

■ CONTROLLED DRUGS

Streamlining the regulatory framework

From Mr N. V. Morley, MRPharmS

C. Ralph (*PJ*, 15 January, p55) makes a valid point concerning the appropriateness of the classification of scheduled Controlled Drugs. This same point was made by both myself and many other contributors to the Shipman Inquiry and the Controlled Drugs seminars. Indeed, Mr McFarlane, Chief Inspector at the Home Office, stated that a proposal exists to simplify the categorisation and to streamline the regulatory framework.

In addition, the Royal Pharmaceutical Society has indicated that it would welcome a more logical grouping of CDs.

Dame Janet Smith stated in the Shipman Inquiry fourth report that the essential criterion should be: "How great a social evil is the misuse of this drug?" If great, strong regulatory measures are needed. If modest, less regulation is required, she said.

It is my understanding that the appropriate stakeholders are considering this matter in depth.

Nigel Morley

*Managing Director
Surelines Pharmaceutical Services Ltd*

■ DIAMORPHINE SHORTAGE

A question of ethics and professionalism

From Professor J. Wingfield, FRPharmS

It is always difficult for a member of the Royal Pharmaceutical Society's staff to give instant and short replies to queries on ethics (I know, I have been there) but I find the "official" response to the letter about reissue of diamorphine ampoules both dismissive and disheartening (*PJ*, 22 January, p85).

Ethics, particularly when applied to health care, is rarely a matter of absolutes. Can we conceive of no situation when the reissue of a medicine which appears to have retained its integrity can be justified? Well, actually we already have — in NHS hospitals. Patients' own drug are reissued, albeit it is hoped to the patient who brought them into hospital, after screening by a technician working within a set of exclusion criteria designed to reduce to a minimum the

likelihood that the medicine is not of known quality.

Of course, it is true that "poor storage may have been such that it [diamorphine] is no longer efficacious or stable". It is equally likely that storage has been perfectly adequate. Can one not inquire into these matters?

Laws and codes of ethics can never cover every situation that may confront a health professional, although they may well apply to the vast majority. Surely the mark of a professional is the capacity to make individual judgements when the extreme or unexpected arises, albeit in the expectation that one had better have a well-reasoned basis for that judgement and to be held accountable for it. Would patients in severe pain agree that diamorphine should be withheld from them, even when we have no good reason to believe that it has deteriorated?

In my view, for the Royal Pharmaceutical Society to say it cannot endorse the supply of patient-returned medicines (what, never?) sells us short and undermines our claims to professionalism.

Joy Wingfield

*Professor of Pharmacy Law and Ethics
University of Nottingham*

Common sense should prevail

From Mrs J. M. Maynard, MRPharmS

Further to the Royal Pharmaceutical Society's refusal to endorse the supply of patient-returned diamorphine, which is in short supply, would Priya Sejal (*PJ*, 22 January, p95) feel the same if she, or a relative, needed

diamorphine to cope with the severe pain of terminal illness? Has pharmacy completely forgotten patients and their needs? Common sense should prevail.

Janet Maynard

Exmouth, Devon

■ MEDICINES INFORMATION

Error database clarification

From J. M. Horwood, MRPharmS, and others

We would like to clarify the recent news item about the establishment of a medicines information error database (*PJ*, 15 January, p42). As written, the piece could suggest that this database is duplicating work already being undertaken by the National Patient Safety Association and other recognised schemes. We would like to reassure readers that this is not the case and explain its purpose.

The database referred to has been set up by the Clinical Governance Working Group of UK Medicines Information (UKMi) to capture data on incidents (errors and near misses) occurring within the practice of MI services in NHS hospital pharmacy departments across the UK. It has been named IRMIS (Incident Reporting in Medicines Information Scheme) to reflect this. It has not been set up to record medication errors and near misses occurring during prescribing, administration etc, because there are existing systems to capture these data.

The database is secured on the NHSnet and is accessed via individual user names and

passwords. It is available to all hospital MI services in the UK and all data are anonymous.

Any incidents occurring with MI practice should be reported via hospital trust reporting systems in the same way as dispensing errors, but should also be reported via IRMIS. By collecting data about incidents within our own practice in a central database, we will be able to determine trends and share learning. This will help to reduce the likelihood of similar incidents occurring in the practice of other MI services and inform training programmes, risk management strategies and national standards accordingly.

