

■ REGISTRATION EXAMINATION

Almost pointless

From Mr I. R. Davis, MRPharmS

I would like to offer my heartfelt congratulations to Sultan Dajani following his comments in the *PJ* last week (16 July, p82), in which he questions the ability of the registration examination to cultivate more competent pharmacists, compared with those who qualified before the examination was introduced. I fully agree with his view that the registration exam is almost pointless, and that the preregistration year can easily allow development of competence to practise.

I find his comments particularly timely on this day, as I have a friend who has just discovered she failed the registration examination, solely due to scoring 65 per cent in the calculations, just missing the 70 per cent pass mark by one correct answer. Mr Dajani quite correctly states that the examination tests “time-keeping skills and not competency”. I could see her holding tears back as she told me how she felt so rushed to finish that she did not answer three of the calculation questions, nor did she guess at answers for the sake of it. I have absolutely no doubt she will make an excellent pharmacist, and so how ironic it is that she is deemed not competent to join the Register of Pharmaceutical Chemists at this time, yet had she guessed three answers, she quite possibly could have been deemed “competent” by the Society.

My friend is totally competent to practise, yet she is denied this chance, this right of hers, through nothing more than being beaten by an unfairly imposed time constraint, something which rarely, if ever, has such importance in practice. As Mr Dajani points out, competence (as is demonstrated in the “real world”, rather than in a hall of 200 terrified graduates) can be demonstrated by, for example, making a mistake, identifying it and then rectifying it, learning from it and doing better next time. This sounds strangely like the ethos of a

continuing professional development cycle, a process so warmly embraced by the Society.

Ian Davis
*Eastbourne,
East Sussex*

■ EMERGENCY SUPPLIES

Further scenarios

From Mr B. P. Garrood, MRPharmS

Your article about emergency supplies (*PJ*, 16 July, p76) describes well the situation in holiday areas. There are two other scenarios that occur frequently.

First there is the patient or family that arrives at the holiday destination having decided not to bring their medicines with them, but instead to bring their monthly prescriptions with up to 15 items to the local pharmacy — at about five o'clock on a Saturday afternoon. Among these items will be one or two which are not used by the holiday pharmacy. This means that the patient will be without these medicines until supplies can be obtained on Monday morning.

The second scenario concerns oxygen. One of the pharmacies where I do locum work is an oxygen supplier. Most oxygen patients are sensible and will telephone in advance to say that they will be requiring oxygen and arrangements can then be made. However, every now and again a patient's carer will arrive on Saturday afternoon with two or three empty DD cylinders and a prescription for a dozen new ones. Unfortunately the oxygen supplier telephones on Friday afternoon for an order to be delivered on Monday and it is impossible to increase the order on Monday morning. What happens under the new oxygen arrangements?

But, of course, we are all human and two years ago our senior dispensing technician went on holiday to Australia — minus her atenolol tablets.

Brian Garrood
Norwich

Should cost be an issue?

From Mrs J. Hamer, MRPharmS

I read the article on emergency supplies (*PJ*, 16 July, p76) with interest — particularly the reference to emergency prescription charging. With a professional duty to act in the patient's best interest, once the decision has been made that an emergency supply is necessary, should cost be an issue?

I refer to the “won't pay” rather than those requiring expensive or multiple medicines, and people who know you would not welcome the tabloid publicity of the possible consequences of “just doing without”. I was once infuriated by a woman laden with clothes purchases, who refused to pay a nominal sum for some insulin, when she remarked to her companion, “I knew she'd let me have it eventually”.

As an employee of a large multiple, I incur no personal financial loss in these situations, but it is annoying to see the professional aspect of the service not valued — unlike the car mechanic or plumber.

Jan Hamer
*Milton Keynes,
Buckinghamshire*

■ HOSPITAL PHARMACY

One-stop dispensing

From Mrs A. R. Storey, MRPharmS

Are there any colleagues who share my view that one-stop dispensing is not all it is cracked up to be?

