

NEW CONTRACT

Is money really being devolved?

From Mr S. K. Bagga, MRPharmS

The new contractual framework for community pharmacy from the Department of Health makes the following two statements:

- There are three tiers of services: nationally set essential and advanced services (for which £1.766bn funding is available in 2005/06), and enhanced services commissioned locally by PCTs.
- It is envisaged that there should be a periodic review of services in the contractual framework to allow for updating or revision of service requirement and standards of provision. As part of this, there may be a shift in the categorisation of services, for example, a service might move from being in the enhanced category to the essential category.

This is nonsense. The proposed arrangements show that “essential” and “advanced” services are to be nationally negotiated and dispensing is to be paid from “the new global sum”. The “enhanced services” are to be paid from locally devolved sums of monies which are already considered inadequate by most PCTs. In fact, in some PCTs, there are not enough monies to make even floor payments to GPs for providing enhanced services agreed in the new GP contract! Also, the Government, having devolved 85 per cent of NHS funds to PCTs, has said that they will devolve more money and delegate power to PCTs in the future.

So, there appears to be a contradiction, which the Department of Health must clarify. The impression is being created by the above two statements that locally devolved monies would be pulled back to the centre and transferred to the essential services. If this is correct then why are the monies for minor ailments schemes not transferred to the central pot now? And why are minor ailments schemes not an essential scheme from 1 April?

Other questions also arise. Under what circumstances will the enhanced services be redefined and payments transferred to the central pot? What schemes are they looking at to make the changes?

The second point I wish to make is that £866m of the £1.766m funding for community

pharmacy is labelled as the “new global sum” to pay for dispensing services. This means that at any time the remaining £900m can be devolved to the PCTs to commission local services. Are contractors aware of this point?

Thirdly, where are the milestones for the future? How much of the average community pharmacy’s income is going to be derived from the locally negotiated services and how much from the centrally negotiated income? This is extremely important as the majority of contractors are still under the impression that monies being devolved to PCTs will not affect their income in any way.

Shiv K. Bagga
London E6

CHRISTOWN, Chairman, NHS Confederation Negotiating Team, comments: This letter makes a number of points about the new community pharmacy contract and, although the funding of the contract is entirely a matter for the Department of Health, as chair of the negotiators I will attempt to deal with as many of the issues it raises as I can.

First, it should be noted that the new contract will be introduced in a phased approach and that it will evolve over time. This was always the intention of the DoH and is the reason for the statement in the contract that “it is envisaged that there should be a periodic review of services in the contractual framework to allow for updating or revision of service requirement and standards of provision”.

Many of the points raised in the letter cannot be answered for the simple reason that we do not yet know, and we need to wait to see, the outcome of the negotiations

over the next phases of the contract. Any development in the contract will be the result of negotiation between the Department of Health, the NHS Confederation and the Pharmaceutical Services Negotiating Committee and may, if necessary, involve changes in primary legislation. These changes would be required, for example, to introduce full local commissioning.

Certainly the detail such as funding for moving services between categories is as yet unclear and will be subject to discussion in negotiation sessions over the coming months and to direction from the Department of Health. What is clear, however, is that the trend is to continue to localise funding with the primary care trusts as in “Shifting the balance of power” and this is not likely to change.

It is important to appreciate that what we have now is the initial contractual framework and that details in terms of the development of the contract will become clearer over time as we discuss these issues in future negotiations.

Contract rewards quantity not quality

From Mrs E. E. Hopkins, MRPharmS

The new contract was supposed to be about fair funding — quality not volume — and an extended range of services.

At a recent London Pharmacy Forum it was highlighted from a Department of Health document on the pharmacy contract that:

- All contractors, large and small, depend at present on profits from purchase of medicines dispensed

for the NHS to supplement the Global Sum income. This income source is substantial, but was not recognised under the present arrangements.

- Pharmacies’ reliance on purchase profits has been recognised by the DoH and the Pharmaceutical Services Negotiating Committee. Thus, money released from a reduction in reimbursement prices for generic medicines will be used to contribute to funding the new contract.

