

NEW CONTRACT

Ballot date should be put back

From Mr I. Abrahams, MRPharmS

Pharmacy contractors are each about to make their most important professional or business decision since they decided to become pharmacists; indeed this is probably an even more important moment than when they decided to buy a community pharmacy. Why then has the Pharmaceutical Services Negotiating Committee given such a short time in which we must decide on how to vote? For those contractors whose local "roadshow" is not until 14 November, they will have less than a week to make up their minds and not even have a chance to read how the debate is going in the following weekend's press.

Considering the time taken to produce the final version of the offer, bearing in mind that this is a busy trading period, do we not deserve at least until the end of the year to vote? Is it because the PSNC is trying to pressure us into voting "Yes" before we have taken on board all the drawbacks? Is it because it does not want to answer the searching questions which will no doubt be asked? Or is it the Government that wants to get started on 1 April?

If it is Government pressure, tell them hard luck — we will not be pressured. If it is not the Government then please put back the voting date so all can be discussed. I am saying this as a contractor who wants to vote "Yes" but needs a bit more convincing.

If the PSNC does not agree, I hope that we have the courage to say "No". After all, that is what negotiation is all about.

Ian Abrahams
Pinner, Middlesex

Two points to consider for independent contractors

From Mr J. A. Patel, MRPharmS

While we are discussing the new contract two points need to be addressed, especially for independent contractors in London. First, inclusion of a "London weighting allowance" in the payments, and secondly, some element to favour independent contractors since the multiples

have far greater buying power with Drug Tariff discounts.

A contractor, like myself, with a rates bill of £10,000 per annum in London is paid the same as a contractor in the North of England providing a similar service. No account is made for the extra living costs in London, as it is in other professions.

Similarly no distinctions exist between multiples and independents, which have a much smaller buying power. The proposed new contract, by removing Drug Tariff price difference, in effect takes more away from independents in order to pay for the extra services. As the number of independents shrink they will bear a proportionately greater cost.

I think all independent London contractors should raise these two points with their local representatives on the local pharmaceutical committee and the Pharmaceutical Services Negotiating Committee.

Jayesh A. Patel
West Wimbledon, London

Put in the disposable category

From Mr S. S. Kalsi, MRPharmS

When the new contract was being promoted everyone was on a high. We would be true clinicians and lose that "tablet counting shopkeeper" label. But the finished article does not live up to expectation.

The majority basis is still on prescription numbers and the pharmacies at the bottom have been put into the disposable category. Yet these are the very people who have brought success to primary care

trusts with stop smoking, minor ailments and prescription intervention schemes, to name but a few.

The real slap in the face is the one year exit payment. Is this the true worth of people who have invested their lives' work in community care in its truest form, and who were practising it even before it was a twinkle in the Government's eye?

Surinder Singh Kalsi
Ilford,
Essex

Will new services be properly funded?

From Mr J. R. Ahmed, MRPharmS

At a recent Birmingham Local Pharmaceutical Committee meeting, a question was asked whether, under the new contract, the average contractor would be better or worse off than at present. The reply from the LPC chairman was that the negotiations were held under the premise that no contractor would be worse off.

I was under the impression that the Pharmaceutical Services Negotiating Committee was negotiating on the basis of new money for new services. If I am to receive the same remuneration for more work then this new contract will be a non-starter as far as I am concerned. Being remunerated for new services with no increase in overall funding means my dispensing fee will have to be reduced, perhaps to as little as 65p an item. I would have to employ extra staff to dispense prescriptions while I lock myself in my new consultation room. As an independent contractor, my

expenses will dramatically rise, which I cannot afford unless my income goes up, which looks like not occurring under the new contract. One may argue that dispensers cost less than a pharmacist so dispensing fees can go down but overall my expenses will rise. I find dispensing rewarding and I am happy with the prospect of undertaking the new essential services, but only if I can afford to do so.

Would the PSNC tell all contractors what the new contract is going to do for us in terms of a professional service funded in a professional manner?

J. Ahmed
Birmingham

MIKE DENT, head of finance, Pharmaceutical Services Negotiating Committee, replies: Mr Ahmed should by now have received his copy of the PSNC book 'The new contract for community pharmacy 2004'.

