

■ COMMUNITY PHARMACY

Community pharmacists need access to patients' medical records

From Dr N. Kometa, MRPharmS

I read with interest the letters of Gordon Appelbe and Stephen Potter (*PJ*, 27 January, p105) regarding to the case of *Horton vs Lloyds Pharmacy Ltd 2006*. They made me think about some of the shortcomings of community pharmacy practice.

When assessing a prescription, as stated in the Royal Pharmaceutical Society Code of Ethics, most pharmacists will generally use their knowledge, experience and reference sources, and then contact the prescriber if there is any ambiguity with the prescription. However, community pharmacists do not have the primary and essential piece of information they need at hand to undertake a complete professional assessment of a prescription presented for dispensing for that particular patient, namely, the patient's medical notes, which may include the consultation, diagnosis and medicine(s) prescribed and the rationale behind it.

I assert that the professional assessment of a prescription will never be complete for as long as community pharmacists do not have access to patients' medical records. Because no two consultations are the same, neither is dispensing.

There are fundamental flaws, therefore, that underpin and permeate the practice of community pharmacy. These flaws include the lack of access to patient medical notes (as stated above), the lack of a requirement to disclose the indication for prescribed medicines, and high-volume dispensing with its resultant time pressure and minimal patient contact.

In practice, it is not always possible to contact a prescriber if needed, as any community pharmacist will testify. Therefore, I ask pharmacy's representative bodies, including the Society, the National Pharmacy Association, the Pharmaceutical Services Negotiating Committee and the

Pharmacists Defence Association, to recommend to the Department of Health and all the health authorities and boards to arrange for community pharmacists to have access to a patient's medical notes when dispensing a prescription for that patient.

Prescribers' computer systems should also be redesigned or the software modified to include a brief indication for the medicine.

There is no doubt that the implementation of electronic transfer of prescriptions across the NHS has presented pharmacy representative bodies with an unprecedented opportunity to put forward a strong case to enable pharmacists to have access to patients' medical records at the point of dispensing so that they can provide the duty of care to each individual patient as required of them by law.

Nsanyi Kometa
Birmingham

Subscribe to journals and keep up with informed patients

From Mr R. I. Dunkley, MRPharmS

Your article about patients accessing the internet for health problems and then going to their pharmacist or doctor with their results was thought-provoking (*PJ*, 3 February, p143).

I applaud efforts by pharmacists to access the internet when helping patients, but have they considered accessing the various online issues of the major medical journals?

If they were to go to Medline, as I do, as a first stop, then there is a good chance that the paper required is in one of these major journals. However, when the link to the journal is followed, unless the enquirer is a subscriber, all he or she will get is the abstract of the paper.

Papers can be ordered from the Royal Pharmaceutical Society's library at a cost. Thus I was spending a great deal of money to obtain papers to help my patients. I then discovered that an online subscription to the major medical journals would save much money. I currently subscribe to the *BMJ* (£24), *The Journal of the American Medical Association* (£50), *Archives of General Psychiatry* (£53), *The New England Journal of Medicine* (£34), *The American Journal of Psychiatry* (£54), and *The Lancet* (£103). Yes, the figures appear huge, but if we are going to provide an

information service to our patients, then it is worth it. We would get access to the complete content of the journals, and we could download as many papers as we want.

Bob Dunkley
Community Pharmacist
Dewsbury,
West Yorkshire

Where is the funding for the PSNC's low-volume LPS?

From Mr D. R. Kent, MRPharmS

Your report of the "off-the-shelf" low-volume local pharmaceutical service (*PJ*, 3 February, p124) cannot pass without comment. In the opinion of those who have been striving to get fair pay for low dispensing volume pharmacies (LDVPs) this proposal is no more than window-dressing by the Pharmaceutical Services Negotiating Committee, which is fully aware that this proposal requires funding by primary care trusts — and therein the problem lies.

PCTs have little or no cash even to continue many recent, and in some cases long-standing, commissioned services from pharmacy contractors and have firmly stated that support of LDVPs from their available funds is not possible. What the PSNC has done is to seem to be acting — but to ignore this blatantly obvious fact. It has been brought before the committee time and again over the past two years that funding outside the new community pharmacy framework will never be achieved; the committee chooses to ignore this.

