

■ ANTICOAGULATION SERVICES

Pharmacists are well placed to meet demand

From Miss F. O. O. Akinwunmi, MRPharmS

I share Duncan McRobbie's views with regards to the role of community pharmacists in the provision of anticoagulation services (*PJ*, 19 March, p327).

There is an increased demand for services because evidence shows the benefits of warfarin in prevention of stroke¹ and because of standard 5 of the National Service Framework for Older People² (reducing stroke incidence) coupled with the UK's ageing population.

With the introduction of near patient testing and computerised decision support software (CDSS), primary care service models are now a feasible alternative to the traditional secondary care model.

At the Barts and The London Trust anticoagulation clinic, we have seen a four-fold increase in patient demand since 1991, which has prompted an examination of providing community-based anticoagulation services. The clinic runs one outreach service with a GP practice for a small number of its patients. We have recently piloted two domiciliary services³ (one involving a pharmacist using both near patient testing and CDSS) for mobility-impaired patients who previously had to endure long journeys to and from the clinic and variable waiting times. Results showed that during the study domiciliary INR (international normalised ratio) control was equivalent to that achieved in the clinic⁴ and that there was a significant improvement in patient satisfaction.⁵ A domiciliary service has now been implemented.

Other studies have shown that warfarin is underused in patients with atrial fibrillation.^{6,7} Stroke is the biggest cause of severe disability and the third most common cause of death in the UK. With this in mind it is clear that limiting new referrals will lead to marginalisation of patients and inadequate stroke prevention. This is not the way forward.

Pharmacists are well placed to meet the increased demand and to reduce the pressure on hospital services. Evidence shows that community pharmacists can achieve good INR control.^{8,9} Their understanding of drug interactions and pharmacokinetics, coupled with their knowledge of local

patients, aids the dosing process. Furthermore, there is a role for pharmacists in identifying unmet need (eg, screening for patients taking digoxin) and in supporting self management.

Frances Akinwunmi

Research Pharmacist
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University of London

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A4 certificates

At the request of members performing locum duties, the Royal Pharmaceutical Society has made available an A4-size registration certificate. Any member wishing to take advantage of this facility should write to the Society enclosing their current registration certificate together with a fee of £10.

■ RFID TAGGING

There are privacy issues to be considered

From Mr A. Phillips, MRPharmS

I read with interest your article on radio-frequency ID tagging (*PJ*, 19 March, p330), and thought a counter-view was required.

Although no one will object to improving accuracy of dispensing or cutting down on counterfeits, there are privacy issues which were not mentioned in the article. RFIDs, unlike barcodes, can be read without having sight of the tag, thus they can be read through bags or clothes. If left active, RFID tags could be read by anyone with a scanner and appropriate software and the scanners are being incorporated in mobile telephones.

How happy will patients be to have their medication details available to be read by all and sundry? If consumer response in the US is anything to go by, not very. Maybe this is why one of the participants in the scheme declined to be named.

Alun Phillips

Liverpool

ALISON WILLIAMS, director, Aegate Ltd, replies: We agree and thank Mr Phillips for highlighting that there are important privacy considerations which must be addressed if using RFID, particularly on medicines.

We should point out that the pilot also used unique barcodes as an alternative solution to using RFID. These were equally as successful as RFID in achieving much of the patient safety benefits. However in the fight against counterfeits, the level of security is much improved with the use of RFID.

Although it was not covered in the article, Aegate takes seriously the privacy concerns associated with the use of RFID. There are a number of different types of RFID tags available and not all of these are suitable for use on medicines. In setting up the pilot a number of issues concerned us, including reliability of tag deactivation. Aegate took advice from a number of privacy groups and developed a code of best practice that required all participants to comply. This can be viewed at www.aegate.com/privacy.html.

In essence, we selected RFID tags that had a read range of only a few centimetres. These tags were read-only and contained nothing more than a random "dumb"

number. This ensured that even if the tag had been read while in a bag or clothes, only a meaningless number could be viewed, it could not possibly identify the type of medicine or the person carrying the item. As a result it was not necessary to deactivate tags. All participating dispensaries were also required to display a notice stating where both the readers and tags were situated.

We believe that this pilot has set the standard and method for an acceptable use of RFIDs in pharmaceuticals. Most of the 120 consumers we interviewed did not recognise what RFID was. One told us "it's just another technology, it's how you use it that's important". We agree.

