutic drug monitoring. I share his concerns but I believe the best way of tackling this problem is not by diluting the science on the degree course but by giving the students more experience and hence the confidence in applying it. How can you tackle basic therapeutic drug monitoring without an in-depth knowledge of the drug? For example, to undertake monitoring of gentamicin, the pharmacist must be aware of the spectrum of activity of the drug and the desirable plasma levels associated with inhibition or death of the causative organism. Knowledge of the drug's pharmacokinetics and the factors that influence it are equally essential. Finally the chemistry of the drug must be understood to prevent possible interactions if the drug is co-administered with other drugs, eg, beta-lactams used for a synergistic effect. I do not accept that our students should tackle therapeutic drug monitoring without such an in-depth knowledge.

I recognise that the vast majority of our graduates leave university absolutely delighted that they will never see a spectrophotometer or gut bath again. However, the scientific knowledge that they have learned and applied with us will set them in good stead for their future in the profession.

Michael J. Norris
Head of Division of Pharmaceutics
School of Pharmacy and Biomedical Sciences,
University of Portsmouth

Reasonable level of patient contact needed

From Professor L. I. Goodyer, MRPharmS

In many respects I would agree with Duncan McRobbie's sentiments concerning the focus of the MPharm courses towards pharmacy practice (*PJ*, 26 June, p802). However, I do believe that sufficient scientific content must be included in the curriculum to provide a firm basis for future practice. For instance, the programme should aim to develop an understanding of the physico-chemical properties of drugs, dosage form and design, chemistry and pharmacology but contextualised as far as possible to application in pharmacy practice, ie, to the patient. In other words I am arguing for applied scientific content within the MPharm degree that is of most relevance to drug therapeutics, which may result in certain subjects being taught in less depth than has been the tradition in many schools of pharmacy. We should therefore be aiming to produce pharmacists who have a good grasp of the

Letters to the editor

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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.

science supporting the subject area rather than a "scientist" in the true sense of the word.

In my opinion, the only way to produce graduates more oriented towards the health professions is to ensure a reasonable level of patient contact throughout the undergraduate period, as alluded to by Mr McRobbie. In so doing the curriculum can provide relevant learning opportunities and also practical interprofessional education within the working environment. The placement system is, after all, how all other health professionals are trained.

I recognise that this direction presents huge challenges and changes to the current system of pharmacy education, but if government policy is to make use of the pharmacist as a health professional to deliver the NHS agenda it is a situation that cannot be ignored.

Larry Goodyer
Head, Leicester School of Pharmacy, De Montfort University

Has extra year not provided more practice experience?

From Mr P. I. Wilson, MRPharmS

In response to the letter by Duncan McRobbie (*PJ*, 26 June, p802) I would support his view that the undergraduate pharmacy degree has not prepared students for their future pharmacy practice. Having graduated as one of the last cohort of BPharm students I spent the first six months of my preregistration year in an industrial setting. When I started the second six-month placement in a hospital I quickly realised how little I knew about clinical practice. Only excellent clinical training in an understanding environment both in my preregistration year and then as a junior pharmacist, including that provided by Mr McRobbie himself, has led to my current competence. I know I am not alone in having felt little confidence in my abilities on starting out in clinical practice.

However, I would have expected that since my qualification the standard of clinical knowledge and confidence of graduates entering preregistration positions and therefore newly qualified pharmacists should have improved. Surely the extra year of undergraduate study now undertaken should have provided an ideal opportunity to increase the exposure of undergraduate pharmacy students both to clinical knowledge and experience and to the way in which they will be learning postqualification. Since the extra teaching time the MPharm degree gives has occurred as pharmacists are endeavouring to undertake increasingly clinically focused roles, I would expect this to be reflected in the knowledge gained by undergraduates.

I am ignoring differences between undergraduate pharmacy courses exemplified by the split preregistration year used in Bradford, which may provide a greater clinical impact for the students who experience it.

Patrick Wilson
Nottingham

What is the fourth year being used for?

From Dr I. H. Stockley, FRPharmS.

Duncan Robbie says: "... UK pharmacy undergraduate programmes fail to prepare future pharmacists for practice" (*PJ*, 26 June, p802). If this is so, what is the additional fourth year of the degree course being used for?

Ivan Stockley
Willoughby-on-the-Wolds, Leicestershire

BIG CONVERSATION

Pharmacists should manage the primary care drug budget

From Dr N. J. Gray, MRPharmS

I was disappointed that the report of the "Big Conversation" meeting with Rosie Winterton did not accurately reflect one of the "radical" ideas that were presented to the Minister during the group discussion at Lambeth last week (*PJ*, 26 June, p791).

