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SHIPMAN INQUIRY

Evolving distance learning programme needed

From Mr B. Shooter, MRPharmS

Dame Janet Smith's fourth report into the Shipman Inquiry makes riveting reading. I think that even my hero, Hercule Poirot, would have had a job realising that an apparently caring and charismatic GP was in fact the most prolific peace time mass murderer ever.

Pharmacy training and education has changed over the past years because of the first *Which?* report and the peppermint water tragedy and will now do so because of Shipman.

The inevitable reaction to these sorts of events has been crisis management; the education and training of members of our profession deserves more than that.

I would like to see the Royal Pharmaceutical Society, the schools of pharmacy and the Centre for Pharmacy Postgraduate Education come together to devise an ever evolving distance learning programme that pharmacists would have to complete as part of their continuing professional development. The current CPPE initiatives should continue as at present and much of its superb resource would be used in the new programme.

The programme, personal to each member, should cover at least the first 10 years of post qualification experience and those aspects of pharmaceutical education and training that, for the reasons stated by recent correspondents, are not included in the undergraduate courses or in the preregistration year. It would also ensure that all pharmacists would be accredited for the new roles that the new contract will highlight.

Barry Shooter
Romford, Essex

Professional back-up lacking

From Mr B. S. James, MRPharmS

It is a shame that the Society is considering whether action should be taken against Ghislaine Brant following the Shipman Inquiry (*PJ*, 24 July, p103). I cannot agree more with C. Anderson, Chris Legg and Chris Morris (*PJ*, 31 July, p147). This case shows a complete lack of support for this pharmacist, instead seemingly intent on finding fault in her otherwise dedicated work, which can be difficult enough at the best of times as any pharmacist who has worked in a busy pharmacy will testify. Dame Janet Smith's notion that she did not fulfil her professional obligation to "scrutinise the prescriptions to ensure they were appropriate for the patient" is absurd. Would any pharmacist refuse to dispense a prescription confirmed by the prescriber for a terminally ill patient they had never seen? Should it not be the chemist inspection officer who is called into question in this case, since his or her prime role, or so I was told by a visiting inspector, is to examine doctors' prescribing habits and to look out for addicts who may be signing on at more than one surgery.

I once worked in a dispensing doctors' practice and was surprised to find that there was no regulation of Controlled Drugs whatsoever, to the point that the technician was keeping Oramorph in the CD cabinet and MST on the shelves. Whenever one of the doctors needed anything for their bag they could just walk into their own dispensary and take whatever they wanted. If doctors really wanted excessive supplies of CDs all they would have to do is get a job in a dispensing doctors' practice.

In conclusion, this appears to be a situation whereby a member of our profession in need of professional backup has received the exact opposite. The sooner we have separate professional support like the British Medical Association, the better.

B. S. James
Cardiff

Report GPs to primary care trusts if concerned

From Ms A. M. Baker, MRPharmS

The letters from Chris Morris and Chris Legg in this week's *Pharmaceutical Journal* (31 July, p147) both raise the issue of reporting prescribing which causes concern. Mr Morris in particular was wary of putting his concerns in writing.

Can I suggest to any community pharmacist who is genuinely concerned about the prescribing habits of a GP, that they contact their local primary care trust? Either the medical director, the pharmaceutical adviser, or those holding similar posts will be able to assist.

I have been involved in several investigations where concerns were initially raised by a community pharmacist. I would like to reassure Mr Morris that the pharmacist does not have to be named to bodies such as the General Medical Council if the PCT can gather evidence of its own relating to the prescribing in question. I cannot speak definitively for my colleagues who work in other PCTs, but I would imagine that most will respect any desire for confidentiality from community pharmacists. And most will examine any concerns raised with them, even if this is done via an anonymous letter or telephone call.

To take Mr Morris's example of regular prescriptions for 500 temazepam tablets once the concern has been raised it is a relatively simple matter for the PCT to confirm or deny this prescribing using Prescription Pricing Authority data. They need not involve the community pharmacist in any way from that point forward, and the doctor concerned need never know who first queried the prescribing.