This acknowledges the fact that all contractors, including smaller contractors (who operate much nearer the break even point than the rest), are currently benefiting from the available discounts. It has also been said that the DoH objective is to reimburse pharmacies as closely as possible to the price they pay for medicines for dispensing under the NHS. To avoid underpayment, which would threaten the viability of the pharmacy network after considering the costs of running the network, the DoH agreed to transfer the so-called profit on purchasing to pay for various elements of the agreement. But it excluded those dispensing less than 2,500 items a month from receiving the full annual establishment payment (£21,821 per annum), which, along with the variable volume-related practice payments, makes up the front-loading necessary to ensure that fixed overheads are covered for all pharmacies. At 2,000 items a month the annual establishment payment is £20,000 a year. This means that a pharmacy dispensing 1,999 items a month will lose £20,000 a year for not dispensing 12 more items; therefore each prescription is effectively worth £1,666.

The proposals put to a vote were unfair. Noel Baumber (*PJ*, 20 November, p743) showed that monies have been transferred from front-loading to back-loading the remuneration package without any disclosure to contractors. I believe this should be challenged in law.

In my opinion the new contract will not extend the range of services because the cost of providing the services will exceed the resultant income and create more hassle.

Minister, rethink the proposals before you are forced to. Expect a challenge. I would not accept this lying down. Someone should be accountable for loss of service to my community.

Elisabeth Hopkins
Ealing, London

Letters to the editor

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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.

 NEW CONTRACT

Points system for GPs' new money

From Mr D. K. Rayner, MRPharmS

Those who have recently voted in favour of the new pharmacy contract may find the following facts somewhat disturbing.

My daughter has almost finished setting down the protocols, computer listings, etc, for the new medical contract in respect of the practice where she is a partner. The Government has organised a "points" system in which the practice has been offered a maximum of 116 points to be achieved. This includes influenza vaccination targets, computer documentation of scans, X-rays, staff and safety protocols, etc. For each achieved point there is a payment (new money) of £1,050 giving a total of £121,800 for the practice next year.

At the moment she has achieved 85 points and fully expects to reach the final total within the next week. Since there are five partners, each will receive £24,360 in extra gross wages next year.

Perhaps you would be kind enough to ask Sue Sharpe to comment on the lamentable comparison this makes to the new pharmacy money on offer?

David K. Rayner
Bradford

SUE SHARPE, chief executive, Pharmaceutical Services Negotiating Committee, replies: The new community pharmacy contract was negotiated on the basis of evidence of costs and expert advice on funding. It is for the community pharmacy service, and it is not relevant to compare it in structure or detail of funding with the GMS contract.

Independent contractors should form own alliance

From Mr B. Nathwani, MRPharmS

At a House of Commons briefing on Wednesday 17 November a question was put to John Reid that struck such a chord that most of the 250 pharmacists present burst into spontaneous applause.

The question was, although all pharmacists agree with the new clinical roles envisaged, why was a model of distribution chosen that could lead to a number of small

pharmacies having to close? Contractors were not asking for extra money but a fairer distribution. Dr Reid's assurance was sought that he would not sign off the new contract unless a fairer distribution was in place.

We need to know whether it is the Department of Health, or the Pharmaceutical Services Negotiating Committee, that has failed smaller contractors. I believe it is the PSNC that is to blame because disadvantaging low volume contractors located in deprived areas is not in line with Government policy.

Sue Sharpe (*PJ*, 24 April, p495) "denied that the PSNC has analysed how many small pharmacies might close". She confirmed that the PSNC has a lot of detailed data and models related to pharmacy remuneration but that the data "are confidential and we are not going to disclose them." The *PJ* (2 October, p454) also reported: "Mrs Sharpe declined to provide any pointers to how the money is likely to be shared out . . ."

We can now understand why the PSNC was scared to share these models with its own contractors. The PSNC failed to provide adequate tools for contractors to assess the impact of the new contract on their businesses and then has the temerity to denigrate the North East London Local Pharmaceutical Committee model.