You may wish to ponder that no other primary health care negotiating body has ever sought to disadvantage their weaker members.

These are my personal views and do not necessarily represent those of any organisation with which I may be associated.

David Kent
London

SUE SHARP, chief executive, Pharmaceutical Services Negotiating Committee, responds: Mr Kent is unduly pessimistic. One PCT has already contacted the PSNC to express interest in this proposed local pharmaceutical service.

■ PFIZER PROPOSALS

Protest in the name of the environment

From Mr W. J. Parsons, MRPharmS

At present the pharmacy in which I work has two deliveries a day from my local wholesaler. If the proposals made by Pfizer (and likely to be copied by other big pharmaceutical companies) come to fruition, I may expect to receive as many as 10 deliveries a day. Nationwide, this will result in tens of thousands of absolutely unnecessary journeys every day with consequent damage to the environment. May I use your columns to ask every pharmacist concerned about the environment (all of us, I hope) to raise this issue with their MP and to oppose these proposals?

John Parsons
High Peak, Derbyshire

Letters to the editor

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

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

Telephone number

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

■ COPD

Give COPD the priority it deserves

From Mr P. Jerram, MRPharmS, and Ms S. Kearney

Chronic obstructive pulmonary disease (COPD) is a major drain on NHS resources. It was responsible for 1,152,023 bed days in England in 2005 (when these patients were the third largest group of bed users). It is currently the fourth biggest killer in the UK and it is predicted that by 2020 it will be third in the leading world-wide cause of death from chronic disease.

There are two key changes occurring in the NHS in England that make the management of COPD more important than ever before: payment by results (PBR) and practice-based commissioning (PBC). PBR is a new finance system for paying hospitals that was first introduced in England in 2003 and was greatly expanded in April 2006. It is important for primary care because it makes it possible for primary care trusts and GPs to disinvest from hospitals for the first time; if a patient is not admitted, the GP does not pay the hospital. Under the old financial system it was extremely difficult to do this.

PBC, where clusters of GP practices opt to hold the budget for prescribing and hospital care, was first introduced in April 2005 and now nearly 90 per cent of GP practices are involved. PBC is important because GP clusters that save money on their budgets can reinvest these savings into additional patient care.

The Health Care Commission report on COPD in June 2006 said that a good deal more could be done to diagnose and effectively treat COPD. Furthermore the Department of Health announced that it was commissioning a national service framework for COPD, although this is not due for publication until 2008.

We believe that now is the time to work with colleagues to ensure COPD is given the priority long

since afforded to cardiovascular and mental illness and that PBR and PBC offer the levers to make this happen.

Paul Jerram
Head of Medicines Management
Sarah Kearney
Respiratory Nurse Specialist
Isle of Wight Primary Care Trust

■ STATINS

There is evidence that switching statins has consequences

From Mr J. L. Woodward, MRPharmS

In a previous letter (*PJ*, 23/30 December 2006, p767), I stated that Brian Curwain was only interested in saving millions of pounds for the taxpayer, patients' quality of life being secondary. This referred to him not only advocating the changeover of patients from atorvastatin to simvastatin, but also asking community pharmacists to support him in his quest. I also posed the question as to whether or not there was sufficient evidence to show that the lifespan of patients undertaking such a change in medication would not be decreased or affected in any way.

May I refer him to the correspondence in *The Lancet* of 6 January, where Rob Butler and James Wainwright, from the department of cardiology, University Hospital of North Staffordshire, Keele University, categorically state that such a procedure is purely for fiscal reasons and increases the morbidity and mortality of patients with cardiovascular disease. Despite clinical objections, the local primary care trust and the national health care trusts imposed this changeover on the physicians.

Intervention of this nature is completely unjustified with it being against the wishes and recommendations of the consultant cardiologists. Has the North Staffordshire PCT advised other PCTs of this important finding — cardiac readmissions nearly doubled and deaths increased by more than three-fold? Personally, I do not find the reply from Dr Curwain greatly convincing and pose the question as to whether or not such decisions should lie in the hands of the PCTs. That role surely should be left in the hands of health care professionals.