Finally, I think pharmacists put themselves at far greater professional risk by dispensing a prescription which causes them concern, than by reporting those concerns.

Alison Baker
Head of Medicines Management
North Cumbria Health Services

AMLODIPINE

Give pharmacists power to substitute generics

From Mr C. Morris, MRPharmS

In a bid to save NHS money pharmacists are informed that they can now dispense, and be paid for, generic amlodipine. Unfortunately, most prescriptions turn up as amlodipine besilate, not amlodipine maleate, so we are still forced to dispense Istin.

I initially thought this was a scheme by the drug companies but have now realised that it is not that complex. It is purely because that is the way the prescribing computers are set up and GPs do not realise the problem this causes.

I should have realised that this would be the case — how many pharmacists face the problem of patients only wanting a certain brand but doctors not understanding that the brand name needs to be written on the prescription?

How many pharmacists have seen hormone replacement therapy prescriptions written generically, or dangerous lithium and theophylline prescriptions written generically?

Is it not time that it was pointed out that any government campaign to cut costs will not work until the final choice of which brand is given is wrested from the GPs who are unaware of the way prescriptions are paid for.

Let doctors go back to writing prescriptions for branded drugs, therefore saving time, and possibly lives, on inappropriate generic prescribing and give pharmacists the power to substitute generics when it is advisable.

If a three-month test were put into practice I am sure the power would not be revoked.

Chris Morris
Newquay, Cornwall

Letters to the editor

Letters for publication can be posted, faxed, or sent by e-mail to **letters@pharmj.org.uk** and should not normally be of more than 400 words. *The Journal* reserves the right to abridge letters and to edit them for clarity and style. Pharmacist correspondents should supply their membership numbers and a contact telephone number should always be given. Women correspondents should specify a preferred title otherwise "Ms" will be used.

Letters are accepted for publication on the understanding that they have not appeared anywhere, including electronic media, previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform *The Journal* at the time.

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication will usually be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

AMLODIPINE

Clear instructions needed

From Mr G. J. Weaver, MRPharmS

I am sorry if there has been an announcement in *The Pharmaceutical Journal* that I have missed, but I believe that the Royal Pharmaceutical Society's legal department must give a clear instruction to pharmacists dispensing prescriptions for amlodipine. Until generic amlodipine maleate became available there was no doubt that amlodipine besilate (Istin) was dispensed. Now patients using several pharmacies may find they sometimes receive besilate and sometimes maleate. If it is to be accepted the two are bioequivalent the patient information leaflet must include a text of reassurance for the patient.

G. Weaver
Bathford,
Avon

LYNSEY BALMER, pharmacist adviser, fitness to practise directorate, Royal Pharmaceutical Society, replies: The Code of Ethics requires that "except in an emergency, pharmacists must not substitute any other product for a specifically named product without the approval of the patient or carer and the prescriber". Therefore, if a prescription specified an amlodipine salt, a pharmacist would be expected either to dispense that salt or to consult both the prescriber and patient regarding any substitution.

It has been brought to the Society's attention that some GP computer prescribing systems automatically default to a specific amlodipine salt. In such circumstances, pharmacists may wish to develop locally agreed protocols with prescribers. However, consideration would need to be given to instances where a patient is expecting a particular salt and the prescription would need to be appropriately endorsed.

Patient information leaflets are product-specific and the information provided is the responsibility of the individual marketing authorisation holder. Pharmacists are required to ensure that patients have sufficient information to enable safe and effective use of their medicine. As with all generic medicines, the different amlodipine products that are now available may give patients cause for concern. Pharmacists would be expected to ensure patients are appropriately counselled on the different amlodipine salts and their recognised bioequivalence.

