

■ PHARMACY EDUCATION

Integration, not balance, of science and practice is required

From Dr A. W. Smith, MRPharmS

Both Patrick Wilson and Ivan Stockley (*PJ*, 3 July, p19) raise questions about the fourth year of the MPharm degree programme and the preparedness of future pharmacists for practice. The fourth year, taught at master's level, provides the opportunity to take students to the forefront of the discipline and to enable them to reach judgements in complex scenarios where data may be incomplete and where there is uncertainty. So, for example, in my own school of pharmacy, a significant component of the fourth year is clinical pharmacy and ward-based teaching where students consider medicines management for patients with multiple conditions in exactly the same way as colleagues face in practice every day. The additional year has also enabled a clinical placement to be included in the third year, together with opportunities for interprofessional learning alongside medical and nursing students. These, too, offer context to the fourth-year studies.

Two issues are relevant to the current discussion. First, who teaches in our schools of pharmacy? The schools are not ivory towers populated by pharmacist and non-pharmacist academics with little understanding of, or interest in, the practice of the profession. Rather, they comprise an integrated group of academics and practitioners who collaborate closely in planning, delivering and

assessing all aspects of the MPharm degree. The second substantive issue is that of the science/clinical practice debate. The profession must move on from talking about the balance between science and practice in the undergraduate curriculum. Balance suggests that the two are different and set against each other. They are not. The talk must be of integration, for without the underpinning molecular and pharmaceutical sciences there is no foundation upon which to build clinical practice.

Others in these columns have commented on frequently questioned topics such as drug synthesis, molecular structure determination, thermodynamics etc. It is true that the challenge for schools of pharmacy is to ensure these topics have a clinical context, however these "hard" sciences should not be abandoned in favour of verbatim cramming of the current issue of the British National Formulary. In delivering a master's level qualification, the schools of pharmacy have to consider the long term as well as the short-term "oven-readiness" of graduates. In particular, the schools must take account of knowledge half-life and focus on those concepts that will sustain postgraduation learning and development well into the mid-21st century. It is a truism that medicines usage and pharmacy are always changing, but this is never more true for today's graduates, whose careers will be defined by the era of genomics. If pharmacists are to be relevant to medicines development, utilisation and patient care in the genomics era, then they must continue to understand what makes drugs work at the molecular, cellular, tissue and whole patient level.

With time and continuing professional development, today's pharmacy graduates more than ever before have the underpinning knowledge and skills to come out from behind the BNF, stop being passive bystanders and really contribute to the advancement of patient care.

Anthony Smith

Head, Department of Pharmacy and Pharmacology,
University of Bath

There are no shortcuts on the long journey to expertise

From Mrs L. M. O'Loan, MRPharmS

I have been following the science versus practice in pharmacy education debate with great interest over the past few weeks. I am currently undertaking an Open University MA in Education, and would like to offer my view from an educational perspective.

The "theory-practice divide" is well established in the field of education.¹ Theoretical knowledge, which is abstract in nature and is often acquired in a classroom setting,² has historically enjoyed a higher status than practical knowledge,^{3,4} which develops through participation in "real world" practices.^{1,2,5} It has been suggested that greater emphasis should be placed on practical knowledge to reduce the problem of "knowing without doing",¹ but that this should not be done at the expense of theoretical knowledge, otherwise the problem could become reversed.^{1,2}

Expert knowledge is both theoretical and practical.⁵ Indeed, it has been noted recently that experts in clinical pharmacy "need extensive knowledge both of the literature and from experience".⁶ So how can we integrate theoretical and practical knowledge? Various solutions to this question have been proposed, including highlighting the relevance of theoretical concepts to the "real world",¹ employing "real world" problems to "problematise" theoretical subjects,⁷ and using simulated work experiences,⁸ all of which are useful but do not provide the definitive answer.

It has been suggested that "an understanding of the context is critical to make sense and use of the theoretical and abstract knowledge of science".¹ This would lend support to Larry

Goodyer's view that "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" (*PJ*, 3 July, p19). While this approach could help students to link theoretical and practical knowledge, the issue of how (and whether) knowledge is transferred from one setting (such as the classroom) to another (such as the workplace) remains contentious.^{8,9}

My view from an educational perspective, therefore, is that, although we should be aiming to integrate theoretical and practical knowledge, there is unlikely to be a shortcut on the long "journey to expertise".⁶

Laura O'Loan

Annual Programme Co-ordinator
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■ PHARMACY EDUCATION

If pharmacists have no communication skills, knowledge is wasted

From Mr B. Shooter, MRPharmS

A. T. Florence (*PJ*, 3 July, p18) makes valid points about the importance of the scientific content of the MPharm course and how it will vary to suit the perceived present and future needs of the profession and its members. Pharmacy itself is surely the dissemination of this knowledge to those who require it whether they be patients or professionals.