He will see that fears of a reduction in item fee to 65p are unfounded and that there is new money available. The PSNC is currently running an extensive programme of roadshows on the new contract before the ballot, and would encourage contractors to attend one of these. Information is also available on the PSNC website.

Support new contract

From Mr M. H. Smith, MRPharmS

I have recently returned from the UniChem Convention and I am pleased to say with a degree of optimism for the future of our profession. The presentations clearly demonstrated that the new NHS contract represents not only a fair deal for pharmacy but also an outstanding opportunity for the profession in the future.

I believe that the sound evidence-based approach of the Pharmaceutical Services Negotiating Committee contributed much to the satisfactory outcome of these long and protracted negotiations. I would urge all contractors to support the new contract.

At the convention, the message from Howard Stoaite, chairman of the All Party Pharmacy Group, was clear: "The DoH has done all that it can for pharmacists — now it is up to you."

Mike Smith
Chairman, UniChem Ltd

Letters to the editor

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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.

 MEDICINES MANAGEMENT

Numbers do not add up

From Mrs P. K. Sandhu, MRPharmS

I refer to the news item "Trigger questions useful to identify medicines support need" (*PJ*, 16 October, p549). First, I commend the attempt to develop a single assessment process (SAP) with only four questions because this has the potential to simplify the process enough to be used in wider practice.

Would the project managers please clarify a few issues on the methodology and results stated in the article since I have been left a little perplexed.

Question 3: "Can you swallow and use all of your medicines and get all of your medicines out of their containers?" contains three questions. Does the patient have to say "yes" to all three parts to qualify? If all three parts are relevant and important, which they seem to be, then surely it should be split into three questions producing an SAP that consists of six questions.

The inclusion criteria of responding "yes" to any of the questions is also puzzling. Surely, saying "yes" to "Do you always take all of your medicines the way the doctor wants you to?" seems to be the perfect response. Am I to understand that by saying "yes" a patient is actually demonstrating non-compliance as, after all, none of us is perfect so he or she must be lying?

Finally, with regards to the results, could you please explain where the 88 per cent of older people needing an alteration to their medicines was derived from. I understand we have limited data in the story but the figures just do not add up (or divide).

Since supporting older people is such a key area in medicines management, an initiative such as this has great potential value. It would help if we could be assured of the robustness of the methodology before it receives wider adoption.

Pam Sandhu
Southall

LELLY OBOH, project co-ordinator, replies: First, I must correct the statement in the press release: "A response of 'yes' to any of the four questions indicates a potential pharmaceutical care need." It should state: "A response that indicates a problem in any of these areas shows that the older person may have a potential

pharmaceutical care need." The confusion is because the four trigger questions were originally statements where a "yes" response would indicate a need. However they were rephrased as questions in the final report, which changes this. I hope this clarifies Pam Sandhu's next two questions.

One of the eight objectives of the project was to test the four trigger questions to determine if they can identify older people with a potential pharmaceutical care need within the single assessment process. They were asked as part of the overview assessments (or case finding process) along with other non-pharmacy questions (with or without prompts) to trigger a referral for further assessment for support. All of those, for whom the trigger questions highlighted a need, were subsequently found to have a pharmaceutical care need in the in-depth assessment. The project was not geared to validate the questions and further work will be needed to do this.

In 88 per cent of the older people who were part of the evaluation, there was an alteration made to at least one medication, and in many cases, more than one. Although the sample size is relatively small ($n=32$) we feel this observed outcome remains important and representative of reality. The reported proportion refers to the number of cases (patients) not the number of medicines observed.

The three pilot sites employed different methods to case find their project population. However each site was limited to 17 patients for the in-depth medication assessment irrespective of the numbers found. For the explanation about the numbers see Table D-1 and footnote on p26 of the final report (www.london.nhs.uk).

 REGISTRATION EXAMINATION

What has happened to the preregistration year?

From Concerned Pharmacist

When I qualified as a pharmacist in 1976 I completed a preregistration year under a specially trained tutor and was signed off at the end as being a responsible person. The system worked well and as far as I know there was no suggestion of incompetent or dangerous pharmacists being admitted to the Register.

