

■ PSNC

Why is the PSNC so unsure of its position?

From Mr D. R. Kent, MRPharmS

Your report on the revelation by Sue Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee, that in 2006–07 there are likely to be fewer than 260 independent pharmacies dispensing between 1,100 and 2,000 items monthly (*PJ*, 1 April, p372) and that fewer than 100 may close in 2008, cannot pass without comment.

This claim was made at the local pharmaceutical committees' conference on 22 March and, when it was challenged, the conference was told that it had come from the Department of Health; further details when requested were withheld.

The latest published figures (Statistical Bulletin 2006/01) indicate that in 2005 there were 873 pharmacies dispensing fewer than 2,000 items per month, of which approximately 600 dispense between 1,100 and 1,999 items per month; there is no published evidence of the substantial drop which would be necessary to support the PSNC's claim. If we assume the same proportion of independent and company pharmacies in this target group as in the total number of registered pharmacies then there were 288 independent pharmacies during the period to which the bulletin refers. This is, in fact, probably an underestimate.

Where, then, have the 188 or so missing independent pharmacies gone?

The answer could be that the PSNC expects them to close between now and the end of the so called "period of protection" with the final 100 closing at that time; and if this does in fact take place it will be a direct consequence of PSNC remuneration policy. With these independents dispensing between 1,100 and 1,999 items per month standing to lose up to £20,000 of their net profit with no reduction in expenses it is likely that the majority will fail.

There is no logic to the PSNC putting off a decision on varying the current remuneration model when pharmacies, by the PSNC's own admission, will fail. If there is cause to vary the current remuneration model in 2007 or 2008 then that also pertains today. In the meantime, the lower dispensing volume contractors are living with the stress of not

knowing whether they will have a viable business in 2008.

The PSNC suggests that these contractors serve no purpose; they are wrong. To put their contribution into perspective, a pharmacy dispensing 1,800 items per month is dispensing for about 48 patients per day or about double the number of patients seen by a GP. Has anyone suggested that GPs with smaller lists should also have their remuneration severely reduced? These pharmacies provide a valuable personal service to their patients; it is not their fault that their better placed colleagues take most of the available prescriptions.

Another unexplored consideration is where the young aspiring independent contractor will find an affordable first pharmacy after 2008. The PSNC is pushing our profession further into the company-dominated scenario.

To come back to my opening premise, one really has to ask why the PSNC is so unsure of its position that it has to put forward unsupported, and plainly ludicrous, statistics to support an untenable position. The question of whether the PSNC acts in the best interests of all those from whom it collects levies also needs answering. The lifeline you report is illusory; these pharmacies may be "on the agenda" but being on an agenda is a euphemism for "do not worry us now" or possibly in the future.

David Kent
Secretary
Camden and Islington Local
Pharmaceutical Committee

SUE SHARPE, chief executive, PSNC, replies: Mr Kent is confusing figures. As the article to

which he refers makes clear, the numbers I referred to are those for England alone. The figures he quotes are those in the NHS Statistics for England and Wales.

I estimated that in 2006–07 there will be fewer than 100 independently owned pharmacies in England that are not essential small pharmacy LPS pharmacies, that will dispense between 1,100 and 2,000 items. Analysis of the Statistical Bulletin he cites tends to support this.

The Statistical Bulletin provides figures for the numbers of independent pharmacies in England and Wales dispensing between 1,001 and 2,000 items monthly (this figure is calculated by deducting the number of pharmacies owned by chains of more than five pharmacies from the total number of pharmacies, for this dispensing volume):

1999–2000	798
2000–2001	701
2001–2002	564
2002–2003	497
2003–2004	435
2004–2005	383

If, as Mr Kent assumes, 10 per cent of these dispense between 1,000 and 1,100 items, those dispensing between 1,100 and 2,000 items in 2004–2005 was around 345.

The trend over the past five years has been an annual average of 20 per cent reduction of pharmacies dispensing these volumes (due largely to prescription volumes generally increasing — the statistics to which Mr Kent refers confirm that over that five-year period, the total number of pharmacies has remained fairly constant). Assuming that the trend of reducing numbers

continues, by 2006–07 the number of independent pharmacies in England and Wales dispensing between 1,100 and 2,000 items would be 221. Wales has about 7 per cent of the pharmacies, so 15 of these could be in Wales, leaving 206 independent pharmacies in England dispensing between 1,100 and 2,000 items.

