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HOMOEOPATHY

Continuing to champion it

From Mr F. Khan, MRPharmS

I commend *The Journal* for the comments in this week's leading article (*PJ*, 3 September, p272). *The Lancet's* conclusions will have helped close the minds of many health care practitioners to the possibility that homoeopathy can be an effective remedy for certain patients, and not just by a placebo effect. Many, like me, who have studied homoeopathy and have been successful in using it personally and have used it effectively on patients, will read comments like James Semple's in your news feature (p277) and feel it a shame that his views now will add to the current indoctrinated scepticism regarding homoeopathy that exists in the fields of science and medicine.

However, there will always remain the many thousands, if not millions, of open-minded people who are convinced of homoeopathy's efficacy and will continue to champion it, regardless of the "official results".

Faez Khan
Leeds, West Yorkshire

Not convinced

From Mr J. Sharp, Hon.MRPharmS

In your leading article "Homoeopathy hubbub" (*PJ*, 3 September, p272), as a token of your belief that "journalists, like scientists, should have open minds", you state: "There may be no convincing proof that homoeopathy works, but equally there is no convincing proof that it does not work." That, surely, is to take open-mindedness to an unscientific level. The burden of proof must be with the proponents of homoeopathy, to present evidence of the truth of their contentions. This they singularly fail to do.

Using the analogies of "relativity and plate tectonics" is inappropriate and irrelevant. You say that these were "pooh-poohed when they were first proposed". Are you able to quote any references to the "pooh-poohing" of relativity that have been published in any reputable journals?

You urge the suspension of "negative attitudes". The accusation of "negativity" is the last resort of those attempting to defend the indefensible. To impute "negative attitudes" to those who would deny the validity of nonsense is like accusing Copernicus, Kepler, Galileo and Newton of having "negative attitudes" because they refused to believe that the planets were pushed around the earth by harmoniously singing angels.

It is perhaps worth noting that the policy of the Royal Pharmaceutical Society, as published in the *PJ*, June 14, 1986 is: "...with regard to the actual composition of the 'homoeopathic remedies', there is no scientific evidence for their efficacy, only anecdotal and subjective reports. It is unlikely that the benefits attributed to homoeopathy could extend to over-the-counter recommendation or self-selection sale.

"The Society's Council therefore recommends members to inform any persons seeking advice on homoeopathic products that there is no scientific evidence for their efficacy beyond that to be expected from a placebo response."

I am not aware that there has been any formal amendment to that policy.

In your news feature (*PJ*, 3 September, p 277), you quote Christine Glover as stating that a double-blind randomised controlled trial "...is not an appropriate paradigm to use for homoeopathy, which is usually tailored for individual use." But is it not a fact that the great majority of homoeopathic "remedies" are sold on a self-service and self-selection basis where there is no possibility whatsoever of individual "tailoring"?

John Sharp
Woodley, Berkshire

We thank Mr Sharp for drawing attention to the Society's policy that pharmacists should mention the lack of scientific evidence for homoeopathy without condemning it out of hand. This is an excellent illustration of the open-mindedness advocated in the leading article — EDITOR.

Forcing a round peg into a square hole

From Mr S. B. Kayne, FRPharmS

One might be forgiven for approaching the latest burst of debate concerning homoeopathy with a degree of frustration. The results from Switzerland (*PJ*, 3 September, p277) add nothing new, for yet again researchers have tried to force the round peg of homoeopathy into the square hole of randomised clinical trials. There are always going to be difficulties associated with analysing data derived from the application of rigid RCT protocols. Data that, as a result of standardising the populations and dose regimens, do not reflect the way in which homoeopathy is routinely used in day-to-day practice.

Why should the RCT be considered the gold standard? Because there is nothing else? Is it not time we developed a robust patient-oriented outcome measure that would establish conclusively whether homoeopathy works or not? Many orthodox interventions are made on the basis of simply responding to symptoms and could also be assessed using the tool. I suggest that this approach is preferable to merely stating that 200 years of homoeopathy has taught us it is a placebo effect. It seems to be a case of petulance — "if you are not playing my game do not come to the party."