I work at a hospital where one ward out of six currently uses the one-stop system. On a daily basis it can take in excess of three hours to complete the ward visit and dispense the relevant items. For some patients we redispense parts of the same “to take outs” (TTOs) several times before them going home, due to dose changes etc. According to the media, one-stop dispensing is a more efficient system. We never had a problem with patients having to wait for their TTOs in the first place.

I recognise that it is great for the nurses, but surely it cannot be cost-effective for pharmacy? Time spent on this ward can be prohibitive to other duties and drug returns from the ward have shot through the roof. With only one pharmacist on site two days or more of every week and no prospect of being inundated with extra staff, can someone explain to me how we should be expected to roll out this system to our other five wards?

Amanda Storey
Birmingham

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.

■ NATIONAL BOARDS

Clarifying misconceptions

From Mr P. Jones,
MRPharmS

The leading article in *The Pharmaceutical Journal* of 9 July (p34), drew attention to the small amount of correspondence submitted regarding the proposed new national boards. Could it be that members wishing to submit a response have felt constrained by the amount of space offered by a letter, and that their considered response to the consultation paper has been sent to Michele Savage direct?

The letter you published from Stan Wheatley (p45), however, deserves a response because it perhaps identifies some of the misconceptions that may exist.

The three national strategies referred to are similar, but not identical, in the same way that bricks and mortar may all look similar, but the buildings they ultimately comprise vary considerably in shape and design.

For example, the English "Pharmacy in the future" is essentially a strategy for pharmacy, whereas Scotland's "The right medicine" is a strategy for pharmaceutical care, in which it is acknowledged that pharmacists are key stakeholders in delivering pharmaceutical care, but not the only stakeholders.

Since the establishment of the Scottish Parliament in 1999, Scotland's health, a devolved matter, accounting for approximately 40 per cent of the total budget, has had a high political profile. It should be remembered, however, that since the inception of the NHS in 1948 Scotland has always had a separate NHS, with separate NHS Acts and Circulars. Furthermore, when the Secretary of State for Health speaks in the House of Commons his or her comments only refer to England and Wales: they do not apply to Scotland.

It may be helpful at this stage to give a few examples of some of the developments in Scotland since devolution and how this has differed from what is happening in England:

Scotland has moved towards developing community pharmacy as an integral and visible part of NHS primary care services.

Community pharmacies in Scotland are regarded as walk-in centres, providing access to NHS primary health care services. It has

not been necessary to set up separate facilities.

The chairman of the Scottish Executive has been able to give oral evidence to the Health Committee on the draft Smoking, Health and Social Care (Scotland) Bill.

A professional view on supervised methadone has been submitted to the Petitions Committee of the Scottish Parliament in response to a petition raised on this subject.

A parliamentary briefing on the issues surrounding the proposals to change or abolish prescription charges has been delivered in partnership with the British Medical Association.

Ministers and MSPs are readily accessible and welcome approaches by health care professionals on matters that have a bearing on delivering the health care agenda in Scotland.

The Royal Pharmaceutical Society is a London-based organisation with an agenda attuned to the Department of Health. The Scottish Executive Health Department (SEHD) has a different health care agenda with different priorities, so can a body in London really be the most effective organisation to formulate policy which is not in tune with the agenda of the SEHD? Devolution provides an opportunity to engage more closely with the audiences pharmacists need to address: it is not necessary for everything to be done in London — indeed devolution offers an opportunity to make more progress and to do so more rapidly through being able to have more focused national perspectives.

Formation of three boards would have the advantage of the Council operating at a strategic level and concentrating on the regulatory issues, whereas the boards would be able to be the professional arm of the Society dealing with the professional and practice aspects of the profession. Scotland has been able to benefit already from developments under a devolved structure — is there any reason why England should not similarly benefit? Without a separate board for England, the Society's Council would be in the difficult situation of trying to offer English operational and strategic policy advice while at the same time, providing British regulation and development of a GB-wide policy.

