

■ WHITE PAPER

I beg the Council not to waste the chance but to raise their heads

From Mr P. J. Curphey, FRPharms

Despite the anguish of the past year and, in my view, the rudderless behaviour of the Royal Pharmaceutical Society's Council I am a subscriber to the "we are where we are" school of thought (*PJ*, 10 March, p268).

The way forward has been signalled. Indeed, more than that, it has practically been prescribed. Yet there is still no great appetite among pharmacists to offer views of how we should proceed.

It became clear some years ago, at the end of a careful analysis, that nearly all the work of the Society is capable of being interpreted as being regulatory (particularly in the context of the then description of a "modern regulator"), although there are important exceptions surrounding the branches etc. The activities of the proposed General Pharmaceutical Council are clearly defined and will be further clarified over the next weeks and months.

My concerns are over the so-called royal college model of the professional leadership body. It has been made explicit that this will not carry the trade union connotations of a representative body but rather will be representative of the profession and of practitioners in the practice of their profession, just as the Society is today.

A medical royal college is usually a repository of academic excellence. It attracts postgraduates and awards postgraduate qualifications, or it may have a slightly different route to membership rather like the Royal

College of General Practitioners. Is it likely that we in pharmacy can constitute that kind of college? Perhaps in tens of years we could, or we could start now with, say, 100 members and hope. A model like this would be unlikely to be sustainable unless there were a mandatory element to membership. In those circumstances it would lose its *raison d'être* of academic excellence.

What it seems to me we should be looking for, is an all-embracing, inclusive institution (maybe it should be called the royal institute of pharmacy — although, sadly, that abbreviates to RIP) which could attract all who have the interests of the profession of pharmacy at heart. In that way we could, at last, have something to offer pharmaceutical scientists, for example, whose academy could sit well inside an overarching body. Some of them are pharmacy graduates who see no need to register, but many of them are not. We might also reignite interest among academics who have felt undervalued within the Society.

It might be, too, that those who feel swamped by the generalist, community pharmacist majority could be given protected status within such an institute. I include, of course, the vital group of technicians.

I sense an expression of fear among pharmacists who believe that support staff have no place in our company. Is that because we have got used in community pharmacy to using such staff in a mundane way, requiring a "licking and sticking" pill counter instead of a strong right hand (try doing half a dozen medicines use reviews without brilliant support). If so, then we must think again.

The progress of hospital pharmacy and the acceptance of

pharmacists in the most senior positions within acute trusts owe much to the competence and confidence of a strong supporting team of technicians. They are the bedrock of a clinically oriented profession.

Or is it really that many pharmacists over the age of 35 do not actually see themselves ever being part of such a clinically focused team but as servants of the dispensing piece-work scheme called the NHS pharmacy contract?

Let those who want representation of their grouping for employment purposes form such groups. But those who have formed specialist groups because they believed that the Society could not or would not do it for them must be welcomed back into the fold in special compartments of the institute. It would represent them all professionally.

I suppose I am saying, in summary, let them all come: representative groups, specialist groups, employers and employees, pharmacists and non-pharmacists; all in fact who have helped to build and will continue to help to build our amazing profession. Whatever the outcome, it must be sustainable, remembering it may be voluntary, and must support its staff, in both salary and pension terms, who will be required both to service the new entity and represent that entity externally.

We have a real opportunity to raise our gaze from navel to horizon for a revelatory moment and grasp a change that has been offered to us on a plate.

I beg the Council not to waste the chance but to raise their heads.

Peter Curphey
Past President
Royal Pharmaceutical Society

It is just as much about principles and concepts as material goods

From Ms S. A. Wilcox, RegPharmTech

Jonathan Buisson asks, in his **Broad spectrum** article (*PJ*, 28 April, p484), "What are you going to bring to the royal college party for pharmacy?" and invites replies. First and foremost, both regulation and professional leadership must be centred on the patient. This is applicable to the whole of pharmacy in many areas, such as safety, service delivery and research. Of course, the resources that organisations bring to the table will help enable the delivery of professional leadership, but it is just as much about principles and concepts as material goods.

One of the greatest benefits of an inclusive royal college-type body would be partnership working. The processes involved in providing a safe and effective pharmacy service can be compared to a chain, which is only as strong as its weakest link. There is strong evidence that teams that have a common goal, that work closely together and in which all understand their part in the process, have fewer weak links. This is the primary reason for believing that a single royal college-type body for the whole profession is absolutely right.

So what will the Association of Pharmacy Technicians UK bring to the party on top of partnership working?

We are not a big association but we are committed and passionate about what we do. None of our national officers is paid but they all, voluntarily, put in long hours on behalf of the members they represent; such commitment would

Letters to the editor

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represent a considerable gain for a college.

APTUK is not rich in monetary terms, and does not have any buildings to bring to the party but it does have a bit of history, of which it is proud and certainly would not like to forget. Members are something that we do have, although I suspect that, like members of other organisations, our members will want to see what is on offer before they join a new body. APTUK has a quarterly journal and a well maintained website and these are its main communication media, allowing it to keep its membership well informed. Our national officers are drawn from all over the UK and from all sectors. They all have a significant amount of experience and expertise, both of which would be useful to a royal college for pharmacy. As for activism, we certainly have plenty of that. We have an annual four-day conference, which is open to pharmacists and is a successful event, attracting some excellent speakers.