Steven Kayne
Glasgow

Leave it alone

From Mr K. R. Nathwani, MRPharmS

Here we go again, researchers investigating another negative hypothesis about homoeopathy (*PJ*, 3 September, p277). Why is it that it is always those people commissioned to conduct trials who are not practising homoeopaths, who make ridiculous claims that homoeopathy is no more effective that placebo.

I would like to recap that homoeopathy is an art and science of holistic healing, proven to be successful for over 250 years without any changes to the philosophy and principles by which homoeopaths prescribe.

I recollect that the *PJ* some years back said that they would not publish any more letters regarding homoeopathy because it is an endless debate. By the same token the *PJ* should not publish such ridiculous trials which only serve to infuriate respectable homoeopaths.

It is high time that individuals with limited knowledge of homoeopathy stopped interfering with this gentle form of healing. Ask the many children who have been cured by homoeopathy without any adverse effects if their treatment is a placebo. It is easy for Swiss and UK researchers to quickly give homoeopathy headlines by their results of their so-called (negative!) trials.

What about the medicinal drugs such as Vioxx, Celebrex, co-proxamol, etc, making the headlines? At least the system of healing by homoeopathy to date has not killed anyone!

Kindly ask those who have been cured for their comments. Remember "trials" are not holistic, ie, treating the whole person rather than the disease. The Swiss trial conducted is questionable and baseless, used to undermine the profession of homoeopathy. These researchers should concentrate in areas of their expertise and leave homoeopathy alone.

Kamal Nathwani
Hertford

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.

HOMOEOPATHY

Logical errors

From Mr S. A. Malcolm, MRPharmS

The writer of your leading article on the homoeopathy debate (*PJ*, 3 September, p272), in attempting to keep an open mind, has made some logical errors.

In talking about the dilution process he states, "It may be contrary to conventional scientific wisdom...but many scientific principles that are now generally accepted were pooh-poohed when they were first proposed — relativity and plate tectonics are just two that come to mind."

There are two problems here; first the dilution process is just that, a process not a principle. Secondly, relativity and plate tectonics are theories to explain well-recognised phenomena, whereas it is the very existence of a homoeopathic effect that is in question. The writer makes the same error when he states, "…it is only in recent years that we have even begun to understand the pharmacology of the salicylates even though, in the form of willow bark, they have been used for some 2,500 years." Again the benefits of the use of salicylates are unquestionable. Nobody has ever suggested that treatments that work but whose mechanisms are unknown should not be used.

Your writer then adds, "Even if we believe that homeopathy is quackery we need to remember that many people are convinced of its power to heal. That power may derive from the placebo effect, but what is wrong with that?" Like religion, homoeopathy depends on faith. In the case of medicine, placebo effects occur when a patient sincerely believes that they are receiving a treatment that has been proven to be effective. But this raises ethical questions. Should treatments that depend on deception ever receive the endorsement of the medical profession? There are two reasons why they should not. A deception discovered will result in mistrust of those providing the false assurance and a disease may worsen if not properly treated. There may be some rare cases where a placebo rather than effective medication should be prescribed but the job of the medical profession is to provide patients with evidence based treatment.

Stewart Malcolm
Bures,
Suffolk

PHARMACY PRACTICE

PDA — working hard to give pharmacists a break

From Mr M. Koziol, MRPharmS

Several previous correspondents have referred to the "Dealing with, and overcoming, problems in contracts of employment" guide which has recently been published by the Pharmacists' Defence Association and distributed to over 18,000 employee and locum pharmacists and to almost 2,000 employers at their request.

In particular Chijioke Agomo (*PJ*, 27 August, p251)) believes it is important for the PDA to present its work to policy makers in pharmacy, so as to secure a more balanced outcome for employees and locums.

I can assure Mr Agomo that the guide has been sent to both the Royal Pharmaceutical Society, and also to the Company Chemists' Association, and we have invited them to respond to the guide and also the contract for services for locums. The PDA, in the meantime, will continue to lobby widely for improvements to the working environments of employee and locum pharmacists wherever appropriate.