I openly challenge the PSNC to confirm or deny (only a simple yes or no) the following points:

- The PSNC put forward to the DoH distribution models which were fairer towards low volume pharmacy contractors
- The DoH rejected these distribution models, which were fairer towards low volume contractors
- The PSNC can prove by demographic mapping that smaller contractors are not disproportionately located in deprived areas
- The PSNC can prove that pharmacies dispensing fewer than 2,000 items per month and with a 80:20 NHS:OTC split will not be worse off with the new contract (no other income assumed); this is why it has provided inadequate comparison tools.
- The PSNC does not have data that show by health authority, or PCT area, the number of pharmacies that dispense fewer than 2,000 items per month

The answers will be a telling indictment of the PSNC.

The silence of the National Pharmaceutical Association in protecting its smaller members is worthy of note. The NPA, it seems to me, is becoming a representative group for the multiples and big business.

Independent contractors should consider forming an independent contractors only alliance to represent their interests and collect information on the pattern of distribution of pharmacies that will be worse off. They also need to meet their local MPs and explain the true consequence of the new contract. Even at this stage political pressure will have effect.

Bharat Nathwani
Pinner, Middlesex

Controlled release of information?

From Mr C. Morris, MRPharmS

What a joy to see an "overwhelming majority of contractors said 'yes' to the new contract" (*PJ*, 27 November, p773). I calculated that around 68 per cent of eligible community pharmacists voted "yes", but then that would probably be more than voted for most of our elected leadership; so perhaps the majority was overwhelming.

I was interested to see the article in *Chemist & Druggist* of 4 December where a member of the Pharmaceutical Services Negotiating Committee pointed out that to carry out the advanced services mentioned in the new contract most shops will probably need a refit. How amusing that this article was not written before the cut off for the vote. If the electorate had seen this article before the incredibly accelerated cut off date it might have tempered their "overwhelming" enthusiasm.

In the letters pages of *The Journal* (4 December, p813) Adrian Korsner points out that a lot of the facts and figures are not yet known about the contract. As to whether this is true I cannot attest but the article in *Chemist & Druggist* does seem to point to a controlled release of information.

I know this is now moot. The contract has been agreed and large stores will probably gain more than small ones.

With the probable loss of 22 per cent of part-time pharmacists according to the PDA vox pop (*PJ*, 4 December, p805), and the ensuing pharmacist shortage that this may cause, plus the added costs required actually to get the "brass

ring" offered by the wonderful new contract — who knows? Maybe the idea of practising or non-practising pharmacist will no longer apply; maybe we will arrive at the place that pharmacy has been heading for so long and only the multiples will remain; maybe all that will matter, then, will be which company you work for.

Chris Morris
Newquay, Cornwall

 PPRS

Ups and downs

From Mr D. J. Hamblin, MRPharmS

The daunting prospect of having to deal with the pending 7 per cent Pharmaceutical Price Regulation Scheme reduction in branded prescription drugs (*PJ*, 6 November, p669) at one of the busiest times of the year has been somewhat improved by the much welcomed letters from AstraZeneca and GlaxoSmithKline informing of their intentions in good time. Let us hope that the rest of the industry can be similarly transparent.

AstraZeneca has announced significant cuts on four major products. Does this give scope for an increase on the rest of their portfolio?

David Hamblin
Norwich,
Norfolk

 REGISTRATION EXAM

Who is benefiting?

From Ms N. Hampson, MRPharmS

I am writing to add my concerns to those already expressed regarding the relevance and validity of the registration examination. My personal experience of the examination (taken in 1995) was that, at the end of a rewarding and enlightening preregistration year, it presented me with a final bureaucratic hurdle to overcome before gaining registration. It tested my memory and my ability to check reference books against the clock, but it did not allow me to demonstrate the knowledge and skills which I had gained during my preregistration year.

Since qualifying, I have completed a diploma in clinical pharmacy and, more recently, qualified as a supplementary prescriber. Both of these qualifications focused on learning

in practice, competence-based learning, Objective Structured Clinical Examinations and reflection, all of which are being used more frequently to assess the competence of our health care colleagues in the medical and nursing professions. These more modern methods of assessment seem to me to be more relevant in the production of a rounded, clinically aware and patient-oriented pharmacist. I would urge members of the Council to review the current examination and ask themselves who is it benefiting.

N. Hampson
Nottingham

Exam inconsistent with philosophy of CPD

From Miss R. N. Price, MRPharmS

Sultan Dajani's Broad spectrum article (*PJ*, 13 November, p712) poses some thought provoking questions.