The NPSA is aware of the scheme and we will ensure our learning is fed into the work of the agency so that it is shared more widely.

Julia Horwood

Elena Grant

Fiona Woods

*Clinical Governance Working Groups
UKMi*

■ PLACEBO EFFECT

Benefits being missed

Mr M. Morris Levy, MRPharmS

With reference to Brian Furman's letter (*PJ*, 1/8 January, p12), I think that the health and financial benefits of the placebo effect are being missed. There are many medical conditions where the placebo effect is high (eg, erectile dysfunction).

If a placebo is given for non life-threatening disorders, first, those patients who respond to it would gain by being drug-free for longer. The system would gain financially (placebo cost vs drug), and there would be an added bonus of no drug interactions or side effects, both of which could lead to further treatment.

There are some ethical and practical problems here, including having to charge the patient a high price for the placebo. (Patients sometimes perceive that cheap medicines do not work so well.) Also, with today's freedom of information rules, it would be hard to hide from the patient what drug or placebo he or she is receiving.

We can work out how the placebo effect works later because it certainly will not harm patients (as long as their condition is properly monitored).

Morris Levy

Jerusalem, Israel

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.

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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.

■ THE SOCIETY

CPD is smoke and mirrors

From Mr C. Morris,
MRPharmS

As I read through the article in on the retention fee process (*PJ*, 22 January, p94), the thought struck me that there is a loophole. The idea behind continuing professional development and the non-practising pharmacist category is to ensure that pharmacists are competent to call themselves pharmacists.

The CPD scheme is set up to record the courses, etc, that we have picked ourselves. I have met pharmacists, young and old, whom I would consider to lack knowledge that I believe they should have. Someone else might think the same about me. Who knows? But I have yet to meet a pharmacist who would set out to cause damage or injury.

By definition, pharmacists who lack knowledge or who have incorrect knowledge do not know it. If a pharmacist is dangerously incompetent, allowing that pharmacist to pick a few courses at random is not going to fix the situation. He does not know what he does not know.

The CPD scheme seems to be a smoke and mirrors operation to keep the Department of Health happy, so why not try to keep the electorate happy, too?

I was always told that the most important part of my job was knowing what I can safely treat and advise upon and when I need to hand over to another professional or body, for example, a GP or an accident and emergency department. Surely a non-practising pharmacist should be given the same courtesy.

Chris Morris
Newquay,
Cornwall

The CPD exercise could become farcical

From Dr P. J. Brown, FRPharmS

The issue that has yet to be addressed in appropriate detail in correspondence about the new registration rules and continuing professional development is straightforward. What competencies do practising pharmacists have to possess in order to discharge their responsibilities to the public and,

hence, what study must they undertake in their self-managed CPD programmes? This is central to the whole dispute, since the CPD requirement is the main reason why the "senior citizens" of our profession are resigning reluctantly, tearfully and angrily from the Royal Pharmaceutical Society's Register.

There can be two approaches to the scope of CPD. Either the requirement is dictated by the validated MPharm educational curriculum laid down for schools of pharmacy by the Society (in which case practising pharmacists must be competent in all the subjects they were taught) or the requirement for CPD is dictated by pharmacists' day-to-day activities. In deciding which to choose, we must not lose sight of the fact that the whole thrust of CPD is to ensure that the patient gets the best possible advice and treatment.

In practice, community pharmacists working in their registered premises must be able to dispense medicines safely and accurately and give advice on minor ailments. So CPD should concentrate on these aspects of practice. From a patient protection point-of-view, everything else is a sideshow.

It is a fact that much of the curriculum of the MPharm degree is, at best, of indirect relevance when it comes to dispensing medicines and advising on minor ailments. It should also be remembered that little is taught to undergraduates about the treatment of minor ailments. What is there to be taught about treating a headache or a cough or a rash, particularly since, when in doubt, the best advice is "go and see your doctor"?