Where should the skills needed to manage and communicate this knowledge be acquired? During the course, during the preregistration year or by experience while practising?

I have the great privilege of being able to combine the practice and management of community pharmacy with the teaching of these aspects of the profession. The students with whom I have contact are given tuition in communication skills, and are encouraged to gain work experience during vacations, to make full use of their preregistration year and to participate fully in continuing professional development once they are qualified. Unless pharmacists have the will and skills to communicate, their scientific knowledge may well be wasted.

Barry Shooter

Romford,
Essex

The extra year is for integrating science and practice

From Professor M. Heinrich

In response to the important and intensive discussion on the curricula in schools of pharmacy, I am concerned that a four-year degree course is seen as one which is only there to prepare for practice (see letter from Patrick Wilson, *PJ*, 3 July, p19).

One of the strong aspects of a course like pharmacy is the integration of (basic and applied) science with practice. Getting the balance right is difficult but, while a university will be able to lay the groundwork for "clinical practice", the everyday and continuous experience (and training) will have to come during the preregistration

year and, of course, afterwards (through continuing professional development).

The complexity of modern science requires a profound understanding of a multitude of basic scientific concepts relating pharmacy to other and diverse sciences (eg, biology, chemistry, material sciences). It is this multidisciplinary nature of pharmacy which makes it unique, provided that we are able to focus on the core tasks of pharmacy: the formulation, pharmacological effects, quality, clinical use, discovery and other aspects of medicines. Clinical practice without understanding the scientific basis of these medicines would be a worrying risk to patients, but also implies serious risks to the profession. If graduates have problems in the area of drug

monitoring, this is as much a challenge to improving the training in the natural sciences as in clinical pharmacy. It will be essential not to underestimate the complexity and diversity of the scientific knowledge base required.

Lastly, we should remember, that schools of pharmacy today train people who will be dispensing medicines for 40 to 50 years and, for example, in order to profit from continuous professional development, they will need a profound understanding of the relevant areas of science.

Michael Heinrich

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Off the record

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

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 gaeme.smith@pharmj.org.uk for consideration

ST JOHN'S WORT

Was meta-analysis meaningful?

From Dr R. J. Schmidt, MRPharmS

The recent article (*PJ*, 12 June, p731) reporting the results of a meta-analysis of published trials of St John's wort as an antidepressant (Werneke U *et al*, *Journal of Clinical Psychiatry* 2004;65:611) appears to suggest that this herbal product is essentially just a placebo. For the benefit of those pharmacists who either sell, recommend or indeed use St John's wort, could I ask whether Dr Werneke and her co-authors took into account the identity and quality of the St John's wort used in the various trials they submitted to meta-analysis.

I recently drew attention (*PJ*, 27 March, p381) to a problem identified by others that St John's wort preparations (because they are not treated as medicinal products) may not actually contain what the label states they contain. Furthermore, if they have been standardised for their hypericin content rather than for their hyperforin content, it will be impossible to interpret the results

of any trial investigating their antidepressant activity because hyperforin rather than hypericin is now believed to be the active principle. To the best of my knowledge, no one has yet published a study in which the relationship between hypericin and hyperforin content of St John's wort is investigated.

If those who conducted the various trials did not take steps to authenticate and standardise for hyperforin content of the St John's wort they used, then the results of those trials will be meaningless. Any attempt to subject these trials to meta-analysis, irrespective of the sophistication of the statistical method used, will similarly be meaningless. Can Dr Werneke and co-authors reassure us that their study was meaningful?

Richard J. Schmidt
Barnoldswick, Lancashire

URSULA WERNEKE responds on behalf of the authors: We are surprised at this letter suggesting that our meta-analyses may be meaningless. Dr Schmidt justifies this opinion raising issues we have actually addressed in the original

article.¹ Our meta-analyses showed that St John's wort might be less effective in the treatment of depression than previously assumed. In our cumulative analysis, we also identified a trend towards reduced effect size with the increase of sample size. We pointed out that with the reduction of cumulative effect size over time St John's wort might finally be shown to be ineffective if future trials continued to confirm this trend.