We asked that pharmacists should manage the primary care drug budget, not the community pharmacy budget. The background information presented for our discussion asked how community pharmacists could best re-engineer their services with an ongoing 8 per cent annual increase in dispensed items. We made the point that there was no reason to assume that this should always be so, if community pharmacists could optimise patient therapy. Quality from optimising patient therapy should result in cost savings through waste reduction. Our discussion group believed that there is great expertise among community and primary care pharmacists to undertake this task. Community pharmacists are well used to managing budgets in their practices. Some practice and primary care pharmacists are managing their own drug budget in all but name. Hospital pharmacists have taken this responsibility for many years now, playing a pivotal role in the introduction of new drugs into practice, and developing and managing formularies. We have the skills, and we are training pharmacists who will also have the skills. Pharmacists, in partnership, can achieve this.

It was this suggestion that prompted Howard Stoate to say that he believed, as a GP, that other GPs would welcome it if pharmacists took over chronic disease management: it would let them get on with other things.

Pharmacists have an excellent argument to present in order to make optimal use of their medicines expertise for patient and NHS benefit. Responsibility for managing the drug budgets, at an individual patient and local population level, would be a most logical and professionally satisfying move that would cement pharmacists' role within the primary health care team.

Nicola Gray
Member of Council

The community/primary care drug budget was described in error as the community pharmacy budget. — EDITOR.

Let's clear the decks of the time wasters

From Mr N. Baumber, FRPharmS

It is both exciting and nerve-wracking to see a health minister discussing the future with pharmacists who are always eager to please, and the latest "Big Conversation" exercise held at the Royal Pharmaceutical Society with Rosie Winterton is no exception. However, apart from any government's inability to pay for what it gets, the problem for community pharmacists remains the lack of time.

As a caring sort of person I do not mind too much spending three evenings each week checking trays for the elderly. It is an essential part of secondary dispensing but there is no time to do it in a busy working day. It also clashes with evening meetings creating problems for continuing professional development, holidays and family life. There is still no rational method of payment to cover the costs in our part of the world.

And I do not mind spending an hour on my way home visiting patients because this seems to take the stress out of their lives and resolves the problems of the day.

Of the hurdles that we have to cross, to be able to work in a different way, it is the time wasting things that are most annoying which have been created by previous legislation. At the top of my list is the handwritten record of sales and purchases of methadone. Supervision is on the increase and has become a permanent daily feature. It takes a while to pre-fill the bottles, especially at weekends and bank holidays, but the laborious entry of details that is duplicated on the prescription and in the Controlled Drugs ledger is nonsensical. Storage considerations apart, its classification should be no more onerous than temazepam or buprenorphine.

However, the main time waster is still created by the prescription charge and the consequent insistence on policing the exemptions on the back of the prescription form. I estimate that this consumes about three million hours of pharmacist time per year in England and Wales, not including the time spent by staff trying to pin down signatures, payment and evidence in a busy pharmacy. The gross income to the Exchequer is no more than £16 per taxpayer per year but it costs pharmacy dear in many ways (see *PJ*, 13 September 2003, p320).

Clear the decks of time wasting activities and we might find the time to plan, to learn, to teach and to become caring, motivated human beings. The ball is in the politicians' court.

Noel Baumber
Grantham, Lincolnshire

Off the record
Our new occasional series is open to any writer. Readers are invited to send either 400- or 600-word items about some anecdotal aspect of pharmacy practice that they think is worth sharing. Items are published anonymously but contributors must supply their full name and address. Items should be sent to graeme.smith@pharmj.org.uk for consideration

ELECTRONIC PRESCRIBING

Electronic prescribing must be introduced for the right reasons

From Mr A. Barker, MRPharmS

Lord Warner's announcement (*PJ*, 19 June, p755) that the introduction of hospital electronic prescribing is being brought forward to 2006 should be welcomed. However, the rationale for this decision appears to be a little suspect. Although electronic prescribing will deliver the ability to conduct prospective audit, and feedback, on the use of National Institute for Clinical Excellence recommended medicines, this should not be a prime reason for its introduction.

There is no doubt that electronic prescribing will make a major contribution to increasing patient safety and the quality of clinical care and, if it is to achieve the level of clinician support that will be required for successful implementation, these must be the reasons for its introduction.