■ REPEAT DISPENSING

Already agreed as an essential service

From Mrs S. Smith, MRPharmS

In both his **Broad spectrum** article (*PJ*, 26 February, p232) and his subsequent letter (*PJ*, 19 March, p336), John Wilson seems to have confused the problems with the introduction of electronic transmission of prescriptions (ETP) via the National Programme for IT (Npfit) with those that arose on GP clinical systems, such as EMIS, during the early implementation of repeat dispensing in first-wave pathfinder sites.

I believe this ought to be clarified, as his suggestions for photocopying prescriptions may confuse some readers (although they were undoubtedly well-intended, with patient benefit and waste reduction in mind).

Repeat dispensing and ETP are not inherently linked; repeat dispensing can be implemented as a paper-based system, without ETP being in place. In the future it is envisaged that the two systems will run together, but the delay in ETP need not prevent primary care trusts from implementing paper-based repeat dispensing systems now.

Most of the repeat dispensing software problems with GP clinical systems, experienced by many first-wave pathfinder sites, have now been rectified. As a second-wave repeat dispensing pathfinder site, Northamptonshire Heartlands Primary Care Trust now has at least 1,000 patients benefiting from the paper-based repeat dispensing system, with this number growing daily. Many other pathfinder PCTs have made similar or better

progress. The necessary regulations, processes and paperwork are already established; there is no need to "invent" a new system involving photocopying, stamping and signing copies, etc.

From 1 April, as "Essential Service 2" under the new pharmacy contract, all PCTs will be able to implement repeat dispensing and all community pharmacists in England were recently sent the Centre for Pharmacy Postgraduate Education training manual. There will be no need for the Pharmaceutical Services Negotiating Committee to "negotiate an additional payment", as suggested by Mr Wilson; this has already been agreed as an essential service payment under the contract.

Sue Smith

Head of Prescribing and Pharmacy Policy, Northamptonshire Heartlands Primary Care Trust

A warning from NZ about bean-counters

From Mr D. R. Sullivan, MRPharmS

John Wilson's suggestion for how a repeat dispensing system could work in lieu of electronic prescription transfer (*PJ*, 26 February, p232) sounds similar to the excellent repeat dispensing system that New Zealand once had. For most patients taking medicines regularly, the GP would prescribe in three-monthly amounts, and the pharmacist would dispense in monthly instalments. The GP's workload was lower and pharmacists had an excellent opportunity to demonstrate how they could be of benefit in managing patients' medication.

However, a word of warning: the bean-counters will always be looking for how to reduce costs further. Two years ago Pharmac (the NZ government agency in charge of controlling medication costs) decided that paying pharmacists three dispensing fees per prescription was too expensive. The repeat dispensing option was, therefore, effectively removed for most medicines and most patients now receive three months' worth of their medicines at once. The risks to patient safety and of wastage were ignored and the change had disastrous implications for many small pharmacies reliant on dispensing income, in some cases forcing pharmacies to close down.

Pharmacists wishing to pursue repeat dispensing in the UK must, therefore, ensure that the role they play in managing patient medication as part of the repeat dispensing process is recognised and valued by those controlling the purse strings, or else risk further erosion of their dispensing income and professional role.

Daniel Sullivan

Auckland, New Zealand

■ COUNCIL ELECTION

Voters have an unenviable task

From Mr M. Astbury, MRPharmS and Mr S. I. Wells, MRPharmS

Pharmacists have the unenviable task of analysing Council election candidates' statements. Who represents them? Who represents himself or herself? Who represents the Department of Health? Does the hangman represent the

condemned at the pre-execution committee?

We and another member of the Royal Pharmaceutical Society's Council discussed at length the best way of obtaining a council that would not be afraid to stand up against the Department of Health and, in some cases, Lambeth itself.

We decided that giving our support to the Save Our Society pledge was the correct way forward. The pledge coincided with our aim to take back the Society for its members.

We cannot guarantee that the SOS candidates will always vote correctly. What we can guarantee is that their hearts are in the right place. Also, what concerns us is the lack of co-ordination when implementing new initiatives and the way our policies are driven and pre-approved by pseudo-civil servants isolated from the membership. Would pharmacists not rather have a "listening" Society that can act upon the ideas and aspirations of its grassroots workforce, not least through its individual branches? Where has the power gone to change policy from the bottom up?