Do dispensing pharmacists really have to keep up to degree standard their knowledge about the pharmacological activity of all the medicines they dispense and how they are produced? Do they have to know about the advances in knowledge concerning the treatment of all illnesses from which the patients whose medicines are being dispensed are suffering? Questions such as these help define the actual role of the pharmacist in community pharmacy from the patient's perspective. Are we prepared to admit that it is still a dispensing role with little intellectual content that could well be fulfilled by someone with far less rigorous educational qualifications?

If we examine the issues raised by the Shipman enquiry, the failure of the medical and pharmaceutical

professionals was not to realise what was going on. What cost so many people their lives was not a failure arising from a lack of up-to-date knowledge about medicines, it was the failure of observation and interpretation, which suggests that CPD should be concerned with what is plain, simple and relevant.

Clearly, the CPD requirements of pharmacists working in hospitals are somewhat more comprehensive than those in community pharmacy, given the nature of the work. And pharmacists filling the statutory pharmacist role in industry likewise should be able to define the appropriate scope of their CPD study. But when we get to pharmacists doing other things in industry and elsewhere, what CPD do they require in the name of patient safety? For the academic pharmacist life is one long CPD exercise, as also is the case for pharmacists who are journalists. What CPD content can the Society require of these pharmacists that makes sense so far as patients at risk are concerned?

Until the Society tells pharmacists in all walks of life precisely what is required in CPD and faces up to the possible uncomfortable facts of life in so doing, the whole exercise could become farcical. As one community pharmacist told me recently: "You can make it up as you go along, and as long as it has some relation to pharmacy who is to tell you otherwise?" But will the patient be better off is the real question. The sooner and the Society defines the rules the better for all concerned.

Philip J. Brown
Weybridge, Surrey

Fellowship issue has not been properly thought through

From Dr M. J. Groves,
FRPharmS

I was outraged by our Secretary and Registrar's blithe dismissal of the arguments made by other fellows of the Royal Pharmaceutical Society that the fellowship is an honour or recognition of achievement in the profession of pharmacy, not a statutory registration (*PJ*, 15 January, p49). When I received my fellowship it was made clear to me that I was a pharmacist first, with my name in the Register, and a fellow second, with an "F" by my name to indicate this recognition. Incidentally, nowhere on my

fellowship certificate does it say it is the property of the Society, unlike the membership certificate.

May I suggest that this issue be considered by a panel of distinguished fellows, including Trevor Jones (*PJ*, 18/25 December 2004, p882) and Stephen Axon (*PJ*, 15 January, p49), in order to get our Secretary and Registrar to reconsider her intransigent viewpoint. At this point in time it is rather sad to realise that this issue has clearly not been thought through properly.

Michael Groves
Deerfield,
Illinois

Fellowship strictures open to question

From Mr I. M. Caldwell,
FRPharmS

The Secretary and Registrar's reply to the three letters concerning the fellowship of the Royal Pharmaceutical Society (*PJ*, 15 January, p49) used the phrase "this has always been the case" correctly in relating fellowship and membership. The origins of this relationship are, I would suggest, outdated and refer back to things as they were in the 1930s and the 1950s. Before the 1933 Pharmacy and Poisons Act, the Society had a major and a minor examination but the minor qualifiers did not have to pay fees. There was not a little discontent among these people when they were required to join the Society and pay fees. It was possible then to pay an enhanced fee and become a life member; indeed the last life member has only recently died (*PJ*, 18/25 December 2004, p893).

The next upset was when the major (PhC) and minor (C&D) qualifications were merged under the 1953 Pharmacy Act, leaving only the PhC. In anticipation of this, those members who had qualified with the longer PhC on or before 1 February 1951 were enabled to apply for a fellowship on the basis of their longer and more detailed studies. It was this fellowship which was, by definition, a registrable qualification. The 1953 Act was recognising this fellowship, this academic qualification, as a restricted title akin to those of various Royal Colleges. The decision of a later Council to create a fellowship by designation which recognises outstanding contributions to the profession leaves us with two different classes

of fellowship. Some of the original, pre-1951 fellows are still with us. The other, more recent fellows are effectively members of a club; one which has no privileges, no premises, no organisation, pays no special fees and lacks practising status but which has an awful lot of experience and pride.

To subject the current fellows to the strictures of legislation framed for the totally different circumstances of half a century ago is open to question.