Already our own limited experience of implementing electronic prescribing has resulted in improvements in the quality of prescribing, with approaching 10 per cent of prescribing transactions being modified by the provision of online decision support. However, the improvements we have seen have not been restricted to prescribing. Electronic clinical pharmacist verification and administration recording, together with full integration with pharmacy stock control, have led to significant improvements in the safety, quality and efficiency of other medicines-related activities.

We must guard against any acceleration of the development of electronic prescribing resulting in loss of potential major advantages that a more prolonged gestation period may provide. My concern is that if the focus of the development is on "mechanisms to allow prospective audit and feedback on usage of drugs" we may well end up with little more than electronic "order communications" for medicines, with many of the potential improvements in patient safety and the quality of clinical care that could be offered by a fully integrated prescribing administration and medicines management system being lost along the way.

After all, reasonable information on the use of NICE recommended medicines can already be provided by existing hospital pharmacy computer systems and any shortfall in uptake of NICE recommendations is more likely to be due to lack of resources than lack of information.

Andrew Barker
Clinical Director — Pharmacy and Medicines Management
Doncaster & Bassetlaw Hospitals NHS Foundation Trust

ADVERTISING

Advertisement for Senokot may be misleading

From Mr C. Morris, MRPharmS

Ever since Senokot started its "contains safe, natural senna" campaign, I have fumed. Senna is natural but it is far from safe in long-term use.

I think that senna is a good laxative for short-term use but too many people use it continuously to the point where they have to take it since they have little or no bowel muscle tone.

Now we have a new advertisement. I have seen it twice and it took both times watching it to catch the small reference to constipation. Apparently "natural senna can promote digestive health"; it seems to be being sold as a health food supplement. These days everyone seems to go for vitamin supplements and healthy natural alternatives.

I was wondering whether anyone else had noticed it and whether anything could be done about possibly misleading advertisements.

C. Morris
Newquay, Cornwall

TIM BAXTER, medical affairs director, Reckitt Benckiser Healthcare, replies: I am sorry to hear that Mr Morris is concerned that our advertisement for Senokot may encourage the inappropriate use of constipation remedies.

As leading manufacturers of over-the-counter medicines, Reckitt Benckiser Healthcare is always conscious of its duty to ensure that it does not promote any of its medicines in a way that might encourage them to be used inappropriately.

This advertisement was written to a specific brief that was wholly intended to target constipation sufferers. That is why it was ensured that the indication for relief of acute constipation only is made clear in the very first line of the script, and that the story then clearly shows the heroine suffering from constipation, taking our remedy, and then getting relief from her condition.

Like most major advertisers, Reckitt Benckiser Healthcare conducts extensive research before making a new television advertisement, using independent research companies and recognised and well-respected research techniques. In speaking to over 250 constipation sufferers, it did not encounter anyone who believed that the advertisement in any way suggested, promoted or endorsed the use of Senokot as a daily health supplement, or for any indication other than for the relief of constipation.

In addition to this research, before any advertisement can be broadcast, it must also satisfy two independent regulatory bodies that the film's content meets all legal requirements. These two bodies are the Proprietary Association of Great Britain and the Broadcast Advertising Clearance Centre. Approval was obtained from both bodies before broadcast.

I hope this helps to reassure you that Reckitt Benckiser Healthcare takes its responsibilities as an advertiser extremely seriously, and that it has been careful to try to ensure that its advertising does not in any way encourage or condone the misuse of constipation remedies.

STATINS

Marketing or patient empowerment?

From Mr J. H. A. J. Durodie, MRPharmS

The response by Stephen Mann and Jeremy Cottrell (*PJ*, 26 June, p804) brings up some important issues. They state that "extrapolation . . . can be undertaken with considerable confidence". No true science can be based on extrapolated results: such results may be valid but need to be treated with caution as opposed to "considerable confidence". This simply re-affirms the paucity of firm evidence.

They further question whether considering number needed to treat (NNT) is appropriate for over-the-counter sales — I would dare to dispute that, unless we believe that the punters can get anything so long as they pay for it. In a case where community pharmacists will need, and be expected, to make an assessment before a sale together with providing appropriate advice and counselling about the use of an OTC medicine, NNT has to be part of the knowledge base drawn upon before that sale. The reality is that with a NNT of 71 (see *PJ*, 5 June, p706) this does not bode well for the individual patient — I just hope my neighbour is not relying on the same odds lest I help him benefit at my cost. Furthermore, bearing in mind that for any long-term medication compliance falls to abysmal levels after about two years, the likelihood of "customers" continuing with simvastatin 10mg for any meaningful period is debatable, despite the fact that this is what they would need to do.