Martin Astbury

Chester

Council Election Candidate

Steve Wells

Abergele, Conwy

Council Election Candidate

Young and newly qualified pharmacists must vote

From Mr N. P. S. Sewak, MRPharmS

With the Royal Pharmaceutical Society's Council election under way, I urge all pharmacists, especially young and newly qualified pharmacists, to exercise their right and vote in this year's election to ensure that the right candidates are elected. It is especially important that there are both young and old representatives on the Council so that there is voice for all. With so many pressing issues affecting young pharmacists, including continuing professional development, independent prescribing, retention fees and the new community pharmacy contract, there has never been a more exciting time to enter this stimulating profession.

Traditionally the turnout among young pharmacists has been poor but with a completely new Council being elected this year it is

an ideal opportunity to choose some new faces to represent the profession. I hope that young and newly qualified pharmacists seize this opportunity and make their votes count.

Navin Sewak

IT Officer

Young Pharmacists Group

Integrity and professionalism

From Mrs Linda Stone, FRPharmS

As one who cares passionately for our profession I thought long and hard before putting pen to paper. I believe in integrity and professionalism and I wish to put on record my very grave concerns that certain recent statements seem to have been made with the potential to mislead.

Some election candidates are claiming that they will "reverse" certain Council decisions, in particular the recent change in the fee structure. Remember, this is the fee structure recommended by the committee chaired by the Vice-President and endorsed by the Officers. This same fee structure could not have been adopted by Council if it had not been supported by a majority of Council members. These Council members included some Save Our Society supporters who are now standing in the election.

Linda Stone

Council Election Candidate

Solihull, West Midlands

Letters to the editor

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

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

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

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

Council election candidates

Pharmacists standing for election to the Royal Pharmaceutical Society's Council are reminded that *The Pharmaceutical Journal* will accept from them no more than two letters for publication in issues between 5 March and 9 April.

Each letter must be on a different topic, must not exceed 400 words and must be about issues, not personalities.

Contributions sent on behalf of candidates will be treated in the same manner as contributions from candidates themselves.

The editor reserves the right to remove or amend material or refuse publication outright (see *PJ*, 1/8 January, p33).

 COUNCIL ELECTION

The Society needs to be balanced

From Mr M. A. Walker, MRPharmS

Your leading article (*PJ*, 12 March, p286) makes a mistake in hoping that the new Council will be balanced. It is the Royal Pharmaceutical Society which needs to be balanced, not the Council. For many years in my view, the Society's staff have mainly pursued a regulatory agenda. Charitable status and the Charter debacle are clear examples of Lambeth's direction. In order to counterbalance the Lambeth focus, we, the ordinary members, need a Council which gives a strong representative focus. I voted for the Save Our Society candidates in the expectation that this will lead to a representative Council and a balanced Society.

Mark Walker
Oxford

A tasteless and inarticulate object

From Professor J. B. Harris, MRPharmS

Although I have worked for most of my life as a teacher and researcher in a medical school I have retained my membership of the Royal Pharmaceutical Society. I have done so because the early training I received in pharmacy has contributed greatly to my academic life. I have always voted in Council elections but the card I recently received inviting me to vote for a slate of candidates in the elections to Council was without precedent.

Fifteen names were put forward. They seem to have little in common but an interest in the Save Our Society campaign. The card was sent to an outdated address in the University of Newcastle, was printed in "tabloid" style and asked me whether I thought the Society's plan to call me "non-practising" was barmy (*sic*) and suggested that some sanity should return to the Society's affairs. The card was written with poor regard for grammar and syntax. I found the actions of those who produced the card demeaning, unprofessional and unhelpful.

Like most members, I wish the Society to remain a highly respected, professional and learned society. Our Council is dealing with a range of challenging societal

changes that influence the way the general public views the professions and with long overdue reforms to the way we govern ourselves. We shall do nothing to retain the respect of our fellow professionals by openly circulating such tasteless and inarticulate objects as the card or by electing to the Council members of our Society with a shallow appreciation of the potential strength of the Society.

I do hope that the candidates named by the author(s) of the card had nothing to do with its production or circulation.

John Harris
Professor of Experimental Neurology
University of Newcastle

 PI INSURANCE

To insure or not to insure?

From Mr G. Southall-Edwards, MRPharmS

R. S. Boorman (*PJ*, 19 March, p334) makes the case for all pharmacists having their own professional indemnity insurance, whatever their employers may say that they provide. He is correct in stating that there is nothing to stop the employer (or its insurers) from going after the negligent employee and seeking to reclaim damages paid out by virtue of his or her actions, which may have resulted in a claim against the employer by reason of the latter's "vicarious liability" for these actions.