In researching and disseminating the guide on such a scale, the PDA has provided the majority of employee and locum pharmacists with a practical, risk management framework which will enable them to recognise and challenge unreasonably imposed terms and conditions. In addition, members have the support of an association that will protect their interests in the event that this leads to a dispute with their employers.

More importantly however, the PDA is undertaking research, which is examining the link between work breaks, staffing levels and dispensing errors. We are confident that, when linked to a public safety issue, the work break and staffing level debate will be elevated to a new level and will be taken much more seriously by both the regulatory authorities and, consequently, the pharmacy employers.

We hope to be able to complete this work in time for our next annual conference to be held in Birmingham in February 2006.

We invite any employee or locum pharmacists who have encountered poor experiences relating to lack of work breaks and poor staffing levels to share their experience with the PDA via email on enquiries@the-pda.org

Mark Koziol
Director
The Pharmacists' Defence Association

RECIPROCITY

From the Society's perspective

From Mr G. S. Phillips, MRPharmS

As the recently appointed chairman of the Royal Pharmaceutical Society's Education Committee, I would like to take the opportunity to respond to the concerns of Ian Dean (*PJ*, 13 August, p194) and other colleagues.

When the Royal Pharmaceutical Society's Council took its decision in 2003 to end reciprocal agreements with Australia and New Zealand it did so knowing the decision would be controversial. As Mr Dean points out, the Society thought a continuance of the existing agreements could be "construed as being discriminatory and risk legal challenge". A key part of our thinking was the knowledge that new legislation stemming from the 1999 Health Act would not allow for reciprocal arrangements (not just for pharmacists but other professions too). Clearly the Society has no choice but to take this into account. This being the case I must correct one assertion made by Mr Dean: that the Society is out of step with other health care regulators in ending historical agreements. The reverse is true and the General Medical Council and General Dental Council have done the same thing recently for the same reasons.

David Newgreen (*PJ*, 27 August, p252) is right that EEA nationals can register in the UK but, unlike reciprocal agreements, that is a matter of EU law and we, like the competent authorities in all member states, are bound by it.

Furthermore it is not accurate to say applicants are accepted as a formality: every application is scrutinised fully by expert staff to ensure education and training is appropriate and in accordance with clearly defined EU requirements.

I accept Mr Newgreen's points about standards of pharmacy education in Australia and New Zealand, which we know to be high and, for this reason, staff in the Society's Education and Registration Directorate are actively exploring alternative mechanisms for recognising the competence of overseas pharmacists where there is a sound professional case for doing so. However, in a modern, regulatory environment, mechanisms must be transparent and no matter how seductive, not based on assertions such as "Britons and Australians are the most compatible of people, blending seamlessly and unnoticeably into each other's communities" (Ian Dean, *PJ*, 13 August, p194).

There is a clear difference between pharmacy graduates in the UK and those from Australia and New Zealand in that we now require registrants to be educated to master's level, whereas education in Australia and New Zealand remains at bachelor's level. This is not to say that the education in Australia and New Zealand is inadequate, but it is different and we do have to acknowledge this.

It would not be fair or equitable to let applicants enter the Register in the knowledge that they have received different education to their UK equivalents, no matter how good it may be. We have to be sure that at the point of first registration in the UK all overseas pharmacists (not covered by EU legislation) have met the same criteria.

I would like to assure colleagues that there really is no hidden agenda in the action that the Society has taken — as a working community pharmacist I am all too acutely aware of the shortages within the profession.

The Society is continuing to work with pharmacy regulators overseas and is seeking to develop properly evaluated processes to assist the exchange of pharmacists between the UK and other jurisdictions. This process has already begun and I am aware that the President is taking a personal interest in this and in maintaining the best possible relations with our pharmaceutical cousins in Australia and New Zealand. Society staff will be meeting with colleagues overseas in the next few months to explore mutually acceptable ways forward.