THE PROFESSION

Top tip: be a plumber

From Mr J. J. Durand, MRPharmS

I have to agree with Christopher Chapman (*PJ*, 31 July, p151). It is heartening to read such a perceptive letter from a pharmacy student. Pharmacy is overloaded with bureaucracy and paperwork more than ever. It is getting harder and harder to do a good job for a decent salary. Mr Chapman believes he may have to look elsewhere to earn a living. He is probably right if he wants to earn a salary commensurate with his responsibilities and not have to work long and inconvenient hours. It would be a shame to waste all the knowledge he has gleaned and I urge him to finish his degree. It may come in useful one day.

Many pharmacists are aggrieved by their pay, conditions and professional status, but bury their heads in the sand. But I think the worm is about to turn. If you can earn more by repairing washing machines, plumbing or painting and decorating, why be a pharmacist? All other closely related professions earn at least twice our salaries, on average, many much more. Just look at dentists. They must be pleased with themselves. What is it going to take for pharmacists to realise how bad a hand they have been dealt?

Consider the near future. In real terms, being a qualified pharmacist is going to cost over £1,000 a year before you earn a penny. By this I mean the Royal Pharmaceutical Society's fees, indemnity fees and the time taken up by continuing professional development. Please note all other medical professions connected to the NHS are paid well for undertaking CPD; how about us?

There is a lot of food for thought at the moment and I am sure many pharmacists are at the end of their tether and are looking about for alternative ways of making a living. Many will leave, never to return. If you wish to make an average living, struggle to pay the mortgage, never own a brand new car and be looked down upon by other professions, be a pharmacist. On the other hand, the world is your oyster. You are bright and intelligent, make the most of your practical and cerebral skills — become a plumber!

Jonathan J. Durand
Fareham,
Hampshire

THE CHARTER

Use your vote

From Mr C. Ranshaw, FRPharmS

May I applaud the Council on arriving at a draft Charter that has been sent out to the members seeking approval by postal ballot.

This is obviously the result of sensitive negotiations and a lot of hard work for all those concerned. The Privy Council agreed to put on hold the Charter petition allowing for minor alterations. The timetable for the Section 60 Order fortuitously slipped allowing time for this and time for a postal ballot.

This must therefore mean that substantially the original petition was almost satisfactory and we must thank some honourable pharmacists, members of Council (past and present), Officers and others who participated in the process for their contribution and all their hard work. It would be unfortunate, indeed, if history wrongly attributed this draft Charter only to the present Council's deliberations.

It is easy for people with a great deal of energy to define themselves as being against something, giving a sense of identity and fellowship. It is now time to move on from that negativity and for all of us to show that we care about our profession.

Too often I read of pharmacists complaining that the Society "never does anything for me", when what they should be saying and asking is "what can I do for my profession?". You can vote! I would not dream of suggesting how to vote, but we must all use the vote that the opportunity of a ballot has given us. A massive return on the ballot will send a clear message that we are a strong profession and that this is our greatest asset — an asset built by generations of pharmacists over the past 160 years, an asset that cannot be measured in pounds and pence.

The Charter is a high level enabling document to allow the Society to fulfil its functions over the next decades. I firmly believe in representative democracy and the Council is our democratically elected representative executive that must be free to act within the objects and powers of the Charter. It is now up to you to give them that freedom and that mandate.

Colin Ranshaw
Barry,
Vale of Glamorgan

Let us hope nothing has been omitted

From Professor H. McNulty, FRPharmS

I am pleased that the Royal Pharmaceutical Society's Council has collectively agreed the Charter revisions and that past presidents support it. The revised Charter is much better for spending just two extra days on it after six months in purdah. However, the whole process has been most unsatisfactory, since last October we had the previous version with five weeks' consultation and no local discussion. Now nine months later we have to vote on a final version that is untested and not discussed beyond Council. This is our only chance to get the Charter right for the profession for the next 30 to 50 years and it is easy for things to have been missed or not fully thought through in a pressurised Council meeting.