I am convinced that over £150 per annum spent on lifestyle, notably dietary, improvement would give customers a far better overall health return for their money than committing themselves to long-term medication and its associated interactions and adverse effects.

I am grateful to Peter Burrill (*PJ*, 29 May, p670) and David Phizackerley (*PJ*, 5 June, p706) for highlighting some of the not insubstantial issues related to this POM-to-P move and would urge all community pharmacists to find out about the evidence (from sources over and beyond that provided by the marketing representatives) so as to be clear what advice they offer customers seeking to purchase simvastatin 10mg.

This matter does not lead to a "resounding yes" as Johnson & Johnson would have us believe. It may well, however, become a postcode money-spinner at the expense of the "worried well".

The Government is encouraging our public health role: so, please, think twice before enabling "customers" to "swallow the tablets" — hook, line and sinker!

J. Durodie
Redhill, Surrey

FREE MOVEMENT IN EUROPE

One-way traffic?

From Ms E. A. Mishon, MRPharmS

Miall James's letter (*PJ*, 19 June, p768) and Martha Pawluczyk's reply concerning the recognition of pharmacist asylum seekers, coincided with John Ferguson's explanation (*PJ*, 19 June, p768) of

the language problems presented by the requirement to permit reciprocal registration of European pharmacists. Since the EU was enlarged last month to include Eastern Europe, the language problem may become more serious.

There is no doubt that Mr Ferguson's letter is factual and up to date, however the correspondence raises more questions than it answers. Whatever the Market Director-General is saying at the moment, it is not relevant to the immediate situation; or to what has gone before.

When the possibility of reciprocal registration for pharmacists across Europe was published in the British pharmaceutical press, I was enthusiastic. I first tried to register in France more than 10 years ago and I discovered that mutual registration was not a reality. The French pharmaceutical society, among other things, was making an illegal language requirement and I alerted the Royal Pharmaceutical Society at the time. I have learned recently from other ex-pats who hope to work here that there has been no change.

I am a subscriber to *Le Moniteur des Pharmacies* (the French equivalent to the *PJ*) and have noted that there are British employers who advertise for French pharmacists to work in the UK. This would indicate that French pharmacists can be "eased" into Royal Pharmaceutical Society registration. But certainly there is no facility to assist British pharmacists over the 10 conditions that the French pharmaceutical society demand to register in France. An explanation for this apparent one way traffic would be welcome.

Ms Pawluczyk says that there have been 32 applications from asylum seekers to register with the Society through the Adjudicating Committee since 1999. In the context of the present debate, she does not say what the language requirements were, how many candidates were successful, and what support, if any, was offered.

Anne Mishon
Laurac le Grand, France

MARTHA PAWLUCZYK, adjudication manager, and PETER BURLEY, head of preregistration division, Royal Pharmaceutical Society, reply: The Royal Pharmaceutical Society does assess the language competence of all applicants where it has the power to do so. For those where it does not have the power to assess language before registration, then language competence becomes a postregistration fitness to practise issue. All applicants are advised that they will not be able to practise ethically unless they are proficient in English.

There is no question of "easing" French pharmacists onto the register. EEA nationals (with appropriate qualifications) have absolute rights under the relevant Directives which the Society cannot set aside. Equally, though, they are bound by the Society's code of ethics and standards once they are on the register.

GB pharmacists encountering difficulties registering in accordance with these Directives elsewhere in Europe might like to explore if the European Commission's "EUROJUS" service could help them. This is a free legal advice service specifically to help with matters such as recognition of qualifications, providing services, employment, and residency. Details of the UK EUROJUS service can be found on www.cec.org.uk/feedback/legal.htm; there is an equivalent service in each EU state.

While the Society receives many enquiries from "asylum seekers" they have no formal status as such with the Society or the Department of Health and they must be treated as any other applicant. If the Home Office grants them formal refugee status, then their position does change. Refugee status confirms that the Home Office is satisfied as to the authenticity of all the information they have provided, and, much more importantly for this query, the applicants have access to the Department of Health's "Overseas and health professional refugee education" programmes, which include language and other such training to enable them properly to enter the UK labour market. (Details on the DoH website under www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/LearningAndPersonalDevelopment/PostRegistration).

ST JOHN'S WORT

Peddling products of dubious safety, quality and efficacy

From Mr P. Penson

I was not surprised to read your article "Confidence in St John's wort misplaced?" (*PJ*, 12 June, p731), which described a recent paper questioning the efficacy of this product when used as a treatment for depression. I am sceptical of many herbal "medicines" for a number of reasons.