Graham Phillips
Member of Council,
Chair of the Royal Pharmaceutical Society's Education Committee

E-mail
E-mail correspondents are asked to give a full postal address or membership number

NICE

Will not and cannot end postcode prescribing

From Mr B. T. Brown, MRPharmS

The headline to my letter "Ending postcode prescribing a bad idea" (*PJ*, 3 September, p282) is the sole property of the *PJ*. The import of my letter was that the National Institute for Health and Clinical Excellence (NICE) will not and cannot end "postcode prescribing". Both central planners and the media must debunk the idea that NICE will bring an end to the concept and inflate consumer expectation in the process.

Paradoxically, much lobbying that led to the establishment of NICE was supported directly or indirectly by "big pharma". Understandably the industry does like local formulary decisions that side-line drugs accepted by others. Because there is this form of market in place there is scope for the use of a wide range of drugs and competition that underpins research and development.

If NICE develops a *de facto* national formulary, "big pharma" may become very selective in its product development. Cutting edge research would be impeded. The flow of new treatments may slow significantly and potential treatments may be denied to patients. The end of "postcode prescribing" sought by "big pharma" may be counter-productive and not actually what it wants.

NICE is probably here to stay but my concern is that we, as health care professionals, risk ascribing unachievable aims to it. What is imperative is that we do not inflate consumer expectation by pretending that NICE is what it clearly is not and will deliver what it cannot.

Etymologists may enjoy the Oxford English Dictionary root of the word "nice". Its use as an acronym here just may be inappropriate.

Bruce T. Brown
Birmingham

Telephone number
All correspondents should supply a daytime telephone number, in case we need to contact them urgently

RETENTION FEES

A good time to leave

From Mr C. R. Legg, MRPharmS

Like Christopher Palin (*PJ*, 20 August, p227), I fall into the 44-year trap. After a life spent at the bench, I had cut the work load and was intending to leave the Register in December 2004. By popular demand I decided to give it another year, or until I was forced out by a lack of written proof of being fit for practice. Any mechanic will tell you that the MOT was introduced to get all the old cars off the road, and there is no doubt in most minds that older pharmacists are now seen, by the powers that be, as scrap metal. So we have to go, but when? And if we cut all our professional ties, will we really miss it? According to my retired friends and wife (ex-consultant) — a resounding no!

There will be absolutely no point in paying through the nose for *The Journal* until I hopefully reach the 50-year pearly gates. There is another exciting world out there so roll on this December, or 2006 at the latest. My client friends will lose a pair of safe hands and the Society another avid fee payer. I thought I cared but gradually my mind has begun to relish no more rota, no more days without breaks, no more companies to chase for payment. I could go on. Perhaps I will think, "thanks for the memory", but I am going to be too busy doing what I want to for a change.

Chris Legg
Sudbury, Suffolk

SEXUAL HEALTH

Correlation?

From Mr R. J. Shepherd, MRPharmS

Has anyone else made the connection between the unfettered access to emergency hormonal contraception — often repeated and free via a patient group direction — and the need now for a national chlamydia screening programme?

Bob Shepherd
Honiton, Devon

Advertisement

MEDIA REPRESENTATION

Showing the "face" of pharmacy to the public

From Mr J. E. Balmford, MRPharmS

Further to the Broad spectrum article (*PJ*, 27.August, p 250) something must be done to show the "face" of pharmacy to the public.

For several years, the assistant secretary to the Royal Pharmaceutical Society, Bruce Rhodes, was excellent in his performance on television. I often saw him on *BBC Breakfast*, putting forward the position of pharmacy. He carried out his task with aplomb.

After his retirement early in 1990, Roger Odd appeared from time to time, but after he left the Society nobody has regularly presented our profession to the public.

I would have thought that Beverley Parkin could have found a pharmacist with the aptitude to perform this important role. I say important role, because most of the public have no idea what a pharmacist does, both in the retail sector and in hospital, not forgetting the part played by our profession in research.

Such exposure would also help with the recruitment of outstanding students to our profession, by showing what an exciting and challenging profession pharmacy is.

We used to do it in the past, and I wonder why it has not been done in recent years.

John E. Balmford
Past President
Royal Pharmaceutical Society

Raising our public profile

From Mr R. S. Kaye, MRPharmS

I had to write in and say how much I agreed with Martin Palmer's Broad spectrum article (*PJ*, 27 August 2005). I have been making these exact points about pharmacy input in factual and fictional TV, to students and collegues for several years.