John L. Woodward
Stafford

■ COMPLEMENTARY MEDICINE

Need for research into safety and efficacy

From Professor E. Ernst

The article on frequently asked questions about medicines was most revealing (*PJ*, 3 February, p140).

In particular, I was surprised how many of these questions relate to complementary and alternative medicine (CAM). This indicates a level of uncertainty which, I think, needs addressing by adequate research and reliable information. Sadly neither is being pursued at present by the UK government.

In 2000, the House of Lords issued a report on CAM which recommended more research, primarily of the safety and efficacy of CAM, and better information for all concerned.¹

The Government did not follow these recommendations. Instead of rigorous research into safety and efficacy issues, it initiated several PhD projects mostly on the sociology of CAM.²

Instead of adequate patient information, it funded a patient guide, which reads like a promotional brochure for CAM and tells us nothing about efficacy and little about safety. In fact, a draft of this guide did contain some rudimentary efficacy data. They were, however, omitted in the final text.

The Department of Health later claimed that such information was never part of the contract with the Prince of Wales Foundation for Integrated Health, the organisation responsible for the guide.

Wills and Campbell have convincingly demonstrated that questions about CAM are among those most frequently asked by patients. Is it therefore not time that the DoH helps us to get in a position from where we can answer them reliably?

Edzard Ernst
Director of Complementary Medicine
Peninsula Medical School
Exeter

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1. House of Lords, Science and Technology Committee Sixth Report. 2000.
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■ NHS

What is wrong with patient-centred, individual care?

From Mr G. Mileusnic, MRPharmS

Having read the item regarding the Community Pharmacy Wales advice on seven-day prescriptions, which includes the words "colluding" and "fraud" (*PJ*, 20 January, p67), it makes me wonder yet again about the actual point of the NHS and in particular community pharmacy.

How the word "fraud" can be used for issuing seven-day prescriptions instead of one 28-day prescription evades me. How the work of collecting, dispensing four times, and delivering four seven-day prescriptions can be construed as non-NHS work also evades me. Surely the whole point is that this is delivering the best care by the GP and pharmacy.

Working closely with GPs, district nurses and social services, I have carried out this practice for a number of years. The real benefits to patients are clear for anyone who cares to be involved. Yes, "real benefits to patients". I do realise this seems to be an old fashioned way of looking at health care but it is the way it should be viewed.

Compliance is checked weekly, as is the health of the patient, since the same trained member of staff goes each week. This is patient care.

To address what is clearly the most important issue to bureaucrats, namely money, the benefits are so obvious I think perhaps I am the one missing something. When a monitored dosage system is started several carrier bags of medicines are removed from patients' houses. Vast amounts of stockpiled medicines in their original dispensing bags are collected. Patient compliance is clearly almost nil. Huge amounts of NHS funds are wasted daily in over-prescribed medicines. People stockpile — that is a fact. If they only receive one week's supply each week, stockpiling ends, immediately saving large amounts of money and time in prescribing and issuing unnecessary prescriptions. The health of patients usually improves since compliance improves. Hospital admissions decrease for the same reasons.

We notify GPs and district nurses if problems with patients occur since we know our patients and work together with colleagues. Take, say, a three-item prescription. Yes, we get three fees, but for this

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we supply the MDS, fill it, check it, deliver it, check compliance, talk to the patient and, if necessary, discuss their case with colleagues. Is this not clinical governance?

So how does this service not seem effective? How can it be described as fraud? The savings in stockpiled medicines alone will pay for this service many times over.

Patient-centred individual care. What is wrong with that?

George Mileusnic
Batley, West Yorkshire

PHYSICIAN-ASSISTED SUICIDE

People can use living wills to make their wishes known

From Mrs R. B. Arnold, MRPharmS

There have been several correspondents voicing concern over the ethical dilemmas for pharmacists who may be faced with physician-assisted suicide. I agree that this concept of health care does not sit easily with some, and that the Royal Pharmaceutical Society should promote a conscience clause for those who do not wish to dispense medicines for this purpose. As far as I am aware this has worked for those who do not wish to supply medicines in other circumstances that provoke ethical dilemmas. I think it is important that the Society takes its members' views into consideration and does not force them to act against their consciences.