First, they play on the public perception that "natural is safe". Pharmacists know this not to be the case, given the extensive range of drugs with which St John's wort is known to interact. Secondly, the evidence base for many of the supposed uses of these products is shoddy, and thirdly, herbal products do not have to meet the same criteria of pharmaceutical quality as do conventional medicines.

This is not to say that there is no benefit to be gained from herbal products. Some of our most successful medicines, such as digoxin and aspirin, are the result of an application of good science to folk remedies. If it is the case that these herbs we sell are of medicinal use, then we should work towards identifying and extracting the active ingredients, and marketing them as conventional pharmaceuticals. How can we hold ourselves up as health professionals when we are peddling products of dubious safety, quality and efficacy to an unsuspecting public?

Peter Penson
Fourth-Year Student
University of Wales, Cardiff

THE PROFESSION

A real sense of déjà vu

From Mr K. J. Knight, FRPharmS

As I read the penultimate paragraph of Alan Nathan's "Are we seeing the death of pharmacy?" (*PJ*, 12 June, p764), I felt a real sense of déjà vu.

Over 10 years ago I set out, with background and reasons for my forecast, the future of community pharmacy if it did not adopt computer screening. My article "A decade is all we have felt . . ." was published in *Chemist & Druggist* (2 February 1994, p248).

The concluding paragraph read: "And community pharmacy will cease to exist. But the Society would still be in existence. It would be the voluntary professional home of pharmaceutical graduates and those of related disciplines, and keep the register of licensed sellers of human and veterinary medicines." (The Society will begin to keep the register of pharmacy technicians in 2007.)

The only real difference between Alan Nathan's views and mine is that he thinks it could happen but hopes it will not; I, sadly, am certain that it will.

K.J. Knight
Crewkerne, Somerset

Long live the pharmacy technician!

From Ms T. O. O. Banjo, MRPharmS

How I wish I entered the pharmacy profession as a technician. Pharmacy technicians have come a long way and although I am not a technician I admire their focus, their drive and their unity. They are a group of professionals armed simply with BTEC or NVQ level 3 qualifications, whom have moved forward in leaps and bounds — but where are pharmacists? Still trudging behind technicians in my opinion.

We are focused but I believe we are lacking in unity and drive, and although most of us have a master's degree or more, professionally we are no better off than technicians. Take for instance a C or D grade pharmacist with 10 years' experience — they would have been better off rising through the ranks to MTO 5 with less educational strain. Let us face it, technicians can do everything we do, including medicines management. I hope they can train as supplementary prescribers too, given the right training they would be good at it.

Technicians are willing to take responsibility and they never sell themselves short, but pharmacists are the exact opposite. If pharmacists are to survive we need to borrow a leaf or two from the technicians. They are heads above technicians in other professions.

My daughter wants to be a pharmacist, but I would rather she trained as a technician — they are forward thinkers who know what they want and get what they want and deserve to — because they are united.

Long live the pharmacy technician!

T. O. O. Banjo
Enfield, Middlesex

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

THE PROFESSION

A symptom of general apathy?

From Mr D.W.Higgins, FRPharmS

On 1 April 1903 a meeting of chemists resident in the Thames Valley district was convened by the London Chemist's Association to discuss, among other things, the desirability of forming a local organisation.

A committee meeting on 21 April held in Kingston discussed rules of the association, which included the name "Thames Valley District Chemists Association" the objects for which the association is established, namely, the consideration and discussion of all matters affecting the interests of chemists, and the promotion of friendly and social intercourse amongst chemists. The association was to consist of members, registered chemists, and such others as may be elected by the members. The annual subscription was five shillings (the same figure when I became a member of the branch in 1966). In addition to rules concerning governance of the branch it was also decided that the motto connected with the association should be *Nihil sine unitate*.

One hundred years on, the current committee of the Thames Valley Pharmacists Association decided that this milestone in the history of the association was worth celebrating. (After all, the Diamond Jubilee celebration dinner attracted more than 360 members and guests). The idea to celebrate with a formal dinner was put to the membership at a couple of branch meetings and, by show of hands, appeared to meet with general approval. A considerable amount of time and effort was put into the project by the members of the committee in finding a suitable and affordable venue; not least by David Thomas, who managed to secure sponsorship from Moss Chemists and SSL, which had the effect of halving the cost to the individual guests.