We then explored further explanations for our findings. Where available we looked at the hyperforin contents. However, there is only one trial available comparing different hyperforin concentrations.² We also tried to account for this by exploring the impact of the dose of the extracts *in toto* in our meta-regression, and found this not to be significant. We then concluded that "future trials should test extracts in which the hyperforin content is maximised". We also analysed further factors which could influence the outcome of individual trials or meta-analyses. Most trials were conducted in heterogeneous patient populations so that the question of whether St John's wort was effective in

patients with mild depression remained unresolved. We acknowledged that, although St John's wort may be found to be no more effective than placebo, effect sizes for conventional antidepressants were also surprisingly low.

The suggestion that all trials which did not standardise on hyperforin should be discarded is ill-founded. All currently available St John's wort preparations are standardised on hypericin, and clinical effectiveness studies are about the "real world" rather than an "ideal world" of a hyperforin enriched extract, which to our knowledge currently is not widely or easily available. It is important to discuss these issues with patients in order to avoid unrealistically high expectation without supporting clinical evidence.

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■ DISPENSING

Law appears to allow generic substitution by drug companies

From Mrs C. J. Hutchinson,
MRPharmS

We all know that a prescription for a branded product requires the supply of that branded product. At no point is generic substitution even an option. However, it appears that pharmaceutical companies can do it and have the law on their side. I refer to the product Innovace 5mg, its parallel import and the branded generic Rinetec (enalapril, also made by Merck).

Recently, a customer returned a packet of parallel-imported Innovace saying that the contents were not Innovace. On examining the pack, I found it contained Rinetec foils which had been overlabelled "Innovace". My supplier contacted the licence holder, who said that since the product was made by the same company and the leaflet referred to all three variants (Innovace, Rinetec and enalapril), this was permitted within the licence.

I then contacted the Royal Pharmaceutical Society which referred my query to the Medicines and Healthcare products Regulatory Agency. I received a reply which quoted licensing law, also stating that the product was legal since it met the criteria for equivalence to the original brand.

I then questioned my local inspector, who said she was aware that such products existed but this was nothing to do with the Society. She said that if I thought the product was unethical then I could refuse to use it. (Great, I thought, but I bet I will not be paid to use the British product.)

Has anyone else come across this problem? Am I making a mountain out of a molehill? Does the (unintentional) supply of Rinetec constitute a dispensing error in that what the GP wanted has not been supplied? I have, after all, had boxes of Rinetec on the shelf but only used them for enalapril prescriptions. Other opinions would be gratefully received (e-mail carol@hutchinsonfamily.freeserve.co.uk).

Carol Hutchinson
Rugby, Warwickshire

■ ANTIMICROBIAL RESISTANCE

Overwhelming need for national data collection

From Mr C. E. Curtis, MRPharmS

The **News feature** "How to promote rational antibiotic use" (*PJ*, 3 July, p10) highlighted the forthcoming conference to promote the rational use of antimicrobials in acute care and the role that pharmacists can play. Although I fully endorse the comments of Jonathan Cooke with regard to data collection, great caution will be required in any interpretation of antibiotic usage figures. The number of defined daily doses prescribed for each antibiotic is the crucial first step and this should be provided by all acute hospitals. The denominator is more problematic and although the 100 bed days favoured by the World Health Organization is useful as a comparator between hospitals and also internationally, there are a number of factors which can influence the results.

I have been working to demonstrate the utility of the FCE (finished consultant episode) as an alternative denominator. This is

influenced less by decreases in length of patient stay for hospital treatment. Results from ongoing work show year on year decreases in total antibiotic prescribing rates for 2001–02 and 2002–03 in a sample group of hospitals when the FCE is used as a denominator whereas, when the 100 bed day is used, there is a year on year increase in total antibiotic usage.

There are also other influences at work, such as individual hospital case mix and variations in the morbidity of the hospital catchment population, which will affect the amount of antibiotic prescribed. It will be important that great care is taken when interpreting individual hospital antibiotic prescribing rates and account taken of some of the factors which can influence the results.

The need for a national data collection programme is overwhelming in the light of increasing antimicrobial resistance levels and I welcome the first steps on the path to creating such a resource.

Chris Curtis
*Head of Pharmaceutical Services
Burton Hospitals NHS Trust*

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■ THE CONFERENCE

Why no speech from a Government minister?