At a time when it has been recognised that pharmacists (like all health care professionals) should be committed to life-long learning and development through the introduction of mandatory continuing professional development, it seems inconsistent that to be able to register is dependent on an assessment made in a contrived and time-limited situation.

I would urge the Society to debate and revise its registration procedure.

Ruth Price
Carrog,
Corwen

Trainees should be supported

From Mr J. M. Patel, MRPharmS

I write to add my voice to those calling for the registration exam to be reformed or scrapped. Many of the problems with the current system have been eloquently discussed in recent issues of the *PJ* but I would like to further discuss the moral issues.

The Royal Pharmaceutical Society's current position can be described as follows: those who fail three attempts at the examination pose such a risk to the public that they should be permanently excluded from the profession to which they have already committed four or five years of their lives.

No one doubts the importance of protecting the public but it could also be argued that the public will be endangered by the effect of stopping these people from joining an overstretched workforce. If people are to be made to feel that they have essentially wasted the past few years of their lives then this decision should be based on strong evidence. Where is this evidence?

I find it hard to believe that it is beyond our wits to protect both the public and those who want to become pharmacists; other correspondents have made suggestions for how to proceed. People who have already failed three attempts have been wronged and deserve another chance. Pharmacy students deserve the assurance that they will be supported if they struggle in their preregistration phase — and not be merely cast adrift.

Jason Patel
Birmingham

Need to get the basics right

From Ms J. S. Razzaq, MRPharmS

The registration examination is the determining factor as to whether you qualify as a pharmacist. I do agree that we should have an examination but it must be vocationally based. It is still a theory examination and the vast majority of us are not research scientists. We need to be tested on core skills such as communication, applying theory to practice, decision-making and teamwork. There is no point in learning vast amounts of theory if you cannot make a simple intervention. Let us get the basics right.

Incidentally, there should not be a limit of how many times to take the preregistration examination. Surely we should be concerned with the quality of the end product.

Jabeen Razzaq
Bolton, Lancashire

PRESCRIPTION FORMS

Contact dermatitis from handling prescription forms

From Mr R. I. Dunkley, MRPharmS

Some of your readers may remember that when the green FP10s were introduced in 1998, I

wrote to *The Pharmaceutical Journal* (18/25 December 1999, p971) saying that my hands, after handling the new forms became cracked and bleeding, and very uncomfortable.

The editor ran the letter as a news item. Within days I had telephone calls from all over the UK from people with similar experiences to mine. Unfortunately, when I was patch tested nothing came of it, but the condition never went away, sometimes my hands were fine, and other times they were cracked.

The purpose of this letter is to ask anyone who contacted me in 1999 or after, the question: "Has your skin condition gone away or got worse?" I have just spent three weeks in Leeds General Infirmary as an inpatient on the dermatology ward as the result of a massive flare up of eczema. It was painful and developed within a week. I was covered in eczema from head to foot. Fortunately the medical and nursing staff brought the condition under some kind of control, and I am on the mend.

I am interested in finding if there is a link between the original contact with the green FP10 forms that produced the bleeding and

cracking, and any subsequent flare ups that may be all over the body, or affect other parts of the body.

I can be e-mailed at bob.dunkley@btinternet.com.

Robert I. Dunkley
Leeds

Off the record

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

Broad spectrum

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

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■ COMMUNITY PHARMACY

Will chloramphenicol eye ointment be available OTC?

From Mr G. A. Hopkins, MRPharmS

Like many other colleagues I welcome the news that chloramphenicol eye drops are likely to be available from pharmacies without a prescription (*PJ*, 4 December, p803). There are many situations when the use of this product is indicated.

However, I would like to make two observations. First, I note that only drops are mentioned. It would be a great pity if we were not allowed access to the eye ointment as well (as are optometrists). There are times when an eye ointment is more appropriate than a drop, eg, for young children (I am aware that the product licence will specify children over the age of two) and at night time.

Secondly, I hope the directions for use will take account of the short half-life of an aqueous drop in the conjunctival sac and recommend more frequent dosing than we regularly see on doctors' prescriptions.