However, I think that Mark Donaghy (*PJ*, 3 February, p133) takes opposing views to physician-assisted suicide to an extreme. He states that "the Society should make a clear policy decision to make a political stand stating that pharmacists, as the guardians of the nation's medicines, object to the use of pharmaceuticals for intentionally killing patients". I think this attitude is wrong. Surely this would be seen as imposing a view with no alternatives, which may not be supported by all pharmacists.

We have all seen changes in views to ethical dilemmas over the years. I think that the concept of physician-assisted suicide is, and will be, one of them. As with abortion, there will always be those who feel strongly for or against it.

A few years ago it was rare for "living wills" to be made, but they are now considered more frequently. Living wills allow individuals to make decisions about their health care in advance, in case

they ever are incapacitated and unable to do so. It allows a competent adult to direct the provision, withholding, or withdrawal of life-prolonging procedures in the event that such person has a terminal condition, has an end-stage condition, or is in a persistent vegetative state. A life-prolonging declaration can also be included.

For those who have experienced the severe decline in health, with associated physical and mental distress, of one who is dear to them, physician-assisted suicide would perhaps be less of a contentious issue. I do not think that it is a decision that should be taken lightly and as pharmacists we need to review the topic from all angles, as I am sure other health care professionals will.

Rosemary Arnold
Derby

Let PAS not be swept under the carpet

From Mr A. Plumridge, MRPharmS

I should like to respond to Mark Donaghy's letter (*PJ*, 3 February, p133) and Anthonia Chalmers's reply (*PJ*, 10 February, p164).

My father died from non-Hodgkin's lymphoma at 49 years of age. During his last week of life he asked me to get him "a splatter gun to stop the pain from his cancer and help him on his way". I found myself extremely torn, as you want to do anything for your parents, and yet obviously I could not comply with his request.

Consequently, I believe I have an insight into physician-assisted suicide (PAS) from both the viewpoint of a professional and as a relative. PAS is something that we need to tackle, discuss and, if it ever happens, draw up appropriate guidelines so that medical professionals have the opportunity to opt out of contributing to the event. Legally this will be a minefield and loopholes will no doubt be exposed. People will be taken advantage of — doctors and pharmacists included — and, if they are, they must not be vilified.

A blanket "yes or no" answer at present is not enough on this matter. The more PAS is spoken about, the more it will be debated and this debate can only be a good thing. There are certain European countries where PAS is already legalised. If the current situation continues, people who decide to end their life by PAS for whatever reason will continue to go abroad.

Their decision will be sensationalised by the media and scorned by some, and the police may want to become involved, as has happened previously. I realise that I do not have all the answers. However, PAS does need to be talked about and must not get swept under the carpet.

Adam Plumridge
Cheltenham, Gloucestershire

I have to act according to my conscience

From Mr S. J. Lewis, MRPharmS

I write in response to Anthonia Chalmers's letter (*PJ*, 10 February 2007, p 1648) regarding physician-assisted suicide.

Although I sympathise with the intention behind her views, ie, the relief of human suffering, I cannot agree with her premise that pharmacists and other health care professionals should only act in the best interests of the patient.

I have spoken to people who work in hospices, who say it is only in relatively rare circumstances that a patient experiences intolerable suffering. The hospice movement and others have made tremendous advances in pain control and palliative care.

Also, for those of us who have a theistic faith (as well as many others who do not subscribe to a particular faith), the sanctity of human life takes precedence over actively helping a patient to die.

Although I may be accused of being unsympathetic, I have to act according to my conscience before God. Consequently, I am totally opposed to physician-assisted suicide and would hope that the profession as a whole would not support the deliberate killing of a patient. At the least, a conscience clause for health care workers must be included in any proposed legislation regarding physician-assisted suicide.