I would now like to ask if a Royal Pharmaceutical Society representative could reply here, to tell us what they plan to do to raise our public profile in the media. Surely next time there is a medication-related story in the news, it would just take a phone call from the Society to tell the BBC they have a pharmaceuticals expert they can consult, and we would start seeing pharmacists on TV news programmes.

I am more than happy to make any TV appearances!

Richard Kaye
Loughton,
Essex

Informing the public about new pharmacy services

From Mr P. Jones, MRPharmS

Martin Palmer (*PJ*, 27 August, p250) highlights the important, but difficult, issue of making sure that the public are aware of the changing nature and scope of pharmaceutical services available to them, following implementation of the new pharmacy contract. How do we inform and, at the same time, raise public expectation of pharmaceutical services among the general public? As someone indicated to me recently, "If you are trying to persuade the public to use community pharmacies as the first port of call for NHS primary care services, wouldn't it be a good idea to tell them?"

Good positive media coverage is vital — Martin Palmer refers to TV soaps, and public health medicine specialists tell us that the best way to get a public health message over to the public is to write it into a "soap". GPs also indicate that the day after a key character in a soap is diagnosed with a serious medical condition, their surgeries are full of patients with identical symptoms!

But perhaps we should put our own house in order first so that the public have an idea as to what pharmacies and pharmacists stand for? If you walk down any high street you might wonder whether a pharmacy is a department store, a shop selling cosmetics and baby clothes, a place where you can have your films developed, or perhaps a place where you can buy medicines and have an NHS prescription dispensed.

Is it evident that it is a facility to seek expert advice on health matters, including medicines, free of charge, and without a prior appointment? Some pharmacies display a green cross, but others display a variety of corporate logos. In Scotland most pharmacies now display a corporate logo indicating they are part of the NHS, and are premises where pharmaceutical care is provided. The fact that these pharmacies are part of the NHS came as a surprise to many members of the public. So how about a move towards a corporate professional identity to assist the public: the clients we serve?

All pharmacists should be aware of the need to address the problems highlighted by Mr Palmer. A joint initiative between the local branch in Edinburgh and the health board's statutory professional advisory committee on pharmacy has recently prepared a public relations and communications strategy. This is now being implemented to try and ensure that the public, other health care professionals, staff in social work departments and politicians, both locally and nationally, are fully aware of the exciting developments and changes that are beginning to take place.

Pharmacists are and will continue to provide the public with an ever increasing range of professional services. There is no point in hiding one's light under a bushel!

Peter Jones
Edinburgh

BEVERLEY PARKIN, public affairs and communications director at the Royal Pharmaceutical Society, responds: These correspondents are right to underline the value of having a presence in the media: it helps build the Society's influence as an authoritative, credible organisation and promote the reputation of the profession in all its roles. That is why the Society invests in a proactive media programme as a key component of its communications strategy.

The public relations team works to promote the Council's policies and the profession's viewpoint to the public through the news media. An important part of this is supporting the Society's local pharmacist PR officers, who make an important contribution to the profession's profile in the regional media.

Over the years, the profession has benefited greatly from the skills of some first-rate media communicators, including Bruce Rhodes, Roger Odd and Professor Tony Moffat. The PR team continues to work with excellent spokespeople on the Society's Council, staff, in the branches and in key stakeholder groups to raise the Society's media profile. Print and broadcast media are becoming more demanding, with a proliferation of media outlets to service: our PR resources are focused on supporting Council policy and providing an authoritative position on the Society's priority issues as well as running some five national public health campaigns a year.