Although I appreciate that this is a minor matter in the great scheme of things, have the Council and executive missed the opportunity to bring the Byelaws into line with current realities?

Ian Caldwell

Larkhall, Lanarkshire

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

Disappointed

From Mr J. V. Tapster

Along with many others of my generation, I have reluctantly decided not to retain my membership of the Royal Pharmaceutical Society. This decision has been made with considerable sadness as it represents the end of a satisfying career of serving the public for 45 years, 31 of these as an independent community pharmacist.

What I find, to say the least, disappointing is the attitude of the Society towards those who have decided to give up. We appear to receive no thanks for our efforts stretching over so long a period, having to suffer the indignity of returning our certificates. If we would like to keep it for our own records, we have to accept it back duly marked "cancelled". (I have always thought it demeaning for us to have to display our certificate to prove our competence; what other profession has to do this?)

There is no doubt the attitude towards those at the sharp end is changing. One has only to read the officious and condescending tone of the current retention fee form

to realise that we are being treated with less respect than we deserve. I never thought I would see the day when we are threatened in December of "risking erasure" if we fail to pay our fees by January.

My greatest resentment, however, is the ruling that those of us who qualified through the old PhC course are not allowed to use our title on retirement (*PJ*, 15 January, p52). The qualification we gained after so much blood, sweat and tears was not directly linked to membership, so I fail to see how any restriction can be applied.

The point was brought forcibly home to me last week when one of my former customers asked me to endorse his passport application. How will I describe myself when asked to perform this function in the future? Am I about to become a second-class citizen without status because I have decided to retire? I know of no GP who has been forced to give up his title in similar circumstances. Perhaps the only way to tell is to carry on regardless and see what sledgehammer will be swung in my direction in order to crack this nut.

John Tapster

Abbots Langley, Hertfordshire

An Orwellian situation

From Mr N. Sampson, FRPharmS

Having been asked for, and, as a non-practising pharmacist, having felt unable to provide, advice for a friend on medical matters, I have come to realise that I shall be unable to renew membership of the Royal Pharmaceutical Society next year, and that I shall have to sacrifice my fellowship, which was inspired by my colleagues and friends of many years and which has been greatly appreciated.

I do not want to leave the profession, which has been the centre of my life. Nor do I wish to become active, to go through the farce of continuing professional development when, in truth, its limitations and the lack of day-to-day experience and accruing years will inevitably turn the tide against me.

Far more distinguished pharmacists than I have filled your column inches pointing out the stupidity of the current situation. I hope that reason will prevail, but here and now it is just Orwellian.

Norman Sampson

Melton Mowbray, Leicestershire

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■ THE SOCIETY

I suggest that the Society is marking its early demise

From Mr P. M. Matthews,
FRPharmS

What a sorry state Council and the Officers of the Royal Pharmaceutical Society have got us into by making a series of knee-jerk reactions to current Government policy. Coming to the end of my career I found that the options before me at the end of 2004 were:

- To continue as a practising pharmacist, pay the full fee and undertake a programme of continuing professional development (a course of action that would have little relevance to my daily life). Were I to do this then when asked "What do you do?" I would be able to reply "I'm a pharmacist". Were this to be followed by a question about the enquirer's current or proposed medication I would be able to use my knowledge to give an opinion.
- To register as a non-practising pharmacist, pay a reduced fee and not undertake a programme of CPD. This time, were I to be asked, I would have to say "I'm a pharmacist (not practising)" and would have to refuse vigorously to offer any comment whatsoever on the enquirer's medication.
- To resign from the Register, pay no fees, and undertake no CPD. This time were I to be asked, I could say "I was a pharmacist" and I would be able to use my extensive knowledge base to comment upon the enquirer's medication.

It is illogical to believe that today I am competent to teach clinical therapeutics to leading-edge practitioners and that tomorrow this competence will be gone, solely because I have ceased paid employment and ended a formal programme of CPD. Similarly, it is unreasonable that the Society, which has honoured me with a fellowship, should assume that I am sufficiently stupid not to recognise the limits of my competence.