From Mr J. Wilson, MRPharmS

I have today received the programme for the British Pharmaceutical Conference for 2004 and note that at the opening session there is no government minister in attendance to give a speech. Is this yet more evidence of pharmacy's continuing decline in importance in the eyes of politicians, or were they simply not invited?

John Wilson
Arnold,
Nottinghamshire

BEVERLEY PARKIN, director of public affairs and communications, Royal Pharmaceutical Society, replies: The dates for BPC 2004 coincide with those of the Labour Party conference and no minister is therefore able to attend. However, Mr Wilson will be pleased to know that the Society has excellent working relationships with several ministers and their teams, including the ministers in the Department of Health.

The developments that are taking place in the profession are central to Government health policy and we are pleased that both Sir Nigel Crisp, Permanent Secretary, Department of Health, and Chief Executive of the NHS, and Harry Cayton, Director for Patients and the Public, Department of Health, are both speaking at BPC 2004. Full BPC speaker and programme details are available online by visiting www.bpc2004.org.

■ NHS CONFEDERATION

A missed opportunity for the profession

From Mrs M. M. Keyworth, FRPharmS

I recently attended the NHS Confederation annual conference and exhibition held in Birmingham. The theme of the conference was "Real leadership" and was attended by an extensive list of key strategists and decision-makers from across the NHS both at local and national level. We were promised an exhibition to reflect the modern health service at which charities, service providers, professional bodies and NHS partner organisations would all be

represented. I have attended these conferences for several years and have always made a point of visiting the stand which represents the profession of pharmacy and which has, in the past, usually included representatives from the Royal Pharmaceutical Society, the Pharmaceutical Services Negotiating Committee, the Centre for Pharmacy Postgraduate Education and the National Pharmaceutical Association. I was most disappointed that this year this stand was missing and I would suggest that this was a missed opportunity for these leading organisations to raise the awareness and profile of pharmacy at this prestigious event. Stands that were prominent included the Royal College of Physicians, the Royal College of Nursing, the Chartered Society of Physiotherapy as well as the General Medical Council and the Dental Practice Board.

However, I observed that the UK's largest community pharmacy chain had provided a stand at which delegates were invited to understand how the chain was willing to work in partnership with primary care trusts to achieve targets and deliver improved health care. This generated a great deal of interest and provided a positive image of the role of pharmacy in the community.

I was also aware that delegates from the the NPA were present in the audience at some of the sessions.

Madeleine Keyworth
Brigg,
North Lincolnshire

■ THE PROFESSION

Are we really partners with doctors?

From Mr E. Kalmanovitch, MRPharmS

The front cover of the 5 June issue of the *PJ* boldly states "Pharmacy and medicine in true partnership". Partnership means equality. Perhaps practising members of the Royal Pharmaceutical Society could give views on their experiences of how this applies, if at all, on status, remuneration, earnings potential, professional standing, job satisfaction and so on.

The responses should make some interesting reading.

Eugene Kalmanovitch
Nicosia,
Cyprus

Society must take a leading role in future

From Dr N. Kometa, MRPharmS

The future of the profession of pharmacy lies in it taking a leading role in innovating modern and efficient methods of delivering health care services. The Royal Pharmaceutical Society should take an engaging, coherent and strategic position to represent all sections of the profession which are involved in the provision of services in the NHS either directly or indirectly, and demonstrate how they are making a significant contribution in the evolution of the NHS to other stakeholders such as patients, the public, other health care professions and the Government. A coherent strategy is needed at the highest level of the profession so that organisations that are already carrying out pioneering work in the delivery of modern health care services can be promoted as beacons for others to emulate.

There are many areas where the profession is leading the strategy or making significant contributions. Some of these include concordance, medicines partnership, the expert patient programme, medication dosage review and advice, monitored dosage system, diagnostic testing, repeat prescribing, collection, delivery and domiciliary visit, continuing professional development and good professional governance.

In spite of the cost constraints and funding difficulties, the community pharmacy sector in particular, and the profession in general, should exhibit a propensity to embrace and implement high quality evidence-based research emanating from the different areas of pharmacy practice. In my opinion, funding will be attracted after implementation and demonstration of innovative and efficient modern health care practices in a modernising NHS. In other words, community pharmacy should be pre-emptive and proactive in leading the modernisation of service provision in primary care in the community, otherwise, it may end up being marginalised, as demonstrated in the initial constitution of primary care trust board membership.