Every month, the Society issues some 22 news releases; pharmacy penetrates the national press about eight times; pharmacists are included in national and local broadcasts on average six times. In August 2005, pharmacy's media presence included:

- David Pruce, director of practice and quality improvement, interviewed on BBC Radio 4 about buying medicines from the internet;
- John Gentle, member of the Council, interviewed on Radio Shropshire"about buying medicines from the internet;
- David Pruce quoted in *Yours* magazine about non-steroidal anti-inflammatory drugs for a piece about ibuprofen and risk of heart attack;
- Sue Kilby, head of practice, quoted on *BBC News Online* in a news article about the Medicines and Healthcare products Regulatory Agency's call for over-the-counter painkillers to contain stronger warnings about risk;
- a news feature on *BBC News Online* — "The rise and rise of the pharmacist", for which our PR team provided background;
- a reference to the Society and the British National Formulary included in an article in *The Guardian* about a multivitamin compound for autistic children.

In addition, a typical week's media work will involve preparing statements and news items for the pharmacy and health-related press; handling requests for interviews with pharmacists and requests for background information and comment on a wide range of medicines and health-related issues. Currently, the team is gearing up to promote the British Pharmaceutical Conference, which last year secured over 50 appearances in the national press and broadcast media.

For a roundup of PR activity over the last month, members can visit the Society's website at www.rpsgb.org/news.

Your first correspondent makes an important point about the need to recruit high-calibre students to the profession: the Society's work in promoting pharmacy as a career seeks to do just that. Over the summer, the Society issued a new

suite of careers materials and launched a dedicated website www.pharmacycareers.org.uk aimed at 14- to 16-year-old students. The PR team is currently working with *The Independent* newspaper on an eight-page supplement on pharmacy as a career. This will be the fourth such supplement promoting the profession, which is distributed to over 550,000 readers with the newspaper and *The Pharmaceutical Journal*.

EMERGENCY SUPPLIES

Governed by legislation

From Dr D. N. John, MRPharmS

In response to Susan Howshall's letter (*PJ*, 3 September, p281) it is not the Code of Ethics that dictates the quantity of a prescription-only medicine that a pharmacist can supply in an emergency, at the request of a patient. It is legislation, specifically "The Prescription Only Medicines (Human Use) Order 1997". This states that no greater quantity of the prescription-only medicine than that which will provide five days' treatment can be sold (unless there is a specific exemption within the Order, for example, a quantity sufficient for a full treatment cycle of an oral contraceptive).

Dai John
Senior Lecturer & Head of Clinical Pharmacy, Law, Ethics & Practice
Welsh School of Pharmacy, Cardiff University

THE SOCIETY

Improving the Society's ability to represent pharmacists

From Mr A. J. Pothecary, MRPharmS

Recent correspondents to *The Journal* have suggested that the Royal Pharmaceutical Society should work to ensure that pharmacists are able to have regular breaks in the workplace. Although I would certainly welcome this, it is probably not possible for the Society to become involved in matters like this.

The Society was taken to court in 1921 by Mr Jenkin, a member of the Society and of the Society's Council. The court declared that it was not within the power or purposes of the Society to undertake or perform several functions, one of which was to regulate the wages and conditions of employment as between masters and their employees who were members of the Society. I believe that this legal precedent, although over 80 years old, would prevent the Society from trying to ensure that pharmacists always receive their breaks.

Unfortunately, this shows the awkwardness of the Society's current situation. It has always been supposed to regulate and represent pharmacists, but it seems that representation has become increasingly difficult over the past few years. The Society has never been able to act as a trade union for community pharmacists, some of whom have probably joined other unions such as the Union of Shop, Distributive and Allied Workers (USDAW).

As a result, there is no one body that represents all pharmacists and does nothing else. I think it may be time to reconsider splitting the functions of the Society. The creation of a "General Pharmaceutical Council" along the lines of the General Medical Council and General Dental Council, to take on the current regulatory roles of the Society (ie, registering pharmacists and technicians, fitness to practise, accreditation of educational courses, and the inspectorate) would free the Society to represent the profession. It could act as a trade union in a similar fashion to the British Medical Association. Obviously membership of the Society would then become optional, but if it could demonstrate that it gives value for money then there is no reason why it should not be successful.

Although the National Pharmacy Association does a valuable job providing services and representing the profession, it is primarily an employers' organisation.

Pharmacy regulation in New Zealand has recently undergone a similar split, and doctors and dentists in this country have been regulated this way for many years, so what do we have to fear?

Andrew Pothecary
Gosport, Hampshire