I now learn that if I do resign from the Register then I will also lose my designation as a fellow. Ann Lewis states that when a pharmacist leaves the Register they also lose their fellowship and that this has

always been the case (*PJ*, 15 January, p49). In the past most pharmacists would wish to continue as retired members until their death and this indeed was my intention. However we are denied this simple approach because of the Society's new constraints that I have referred to earlier. I suggest that the Council looks at the questions of fellowship and retirement in the light of the considerable changes to membership conditions that it has introduced over the past two years.

As things stand it would appear that the Society does not wish to recognise long and valued service since it is not cost-effective to the membership as a whole to do so. Any professional body that takes such a short-term, pecuniary view of its membership is unlikely to thrive. Indeed I suggest it is marking its early demise. The Council and Officers of the Society need to review carefully their actions over recent months since it would seem to me that their preoccupation with developing a controlling bureaucracy is at odds with the true purpose of developing and enhancing the role of the profession of pharmacy.

Peter M Matthews
Stourbridge,
West Midlands

No attempt to defend the indefensible

From Dr F. Newcombe

The Secretary and Registrar is to be commended for her response to the recent criticisms from members (*PJ*, 22 January, p94). She took care not to attempt to defend the indefensible. Instead, members were given a lecture on continuing professional development, not the subject of much comment on this occasion.

There was no reference to the Royal Pharmaceutical Society's arrogance in believing it has the right to muzzle non-practising pharmacists, even though pharmacists are full of untrained personnel advising the public on health. Many of them (I am advised by a continuing pharmacist) cannot differentiate between microgram and milligram.

On reflection, rather than pretend to respond to criticism, is it not really better to keep quiet?

Frank Newcombe
Loughborough,
Leicestershire

To practise what? That is the question

From Dr D. J. Roberts, MRPharmS

I read for a BPharm degree (Chelsea 1957–60, specialising in pharmacology and pharmaceutical chemistry) because I wanted to become a pharmacologist, and to this end completed my PhD in 1963. Success in a separate forensic exam qualified me for the Register of Pharmaceutical Chemists.

After several years of research and teaching, I resigned my position as reader in pharmacology at Portsmouth to join the pharmaceutical industry in Spain where, for the past 35 years, I have successfully continued my career as a pharmacologist/toxicologist involved in the discovery, development, licensing and registration of new drugs, and I have continued to pay my retention fee as an overseas member of the Royal Pharmaceutical Society. I have now just retired from full-time employment but continue to advise on topics pertinent to my experience in industrial drug discovery/development and international regulatory affairs, and of obvious necessity I have to continue to keep myself up to date in these areas.

I have never practised pharmacy (preparation and dispensing medicines), not in retail, not in hospital and not in industry, and I have never represented myself as a practising pharmacist. I have no problems with the beginning and the end of the declaration that I will now have to sign in order to remain on the Register as a non-practising pharmacist. It is the bit in between about not working or giving advice in relation to "the science of medicine" that is impossible.

The point that the Society appears to be missing in its seemingly arrogant definition of a practising pharmacist is that the degree for which one has studied is one thing and what one does subsequently to make a career and earn a living is quite another. It is nonsense to suggest (as it did in the guidance leaflet distributed with *The Journal* of 4 December 2004) that a person with a pharmacy degree developing molecular modelling software for medicines is practising pharmacy.

I have had graduates in human and veterinary medicine, pharmacy, biology, physiology, biochemistry and molecular biology working with me as pharmacologists, and there are

many non-pharmacists working in medicinal chemistry, analysis, pharmacokinetics and drug metabolism — and even in pharmaceuticals departments — in industry.

After so many years, do I really have to resign in order to avoid action by the Society if I continue to advise on my non-pharmacy areas of expertise, or have I argued convincingly enough that my circumstances are sufficiently commensurate with "non-practising" to allow me to remain on the Register as such?

David Roberts
Barcelona,
Spain

A pharmacist is what I am, not what I do

From Mrs S. J. Greensmith,
MRPharmS

In response to Norman Fitt (*PJ*, 22 January, p81), I would like to say, with the greatest respect for more senior members of my profession, that I have always felt that being a pharmacist is what I am, not what I do. As such, I would like to reassure Mr Fitt and our colleagues who also joined the non-practising section of the Register on 1 January that they can still "be" pharmacists, they just may not practise.