Simon J. Lewis
Hove, East Sussex

PRESCRIBING

PCT prescribing policy and national guidance

From Mr C. J. Daly, MRPharmS

In my letter published in *The Pharmaceutical Journal* of 21 October 2006 (p481) I asked why local NHS bodies sometimes say

the opposite of national bodies? My concern was around escitalopram and the fact that in many parts this drug is on a "less desirable list" even though the Scottish Medicines Consortium has approved it and the National Institute for Health and Clinical Excellence includes selective serotonin reuptake inhibitors in its guidance on anxiety.

My proposition was that the behaviour of local bodies was sometimes contrary to advice given by national bodies because the local body is less able to take into account total health and social care costs and, in some cases, still views budgets individually.

I think this issue is worthy of broader debate and would welcome the views of colleagues through the letters pages of the *PJ*.

Cathal Daly
Head of Medicines Management
Norfolk Primary Care Trust
(Southern)

NORTHERN IRELAND

All-Ireland rather than UK relationship may be better for PSNI?

From Dr B. P. Leddy, MPSI, MRPharmS

I would like to reply to Stephen Montgomery's letter about the future of the Pharmaceutical Society of Northern Ireland (*PJ*, 3 February, p133).

Speaking from a Republic of Ireland perspective, it seems to me that he has a somewhat blinkered view of how pharmacy on the island of Ireland could be organised in the future.

The Good Friday Agreement introduced the concept of parity of esteem into Northern Ireland, which previously did not exist. I would like to see much closer links between the PSNI and the Pharmaceutical Society of Ireland, and the development of either cross-border or all-Ireland initiatives, which may include a formal relationship between pharmacists in Northern Ireland and in the Republic of Ireland.

We have cordial and friendly relations with our northern counterparts, who might be better served in a north-south relationship than an east-west arrangement.

Bernard Leddy
Lismore,
Co Waterford,
Ireland

■ MEDICINES RECYCLING

Code of Ethics change could help poor countries

From Mrs P. E. Bradshaw, MRPharmS

The Royal Pharmaceutical Society is now holding consultations on a new code of ethics for pharmacists and pharmacy technicians (see www.rpsgb.org/protectingthe-public/ethics).

On the new draft sale and supply of medicines document, comments are invited from pharmacists, technicians and members of the public if anything needs to be added or removed. In this document paragraph 2(e) states: "Medicines returned to a pharmacy from a patient's home, a nursing or residential home must not be supplied to any other patient."

If this paragraph 1.8 were to be reworded to allow pharmacists to give patient-returned medicines to licensed, reputable humanitarian organisations it would help save landfill and incineration costs and pollution and give access to medicines to millions of the poorest people in the world.

Inter Care is a humanitarian registered charity based in Leicester that has been recycling returned medicines for 30 years and will soon apply to be licensed by the Environment Agency to be able legally to collect, sort and redistribute returned medicines from any source. Inter Care selects only medicines more than 15 months in date, in complete original packs and on the World Health Organization essential drugs list, or the essential drugs list of the recipient country. Regular parcels of free medicines have been sent direct by air to more than a hundred resource-poor, non-governmental primary health care clinics and hospitals serving over two million people in six anglophile African countries. Each project has personnel who are medically qualified to diagnose, prescribe and dispense. Medicines required are listed by individual project, all of which are visited and monitored by Inter Care.

More than a third of the world's population, mostly rural, cannot afford to buy, or have no access to even the most reasonably priced generic medicines. Government spending on drugs, including vaccines, is less than £3 a year in many African countries.

Readers who agree with me should respond to the consultation

by March 9, suggesting that Paragraph 1.8 be changed along the lines I have suggested.

Pamela Bradshaw
Derby

■ RETENTION FEES

Trailblazers should not be disadvantaged

From Professor C. A. Mackie, MRPharmS, and others

We would like to add our voice to the many letters and the *PJ* editorial (13 January, p36) expressing concern on the decision by the Royal Pharmaceutical Society that all qualified independent pharmacist prescribers must pay an annual fee of £35 to renew the independent prescriber annotation to their registration in addition to the one-off administration fee of £35 and their annual retention fee.