A claim was made on such a basis in *Lister v Romford Ice and Cold Storage Limited [1957] AC 555* and the House of Lords decided that the employer should recover damages against the negligent employee, who had injured his father while acting in the course of his employment. Since the result was likely to lead to a flood of similar claims, the government of the day indicated that it intended to legislate to prevent such actions becoming a serious threat to industrial relations; the response was a gentleman's agreement between the government and the major insurers that they would not in future seek to recover damages which they had paid out on behalf of employers of negligent employees. To my knowledge, this non-legally binding agreement continues to be the case.

The National Pharmaceutical Association's "we never have and we never would" statement, which appeared below Mr Boorman's

letter, is a reiteration of similar words in *The Journal* last year (*PJ*, 15 May 2004, p606), which I said then in my letter in the same issue, were "a gratuitous promise, unsupported by consideration". By this I meant that although I do not doubt the NPA's sincerity, it has not made a statement which is legally binding upon it.

Although the makers of the statement may have had good intentions at the time of making it, I wonder what their underwriters would force them to do in the event that, say, a dispensing error were to lead to serious and permanent brain damage in an up-and-coming, high-earning professional person aged, say, 30 years, necessitating life-long care and compensation for loss of amenity, plus a huge claim from the relatives for loss of their dependency on the victim's prospective earnings. This is the nightmare scenario for insurers — far worse than any sudden death arising from an error, because the victim in my example would survive to need expensive care.

If such an event were to occur, damages could well run to over £300,000 at current rates; faced with such a pay out, would the NPA's underwriters let them keep their "gentleman's agreement"? The answer is unknown, but the safe way to ensure that no locum or employee is ever in such a situation and to ensure that his or her interests are properly defended, is to carry one's own professional indemnity/defence insurance, whatever the contractor or employer may provide through its own insurers. Remember that when there is a conflict between the interests of the employer and the employee, the NPA is bound by its constitution to assist its member in preference to the employee; where does that leave the servant of the more fortunate master?

As Mr Boorman observes, we live in an increasingly litigation-conscious society with a burgeoning number of claims being fuelled by the ready availability of "conditional fee" arrangements and much television and other media advertising of their availability. The purchase of one's own PI insurance costs not much more per year than the average locum or pharmacist employee can earn in a day before tax; is it worth taking any risk for such a small saving, whether or not it can be offset against income tax liability?

Graham Southall-Edwards
Barrister-at-Law
Tyrol, Austria

The relationship between SOPs and PI insurance

From Dr R. J. Schmidt, MRPharmS

R. S. Boorman's letter (*PJ*, 19 March, p334) and John D'Arcy's reply from the National Pharmaceutical Association regarding public liability insurance seem to miss the point as regards standard operating procedures and professional liability. Judging by the commentary provided by Mr Boorman, I am not sure that his employers (or their advisers) understand the nature and purpose of the written SOPs that they have introduced.

The Royal Pharmaceutical Society requires community pharmacies to carry out their dispensary activities in accordance with SOPs. These are the documentary evidence of the existence of a quality system in the dispensary, and describe the way in which things are done in order to ensure that a consistent, effective and safe service is provided. They are part of a wider quality system that starts at the beginning of the supply chain where a medicine is manufactured, and which should extend up to the point at which a dispensed medicine is taken by or administered to a patient. So, if a patient experiences an unexpected problem, it should be possible to follow the trail back through the quality system to the root cause of the problem and then, if necessary and appropriate, to make changes to procedures (and hence to SOPs) that lessen the probability of the problem reoccurring.

In part, SOPs simply explain the mechanics of how things are done in the pharmacy to which they apply, eg, how the prescription charge is to be rung into the till, how the tablet counter is to be used, or how the dispensary computer back-up is to be performed. In part, SOPs also import guidance provided by the Society's "Medicines, ethics and practice" guide. In part, they also import good practice generated from the experiences of others. In turn, properly implemented SOPs become an extension of each employee's contract of employment — a matter that seems not to be widely recognised. Any employees who are obliged by their employers to comply with an SOP should be trained with the SOP in mind. The fact that training has been given and received should then be properly documented, with both the trainer and the trainee adding their dated

signatures to the staff training sheet associated with that particular SOP. A dispensary SOP needs also to be ratified by the superintendent pharmacist on behalf of the employer because of its status as an extension of employees' contracts of employment.