Above all, it should not be forgotten that all human endeavours are concepts that become practice that are adopted and expanded.

Nsanyi Kometa
Hull

■ THE SOCIETY

Take a lead from the Statutory Committee model

From Mr J. R. Ferguson, FRPharmS

I write to support the main point made by Robert Blyth in his excellent **Broad spectrum** article "Why wreck the Society just to satisfy a 'one size fits all' regulatory policy?" (*PJ*, 3 July, p17). I have asked that question several times in the past and, as yet, no satisfactory answer has been given.

May we just remind ourselves of the current situation and how it developed. As Mr Blyth wrote, the Statutory Committee was established by the Pharmacy and Poisons Act of 1933. It is now a feature of the Pharmacy Act 1954, which was, of course, going through Parliament at the same time as the 1953 Supplementary Charter was being negotiated. The 1954 Act makes it clear that the Statutory Committee is a committee of the Society, not of the Council. The Chairman, an experienced lawyer under the provisions of the Act, is appointed by the Privy Council and the other members by the Society's Council. Any decision to remove the name of a pharmacist from the Register has no effect unless the Chairman agrees.

Any appeal against a striking-off order lies to the High Court in England or the Court of Session in Scotland. If there is an appeal, the 1954 Act makes it clear that the Society will be the body against which the appeal will be made, although the "governing body" of the Society, the Council, has played no part in the process leading to that appeal. The civil servants of that day worked out a structure that has stood the test of time. I know of no criticism of the disciplinary proceedings of the Society that has been made by any government department, consumer or patient support organisation.

In 1933 and 1954 it was the inter-relationship of the disciplinary role of the Society and its functions as a representative professional body that was addressed and a solution found. The solution both preserved the integrity of the Society as a Chartered Body and ensured the public interest was safeguarded. Now we need to find a model which ensures there is more lay input to all the Society's regulatory functions, not just its disciplinary role.

Jim Smith, chief pharmacist for England, should ask why a lead

cannot be taken from the Statutory Committee model. Could not a regulatory board, as a board of the Society rather than the Council, be established under the Health Act Order? The constitution of that board in terms of appointees of the government and the Council could be set out, with whatever proportion of lay members the government deems necessary. The regulatory functions to be exercised by the board would also be set out and it would be made clear that, as with the Statutory Committee, the decisions of the board would not be subject to the approval of the Council. It could also be provided that the board would have powers to establish subgroups to make recommendations to the board on the individual elements of regulation such as education, entry to the profession, continuing professional development etc.

We have some able and wise civil servants in the UK. I am certain that, given the right brief, they could, as their predecessors did in 1933 and 1953–54, devise a model meeting both the requirements of the Government and the wishes of the Society's members. And Dr Smith would have his "coherent way in which [the regulatory functions of the Society] could be exercised other than under the authority of the Council" (*PJ*, 19 June, p777).

John Ferguson
Haywards Heath,
West Sussex

We need two non-conflicting and strong bodies

From Mr C. O. Agomo, MRPharmS

The comments by T. O. O. Banjo (*PJ*, 3 July, p21) concerning the progress made by pharmacy technicians should not surprise anyone. Technicians' unity is as a result of their willingness to work together through a representative association. It is not only them that are united in this way. There is a similar pattern with firemen, rail workers, police, doctors and nurses, to name but a few. Their associations are their voices.

Pharmacists in Britain have refused to work together as done by other pharmacists and professions all over the world, you only hear fragments of voices which are not binding to all. Unless we split the roles of the Royal Pharmaceutical Society into two

non-conflicting and strong bodies, as suggested by Michael Pettit (*PJ*, 26 June, p801), we face our dear profession being taken over by pharmacy technicians in the near future.

I am aware that the majority of employers who, surprisingly, are pharmacists will not agree with this suggestion, because there is this unfounded fear that a strong and binding association for pharmacists might produce pharmacists with confrontational ideas. The truth is that the way things are going it might be the only option left for us to survive as a profession.

Chijioke O. Agomo
London N7

Charter discussions ought to have been like Pharmacy in a New Age

From Dr N. Kometa, MRPharmS

In view of the debacle that has occurred in the drafting of the new Charter, lessons should be learnt from one of the seismic undertakings advocated by the leadership of the Royal Pharmaceutical Society in recent years that stands out in my mind: Pharmacy in a New Age (PIANA). The leadership at the time showed great tenacity, patience and vision. It was indeed a tremendous concept that encouraged debate and invited input from all branches of the profession, and will continue to be expanded and implemented for years to come.