Those pharmacists who are undertaking prescribing programmes are trailblazers for the profession and should not be financially disadvantaged in this way. We are concerned that the decision of the Society to pass the administrative cost of maintaining a register to the individual pharmacist could act as a deterrent to other pharmacists who may be interested in undertaking the exciting challenge offered to the profession in the form of independent prescribing.

Like other correspondents we note that the Nursing and Midwifery Council charges new independent nurse prescribers a one-off fee of £25. The Health Professions Council does not charge for the annotation of its members as supplementary prescribers. Readers will also by now know that nurses pay an annual retention fee of £43 and allied health professionals registered with the HPC currently pay £60 a year. Doctors, who pay an annual retention fee of £290 to the General Medical Council, do not pay additional fees for recognition by the GMC of any specialist qualification.

We hope other pharmacists will join us in asking the Society to reconsider the decision to impose this fee as a matter of urgency.

Clare Mackie
Trudy Thomas
Fiona Stephens
Prescribing Programme Teaching Team
Medway School of Pharmacy
Chatham, Kent

■ RECIPROCITY

Recognition of British-registered pharmacists in the EU

From Mr J. Ferguson, FRPharmS

Andrew Husband makes important points in his **Broad spectrum** article "A solid foundation in science and practice is a must for the NHS's Future" (*PJ*, 27 January, p104). And, on the reasonable assumption that those involved in pharmacy education wish the qualifications of those who register as pharmacists in Britain to be recognised by the other 26 countries of the EU, they will have to ensure that courses continue to comply with the requirements of EU legislation.

The new "Directive on recognition of professional qualifications" (2005/36/EC) has to be incorporated into national legislation by 1 November 2007. If qualifications are to benefit from automatic recognition by other member states, they will have to meet the "harmonised minimum training conditions" included in the directive. In practice, these carry forward the corresponding provisions in the current "sectoral" directives for pharmacists.

Recital 25 in the new directive makes it clear that "holders of qualifications as a pharmacist are specialists in the field of medicines" and Article 44 covers "training as a pharmacist". Paragraph 3 of this Article states that "training for pharmacists shall provide an assurance that the person concerned has acquired the following knowledge and skills:

- Adequate knowledge of medicines and the substances used in the manufacture of medicines
- Adequate knowledge of pharmaceutical technology and the physical, chemical and biological and microbiological testing of medicinal products
- Adequate knowledge of the metabolism and the effects of medicinal products and of the action of toxic substances, and of the use of medicinal products
- Adequate knowledge to evaluate scientific data concerning medicines in order to be able to supply appropriate information on the basis of this knowledge
- Adequate knowledge of the legal and other requirements associated with the pursuit of pharmacy

These provisions can only be changed by going through the complete EU legislative process, involving the Commission, the Council of Ministers and the Parliament. It is unlikely that time will be devoted to such a measure in the foreseeable future. The new directive took more than three years from proposal to adoption.

The list of subjects to be included in the "course of training for pharmacists" is set out in Annex V.6 of the new directive. Apart from "legislation and, where appropriate, professional ethics" all of the subjects listed can, I believe, properly be described as scientific. There is no mention of pharmacy practice. The EU Advisory Committee on Pharmacy Education and Training, on which I was privileged to serve and to chair for some years but which has now been abolished, recognised that the list needed to be updated to adapt to what the directive describes as "scientific and technical progress" and presented appropriate recommendations to the Commission.

Under the old directives, change could only be achieved by going through the complete EU legislative process and the Commission had many other priorities. In fairness, the Commission did inform the then member states of the recommendations of the advisory committee for course development and they were implemented voluntarily by most member states. Under the provisions of the new directive, the list of subjects can be amended via a qualified majority in a committee of representatives of member states (civil servants), after the Commission has consulted "experts from the professional groups concerned" and provided "a reasoned report on these consultations" to the Committee. Thus, there is now the possibility of a faster track than previously.

However, unless circumstances have changed dramatically, and I have no reason to believe that to be the case, anyone who proposes a weakening of the science base of the course leading to qualification as a pharmacist for automatic recognition throughout the EU will encounter stern resistance. On the other hand, proposed developments to reflect "scientific and technical progress" to meet the needs of modern pharmacy practice are much more likely to be welcomed.

John Ferguson
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West Sussex