Once implemented, an SOP becomes an evolving document that is changed whenever a better way is found of doing the activities covered by that SOP. A particularly important feature of an SOP is that it is a powerful management tool that can be used to engage staff as "stakeholders" if they can be encouraged to contribute to the evolution of their SOPs. The corollary to this is that SOPs that are not properly implemented (merely "introduced") serve no real function. Indeed, it could be argued that any pharmacy that has not properly implemented its SOPs has, de facto, failed to comply with the Society's requirement that dispensary SOPs should have been in place in all community pharmacies since 1 January 2005. This is a patient safety issue and, therefore, any failure to comply with the requirement represents a disciplinary matter in which the Society's inspectors should now be taking great interest.

Mr Boorman states that he is uncomfortable with certain aspects of the SOPs with which he is expected to comply. On making representations to his employer, he is told that the SOP in question has to remain as it stands because it represents "company policy". This immediately tells me that the SOP cannot have been properly implemented. If the matters over which Mr Boorman has taken issue with his employer relate directly to the delivery of the pharmaceutical service from his dispensary then he, as the pharmacist in control of the dispensary, surely has the right to amend the SOP if, by doing so, a perceived risk to patient safety is reduced. The superintendent pharmacist has no right to interfere in this matter of professional judgement unless he can provide a reasoned and evidence-based argument as to why the SOP should not be changed. Citing "company policy" is neither a reasoned nor sufficient argument. Indeed, if the proposed amendment does represent a better and safer way of doing the things in question, then the superintendent pharmacist is also then professionally obliged to consider implementing the amended SOP across all branches — and thanking his employee pharmacist for his contribution to quality and safety

of services provided by the company.

Clearly, if an employee pharmacist can make a professional judgement that a certain activity is best carried out in one way while a superintendent pharmacist believes it is better for that activity to be carried out in a different way, then there will surely come a time when this conflict of professional opinion will translate to an apportionment of blame for a dispensing error. If an employee pharmacist has (as I believe he has) the professional right and duty to amend dispensary SOPs as he sees fit, then he should also recognise the importance of having his own personal professional indemnity insurance. If the superintendent pharmacist fails to ratify local SOPs, a serious conflict of interest will arise in the event that an action is brought against the company for a dispensing error perpetrated under an unratified local SOP. The public declaration by the NPA's chief executive that the association "has never sought to recover any losses from an uninsured employee . . . and has no intention of doing so" may come back to haunt him.

Richard J. Schmidt
Barnoldswick, Lancashire

■ GENERICS

When will generics manufacturers help pharmacists?

From Mr I. Morgan, MRPharmS

When will someone have the authority to police generics manufacturers? The rINN names for a large range of drugs have now been available for over a year. We, as community pharmacists, have been duly labelling our dispensed medicines with these new names since their introduction, and even doctors' software has been updated. But what happens? The prescription and the label state, for example, "bendroflumethiazide" and the box states, in large letters, "bendrofluazide". Admittedly, some manufacturers have added the INN name somewhere on the packet in small letters, but these are the exception. The other day, a patient said he did not want bendroflumethiazide as he got on much better with bendrofluazide.

When are these companies going to realise that community pharmacies use the same size labels when over-labelling their products? Those that do provide a "space for dispensing label" range

from those that ensure the space is standard label size — 7cm x 3.5cm (the sublime) through 6 x 3cm and 3 x 2cm — to, my favourite, 3cm x 1.2cm (the ridiculous).

Finally, when labelling most patient packs we find ourselves obscuring at least one important piece of information which the company has taken the trouble to print on the pack.

Ian Morgan
*Hinckley,
Leicestershire*

■ PRESCRIPTION CHARGES

A review of current arrangements is urgently overdue

From Mr D. P. Morgan, MRPharmS

All health professionals, and people with type 1 diabetes, can rejoice at the recent breakthrough in diabetes therapy heralded by the use of islet tissue injections leading to cessation of the need for regular insulin injections for one experimental patient.

However, since he will need anti-rejection therapy for life as

well as regular monitoring of his condition, he will, probably, need to face the burden of NHS prescription tax until age 60, from which, as a treated diabetic patient, he was previously exempted.

Contrast this with the situation of the fibrocystic disease sufferer, having survived against the odds to adulthood, with a regular gamut of therapy to maintain life and normality, hoping against hope that the condition will so damage the islet tissue that substitution therapy with insulin will relieve them of the burden of prescription tax.

A review of the NHS prescription tax arrangements, with another increase coming, is urgently overdue.