Nearly 30 years on I find that it has been replaced by an

examination with a pass mark of 70 per cent, equivalent in some universities to a first class honours degree, which has just failed 29 per cent of the applicants. This means that 50 jobs have fallen through, all of which will have to be readvertised, while pharmacies have no pharmacists and locum dates are vacant. What a shambles!

Of the people who failed, over 50 per cent were taking the examination for the first time, including my son, who scored 68 per cent. He did his preregistration year in the hospital sector and was sent on numerous courses at a local university. He revised nearly as hard as he did for his degree and took an entire week off just before the examination. He got 85 per cent in the calculations and around 60 per cent in the other topics but he still failed. He was devastated. His pharmacy job was cancelled. He cannot take the examination again until June 2005. So after four years at university, one year of preregistration training and a good report by his tutors, the Royal Pharmaceutical Society deems him not good enough to be put on its register. He is now actively considering jobs outside pharmacy and who can blame him? Another pharmacist is lost to the profession.

Concerned Pharmacist
297/30

 LEVOTHYROXINE

Is levothyroxine suspension effective?

From Mr K. Bird, MRPharmS

My recent experience of the treatment of a hypothyroid baby has given cause for concern regarding the use of extemporaneously prepared suspensions of levothyroxine. 'Medicines for children 2003' mentions the use of such a product, which would typically be made from crushed tablets and a suitable suspending agent, eg, Keltrol 0.4 per cent. For a recent patient, such a product was used with no noticeable therapeutic effect. Because of concerns such as whether or not the bottle had been shaken the product was replaced with a fresh supply and support for the parents given via a home-nursing visit.

Unfortunately the substitute also resulted in therapeutic failure; treatment was then altered to a regimen involving levothyroxine tablets and the use of a tablet crusher, which has had the desired

effect. These events have been investigated and factors such as preparative technique and patient compliance were examined but the fact remains that this patient did not appear to respond to treatment administered as an oral suspension.

My letter has two purposes: first, to raise concern over the efficacy of extemporaneously prepared suspensions of levothyroxine (this baby did not receive effective treatment for several weeks), and secondly, to see if anyone else has had similar experiences or has comments which they might be prepared to share.

Kenneth Bird

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 HICCUPS

Social implications of hiccups are important

From Dr E. K. Rosenbloom,
MRPharmS

I read with interest the article "Dealing with cases of hiccups" (*PJ*, 30 October, p647). I have a couple of points to make having reflected on my experience of supporting my daughter in managing her prolonged hiccups for the past three and a half years. The article provides an informative overview but fails to mention two key questions: do the hiccups occur when the person is asleep and what is the impact of hiccups upon the quality of life?

If the hiccups occur when the person is asleep then aetiological factors causing the hiccups should be investigated. If the hiccups are protracted then certainly the person should be reviewed to ensure that there is no underlying medical condition. If all of the routine investigations do not stop the hiccups episode then the risk benefit equation associated with any interventions should be considered.

After six months my daughter was still hiccuping at a regular rate, sometimes 15 times a minute, and it was "irritating" enough for her to try drug therapies. Chlorpromazine was ineffective but haloperidol did stop the hiccups. It also caused extrapyramidal effects that were far worse than anything described in the textbooks. Explaining to a 16-year-old that the fact that she had

no control over the opening of her mouth (and at times sticking out her tongue until it hurt) was a side effect of a drug that she had taken, and that I as a pharmacist had supported, was a professional challenge. This caused her to consider the risks of hiccups and she determined that at present there were none.

It is worth stating that she was assessed at school for the impact of the hiccups upon her ability to take examinations. The impact of the hiccups upon her peers, who were very tolerant of her constant interruptions, was also considered. The only problem that my daughter has ever encountered is the attitude of some teachers who became stressed at the constant interruption and who, on occasions, have requested that she leave the room.

She is continuing her education and will no doubt be reassessed at her university. I am wondering if this comes under the Disabilities Discrimination Act, having lasted for over a year and affected her day-to-day concentration.

I hope that describing a case that focuses on the social implications of treating a long-term condition demonstrates that taking a medical approach may not always solve patients' problems. She only has another 65 years to go to beat the world record. Watch this space!

E. Karen Rosenbloom

Loughton,
Essex

■ PRESCRIPTION PRICING

Our trusted paymasters?