The question of cost of the new arrangements was also raised. It is quite likely that there may be some small additional costs, and perhaps

this is a fair price to pay for an improved and more effective professional body. But has Mr Wheatley considered that for many years Scotland and Wales may have been getting an inequitable share of resources from a body that is ostensibly a GB organisation. Equitable distribution of resources and some element of decentralisation would be in line with the policies of many other London-based organisations, and would also facilitate the sharing of good practice between the three countries.

In conclusion, I strongly support the development of three separate boards for England, Scotland and Wales and believe this to be the correct way forward for the Society to be an effective regulatory and professional organisation within a politically devolved UK. At the same time, let us also be aware of what has happened in New Zealand where the pharmaceutical society has been disbanded and replaced by a government regulatory body. At a time where there are so many opportunities for significant advancement of the profession of pharmacy, a united, positive and proactive approach is vital.

Peter Jones
Edinburgh

Will new national boards mean in increase in retention fees?

From Mr M. A. Walker,
MRPharmS

"Divided, we stand" (*PJ*, 12 February, p164) and "A wake-up call" (*PJ*, 4 June, p666) have been two attempts by the *PJ* to ignite the devolution debate within the Royal Pharmaceutical Society, yet there is scarcely a trickle of letters on the subject of devolution.

Colin Ranshaw (*PJ*, 2 July, p31) extols the need for a Welsh board but fails to make any connection with the cost of such a board. If the 2,200 pharmacists who reside in Wales say "we want, need and will pay for a Welsh board", I would certainly wish them well in their endeavours. However, a Welsh board with a small budget of say £200,000 would cost each Welsh pharmacist nearly £100. Would anyone hear singing in the valleys if this was the size of increase in the Welsh retention fee?

Our elected members of Council must ask some pointed

questions and publish the answers before they ask the members accept any devolution proposals.

As a minimum I expect to know:

- How many jobs will move from Lambeth to Cardiff and Edinburgh
- How many new jobs will be needed in Cardiff and Edinburgh
- What the reduction in running costs of GB representation will be
- What the annual running costs of English, Scottish and Welsh boards will be
- What the transition costs for devolution are
- What the increase in retention fees for pharmacists resident in England, Scotland or Wales will be

Devolution is being proposed as "good idea". Unless the Devolution Review Group produces a full costing of its proposal and says who will pay for the change, then members should expect a significant increase in the retention fee to pay for the extra costs. It could be that members in Scotland and Wales will face a hike in their retention fees. Or maybe Lambeth thought that pharmacists in England would just pay for better representation in Scotland and Wales, without batting an eyelid.

I support better representation by the Society. If pharmacists in Scotland and Wales want and will pay for their own boards, then we pharmacists in England will need our representative board. However we all need to know by how much our retention fees will increase, if we want devolution. Then we need to vote on the matter, as it is a major constitutional change for the Society.

Mark Walker
Oxford

Off the record

Our new 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.

■ RECIPROCITY

Society should delay the move at least!

From Dr D. M. L. Branford, MRPharmS

Having recently enjoyed the opportunities provided by the reciprocity agreements between the UK, Australia and New Zealand, I am amazed that the Royal Pharmaceutical Society can be considering ending them at this time (*PJ*, 2 July, p10). Such a move should at least be delayed but preferably abandoned.

Antipodean pharmacists provide a tremendous resource at a time of pharmacist shortage. It is difficult to imagine why we want to lose the services of about 300 pharmacists. The Society will also lose significant registration revenue, surely enough to pay a decent lawyer to hold off any imagined challenge to such an agreement.

For many people who live in Australia and New Zealand, coming to the UK for an extended period is a normal part of life. This overseas experience is increasingly becoming a two-way event as many of our UK citizens enjoy time in the antipodes. This exchange enriches all our lives and provides valuable pharmacy-related work experience. Future travellers will prefer to work in bars and restaurants rather than incur the costs and time involved with the overseas pharmacists' assessment programme.

Rather than impose such draconian measures on our antipodean pharmacists, perhaps the Society should seriously look at introducing reciprocity agreements for other countries that can provide high-quality English-speaking pharmacists, with a clinical orientation to their work.