When it became apparent that the function might have to be cancelled due to lack of support our hardworking secretary, together with her husband and Mr Thomas, spent a weekend compiling and putting into envelopes further flyers to send to every member.

What is depressing is that after all the effort, apart from committee members, only one other member of the branch wished to attend. Is the general apathy a symptom of the malaise affecting our profession due to the turmoil caused by the civil service's desire to control all aspects of our lives, or is it that we just do not like socialising with other members of our profession?

Perhaps the motto chosen by our Victorian forebears was too negative. Latin scholars will correct me but should it have been *Omnia cum unitate*?

D. W. Higgins
Surbiton,
Surrey

THE JOURNAL

Why cannot *The Journal* be more sexy?

From Mr M. A. Waldman, MRPharmS

The biggest flaw of *The Journal* is that it is too solemn. There is nothing to draw even the slightest inspiration of mirth. In fact it is on a par with the bleakest of Dickens novels *sans* the interesting characters.

In normal life there are daily situations where anecdotes could fill volumes. There are no cartoons; these could be useful for highlighting the news of the week and may even stimulate correspondence. *The Journal* is therefore detached from real life.

What percentage of the readership is interested in the hot news on dissolution rates of the latest drugs? Or other boring articles on scientific analysis? Why cannot *The Journal* be more sexy? Have an anecdote page; cartoons; be more magazine like?

Friday comes around again; I receive another depressing edition; the highlight of my week— not. Given a choice of most things to read I would choose the *PJ* last of all. We need more drama, big, big headlines such as: "Pharmacist dispenses an unsigned prescription for eye drops". That would bowl them over.

Come on!

Maurice Waldman
Woodford Green,
Essex

Off the record

Ladders have been placed against the wrong walls

After 30 years on the register, you can, I hope, forgive a little reflection on some changes seen during that time. I expect, like me, you sometimes wonder why on earth you became a pharmacist. There were never, as far as I am aware, any other pharmacists in my family so there was no family pressure or history repeating itself. I had enjoyed chemistry at school, but thought a degree in that subject alone would be far too narrow. Pharmacy did seem an attractive option because it was a broad, and, perhaps more importantly, a practical subject. A visit to any pharmacy was accompanied by strange smells as concoctions were made and "real" dispensing was done. But, was my becoming a pharmacist a good decision? Sufficient to say that I am pleased to say neither of my children has followed in my footsteps.

It was not long after securing a university place before I had serious doubts. Before starting university I had arranged a six-week summer job at a local pharmacy in my hometown in the midlands. No gap year in those days! The manager was barely 10 years my senior and was already bored with "retail" as it was called then. It was not an auspicious start. His advice was for me to go into the pharmaceutical industry for the variety, if nothing else.

This career advice theme was continued at university. We were advised to pursue a career in academia, hospital pharmacy or "the industry". For some reason, our lecturers frowned upon the "trade" end of pharmacy. It had a dubious image because of selling everything from hot water bottles to cosmetics, from offering photographic services to home brewing kits. So, in 30 years, not much has changed there then, and must still be a major factor as to why pharmacists are not taken particularly seriously except by themselves. The other is the continuous bickering between various factions, which we still see with the Society's Council. The original perceived advantage of the breadth of opportunity that pharmacy offered seems to be the reason too for it to continually try to self-destruct.

So, what has gone wrong? There was a time when pharmaceutical input was necessary. There was a need to actually prepare something, not simply order it ready made from a "specials" unit, or pick an original pack off a shelf. After that change an attempt was made to justify pharmacists' existence by placing great emphasis on knowledge and advice, on being the bare foot — let us be blunt — second rate doctor with a limited repertoire. Was this a good idea? — I think not. In these days of internet access, patients come armed with too much information and too many facts as any GP will tell you. Far better to use an information scientist to distil facts. As for limited prescribing, the public place more confidence in nurses for there to be many opportunities here. In the pharmaceutical industry, which now apparently bemoans the lack of pharmacists, a great opportunity was lost by not fighting to ensure all Qualified Persons (who release all batches of product for sale) were pharmacists. By allowing others to take on that role the unique knowledge base of pharmacists became a myth.

I read a management book recently about how easy it is to place your ladder against the wrong wall. To me that is exactly what pharmacists have done. When the role had to change because traditional manipulative skills were not required in the dispensary, the ladders were placed against the information/patient advice/limited prescribing walls, and we have been trying to climb those ill-placed ladders ever since. This is not where pharmacists' unique skills lay and we have been paying for that mistake ever since. — *Contributed*.