The idea to update the charter of the Society to reflect changes in the modernisation of the NHS and current practice in the provision and delivery of health care service appears to me to be still part of that undertaking. However, the main drawback of this idea was that its implementation was more reactionary than revolutionary. Instead of allocating sufficient time for all sections of the profession to debate the issue and put forward their proposals, the leadership allowed themselves to be led by the timetable of the Department of Health in the drafting of the Section 60 Order.

It would have been visionary if the idea to update the Charter commenced with the NHS plan, which the Government launched in 2000, since the reasoning behind the plan was common knowledge with regards to the Kennedy report and, later, the Shipman inquiry.

In my view, the emphasis placed in maintaining self-regulation or professionally led regulation

appears to overshadow the primacy of public interest and the patient agenda, and their benefits to the profession, in the opinion of the membership. This is notwithstanding the fact that that was the main thrust behind the idea of drafting the new Charter. It is now abundantly clear that enough advocacy should have been given to these areas and communicated at length to all branches of the profession in a PIANA-style debating forum.

In practice, the Society has done a relatively good job in its dual role of regulation and professional representation as demonstrated by the Government's non-interference in the affairs of the profession. The current problem therefore appears to lie in creating a robust theoretical framework for the dual role that will satisfy the public, the Government and the whole membership of the profession.

Nsanyi Kometa
Hull

THE JOURNAL

"Did you hear the one about . . . ?"

From Mr D. A. Ellerby, MRPharmS

I write with reference to the letter from Maurice Waldmann (*PJ*, 3 July, p22) concerning the solemnity of *The Pharmaceutical Journal*.

Over almost 30 years of *Journal* reading I have conditioned myself to hunt down and enjoy the hidden tidbits of humour and "sexiness". It has been difficult, but I have steered myself to the task and more often than not I can find some element of arrant pomposity, outright arrogance or utter somnolence that makes me smile and occasionally laugh.

For me, the sexy, humorous part of the *PJ* lies in the letters and "Onlooker". The former make me wonder why we take ourselves so seriously — maybe because no one else does. The latter astounds me at how interested I am in the contents of the column — maybe I need to get out more, as does the profession.

It is not just the *PJ*; it is the image of the whole profession. We are not a sexy profession. We are not an amusing and witty profession. We are not even an interesting profession. These three preceding comments are not mine, but those of observers from other medical professions (sample size n=2) who seem to have the ability

to bring humour and an appropriate attractiveness (sexiness?) into the professional expression of their vocation. Doctors and nurses have engaged with the world through the entertainment industry for years and consequently have a relationship with the public beyond and deeper than the purely professional. I have never seen a portrayal of a pharmacist in similar terms as for either of those professions.

Apparently I have a sense of humour since, on one or two occasions I have been asked "why are you a pharmacist if you're such a funny bloke?". Sadly there is no stimulating or entertaining response to that question that would make the questioner want to embrace a similar career.

Neither of my daughters has pursued a career in pharmacy, and my wife is about to come off the register. Thankfully, I love my current job as a practice-based pharmacist, which allows me to be actively involved in all aspects of practice life, not just matters pharmaceutical. I am not regarded as sexy by my co-workers, but I have managed to impart a degree of humour to the application of my profession in the practice setting.

Maybe the *PJ* should have a "tabloid" pull-out section, a kind of comic strip, Mickey Mouse, lift-up-flap, knockabout resource which we could enjoy and then leave lying around in community pharmacies, practice tea rooms, hospital canteens and assorted waiting rooms so that all and sundry could see we do have a sense of humour. Heaven knows we joke about ourselves often enough pre and post meetings. We need to "out" the jokes! But let us not pursue the "sexy" agenda. I do not want to see what might arise as "Mr April" or the "Page 2 pharmacist".

Perhaps the Royal Pharmaceutical Society in conjunction with the pharmaceutical industry could sponsor a television "sitcom" about life in and around a community pharmacy. I could supply many anecdotes from my own experiences as could many others. How about a monthly feature of "Spot the spoof article" — although the danger here would be that too many of us would take it seriously. Did you hear the one about the community pharmacist, the midwife and the juggler?

David Ellerby
Elgin,
Moray