Graham Hopkins
Cheltenham, Gloucester

■ MALE HEALTH

A goal for Lloyds!

From Mrs R. A. Hodkinson, MRPharmS, and Mr P. Hodkinson (pharmacy technician)

We have been going to watch Birmingham City football matches for seven years now but one of our highlights (there are not many) was the announcement over the tannoy a couple of weeks ago at the match against Norwich. After each team scored a goal, the announcer named the scorer and said that the goal was sponsored by Lloyds pharmacy. This seemed a bit of a gamble since we do not normally see many goals!

We also believe that Lloyds are going to be at a match in January measuring people's blood pressure. Let us hope it is not an exciting game to add to the effects of all the smoking and beer.

Nevertheless, we would like to congratulate Lloyds on targeting male health issues.

Rachel Hodkinson
Paul Hodkinson
Birmingham

■ COMPETENCY

Should be looking out, not in

From D. J. Fallon, MRPharmS

The cover of the *The Journal* (27 November) poses the question "What makes pharmacists competent?" This is the question being asked by the Government (in my opinion the public do not find this an issue), but the question pharmacists would like answering is "what makes leaders competent?"

By heavily investing in training schemes our leaders try to persuade the Government that this will result in a better quality service but I suspect this will really lead to a generation of pharmacists who are either exceptionally stressed or manage to provide an illusion of competency.

It does not matter how much you know, the rate-limiting step is the time to pass the knowledge on, and from my experience in quizzing patients this is the problem among health care professionals.

I am shocked at the ignorance of patients, and this should be our primary focus. We should be looking out, instead of in, and articles about the competency of pharmacists should not fail to consider the real issues that should be tackled, namely issues of time and stress, although from an ivory tower these points may seem less important.

Dennis Fallon
Birmingham

■ PUBLIC HEALTH

Two cases for 20 quid

From Mrs J. R. Edwards, MRPharmS

Last week saw both the publication of the White Paper on public health warning of the dangers of binge drinking and pharmacists accepting a contract that requires us to advise customers about healthy lifestyles.

I was, therefore, somewhat taken aback to see in my local Sainsbury's store two huge pallets, piled high with cut-priced boxes of strong lager, placed inconspicuously next to the general sale list indigestion remedies — and little more than a trolley's length away from the dispensary counter itself. One can almost feel sorry for the customer who, with the

pharmacist's advice to moderate alcohol intake still ringing in his or her ears, instantly comes across the inducement to break their resolve of "two cases for 20 quid!"

Julie R. Edwards
Knaresborough, North Yorkshire

■ ALCOHOL

Alcohol inhibits vasopressin secretion

From Professor B. L. Furman, FRPharmS

In my attempts to maintain my continuing professional development as a pharmacist who does not yet know whether or not he "is practising" (I have duly e-mailed the Royal Pharmaceutical Society helpdesk to determine if I shall be paying £256 in January, or if I shall, instead, be purchasing 10 bottles of my favourite malt whisky), I read with interest Pam Mason's article (*PJ*, 4 December, p817) on hangovers (in anticipation of an unfavourable outcome of my quest to remain on the practising Register and the consequent purchase of the said whisky).

The article states that alcohol acts as a diuretic, because it inhibits the action of vasopressin (antidiuretic hormone) on the kidney. Although very large concentrations of ethanol were shown to inhibit the effects of submaximal concentrations of vasopressin in rat isolated papillary collecting ducts,¹ and in toad isolated bladder,² most of the evidence in the literature suggests that the diuretic effect of ethanol is mediated by an early inhibition of vasopressin secretion, rather than an inhibition of its renal actions. This has been shown *in vitro* in the rat median eminence using behaviourally relevant ethanol concentrations (5–25 mmol/L)³ and *in vivo* in the human.^{4–6}

Brian L. Furman
Dean of Science
Department of Physiology and Pharmacology, University of Strathclyde, Glasgow

References

1. Ray C, Carney SL, Gillies AH. Effect of ethanol on water and chloride transport in the rat papillary collecting duct. *Mineral and Electrolyte Metabolism* 1992;18:370–4.
2. Meier KE, Mendoza SA. Effect of ethanol on the water permeability and short-circuit current of the urinary bladder of the toad and the response to vasopressin, adenosine-3',5'-monophosphate and theophylline. *Journal of Pharmacology and*

Experimental Therapeutics 1976;196:231–7.