We seem to have ended up with a completely back to front set of agreements. We have to accept pharmacists from countries that are members of the EU for almost immediate registration even though their skill may be minimal and their health care system totally

different. We will be unable to accept pharmacists from countries with close educational links and similar health care systems to our own. At a time when so many nurses, doctors and other professionals from abroad are working in the NHS, restricting pharmacists in this way appears absurd.

As a chief pharmacist of an NHS trust I am aware that we have an almost unquenchable need for clinical pharmacists. Primary care trusts and hospital trusts are creating clinical pharmacist posts faster than we can produce the pharmacists to fill them. Even with the current pharmacy school expansion, any possibility of an increase in available clinical pharmacists is still at least a decade away. Pharmacists from the antipodes and other countries, where the education and training is clinically orientated, provide ideal candidates. The current changes to the reciprocity arrangements should wait until then at least.

David Branford
Chief Pharmacist
Kingsway Hospital,
Derby

■ CPD

Pharmacists should have a choice of several methods

From Mrs C. G. Kellett, MRPharmS

I have been following the correspondence from Perry Melnick (*PJ*, 18 June, p759), Stuart Matousek (*PJ*, 25 June, p789) and Peter Dean (*PJ*, 16 July, p82) regarding continuing professional development, and note the comments by Philip Green (*PJ*, 18 June, p759).

Have those at Lambeth learnt nothing from the Royal Charter debacle? Why must we have a "one-size-fits-all" method of CPD?

Obviously it would be a problem if no rules were laid down, but surely a choice of several methods (perhaps three) should be available, so that members can choose one which suits them, rather than be expected to use the method most convenient to the Royal Pharmaceutical Society. This would then allow members to fulfil their CPD requirement in a manner with which they feel personally comfortable.

Mr Dean need not fear. He has probably amassed a vast wealth of

knowledge and experience during his professional life and no doubt, like me, has probably forgotten more than any of the newly qualified have yet learnt.

Those of us who work in the dispensary, week in, week out, whether in the community or in hospital pharmacy, are presented with a never ending stream of information, which must be assimilated and put into practice. The only problem is finding the time and energy to record some of the more interesting bits as CPD.

Celia Kellett
Worcester

■ GRANDPARENT CLAUSES

Possible scenario overlooked by Society

From Mr P. B. Dean, MRPharmS

May I point out an anomaly that seems to have been overlooked. Should a member decide to resign from the Royal Pharmaceutical Society but wish to continue to work as a part-time dispensing assistant (an unlikely, but not impossible, scenario) he or she would not be allowed to do so unless they undertake the appropriate national vocational qualification course (because the final date for notifying the competence of assistants under their "grandparent clause" has now passed).

Meanwhile, anyone who, though not a pharmacist, is an able dispensing assistant and whose competence declaration was signed before the date, will be able to work in a pharmacy, handling and assisting with prescriptions and, within the protocols, offering assistance and advice on medicines and so on to patients. There will be many members of the Society

Society membership groups

The Royal Pharmaceutical Society has established special interest groups for community pharmacists, for veterinary pharmacists, for industrial, regulatory and technical pharmacists, for hospital pharmacists and for pharmacy academic staff. The groups hold meetings to consider topics of interest within their own fields of practice and they provide a source of advice to the Society's Council on specialist matters. Details of the groups can be obtained from the Society. Contacts are as follows: Community Pharmacists Group and Industrial Pharmacists Group, Angela Canning, practice division (tel 020 7572 2412); Hospital Pharmacists Group and Veterinary Pharmacists Group, Lorraine Fearon, practice division (tel 020 7572 2409); Academic Pharmacy Group, Zoe Whittington, research and development division (tel 020 7572 2276).

whose spouse, partner or employees are in that category. It is surely a ridiculous situation whereby the person who (in many cases) verified the competence of such assistants, would be themselves debarred from carrying out the same tasks.

Peter Dean
Holton,
Oxford

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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