Sally Greensmith
Godalming,
Surrey

Is it time to divest the regulatory role?

From Mr R. H. Ferguson,
MRPharmS

As far as I can see, the recent correspondence in the *PJ* letter pages about retention fees, non-practising/practising pharmacists and distinguished colleagues resigning from the register are a result of the unique nature of the Royal Pharmaceutical Society.

In May 2002 the Council made the decision, as part of the modernisation process, to maintain its dual role: one that is unique among the other health professions — well no wonder!

I never saw the desperate need to maintain the regulatory function. Is it really in the public interest for a professional body representing pharmacists to regulate them, too? Why are we

afraid of being regulated by an independent body?

The reasoning that the status quo be maintained because the Society would “lose its independent self-regulation and perhaps much of its professional identity” (*PJ*, 25 May 2002, p739) simply was not good enough. The result is that now, more than ever, we have a paranoid, self-serving organisation that is attempting to appease its members while doing the Government’s bidding.

If the Society were to divest the regulatory role, pharmacists, whether practising or not, could maintain their membership or fellowship. It would then be up to the new regulatory body to concentrate on regulating active pharmacists, while non-practising pharmacists could use their professional judgement, knowledge and experience when appropriate within their competencies when required.

The new Society could be based on the British Medical Association, which is charged with “the protection of doctors’ professional interests”. It is a voluntary organisation and around 80 per cent of practising doctors are members (see www.bma.org.uk). If membership of the Society were voluntary, I wonder how many pharmacists would choose to join. Pharmacists at the moment do not feel they are getting value for money; the weekly *PJ* is the only tangible benefit.

The regulation of the profession could be performed by a new organisation based on the General Medical Council, whose website (www.gmc-uk.org) unequivocally states: “We are not here to protect the medical profession — their interests are protected by others. Our job is to protect patients.”

Despite this, however, Dame Janet Smith in the recent Shipman report (*PJ*, 18/25 December 2004, p874) said: “It is not appropriate that the GMC should be dominated by elected members. It should certainly be dominated by medical members; I am not suggesting that there should be any increase in the proportion of lay members. But I do suggest that there should be more appointed medical members, people who are not beholden to an electorate and who do not see themselves in the position of representatives of the profession.”

So, how can it possibly be appropriate for the Society to maintain its dual role? Is it not time to shake off the shackles that currently hinder the Society and

turn it into an organisation to which members want to belong rather than have to belong. Just look to the National Pharmaceutical Association for the template. The Society must make a pre-emptive decision that is truly in the best interests of its members and the public.

Ross Ferguson
Glasgow

I shall describe myself as a pharmaceutical chemist

From Professor E. J. Shellard

The statement by the Secretary and Registrar of the Royal Pharmaceutical Society that the members of the Society had two options — to be a practising member or a non-practising member (*PJ*, 22 January, p94) — was incorrect. There was a third choice: that of resigning from the Society, which was the choice I made. I am therefore no longer a fellow of the Society.

I was not promoted to the fellowship, as were the majority of fellows, because of an outstanding contribution to pharmacy and I have every sympathy with those who will be deprived of this honour. I was a fellow because, in 1937, I passed the examination after a two-year course to make me a pharmaceutical chemist rather than a chemist and druggist. Thus I became a pharmaceutical chemist in the same way that I became a BPharm and no one can deprive me of this. So, now that my name has been removed from the Register, I shall describe myself as a pharmaceutical chemist. Nowhere in the Charter or the Byelaws is this title mentioned, so the Society is trying to insult me further by referring to a 40-year-old Act of Parliament which still includes a title no longer recognised by the Society (*PJ*, 15 January, p52).

Like many of those retiring I shall still be able to reply to those who seek my advice about herbal products knowing they will ask me because they know I have the knowledge to do so. I would like to end this letter (during my membership I have written nearly 70 on a variety of topics) by saying that when any revised Byelaws make it possible for me to rejoin the Society, I shall be happy to do so.