3. Brinton RE, Gruener R, Deshmukh P, Yamamura HI. In vitro inhibition of vasopressin release in brain by behaviourally relevant ethanol concentrations. *Neuroscience Letters* 1986;67:213–7.
4. Helderman JH, Vestal RE, Rowe JW, Tobin JD, Andres R, Robertson GL. The response of arginine vasopressin to intravenous ethanol and hypertonic saline in man: the impact of aging. *Journal of Gerontology* 1978;33:39–47.
5. Eisenhofer G, Johnson RH. Effect of ethanol ingestion on plasma vasopressin and water balance in humans. *American Journal of Physiology* 1982;242:R522–7.
6. Leppaluoto J, Vuolteenaho O, Arjamaa O, Ruskoaho H. Plasma immunoreactive atrial natriuretic peptide and vasopressin after ethanol intake in man. *Acta Physiologica Scandinavica*. 1992;144:121–7.

■ LEVOTHYROXINE

Suspensions are not the solution

From Dr J. I. Wells, MRPharmS

I would like to respond to the letter from Royston Morgan and Zilla Huma (*PJ*, 27 November, p785). It is not clear from their letter whether they crushed tablets as their source of drug, or bought in the pure drug. If we, however, assume the former, then any presumption of accuracy of dosing is confounded by the extremely low dose and the difficulty in mixing a tableting blend at target. The British Pharmacopoeia will accept a target dose of ± 10 per cent on a composite sample, and ± 15 per cent on individual tablets. If tablets are crushed in a pestle and mortar, then further dosing errors will occur, especially if a sample of the powder is used, there is non quantitative transfer, there is powder fly and dust generated or rubbing down is incomplete.

However, there is one serious oversight. This product is a solution. The solubility of thyroxine sodium (the salt used in L-thyroxine preparations) is 1 in 600 (Martindale 27th edition, 1977). This translates to 1.666mg ml⁻¹. Since the target dose is 10mg ml⁻¹, this is only 0.6 per cent of the equilibrium solubility. There is no need to use Xanthan gum. I would propose the following instead:

- If tablets are used, count out the requisite numbers of tablets for the preparation and allow them to disintegrate and deaggregate in an aliquot of water. Better still, weigh out the pure drug. Most specialist chemical

suppliers hold a wide range of pharmacopoeial quality drug substances.

- For neonates, to avoid unnecessary excipient additions, disperse the tablets to dissolve the drug in sterile water, and filter through a 40mm membrane to remove the tableting excipients and then through a sterilising filter (0.47mm) into a sterile amber glass container and store in a refrigerator. Alternatively use a combined prefilter and sterilising membrane unit, remembering to discard the first 5ml to account for potential adsorption losses.
- More elegant solutions could usefully contain 50 per cent sorbitol solution to lower the water activity and improve stability, and 0.1 per cent methyl and 0.02 per cent propyl parabens as preservatives. This choice is dictated by the prevailing pH.

As a general comment, compounders should investigate the solubility and stability profile of any drug, when embarking on extemporaneous preparation from another dosage form. Quite clearly

the assumption that an oral liquid derived from solid dosage forms is going to be a suspension is not always true. The residue due to tableting excipients truly clouds the issue. As a play on words: "suspensions are not the solution."

James I. Wells

Rosemont Pharmaceuticals, Leeds

■ COMPLEMENTARY MEDICINE

A complicated topic

From Mr U. Jonsson, MPharmS

I would like to respond to the article by Edzard Ernst "Should we use powerful placebos" (*PJ*, 27 November, p795). First, I guess readers will not need reminding that the phenomenon of placebo-controlled clinical trials not generating specific therapeutic effects certainly is not unique to complementary medicine. Sadly, disappointing results in trials have been the death sentence of many heralded "wonder drugs". Some may have been effective but, maybe due to errors of judgement in trial design, appeared to be ineffective when tested. It can be argued that

the randomised controlled trial has provided a convenient, practical and "cost-effective" way to screen numerous preparations for effect whereas scientifically valid, and arguably more accurate, procedures such as "n=1" tests in individual patients, may take longer to establish the true effectiveness of a product.