There is an estimate of 230 essential small pharmacies entitled to the ESP LPS that are protected through the ESP LPS scheme negotiated by the PSNC. A substantial portion of the ESP LPS pharmacies would be dispensing between 1,100 and 2,000 items.

My estimate, therefore, seems eminently reasonable.

■ ANTIBIOTICS

Suspensions should be dispensed in powder form for patient dilution

From Dr M. L. Truong, MRPharmS

We, as pharmacists, dispense antibiotics in the form of reconstituted suspensions, but should we really be making these up for patients?

Most patients should be able to mix a suspension themselves. It is not hard to mix so many millilitres of water with a set amount of antibiotic powder.

There are reasons why I think we should dispense the antibiotic in powder form:

- At present, if we dispense a suspension, we have to ask the patient to come back to purchase the remainder of the course if the treatment period exceeds the stability period. It is more practical to dispense the whole treatment (as a powder) in one go
- Some people collect their suspension during the day (in a pharmacy close to their workplace) but are then unable to keep it in a refrigerator before returning home
- Dispensing errors with suspensions lead to wastage, as there is no going back to the powder once water has been added
- If the antibiotic is dispensed in powder form, patients have peace of mind knowing that it has not been tampered with or contaminated

Minh-Loc Truong
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Letters to the editor

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

■ PACKAGING

Patients and pharmacy staff being put at risk

From Dr C. Green, MRPharmS

I am disappointed by the reply to my previous letter from Bruce Charlesworth (*PJ*, 1 April, p383). It is as patronising as it is predictable and I doubt that there are many of my colleagues who will have failed to note this. As a health care professional, never mind a pharmacist, I find the suggestion that I am trivialising or dismissing the importance of counterfeit medicines as offensive as it is inaccurate.

Dr Charlesworth likens my letter to one published on 3 December 2005 (p686). This letter refers to the number of methotrexate tablets supplied to patients and does not mention the appearance of packaging. The only similarity between the two letters is the dismissive and patronising reply from the manufacturer. Although medicines are not the same as average consumer products, and I thank Dr Charlesworth for alerting me to that, Walkers Crisps are a classic example of retaining a strong brand image, while differentiating between products. However, its handling of salt and vinegar, and cheese and onion crisps does teach us a salutary lesson about colour coding. Pfizer is subject to the same packaging restrictions as every other pharmaceutical company so if some manufacturers can address these issues, why cannot all of them? Dr Charlesworth suggests it is important to have packaging recognisable as a Pfizer product — fine, but please, can we have it with some noticeable differences between products?

I can tell him of one patient who was prescribed amlodipine 12mg daily due to a doctor becoming confused by the similar packaging of amlodipine 10mg and doxazosin 2mg. Because this was a rather obvious error, it was spotted and dealt with. Had the patient been taking another Pfizer product with a dose in multiples of 10mg, the patient might have been the subject of a serious prescribing or medication error. Another patient was the subject of a dispensing error, where 150mg of fluconazole was dispensed instead of 50mg, largely because these products, with near identical packaging, were next to each other on the shelf. I am certain that pharmacists across Britain and, thanks to the “global brand essence”, pharmacists all over

the world can recount similar stories. As a result of this and similar incidents, there is a trend to rearrange storage of a number of manufacturers' products because it is not safe to store them in traditional order.

Dr Charlesworth describes Pfizer as an ethical company. I would ask him how ethical it is knowingly to expose patients to these risks, day after day, in country after country for the sake of a blue and white global brand essence. And if that branding is not about encouraging and promoting the use of Pfizer products and therefore profits, what is it about?

We often see letters and reports in *The Pharmaceutical Journal* lauding the role of pharmacists as the custodians of the nation's medicines, and as the protectors of patients against the harmful effects of medicines. It saddens me that we have known about the effects of poor packaging for well over a decade but, as a profession, we have never stood up and been counted when it comes to doing something about it to the point of effecting change. I urge my fellow pharmacists to register and join the debate at the National Patient Safety Agency website at www.saferhealthcare.org.uk and make their feelings known about packaging that puts patients' health, patients' lives and, potentially, the reputation and livelihood of pharmacy staff at risk.