Edward J. Shellard
*Hounslow,
Middlesex*

Practising and non-practising

From Miss H. M. Elliston, MRPharmS

The wording of the non-practising declaration on the retention fee form has generated both irritation and confusion. May I suggest that it would be helpful to:

- Amend the declaration by referring to non-practising as “non-practising in the UK or other countries of the EU” since surely the remit of the Royal Pharmaceutical Society is limited to the regulation of pharmacists in these areas. The amendment would enable those pharmacists in other areas overseas to pay a “non-practising in the UK or other EU countries” fee.
- Amend the declaration to include a phrase for “non-practising members in the UK or other EU countries” not to receive payment or benefit either financial or in kind in relation to pharmaceutical advice and practice. This restricts formal employment to those practising pharmacists with up-to-date CPD. This also deals with the occasional request for free “advice” made to retired pharmacists from their families and friends who know they are retired.
- Regard activities such as giving talks on pharmacy to local organisations as public relations exercises. The head of public relations at the Society is, after all, not a pharmacist. Similarly, requests for input of editorial skills are editorial not pharmaceutical ones.

Heather Elliston
London SE3

Should I stop using my degree designation?

From Dr I. Ab I. Davies, MRPharmS

The Council of the Royal Pharmaceutical Society would appear to be sliding inexorably from the sublime to the ridiculous with regard to membership of this august society, firstly in the contrived reply provided by David Pruce regarding an interpretation of the meaning of “non-practising” (*PJ*, 18 September 2004, p380) and now with Ann Lewis’s reply to Brenda Rainbow (*PJ*, 15 January, p52).

Before the restriction of entry to the Register to individuals holding a degree in pharmacy, the only academic qualification recognised for entry was by passing the Pharmaceutical Chemist’s Qualifying Examination but use of the designation “PhC” to denote that academic qualification was frowned upon by the Society. To use the title “pharmacist” or “pharmaceutical chemist” required registration as members of the Society.

Many older pharmacists who read for a degree in pharmacy had to pass the forensic (pharmacy law) examination of the Society to acquire a PhC in order to be eligible for entry to the Register of Pharmaceutical Chemists, the other subjects of the degree course being regarded as acceptable by the Society. The degree awarded by London University was a Bachelor of Pharmacy. When the time comes that I have to resign from the Society, should I stop using my degree designation, which has obvious pharmaceutical connotations?

Iolo Davies
Ballygowan, Co Down

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■ THE SOCIETY

A conundrum?

From Mr J. H. Verrall

I qualified in 1952, not as a pharmaceutical chemist, but as a "chemist and druggist". When this qualification was abolished in 1954, such qualified persons were designated "pharmaceutical chemists".

Since that time I have been registered as "a pharmaceutical chemist and a member of the Pharmaceutical Society of Great Britain". However, now I am not renewing my full membership, and as a retired member can no longer give advice or discuss medicines, I must become a lay person so that I may continue my work for a veterinary practice, whose practitioners have requested me to do as an "unqualified person".

What is interesting is that I have a certificate which states: "The Examiners appointed by the Council under the provisions of the Charter of Incorporation and the Pharmacy Acts 1852 and 1868 having examined [me] are satisfied that he has the skill and knowledge to be registered as a Chemist and Druggist under the Provisions of the Pharmacy Act 1868." Since no such qualification now exists or has any legal standing, there is surely no reason why I cannot indicate my pharmaceutical background by stating that I am, by qualification, a "chemist and druggist" by using "C&D".

John Verrall

Battle,
East Sussex

Three reasons to stay

From Mr K. D. Mackenzie,
MRPharmS

Like many other retired pharmacists I was going to resign from the Register this year in protest at the severe hike in fees. I have however, changed my mind for this year at least for three reasons.

First, since I am one of the "non-contractor pharmacist" representatives for the Scottish Pharmaceutical General Council on the National Appeal Panel, I presume that I still require to be on the Register to call myself a pharmacist.

Secondly, one can hope that a newly elected Council this year can review the whole sorry affair. Judging from the letters to *The*

Journal the issue would appear to be ill-conceived without really giving thought to the ramifications for all the different types of membership. One must presume that it is pure coincidence that you are unable to publish the number of members who have retired from the Register until April — after the next Council election.

Thirdly, my grandfather's name first appeared in the Register for 1905. This was followed in due course by those of my mother, father and myself. It only seemed appropriate to carry this unbroken record into at least 2005.