From Mr G. Morrow, MRPharmS

Having recently noticed a significant shortfall between the number of prescription items priced by the Prescription Pricing Authority and the number I believed I submitted, I attempted to get an explanation. The PPA was pretty clear about it: "we are right and you are wrong" was its response. So I initiated a check with the National Prescription Research Centre.

My February 2004 "bundle" had 53 pricing errors by the PPA: five incorrect items priced, six incorrect quantities priced, 17 incorrect strengths priced, one incorrect zero discount, three items missed, seven fee errors, five incorrect presentations priced and nine incorrect pack sizes priced. To

my amazement the sum of these errors meant that I owed the PPA an extra £39.67.

However, the answer to my reason for the check was even more unbelievable. Methadone prescriptions accounted for the majority of the shortfall. Apparently if a methadone patient picks up more than one day's supply at a time, even though my primary care trust has specifically requested that individual daily doses are dispensed, only one fee can be claimed. The NPRC told me that for Saturday dispensings when Sunday's supply is also given I will get the additional fee if I imply that one was given in the morning and the other in the afternoon. I heard from another source that if I claim one is supervised and the other unsupervised, a second fee will be given. Anyway, why have 14 lines on a blue methadone prescription if only 12 should be used because we are closed on Sundays? If someone gets more than two days' supply at once, even though each one is put in a separate container, there are no extra fees payable. Ridiculous!

The other problem area was listed as follows: colostomy — four forms, 10 items, 10 fees claimed, four given. What? According to the PPA, because the prescriptions had colostomy items on them, a professional fee is only given for the first item on each prescription. I am trying hard not to swear on paper. Can anyone explain that to me?

Still pretty upset about the situation, I checked my next four months of FP34s. Items submitted and items priced again all fell short. They were 83 down, four down, 76 down and 129 down. My methadone and colostomy prescriptions for the four down month must have just got lost. I have initiated another check for June, when the difference was 129 items. I am hopeful I shall get my £39.67 back. I stopped playing the National Lottery years ago; there was too much disappointment. It seems I am still playing a lottery, though, every month when I submit my prescriptions for pricing to the PPA.

Gary Morrow

Pharmacist Director
Morrow Pharmacy Ltd

MICHAEL KING, director of planning and corporate affairs, Prescription Pricing Authority, replies: We are grateful for any opportunity to improve our services and are happy to look, in detail, at issues arising from any dispensing contractor. Clearly, we

prefer to discuss individual accounts with contractors directly. If Mr Morrow would like to contact us directly, we would be happy to discuss this further.

Ultimately, we seek to remain within the 99.8 per cent net cash variance we achieve overall every month.

■ IT

Mega-vendors undermine value of the mainframe

From Mr S. Revell

With the arrival of new technologies on mainframe platforms, from Java and Linux to ERP applications, the mainframe renaissance in the pharmaceutical industry is firmly established.

However, there is a real danger that the mainframe's value is being undermined by the obscene pricing and licensing strategies of most of the software mega vendors in the industry.

There has been an extraordinary hike in prices over recent years and the arrogance of these vendors has created a lot of ill

will. Without a significant change in policy, they are in danger of undermining the credibility of the mainframe and constraining business development and, hence, economic resurgence.

The mainframe is one of the most business-critical technology platforms, it delivers the reliability and high availability that is required today. However, most mega-vendors are still guilty of overcharging on service provision and implementation to the point of placing sometimes crippling costs on their clients.

Implementation should be a means to an end only and should not be a way to drive revenue. In this way, organisations can truly utilise the benefits of the mainframe without being tied into high ongoing costs.

The pharmaceutical industry must now start to push back against unscrupulous mainframe software vendors, demanding pricing and licensing methodologies that reflect the technology's business value.

Steve Revell

Regional Vice President, UK and
Ireland
Analytical Sciences Group

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 PERSONAL CONTROL

An anachronism not an anomaly

From Professor J. Wingfield, FRPharmS

May I suggest that the current arrangements for personal control and the resultant constraints on General Sale List (GSL) sales in pharmacies are not an “anomaly” (*PJ*, 23 October, p589). Their thrust was intended at the time of drafting and reflected the earlier controls in the preceding 1933 Pharmacy and Poisons Act. Their effect is, however, an anachronism in today’s society where the Office of Fair Trading, the Government and now the public regard GSLs as mere commodities in an open market place.