David Morgan
*Abingdon,
Oxfordshire*

E-mail

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Advertisement

■ MEDICINES FOR CHILDREN

Let us have more proactive scepticism

From Dr C. L. C. Tuleu, MRPharmS

I was puzzled by the news item "Child medicine licensing plans inadequate" (*PJ*, 12 February, p168) which let the reader doubt on the true aspirations of the proposed EU regulations on medicinal products for paediatric use. But then I was horrified by the original position statement (at www.prescrire.org/docus/euMedPedEn.pdf) written by Medicines in Europe Forum, which is composed of family and consumer organisations, patients groups, health insurance companies and few para-pharmacy bodies. This may explain the rather politically and financially oriented discourse in the position statement but it certainly does not justify statements such as "most European children are in good health and do not need new drugs", "there is no paediatric therapeutic desert", and "those regulations would increase paediatric consumption of useless and risky drugs, authorised by a paediatric committee affiliated to the [European Medicines Agency] financed mainly by pharmaceutical industry".

It has been internationally recognised that children are at risk because they are administered the only available inappropriate medicines that have not been clinically tested for safety, efficacy and quality in their age group. The proposed regulation to be finalised, it is hoped, by late 2006 aims to establish a legislative framework that will fulfil the following main objectives:

- Increased availability of medicines specifically adapted and licensed for use in the paediatric population
- Increased information available to the patient/carer and prescriber about the use of medicines in children, including clinical trial data
- Increased high quality research into medicines for children

European regulators are in a great position, being able to benefit from the similar positive American experience (www.fda.gov/cder/pediatric/index.htm), to achieve the best outcome for children, carers and health professionals. More energy should be spent to make the draft regulation even more valuable to facilitate ethical paediatric therapeutic advances

rather than to feed the emotive and newsworthy debate "Healthcare of our kids versus profit-making pharmaceutical companies". If we all agree that the draft regulation seeks to "answer an important true need", let us have a more proactive scepticism.

Catherine Tuleu
London

■ THE SOCIETY

Nurse prescribing — no comment . . . ?

From Dr R. J. Harman, MRPharmS

Could the Royal Pharmaceutical Society's Council explain why it chose not make any formal comments on MLX 303 ("Nurse prescribers extended formulary: proposals to expand the range of prescription only medicines")? Indeed, has the Council considered these April 2004 proposals? Comments have been submitted by, among others, the National Pharmaceutical Association and the British Pharmacological Society. Why not the Society?

The failure to have an input into the proposed extended formulary for nurse prescribing would be strange under normal circumstances. However, it is inexplicable in light of the recently announced proposal, MLX 321, on independent prescribing by pharmacists, which is probably the most important and fundamental change in the role of pharmacists for many years.

It is likely that the extended range of conditions and the extended range of prescription-only medicines agreed for nurse prescribing will form the basis of any such list generated for independent pharmacist prescribing. How can the profession not have a view on such a proposal?

Robin J. Harman
Farnham, Surrey

DAVID PRUCE, director of practice and quality improvement, Royal Pharmaceutical Society, replies: The Medicines and Healthcare products Regulatory Agency is currently consulting on proposals to introduce independent prescribing by pharmacists (MLX321) and on options for the future of independent prescribing by extended formulary nurse prescribers (MLX320). Although some of the options for independent pharmacist

prescribing do involve a limited formulary that might be similar to the Nurse Prescribers Extended Formulary, there is a recognition that this approach may not be right one for pharmacists. Indeed a specific question in the consultation asks whether a different approach should be taken for pharmacists than for nurses.

Members of the Council have been involved in discussions with the Department of Health over the development of independent prescribing for pharmacists. In these discussions, it has been emphasised to the Department that it is unlikely that the extended nurse prescribing formulary would meet the needs of independent pharmacist prescribing.

The full Council will be debating the approach that we should take to responding to these consultations. We will publish our responses to both of these consultations once they have been agreed by Council.

■ CPD

Why not stagger CPD helpdesk hours?

From Mr S. J. L. Barrow, MRPharmS

I fully agree with Arun Sharma (*PJ*, 19 March, p 337) about the opening hours for the Royal Pharmaceutical Society's continuing professional development helpdesk. I do not believe that the demand for this service in the evenings and at weekends can really be predicted from the call volume during the daytime on weekdays. If the cost of providing this support is such a problem, why not simply alter the hours, rather than increase them in the manner suggested in the reply given to Mr Sharma?