Kenneth D. Mackenzie

Helensburgh, Dunbartonshire

■ REGISTRATION EXAMINATION

Build a portfolio of evidence instead of examination

From Ms H. Badham

I am a current preregistration trainee. I support the need for a review of the Royal Pharmaceutical Society's registration examination, not because I will sit it this June, but for the following reasons.

The number of preregistration places has decreased in the past few years. As more schools of pharmacy are founded, the number of preregistration places available will, ultimately, limit the number of registering pharmacists. Therefore, a review of the training year is essential to ensure high standards of registration with a practical solution to the many issues surrounding the preregistration year.

During my hospital training I have taken the opportunity to discuss and compare the pharmacy qualification process to that of numerous other health professionals. I have discovered that, aside from the registration exam, other professions have a more integrative programme of learning for practice with their undergraduate studies, such as dietitians have four, 13 and 31 weeks of training throughout their first, second and third years. Within pharmacy, the Society requires that all undergraduates must have some community and hospital experience. However, this can vary from two-and-a-half days to two weeks depending on the university (excluding Bradford). The possibility of students working in a pharmacy during their summer

holidays cannot be relied upon to address this imbalance in practical experience.

Therefore, I suggest that the registration examination should be reviewed alongside work experience placements during university. This would provide a greater structure, integration and consistency to learning. Additionally I believe that local resources, such as primary care trusts, Society inspectors and local branches are underused with regard to undergraduate training and could be involved to increase the innovation of learning.

Students could, therefore, build a portfolio of evidence for registration from university and the preregistration year to demonstrate a greater level of professional development that may overcome the need for a registration examination.

Helen Badham

Preregistration trainee
Sheffield

Calculators should be allowed

From Mr A. J. Young, MRPharmS

I am writing in agreement with letters published over the past few months criticising the Royal Pharmaceutical Society's registration examination. Although I agree that candidates must prove that they are competent enough to join the profession, I do not believe that the current format demonstrates this competence.

The examination has been changed so that candidates must pass the calculations section. This is fine except that calculators are not allowed. Why is this?

Surely passing three or four A-levels and then a four-year degree is adequate enough to prove competence in calculations. Throughout school and university, students are taught and encouraged to use calculators and then are expected suddenly to change and do calculations in their heads during a highly pressured examination.

In my view, it highlights a severe problem with the undergraduate training if a student who has a first-class honours degree is worried about failing the calculations (*PJ*, 20 November 2004, p748)? I ask the Society to consider changing with the times and allowing the use of calculators.

Anthony Young

Newcastle Upon Tyne

■ DISPENSING

Printed labels are not a waste of time

From Mr A. F. Huntley,
MRPharmS

Sage words from pharmacist/lawyer Graham Southall-Edwards (*PJ*, 15 January, p54) who seemingly has lost his logic: "The dispensing is done over the counter with prescription and medicine lying in front of both patient and pharmacist."

How convenient, except for the house-bound octogenarian who has sent along a neighbour. Does Mr Southall-Edwards summon a taxi to bring such patients to take part in this consultation, and who pays for the taxi?

A. F. Huntley

Bristol

■ WE'VE HAD ENOUGH OF . . .

A problem shared is a problem halved

From Mr P. J. Beckley,
MRPharmS

Readers of *The Sunday Express* will be familiar with an amusing weekly feature entitled "We've had enough of . . ." (readers send in suggestions). Since a problem shared is a problem halved, after a particularly stressful day it occurred to me that perhaps *The Journal* could run a similar feature. Many suggestions spring to mind:

- Patients who say "it's only tablets"
- Increasingly large packs that do not fit on the shelves
- Customers who say "I'll wait" and then walk out of the shop
- Parallel-imported packs of four tablets replacing packs of 28 tablets
- Trying to stay awake after a 10-hour day to do continuing professional development
- Increasing workloads and decreasing staff numbers
- Popular medicines that manufacturers cannot supply
- Incomplete hospital prescriptions
- Illegible hospital prescriptions
- Spiralling retention fees

Other pharmacists will have had enough of other things I am sure.

Peter Beckley

Crawley,
West Sussex