Just as the case law and Royal Pharmaceutical Society interpretations of the meaning of supervision became anachronistic in the 1990s, so now is the effect of personal control on GSLs in pharmacies. At that time, the Society (no doubt with Department of Health approval) simply changed its interpretation and decreed that henceforth supervision meant compliance with a specified sale of medicines protocol. Happily this change, unsupported by law, passed without challenge and appears to be largely observed (*pace Which?* reports). Most importantly, the law is still in place and could be invoked if necessary.

A similar solution — a reinterpretation of the meaning of personal control — is surely by now the best response to the current concerns. The use of protocols whereby the absence of the pharmacist is planned, transparent and limited could ensure that the availability of the pharmacist is tailored to periods of highest public demand and at other times the pharmacist could be engaged in professional activities with contingency arrangements if urgent recall were needed.

The scope of such protocols was debated at a meeting of the Institute of Pharmacy Management International in 2003 (*Chemist & Druggist*, 12 April, p14, and *IPMI News*, September 2003) and I offered to explore their possibilities with the Chief Pharmacist as a response to the PharmacyVision 2003 document. Removing the law on personal control could have serious knock-on consequences that must be carefully thought through; for example, the impact on the

employment prospects for pharmacists could be substantial. If the law is retained, the possibility remains to prosecute, or bring disciplinary action against, attempts to abuse any reinterpretation. If the law is revoked, I suggest it will never be reinstated.

Joy Wingfield

*Professor of Pharmacy Law and Ethics
Nottingham School of Pharmacy*

Members must have a meaningful input to consultation

From Mr B. D. Nathwani, MRPharmS

Two points from *The Pharmaceutical Journal* of 2 October make me fearful that the membership view of personal control has and will be ignored by the Royal Pharmaceutical Society.

The first point was the announcement (p454) by the Pharmaceutical Services Negotiating Committee that contractors should wait to see how the new contract money should be distributed. The new contract affects all pharmacists because this is the visible public face of pharmacy with which everyone is familiar. Changes to working practices here will have a huge impact on pharmacy practice. How a pharmacist exercises personal control will be impacted on by the terms of the new contract and individual primary care trust requirements. Can the Society therefore advise us as to what the interface is between itself and the PSNC to discuss these changes and the mechanism by which the whole membership be kept informed of these discussions?

If there is no such interface does the Society think that there should be one? Does it think it right and fair that community pharmacists (not contractors) have had no direct say in the manner in which the PSNC negotiates a contract which will affect all practising community pharmacists? How is the interest of individual community pharmacists being protected?

The second point concerned Lynsey Balmer’s statement (p465) that the Society is working closely with the Department of Health regarding personal control. How does this close working fit in with the new contract? Did the Society seek the views of the National Pharmaceutical Association or the PSNC before embarking on this discussion with the DoH? Will the

Society seek the views of its members and then present a Society membership position to the DoH or has the Society’s executive presented its view of future personal control?

Will this Society executive viewpoint become the DoH position on personal control when it releases its consultation document to all interested parties. This is a fundamental point of governance which cannot be skirted. As it stands I fear that the consultation document which the DoH may produce will present a fait accompli of the direction the Society or the PSNC (by virtue of its negotiated new contract) wants the issue of personal control to go. Thus the opportunity for meaningful individual pharmacist input once this document is released will have long passed.

Proper interfaces enable participation and meaningful input. Failure to engage the membership leads to apathy.

Bharat Nathwani

Pinner, Middlesex

 CONTROL OF ENTRY

Still time for effective lobbying

From Mr J. Ferguson, FRPharmS

There are a few additional points that should be considered alongside the article “New European policy could abolish control of entry whatever NHS wants” (*PJ*, 23 October, p600).

The authors are right to draw attention to Article 14(5) in the draft directive on services in the internal market. Article 14 as a whole sets out “prohibited requirements”, ie, requirements that a member state is prohibited from applying in deciding access to a service activity. Article 14(5) is the prohibited requirement that could affect the control of entry provisions. This, as the authors of the article state, bars “the case-by-case application of an economic test making the granting of an authorisation subject to proof of existence of an economic need or market demand or an assessment of the potential or current economic effects of the activity, or an assessment of the appropriateness of the activity in relation to the economic planning objectives set by the competent authority”. As stated, the Department of Health is not clear on whether the control of entry provisions would be caught by the directive. On the face of it,

considering Article 14(5) on its own, there appears to be every likelihood that they would be.