I have already voted "yes" as we have no real option because of the threats hanging over this process — not an ideal situation but perhaps the best of a bad job. My vote, however, does not mean I fully agree with the Charter wording and I have sent further comments on the need to improve the wording of the objects to the Society. I hope there may still be a chance to clarify this version to remove unnecessary restrictions, convoluted sentences and maybe to add or remove a few words that would improve governance. We need to clarify what we mean by the term "pharmacy", as dictionaries refer only to "preparing and dispensing of drugs" when our role is much wider than that now. In my past experience, the Government can be persuaded if there is scope for further improvement that will not change overall meanings, so I do hope we will at least try. More radically, perhaps why should we not also lead and develop "other persons" — surely that is fundamental to good clinical governance and a risky omission? They could still have their own representative body or bodies within the overall framework.

Omissions, errors or ambiguity in wording can have unforeseen consequences and could lead to

litigation. For those who do not think this will affect them, well it can and has. The too successful North British branch was closed down when the Society was allowed to do so because of the omission of reference to the branch in the then Charter. This happened in 1885, 32 years after the branch was formed (*PJ*, 22 September 2001, p385).

It is not just what is in the Charter, but what may have been omitted that could come back to haunt our successors. I hope those who have been involved in this process over the past two years will not have to repent at leisure, when a few weeks of constructive discussion at some time in the past nine months might have produced a much better and forward-thinking document.

Howard McNulty
Visiting Professor
University of Strathclyde

ANN LEWIS, Secretary and Registrar, Royal Pharmaceutical Society, replies: The result of the ballot on the draft Charter will be reported to the Council at its meeting in September, together with points made by members on the draft. However, as the President has explained (*PJ*, 24 July, p128), this is a vote, not a consultation. We have already consulted extensively with the membership and others, and important changes have been made to the various drafts in response to the feedback received.

There might be technical or typographical issues to be addressed, and the Council would also have to consider any amendments that might be required by the Privy Council, should the draft meet with the members' approval. Otherwise, the draft circulated with the ballot papers should be considered as final and it is the membership's decision as to whether or not it should go forward to the Privy Council.

Disinclined to support the Council

From Mr C. Payne, MRPharmS

Enclosed with this week's *Journal* (31 July) was a printed message from the Society's Council urging me to vote in favour of the new draft Royal Charter. I believe that the Royal Pharmaceutical Society has done everything in its power to make life as difficult and stressful for independent contractors as possible. So I am disinclined to support the Council in any way. I would urge all members to think carefully before voting, and not simply acquiesce to the Council's wishes.

Conrad Payne
Ely, Cambridgeshire

THE JOURNAL

Worth the wait

From Mr N. T. Fitt, MRPharmS

Recent correspondence regarding the dearth of humorous items has obviously been taken to heart. That would explain your report (*PJ*, 31 July, p162) of a tablet for the treatment of premature ejaculation taking about two hours to work.

Norman Fitt
Manchester

Advertisement

A case of mistiming?

From Mr L. M. Hurst, MRPharmS

At around this time last year (*PJ*, 21 June 2003, p859), I pointed out that the Royal Pharmaceutical Society's final roadshow on "Fit for the future" was in danger of being hijacked by the Pharmaceutical Services Negotiating Committee, which had chosen the same evening for its own opening roadshow on the new contract. The PSNC, to its credit, acknowledged this mistiming by arranging an additional date.

Do we now have a further mistiming in the Charter programme itself? I trust not. We have been asked by the Society to give a final yes or no to a set of Council proposals before 20 August, while at the same time being invited by the President to submit comments which, it transpires, will not be considered until the Council's September meeting. There is no spot on the ballot paper to record any concerns. I happen to believe that the redraft seems workable but could someone tell me what restrictions a "final" yes majority would place on any comments that the Council would thereafter be permitted to consider. Fine-tuning can make all the difference to outcome. It would be a shame if the process hijacked valid comment.

Larry Hurst
Princes Risborough, Buckinghamshire