The so-called placebo, and, indeed, nocebo effect is worthy of the description "phenomenon". This description is rather apt — a process known through the senses rather than intuition or reasoning. In other words, from a scientific perspective, it appears we know little, although a lot is written about it. It is a complicated topic that is difficult to explore, or come to conclusions on the ethical problems of giving placebos, in such a short article.

Although Professor Ernst is careful in his wording, there is a risk that his recent comments may be interpreted incorrectly. Readers of *Focus on Alternative and Complementary Therapies (FACT)* published by the Pharmaceutical Press, will be aware that some promising results have been reported, in recent years, for a number of complementary medicine (CM) modalities,

including homoeopathy. It is important that pharmacists are not led to believe that CM is, generally, no better than placebo.

When evaluating clinical research involving remedies such as arnica, which is used both as a herbal and in homoeopathic medicine, it can lead to confusion both by the scientists performing the evaluation and their audience. Pharmacists and their assistants may be interested in the extensive and supportive literature for arnica in herbal medicine, which is reviewed in a recent ESCOP monograph.¹ Pharmacists can be reassured that they are recommending not just a tried and trusted traditional remedy, but also one that has been fully evaluated by an independent and expert European committee.

Ulli Jonsson

*Director of Regulatory Affairs,
Research and Development
Nelsonbach*

Reference

1. "Arnicae flos.". In: ESCOP Monographs: the scientific foundation for herbal medicinal products, 2nd edition. European Scientific Co-operative On Phytotherapy. Exeter/Stuttgart: ESCOP/Thieme Medical Publishers; 2003.

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■ THE REGISTER

Do I get value for money?

From Mr W. T. Brookes, FRPharmS

Clare Bellingham is to be thanked for her clear and well balanced article "To practise or not: that is the question" in last week's *Journal* (p809).

She sets out the issues clearly, especially with regard to fees payable by retired members. Her article makes the point that it is the aim of the Council that such members will ultimately pay one-third of the fee of practising members, ie, a rise of over 100 per cent in 2005 and soon a rise of over 500 per cent (over £100). The editorial and the Council seem to think that is a realistic level. I do not!

The point that is not addressed is whether or not I get value for money for my fee. All I get is *The Journal*, much of which, through no fault of yours, is no longer relevant to me, though there are some parts of interest such as the letters, obituaries and Onlooker. From me, the Society gets a regional secretary, a local branch committee member, a regular attender — and contributor — to branch representatives' meetings and branch and regional secretaries meetings, and the fee. At least a Sunday newspaper would give me articles of relevance, and the football results.

As I have previously stated I will sign on for 2005 so that I can vote in the election for a new Council. If the other 4,358 over-60s and not practising will do the same the grey vote could be significant.

If there is no change in Council policy towards retired members then from 2006 I will have time not only to buy but to read a Sunday newspaper, and maybe one on Monday to get the Sunday football results.

Bill Brookes

South Cheshire Branch
Royal Pharmaceutical Society

It is my degree and training that counts

From Mrs M. A. Clive-Matthews, MRPharmS

It was with interest I read the leaflet attempting to define the carefully worded differences between practising and non-practising pharmacists. After 31 years in the profession I cannot, and will not, accept that I am no

longer a pharmacist unless registered with the Royal Pharmaceutical Society. It is my training and university degree, coupled with the experience gained from my career that makes me a pharmacist, not my membership of the Society, which has done nothing for me personally other than to supply me with *The Pharmaceutical Journal*.

To imply that such conscientious qualified professionals should no longer be trusted to know whether they are sufficiently knowledgeable to give advice is, frankly, an insult to us all.

Despite working in a "non-practising" capacity for nearly three years I have continued to maintain my membership because I did not want to lose touch with my profession. However, I now see little point in paying vast sums for little return and increasing bureaucracy. What a sorry state of affairs!

Margaret C. Matthews

Eastbourne, Sussex

Practising non-pharmacist

From Dr F. Newcombe, FRPharmS

Like many others, I do not wish to pursue formal continuing professional development or pay the higher retention fee but I do wish to continue to advise on the use of medicines. In order not to offend the Royal Pharmaceutical Society, this means I shall now withdraw from the Society and join the thousands of counter assistants throughout the country as a practising non-pharmacist.