However, Article 15(2) in the draft directive sets out “Requirements to be evaluated”. Member states are required to “examine whether their legal system makes access to a service activity or the exercise of it subject to compliance with any of the requirements listed”. If it does, a member state must inform the Commission of any requirements that it intends to maintain and the reasons why it considers that they comply with the conditions specified in Article 15(3). It must under these conditions be non-discriminatory (in relation mainly to nationality), be necessary (objectively justified in the public interest) and be proportionate (not go beyond what is necessary to obtain the objective).

Article 15(2)(a) specifies that a requirement to be evaluated is “quantitative or territorial restrictions, in particular in the form of limits fixed according to population or a minimum geographical distance between service providers”. A number of EU member states control the distribution of pharmacies in their countries by applying one or other of these criteria. Under the directive, they would have to state why they would wish to retain these controls. It would surely be unreasonable that member states, which wish to retain such controls, should be able to retain them if they can show they comply with the tests in Article 15(3), while the UK would have no such opportunity to justify the “right of entry” controls applying the same criteria. In practice, these control the distribution of new pharmacies, because few are economically viable without an NHS contract.

There is another important point, which was made strongly by the French Order of Pharmacists at the hearing on the draft directive before the Economic and Social Committee of the EU on 24 May last. This was that under the current sectoral directives on free movement of pharmacists, the geographical distribution of pharmacies is a matter not for the EU but for individual member states. Interestingly, this provision has been carried over to the new draft directive on recognition of professional qualifications, on which political agreement has already been reached by the Council of Ministers. No such political agreement has been reached to date on the draft directive on services. In “Whereas

13" of the draft directive on services, it is recognised that where a service activity is already covered by other community instruments, appropriate provisions should be laid down "including provisions for derogations, in order to prevent incompatibilities and to ensure consistency as between all those Community instruments."

There is to be a public hearing on this draft directive before the European Parliament on 11 November. There is therefore still time for effective lobbying both at EU and national level. Support of the DoH should be sought for lobbying the Department of Trade and Industry. That strategy, it would appear, succeeded in securing an exemption for medicines in the draft regulation on promotion of sales, the intention of which is to sweep away all restrictions on promotion of sales of products.

John Ferguson

Haywards Heath, West Sussex

■ SUPERMARKET PHARMACIES

Pharmacies and tobacconists should not co-exist

From Mr A. M. Brown, MRPharmS

Last week's *Journal* (23 October, p591) contained a summary of the Scientific Committee on Tobacco and Health's recent report on the dangers of passive smoking, which recommends a ban on smoking in all workplaces and enclosed public places. The pharmacist's role in promoting smoking cessation was specifically mentioned in the report.

Shortly after qualifying, when I worked as a locum, the pharmacy premises sometimes housed an off-licence, where cigarettes and alcohol were freely sold within a few feet of the dispensary area. I remember feeling uncomfortable with this and tended to decline work in those sort of shops. Nonetheless, the juxtaposition of medicines and tobacco was accepted by patients and customers alike. Indeed, patients commonly purchased their cigarettes while waiting for their Ventolin inhaler to be dispensed. Such a scenario would seem preposterous nowadays, of course. Thank goodness our Society subsequently decided to prohibit registration of premises offering for sale "any product which may be injurious to public health, or may bring the profession into disrepute". We have long since moved away from those dark days. Or have we?

Are there not a great many outlets where a pharmacy and tobacconist co-exist under the same roof. I am thinking of the superstores, most of which seem to have a pharmacy within their premises. Surely these situations must be contrary to the Royal Pharmaceutical Society's code of ethics. How has this been allowed to happen?

On the same page of last week's *Journal* (p591), under the report "Boots plans to sell alcoholic drinks at Christmas", the answer to this ethical dilemma was revealed. Our head of professional ethics explained that "supermarkets that operate pharmacies only register sections of their stores as pharmacies", the implication being that the other sections could sell whatever they wanted, presumably including cigarettes. "The situation Boots will be getting into will be no different to the supermarkets," she went on, reassuringly.