Chris Green

Director of Pharmacy and Medicines Management
Countess of Chester NHS Foundation Trust

■ MEDICINES USE REVIEWS

We should not berate ourselves

From Dr D. Petty, MRPharmS

I do not think that we should be berating ourselves for not doing six-monthly medicines use reviews on people aged 75 years and over, who are taking four or more medicines (*PJ*, 1 April, p373). GPs, with the help of practice pharmacists, have made great strides in improving the number and quality of MURs. The Medicines Management Collaborative and organisations like the Medicines Partnership have moved MURs into the consciousness of most GPs and most patients now get an annual review — a great improvement on only a few years ago.

The national service framework's target of carrying out six-monthly reviews with people prescribed four or more medicines has never been evidence-based and represents a huge workload for primary care professionals. GPs, practice pharmacists and community pharmacists (doing MURs) would make better use of their time in concentrating on those patients who need more frequent reviews. These include, for example, vulnerable older people (eg, living on their own), “frequent flyers” (those who have unplanned acute hospital admissions) and those experiencing problems with their medicines, eg, non-adherence and adverse effects. Carrying out an MUR with “Mrs Smith” who is prescribed paracetamol, aqueous cream, multivitamins and senna may score points with the Department of Health but it is “Mr Jones”, who has just had a myocardial infarction and has only been prescribed a glyceryl trinitrate spray and aspirin, who would benefit most from a clinical MUR.

Duncan Petty

Practice Pharmacist, Bradford, and
Lecturer School of Healthcare,
University of Leeds

■ SMOKING CESSATION

Pharmacists have a proactive role

From Ms M. Armstrong

PharmacyHealthLink would like to clarify the situation regarding National Institute for Health and Clinical Excellence guidance as reported in *The Pharmaceutical Journal* (8 April, p409).

PharmacyHealthLink has concerns that this guidance does not reflect pharmacists' proactive role in smoking cessation, for instance, pharmacists raising the topic of smoking when someone is asking for a cough medicine.

Although we recognise — as quoted in your report — that NICE is supportive of the reactive role of pharmacists in smoking cessation, eg, giving advice on stopping smoking to someone purchasing nicotine replacement therapy — this is only part of the role that pharmacists' play in helping people to stop.

Not only does the NICE guidance not reflect pharmacists' proactive role in advising on health issues under the new contract, it also potentially reduces the

Telephone number

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

effectiveness of future mass media interventions. Public awareness campaigns such as the Government's Stop Smoking and No Smoking Day campaigns require the support of pharmacists and other health care professionals (such as dentists) to raise awareness proactively and to encourage people to quit smoking in order to maximise effectiveness.

We think that the confusion may arise from the use of the word “opportunistic”, which most people interpret as meaning both proactive and reactive. But the NICE guidance only endorses the pharmacists' reactive role. We understand, however, that NICE is now reconsidering this specific issue and will respond to us shortly.

Miriam Armstrong

Chief Executive
PharmacyHealthLink

■ STATISTICS

Risk reduction figures should be explicitly clear and differentiated

From Mr J. Bland, MRPharmS

The **Broad spectrum** article by Chris Brewer (*PJ*, 11 March, p290) summed up perfectly the practice in the NHS of prescribing drugs, such as the statins, to benefit society as a whole, as opposed to guaranteeing benefit for any one individual patient. In order for a patient to make an informed choice, as to whether or not to take preventive treatment, the pros and cons need to be clearly stated and understood by the patient. To this end, risk reduction figures where available can be quoted and discussed between prescriber and the patient.

This sounds simple enough but unfortunately it is not. The reason for this is that risk reduction figures can either be stated as absolute risk reduction (ARR) or relative risk reduction (RRR), there being a world of difference between these two statistical terms. In general, RRR figures are much higher than ARR figures, so if a patient is presented with the RRR as opposed to the ARR this will undoubtedly have an influence on the patient's decision-making

process. In my opinion it is the ARR which should be quoted to the patient, because it is the most easily understood and the most clinically relevant.