Frank Newcombe

Loughborough, Leicestershire

■ RETENTION FEE

No virtue in getting old

From Miss E. A. Mishon, MRPharmS

We have heard a lot recently from retired pharmacists in protest over the new retention fee (*PJ*, 27 November, p784 and *PJ*, 4 December, p816). Like these pharmacists I am also retired but, unlike them, I do not feel I am entitled to special treatment: there is no virtue in getting old and age does not confer wisdom. On the contrary some elderly pharmacists become a liability, and there must be a cut-off point. We have all been able to raise our children and pay

for our homes because of our professional activities. We all contributed in some way to what we believed was important. Some of us sat on local committees and some did not.

I decided early on that because the leadership that I needed was not forthcoming, I had to cultivate my own kind of professionalism.

For those people who feel they contributed — OK, fine — maybe they did: but in that case why are we in the present situation? It seems to me that none of us contributed enough. We now have a new young Council, let us see what they can do.

Anne Mishon

Laurac Le Grande, France

■ THE JOURNAL

Editor misjudged her customers

From Mrs H. J. Brown, MRPharmS

What are we to do with our editor? A letter last week (*PJ*, 4 December, p816) questioned her tact. In the Leading article of the same issue (p802) she has done it again, and more.

The members about whom the article was written are those who are considering resigning from the Royal Pharmaceutical Society as a result of proposed changes to the Register. I guess the intention was to persuade those members to not resign. I say "guess" because I am not really sure. Was it maybe just an unproductive, bombastic, editorial moan? If the latter, it is usual to put it in a drawer for 24 hours, reread it, throw it in a rubbish bin, and rewrite. I doubt if this article persuaded anyone not to resign, and may have pushed undecided members to say: "It is time to leave this lot".

Anything aimed at a "customer" requires market research. You know who your customer is, know your product, and decide how to put the two together. This is where our editor got it wrong this week. Most of the members in the group identified as "customers" are those with low or no income. If the aim of the article is to "persuade", do not:

- Include information irrelevant to that customer, eg, cost of cars, holidays, shows
- Insult your customer, eg "fees have been subsidised" — those now being "subsidised" were in the past subsidising others, a situation accepted in many areas

of life by everyone who expects to get old one day

- Use emotive words such as "resent" and "threat" (I especially object to the use of the word "threat". Never in any letter on this subject in *The Journal* have I ever seen this word used by a member. Those considering resigning are doing so with disappointment and unhappiness at the sad end to a career and profession of which they were duly proud. Some will feel anger, but that does not equate to "threat".)

This article was not an example of successful persuasion.

Dear editor, where were your spoonfuls of sugar? Your medicine choked us, it needs reformulating, your research and development is non-existent, your sales are down this week, and I predict your customer numbers will be down shortly. Please ask Santa to give you a rubbish bin for Christmas.

Helen J. Brown

Sunderland

Are letters printed as written?

From Mr A. E. J. Sterry, MRPharmS

The editor of *The Pharmaceutical Journal* may be a competent journalist (*PJ*, 4 December, p816). I do, however, believe that members of our Society and readers of the *PJ* in general have a right to know whether they are reading exactly the words that were originally written in these letters pages or whether they are reading a sanitised or altered version "helped" by the editorial team. I acknowledge the right of the editor to amend letters but I ask that when any such amendment is made a symbol (*) is printed to show that an amendment has taken place. Does this concern anyone else?

Alan E. J. Sterry

Bristol

Letters are primarily edited to make them legal, decent and truthful. A handful are badly drafted, ungrammatical and misspelt but we do our best to preserve the intent of the letter. Major changes are only made with the writers' agreement. When they are unable to accept the changes they withdraw their letters. A system of (*) without detailed explanation would not improve communication of writers' messages. — EDITOR.

Correction

In the letter from James I. Wells (p852), the target dose of thyroxine should have been $10\mu\text{g}/\text{ml}$ and the pore size of the filters should have been $0.47\mu\text{m}$, and not as stated.