Perhaps the helpdesk could be staffed from 7am until 3pm on two weekdays and from midday until 8pm on another two weekdays, then perhaps from 10am until 6pm on one day at the weekend. This system would accommodate those who do CPD before work, after work or at the weekend, as well as those, like myself, who have to contend with different time zones when telephoning the UK and find it difficult to call during UK business hours.

It would cost a little more than the current service, but nowhere near as much as the other proposal described. Just a thought . . .

Sara Barrow
Montesano, Washington

■ THE REGISTER

Let retired pharmacists use the title "doctor"

From Mr M. Samson, MRPharmS

There has been a lot of correspondence recently, including my own, in *The Daily Telegraph* concerning the use of the title "doctor". It was agreed that this title is a correct definition for those persons earning a PhD, whereas physicians and dentists may use this title as a courtesy, in spite of not having a doctorate but having the appropriate bachelor degrees. I understand that a small amount of confusion occurs with less enlightened members of the public if a pharmacist with a PhD correctly calls himself or herself "doctor". Since they can easily dispel this confusion, they ought to be able to use this title at all times.

Might I, however, make a further suggestion that all pharmacists, when retired and no longer a "threat" to the public, be permitted to use the courtesy title "doctor" in recognition of their past heroic services. This, I suggest, would adequately compensate for the loss of their PhC and MRPharmS, etc, designations on retiring.

Michael Samson
Worthing, West Sussex

Bring back the part-time fee!

From Dr B. B. Shetewi, MRPharmS

I contacted the registration department at the Royal Pharmaceutical Society for clarification about retention fees. I am retired and I work a maximum of 12 hours a month delivering training on safe handling of medicines. I was informed that I still have to pay the total fee of £256. Twelve hours a month is equivalent to 3.84 weeks a year, if we take a week to be 37.5 hours. This means that I have to pay the Society £66.67 a week for the privilege of having MRPharmS after my name.

I hope the membership elect enough new councillors to replace whoever brought this new regulation into force and I hope they can bring back a part-time registration fee. Let us hope common sense will prevail in our Society.

B. Shetewi
Leatherhead, Surrey

■ THE JOURNAL

Get the history right

From Mr S. W. F. Holloway

If you are going to urge members to play their part in history, you ought to get the facts of that history right. In your leading article (*PJ*, 12 March, p286) you state that in 1934 “the Society took on the responsibility for compulsory registration of pharmacists” and that the changes of that year were the first major changes to the constitution of the Council since 1843. Both these statements are wrong.

Since 1852 the Society has compiled the statutory registers of pharmaceutical chemists. Between 1869 and 1954 it also produced the statutory registers of chemists and druggists. It has never published a register of pharmacists as such. Under Section 15 of the Pharmacy Act 1868 the title “pharmacist” was reserved for those whose names appeared in the Register of Pharmaceutical Chemists. Section 3(iii) of the Poisons and Pharmacy Act 1908 permitted registered chemists and druggists to “take, use, or exhibit the name or title of pharmacist”. Thus the Society first took on the responsibility for compulsory registration of pharmacists in 1868 and after 1908 all those registered by the Society were legally defined as pharmacists. The Pharmacy and Poisons Act 1933 did not change this registration process. Instead, it deemed, by Section 1, that “every person registered as a pharmacist, shall, by virtue of being so registered, be a member of the Pharmaceutical Society”. The effect of this clause was that more than 7,000 pharmacists, who had previously enjoyed gratis all the benefits of compulsory registration, were forced to pay the annual membership subscription of the Society. Perhaps this is what you had in mind when you wrote of “paving the way for regulation of the profession as it is understood today”.

I am not going to list all the changes to the constitution of the Council that occurred between 1843 and 1933. I will restrict myself to those that were introduced by the Pharmacy Acts Amendment Act of 1898. This Act gave all registered chemists and druggists, whether employers, self-employed or employed, the right to become full members of the Society and to be elected to its Council. Although the distinction between pharmaceutical chemists

and chemists and druggists was maintained by the statutory registers, it lost its relevance in the constitution of the Society. The reservation of two-thirds of Council seats for pharmaceutical chemists, introduced in 1868, was abolished. The 1843 Charter provided that members should elect the Council in person by attendance at the annual general meeting; the 1898 Act introduced voting papers (and thus postal voting). The 1843 Charter provided that two-thirds of the Council should retire annually; after 1898 only one-third did so.