Come off it Society! How on earth can we be taken seriously as a health care and health-promoting profession if we allow the big boys such as Tesco, Asda and others flagrantly to play the system? Either they are worthy of having a pharmacy or they are not. If they persist in selling cigarettes, and this is "allowed" because they can "deregister" part of their premises, then the rules must be changed. Or is it that the big boys effectively "make" the rules, as in so many other walks of life?

Adrian Brown

Southport, Merseyside

■ RETENTION FEES

Branch and regional network will be adversely affected

From Mr W. T. Brookes, FRPharmS

Although reserves and fees were on the agenda of the branch and regional secretaries' meeting on 13 October there was insufficient time for the thorough debate the subject warranted.

Although I have no quarrel with the decision to have a practising and non-practising register I have a major disagreement with the proposed fee structure, particularly since it affects retired members who no longer practice. Bruce Rhodes (*PJ*, 30 October, p643), with his usual eloquence, has pointed out that the fee for retired members will rise to over £100 in a few years — a five-fold increase on today's fee and just as hurtful for being phased in.

I have no doubt that a large number of those so affected will leave the Register and this, I believe, will have a significant adverse affect on the branch and regional network. Many retired members such as me still serve in a number of ways. The loss of this contribution will be a major blow to the system.

The Royal Pharmaceutical Society's Council and the Privy Council already know my views and I am clear about the way ahead for me. If the proposed fee for retired members goes ahead I will stay on the Register for one more year simply so that my vote will count in electing our new Council — a matter of some importance. After that my links with a body I have served for over 50 years will be severed, to quote Bruce Rhodes, "with great sadness".

Bill Brookes

*South Cheshire Branch
Royal Pharmaceutical Society*

Half a cake is better than no cake

From Mr M. Samson, MRPharmS

The Royal Pharmaceutical Society presumably wants more money. In its wisdom it increases the retention fee for its retired non-practising members substantially — the members respond by not paying the fees so the Society receives less, rather than more, money. Does this make sense?

Furthermore, it loses not only the money for the coming year, but for all of the future years those members would have paid had they remained on the Register. Surely half a cake is better than no cake. Therefore, why not have a retention fee of, say, £25 per annum for all retired non-practising members and everybody will be happy?

Michael Samson

Worthing, West Sussex

■ THE SOCIETY

The end is nigh . . .

From Dr C. M. Minchom, MRPharmS

I read with foreboding the letters pages of the *PJ* of 9 October. As an overseas industrial pharmacist I receive my *Journal* two to four weeks after most of my fellow members. The tone of most of the letters published was bleak:

pharmacy education boom and bust; health minister insults community pharmacy; technicians' code of conduct unacceptable; save our conference club; and 14 letters from individuals bemoaning the new fee structure or its effect on Birdsgrove House donations. Many of these latter correspondents indicated that they would be resigning from the Society next year.

Unlike most of my fellow members I did vote in our Council elections hoping that the Save Our Society candidates would reverse the decline and polarisation brought about by their predecessors with the clumsy introduction of continuing professional development and the Charter debacle.

I can congratulate the new Council on reversing one of the above aspects; with the introduction of the new fee structure the membership is significantly less polarised. The vast majority of us are against having to pay more. Those who have no choice will have to pay the 25 per cent increase. Unfortunately those who have a choice and cannot see the benefit of a 220 per cent increase will leave, reducing diversity.

I hope not to have to shout: "The Society is dead. Long live the new monoculture." There is a chance to reverse this — I urge the Council to do so.

Colin Minchom

Toronto, Canada

■ THE JOURNAL

The moko is an admired facet of Maori culture

From Mr I. R. Hyslop, MRPharmS

As a New Zealander by birth, and a member of the Pharmaceutical Society of New Zealand (both old and new), may I reply to Brian Jones's letter (*PJ*, 23 October, p599)? I most certainly did not find the cover of your 16 October issue in the least insulting. The Maori warrior with full moko (tattoo) and facial expression is a traditional and admired facet of Maori culture. While not common, the moko is still seen today on some New Zealanders and is commonly used as a symbol of our country.

Surely someone from Britain should not suggest we do away with a colourful and distinctive tradition.

Ivan Hyslop

Lincoln