In Mr Brewer's article it is an ARR (of 2.4 per cent) that is stated as well as the equally understandable number needed to treat (NNT), which is the inverse of the ARR. Now contrast how Mr Brewer presented his argument, with issue number 21 of *MeReC Extra*, which reviewed the National Institute of Health and Clinical Excellence appraisal of statins. MeReC states that statins "significantly reduce cardiovascular morbidity and mortality by between 20 per cent and 30 per cent". No mention was made that this was indeed a relative risk reduction so, statistically, this statement was meaningless. To a lay person though, or even to a health care professional not attuned to the niceties of statistical percentage statements, quoting a reduction in death or disability of 20–30 per cent would be taken at face value as just that.

Is it asking too much for all reputable publications, including the *PJ*, to make explicitly clear when quoting risk reduction figures whether it is an RRR or an ARR being stated? Perhaps the *PJ* could make it a policy always to state, if it is known, the ARR and NNT figures for future trial results that it publishes, so that everybody, patients and health care professionals alike, can easily understand the significance of the results.

Jonathan Bland
Specialist Clinical Pharmacist
Newark Hospital, Nottinghamshire

STATINS

Pharmacists need to see through the spin

From Mr C. F. Brewer, MRPharmS

Although I welcome Jim Smith's contribution to the debate on primary prevention with statins (*PJ*, 1 April, p382), I am left feeling that he did not actually acknowledge any of the issues raised by my **Broad spectrum** piece (*PJ*, 11 March, p290).

Pharmacists are aware of the benefits of statins; we cannot open a newspaper without learning about the latest breakthrough. What we do not need is spin. I was disappointed with the way in which Professor Smith quoted some impressive statistics while

omitting to mention any of the less favourable findings from the same study.

The meta-analysis commissioned by the National Institute of Health and Clinical Excellence did produce myocardial-infarction reduction figures that were of (borderline) statistical significance.¹ However, the same analysis found that there was no significant decrease in total mortality, cardiovascular mortality, coronary heart disease mortality, stroke mortality, non-fatal stroke, unstable angina and revascularisation. These were surely equally important findings and may indicate that we need to do more research before we start expecting 3.3 million healthy people to change their lifestyle.

The Canadian analysis cited by Professor Smith uses the simple expedient of extrapolating a small treatment benefit to a large population, making the number of lives saved look positively heroic.² Had the analysis been performed in China, the figures would look even better. These types of headline statistics are of no relevance to those of us who treat one patient at a time.

Professor Smith unwittingly reinforces my message that a gulf exists between the objectives of the health establishment and the health care needs of real people. Our patients are capable of making informed choices, provided they are given relevant information in a form they can understand.

Chris Brewer
Medicines Information Pharmacist
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1. National Institute of Health and Clinical Excellence. Cardiovascular disease — statins. Technology Appraisal 94. London: NICE; 2006.
2. Manuel DG, Lim J, Tanuseputro P. Revisiting rose: strategies for reducing coronary heart disease. *BMJ* 2006;332:659–62.

DRUG MISUSE

Clarification regarding certificate course

From Mrs D. K. Roberts,
FRPharmS

Best practice guidance, produced by the National Treatment Agency for Substance Misuse, on the commissioning of pharmaceutical services for drug misusers, is most welcome and timely (*PJ*, 1 April, p378).

I would, however, welcome the opportunity to clarify part of the information included in the feature. I refer to the Royal College of General Practitioners certificate in the management of drug misuse that was completed by pharmacists taking part in the Lewisham local pharmaceutical services pilot scheme.

The open learning pack — "Opiate treatment: supporting pharmacists for improved patient care" from the Centre for Pharmacy Postgraduate Education is not an integral part of the RCGP certificate as suggested in the news feature. At the time that the Lewisham pharmacists undertook the RCGP certificate, pharmacists wishing to undertake part 2 of the RCGP certificate were able to claim exemption from part 1 provided that they were able to prove recent completion of the CPPE's open learning pack.

It is expected that e-learning modules for part 1 of the RCGP certificate will be accessible to pharmacists, nurses and GPs later this year. From then on pharmacists wishing to undertake part 2 of the RCGP certificate will have the choice of either completing the part 1 of the RCGP certificate online, or claiming exemption by providing proof of completion of the new CPPE open learning package on drug misuse.

Kay Roberts
Lead Pharmacist
Royal College of General Practitioners' Substance Misuse Unit

AGENDA FOR CHANGE

Inequity still exists around the UK

From Mr R. Clarey, MRPharmS

Agenda for Change is a Government-led policy to create a level playing field in the pay structure of the NHS, by setting a national standard of pay for people carrying out the same job. However, a structure that has worked well in pharmacy for the past decade is now being turned upside down by local trusts setting their own pay levels.