The changes introduced in 1898 represent changes to the constitution of the Council at least as significant as those of 1933 and 2005. There is one major difference. In 1898 the changes made the Council democratically accountable to the members of the Society; in 1933 and, even more so in 2005, the Council became more subservient to the government.

Sydney Holloway
Leicester

Is this censorship by the back door?

From Mr G. M. Alexander,
MRPharmS, and others

The letters columns of *The Pharmaceutical Journal* have echoed with an unexpected silence recently on the apparently contentious subjects of continuing professional development, the revised fee structure and the related resignation of members from the Register.

It might appear that the members, like the meekest of lambs, have accepted the ultimate wisdom of Lambeth's diktats. What a welcome outcome for the hierarchy, conveniently timed as it is, for the election period. However, things may not be as straightforward as they seem. *The Journal* has taken an editorial decision to publish no more letters on these subjects, thereby effectively denying the membership their voice. The protests of some of the authors of these unpublished letters have reached our ears, and we have sympathy in particular for the following suggestion: that a “tally table” be produced of letters received but not published with a summary of the points made, and with what frequency.

We echo members' concerns that *The Journal's* position may be leading to inadvertent censorship

and creating a dangerous and undemocratic precedent — one strangely reminiscent of the decision to stop publishing letters and decline a Broad spectrum article from the Save Our Society campaign at exactly the same sensitive period in the run-up to last year's election. This did nothing to prevent a landslide victory for SOS candidates a year ago, and we are certain it can only strengthen our ongoing fight for greater membership democracy, openness and transparency within the Society today.

We would like to reassure members that we remain committed to addressing their concerns about these issues and to encourage all the authors of unpublished letters to send them to the Secretary and Registrar with a request to provide copies to all members of Council.

Gerald Alexander
Council Election Candidate
Southgate, London

Shiv Bagga
Council Election Candidate
East Ham, London

Davan Eustace
Council Election Candidate
Solihull, West Midlands

John Gentle
Council Election Candidate
Shrewsbury

Andrew McCoig
Council Election Candidate
South Cheam, London

Bharat Nathwani
Council Election Candidate
Pinner, Middlesex

Graham Phillips
Council Election Candidate
St Albans, Hertfordshire

The Pharmaceutical Journal's editorial freedom is universally valued and respected, and *Journal* staff, as custodians of the principle, do everything they can to ensure that it is maintained.

Editorial freedom means we have the right to publish contributions from readers and investigate stories, as well as the right not to, without fear or favour. However, we have to produce an interesting and informative publication at the same time.

Letters are published provided they are accurate and not defamatory. However, when there is a topic of great interest correspondence inevitably becomes repetitive and once that happens we only publish letters on that topic if they make new points.

Contrary to what these correspondents assert, we have not taken an editorial decision to publish no more letters on

“apparently contentious” subjects. Letters about the matters to which they refer began to be published in our issue of 21 August 2004 and, after a surge in correspondence in the early part of this year, have continued to be published weekly since. This does not strike us as “an unexpected silence” and can hardly be described as “inadvertent censorship”. Moreover, we have asked correspondents whose letters we decided not to publish if they would like us to forward them to the Secretary and Registrar's office. Some agreed; others failed to respond and we believe it inappropriate to forward letters addressed to the editor to any other party without permission.

The matter of our moratorium on comment about the Charter early last year (*PJ*, 21 February 2004, p204) is a different issue. At the time, we were becoming increasingly uncomfortable with the idea that the Society's official journal might be promulgating inaccuracies and misinterpretations which would then be on the record. We would not be doing the pharmacy profession any favours, hence our decision not to publish anything while the High Court action was pending. It was entirely coincidental that the moratorium fell during the Council election period and, as these correspondents point out, it did the SOS candidates no harm.

If we may be frank, we are surprised that these correspondents should raise this as an election issue when there are so many important issues for members to consider. As far as we are aware, publication of a “tally table” of letters received is unprecedented and we question whether it would add value to any debate. However, if these correspondents' desire for publication in *The Journal* of such a table becomes Council policy then, since the editor is ultimately editorially accountable to the Council, we might have to oblige. That would be a sad day indeed for the editorial freedom of *The Pharmaceutical Journal*.

Readers may be interested to learn that *The Journal* is establishing a new editorial board which is designed to be a forum where members of the Society, members of Council, members of Society staff and, indeed, members of *The Journal* staff can raise concerns about the performance of *The Journal* and the behaviour of any party with an interest in *The Journal*. Full details of the constitution of the board are due to be announced at the Council's April meeting.—EDITOR.