I have spoken to pharmacists in both primary and secondary care and it appears that a number of people are finding that with their new pay band their salary will be "protected" for the next two to three years.

This means that they will not even receive an annual cost-of-

living pay increase (ie, every year their pay, relatively, will go down).

Although this is intended to be a national scheme with everybody receiving the same pay for the same job, neighbouring primary care trusts and trusts are awarding staff a different "score" and, as a result, their achieved pay band may be one or two bands either side of that of the person carrying out the same role in the next trust.

I am aware of Whitley scale Grade E pharmacists being graded from a level 6 through to a level 8b. Those at the top of this scale may experience a pay rise, while those at the bottom have effectively been demoted and, as such, feel demoralised and are threatening to leave their posts.

Due to the inequity of the new scheme, there will be "black holes" within the NHS where pharmacists will not want to work due to low A4C banding in their region and higher banded posts being available elsewhere in the country.

This is not just happening to pharmacists; I am also aware of pharmacy technical staff in NHS trusts who are being graded together. There are instances of medical technical officer (MTO) 2 and MTO 3 staff being graded to the same band. In one trust this is comparable to a downgrading of the MTO 3, while in others it corresponds to a promotion for the MTO 2. With such a set-up, why would an MTO 3 wish to continue to carry on managing a department when their MTO 2 colleagues, whom they possibly trained, manage and appraise, will be earning as much as them while they have no opportunity to increase their own MTO 3 salaries?

With all of this going on and the PCTs and hospital trusts being reconfigured, morale in the NHS is starting to fall.

I would urge the Royal Pharmaceutical Society to carry out an inquiry into the pay of primary and secondary care pharmacists to establish the inequity across the country. There is the possibility of the situation of the early 1980s being repeated, when the pay and conditions between the retail and NHS sectors led to a staff shortage in the NHS.

Richard Clarey
High Peak, Derbyshire

E-mail
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 PALLIATIVE CARE

Pharmacists can be an asset to a local hospice

From Mr N. Baumber, FRPharmS

I was pleased to see palliative care in the community being highlighted by Clare Amass in her excellent introduction to the Gold Standards Framework (*PJ*, 25 March, p353).

Community pharmacists can, and do, offer a lot of support to their own patients who are suffering from incurable illnesses and they can also be an asset to their local hospice. My own involvement has been with a hospice charity providing general and supportive palliative care. Our policy has been to accept patient self-referral and referral from carers and families, and not just to wait for medical referrals. Even so, I find that referrals to hospice care are coming later and later and therefore missing the opportunity for anyone to help except *in extremis*.

This may be a local failure in communication but part of the problem is also the tendency for the Government to narrow the definition of palliative care to the last few weeks of life in order to reduce the budget. For someone who is diagnosed with breast cancer, who is at first traumatised, then treated and eventually deemed cured, the process can take up to six years not six weeks. The public perception of a hospice may be as unhelpful to the people who need it as the stereotype of dispensing is when it is misrepresented as the counting of tablets from one box to another.

Specialist care is an essential pinnacle of hospice care but it is applicable to a relatively small number of patients. The whole point of the hospice movement, however, is that support and facilities should be made available from the earliest moment after diagnosis so that the patient and family can benefit from the many agencies that are available to help. Respite beds, day care, hospice at-home services, bereavement counselling and voluntary help can make a world of difference at the right moment if a rapport has been established and the psychological barriers removed by an early introduction.

Depending on what is available in your locality, community pharmacies could become an ideal location for introductory information, leaflets, displays and even referral to hospice services if

the patient so wishes. I hope pharmacists will be moved to broaden their knowledge of local hospice and palliative care services, become involved in fund-raising or even offer their services as trustees. Their help will always be welcomed and much appreciated, especially if that interaction results in earlier referrals.

Noel Baumber
Grantham, Lincolnshire

 THE SOCIETY

Why may I not use my PhC title?

From Mrs D. M. Apps, MRPharmS

I have been in correspondence with the legal department of the Royal Pharmaceutical Society and I have been advised that, should I retire from membership of the Society, I will be unable to use the title "PhC" because it is a restricted title under The Medicines Act 1968.

Although I can accept that I would no longer be able to use the title "MRPharmS" (unless I remain on the Register as a non-practising member and I qualify the title), I find it difficult to understand why the title "PhC" should be any more restricted than that of my colleagues with degree qualifications, eg, BPharm or BSc (Pharm), which I understand can be used with no restrictions, whether or not the holder remains on the Register.

I believe that either all the pharmaceutical qualifications should be similarly restricted or the conditions of the Medicines Act 1968 should be reviewed so that the title of "pharmaceutical chemist" is no longer a restricted one. Without membership of the Society and the title "MRPharmS", surely the qualification of PhC would only be recognised by those who are aware of its existence, and the general public, whom the Medicines Act sought to protect, would not make any association with a practising pharmacist.

The legal department has been unable to offer any satisfactory explanation for the anomaly and gave no reason why the degree qualifications should not be similarly classified as "restricted".

I realise that the number of members with my qualification is dwindling, but I would be interested to hear the opinions of others who may agree with me that their Society would appear to

be penalising those members who hold the Society's own qualification.

Diana M. Apps
Weymouth, Dorset

PHILIP GREEN, deputy secretary and registrar, Royal Pharmaceutical Society, replies: The Medicines Act 1968, Section 78, restricts the use of certain titles. Section 78(5)(a) states that no person who is not a pharmacist shall take or use any of the following titles, that is to say, pharmaceutical chemist, pharmacist, member of the Pharmaceutical Society and Fellow of the Pharmaceutical Society. As Mrs Apps states, the PhC is not a degree which would have a free standing status. PhC is a recognised abbreviation of pharmaceutical chemist — as such it is a designation, not a degree, is encompassed by the Medicines Act, and cannot be used by anyone who is not on the Register.

Fitness-to-practise agenda could be damaging to the public and the profession

From Mr M. Koziol, MRPharmS

Graham Southall-Edwards (*PJ*, 18 March, p322), Gordon Appelbe (*PJ*, 4 March, p264) and others have expressed concern about the relentless focus on what has become known as the fitness-to-practise agenda. The idea seems to be that if the Royal Pharmaceutical Society can be a tough regulator, then not only will it be seen in a good light by the Council for Healthcare Regulatory Excellence, but it will also benefit patients throughout the land.

In some respects this focus on regulation may actually be against the public interest and could yet prove to be the undoing of the Society for a number of reasons:

- While the inspectorate is spending so much of its time on formal PACE (Police and Criminal Evidence Act) interviews and heavy-duty investigations of so many less-than-serious matters, few of them are finding the time to advise, support and generally help pharmacists in the practice of their profession as they used to only a few years ago. This is surely to the detriment of the profession and the public.
- These days, increasing numbers of pharmacists who have previously had an unblemished

record are being embroiled in unpleasant and lengthy Society investigations. Often, this is motivated by nothing more than a patient who is pursuing a compensation claim or even because the patient considers that the pharmacist has been rude to him. Worryingly, this process has the effect of creating a disproportionately high level of stress on the professional and personal lives of these pharmacists. We are aware that subsequently some of these pharmacists choose to cease practising or even to leave the profession altogether. This results in the loss of decent, hard working and experienced practitioners at a time when they are desperately needed by the profession and public alike.

- It may be that the Society will split into two — one side membership and the other side regulation. If this were to occur, and if the Government were to take on regulation, then membership of the Society could become voluntary. In such an instance, I wonder how many pharmacists would contemplate joining a body that hitherto took them to task so severely?

The Society would serve the public's interest much more effectively if it focused on helping pharmacists to improve their practice. There are plenty of areas where the Society's attention would deliver immediate benefits to the public, such as tackling the dangers of inadequate staffing levels in community pharmacies or, in our view, lobbying the Government to stop the Health Act proposal to allow a pharmacy to operate in the absence of a pharmacist. These are the types of issues that will make an immediate and tangible difference to patients.

Many of the health care professional bodies have, rather like rabbits caught in headlights, been unable to challenge some of the less sensible aspects of the Government's tough stance on regulation due largely to the impact of the actions of one man — Harold Shipman.

I hope that it will not take too long for them to galvanise their thinking and articulate a simple truism — a tough regulatory mantra is no substitute for a well-developed, supportive and positive practice support agenda.

Mark Koziol
Chairman
Pharmacists Defence Association