Perhaps another element, not previously mentioned but an important part of any party, is reflecting on how successful it has been or how it could have been improved. APTUK is big on continuing professional development and has worked with the Royal Pharmaceutical Society to set up joint systems for recording CPD. APTUK is in the process of training a network of CPD facilitators and has been involved with the Centre for Postgraduate Pharmacy Education in running a string of CPD training days across the UK. It strongly supports the concept of CPD; now that is something to bring to the party.

Sarah Wilcox

*President
Association of Pharmacy Technicians
UK*

Say yes to stronger technician representation

From Mrs D. Thomas,
RegPharmTech

Registered technicians working in community pharmacy do not generally join the Association of Pharmacy Technicians UK. So as a community technician, I find it bewildering that it presents itself as the voice of pharmacy technicians.

Joining a pharmacist-dominated body, such as the proposed royal

college, is unattractive because it will not help to preserve my distinct and key role within pharmacy. Joining a robust independent organisation that represents all support staff, with the confidence both to work with and to challenge pharmacists and the proposed pharmacy regulator would be attractive.

The key to our future success is not to dilute our representation but to strengthen it.

D. Thomas

*Bridgend,
Vale of Glamorgan*

■ MURS

£25 MUR fee is money well spent

From Dr D. J. Jenkins, MRPharmS

I fear that Jenifer Harding (*PJ*, 5 May, p523) may have missed the point of my previous letter (*PJ*, 28 April, p486), which was merely to suggest that the same intervention may be regarded as a usage or clinical issue, depending on context, and that pharmacists should regard the distinction as artificial. However, Dr Harding does raise some interesting points about due diligence and the medicines use review service's value for money, about which I would like to respond.

For the record, in the case described in my previous letter, I was working as a locum and the patient was housebound. She had hypertension, angina, type 2 diabetes (insulin-treated) and rheumatoid arthritis, and was prescribed 12 items (methotrexate, folic acid, aspirin and clopidogrel [both prescribed by the GP for three years], atenolol, lisinopril, simvastatin, omeprazole, insulin, needles, test strips, lancets). She was offered an MUR, which was conducted at her home, because she never saw a pharmacist face-to-face. Her drug regimen was potentially complex and I wanted to be sure that her physical difficulties did not compromise her diabetes management.

We would all like to work in a system in which all prescribing is evidence-based and all patients are reviewed regularly and thoroughly by GPs who always respond to pharmacists' concerns. The reality is rather different, however, and the MUR provides an excellent complementary mechanism for pharmacists to try to avert patient safety incidents and help improve patient care.

I agree that, in this case, the GP should have stopped the clopidogrel after 12 months and that a pharmacist presented with a prescription for it after this time should have contacted the prescriber (he or she may well have done so every month for all that I, or Dr Harding, know) but the fact is that the MUR did get the clopidogrel stopped. Since this will result in savings to the local drug budget of over £400 per year, I consider that the £25 MUR fee was money well spent.

David J. Jenkins

St Ives, Cornwall

■ THE PROFESSION

Pharmacists' input to the team is greatly appreciated

From Mrs C. J. Sheikh, MRPharmS

I must disagree with Jonathan Kaye's suggestion (*PJ*, 28 April, p486) that pharmacists often have to work around other health care professionals as opposed to with them. I am a surgical specialist pharmacist working in an NHS

hospital. I and several pharmacists in my hospital participate in daily consultant ward rounds where we not only offer our opinions but are referred to for advice. Our input to the team is greatly appreciated but it is unfortunate that resources limit the number of ward rounds that can be participated in because different consultants often undertake simultaneous ward rounds. On our wards we also have a good relationship with the dietitians and will use each other's specialist knowledge to the patient's benefit. I believe that my specialist role is defined and, by being pro-active, pharmacists can work with other health care professionals to portray their specialist knowledge.

Claire Sheikh

Southampton

Broad spectrum

The Broad Spectrum feature is open to any reader. Contributions of around 1,100 words commenting on topical issues should be sent to graeme.smith@pharmj.org.uk for consideration

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■ THE SOCIETY

Well done — at last!

From Mr A. R. White, MRPharmS

I have to admit that I have, in the past, had severe doubts as to whether our editor (as a non-pharmacist) has really understood what drives pharmacists, what pharmacy is about and what the Royal Pharmaceutical Society was created for.

I am glad to say that her leading article (*PJ*, 5 May, p512) shows that she has got there, at last! I am quite sure that the Government and, in particular, Lord Hunt have no idea what they are doing and that if they continue in this fashion it will lead to the ruin of pharmacy. However, unlike Miss Timbs, I believe the same applies to the NHS chief pharmaceutical officers.

Sadly I have to admit that my only consolation is that, as I am now beyond the official age of retirement, I will not be working as a pharmacist by the time the ruination has been completed. But I do echo Miss Timbs's words "Let the Society be preserved" and in substantially its present form (warts and all).

Perhaps someone might show Lord Hunt a copy of the editorial.

Alan White
Gravesend, Kent

Let's save it

From Mr D. I. M. Simpson, FRPharmS

As a Council member elected on the Save our Society ticket, I was pleased to see the headline to your leading article last week: "Let the Society be preserved" (*PJ*, 5 May, p512).

The consistent success of SoS candidates in Council elections in recent years would suggest that there are a great many members who agree with this sentiment.

Douglas Simpson
Member of the Council
Royal Pharmaceutical Society

**E-mail**

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

■ MDS

MDS is not usually the best way

From Miss S.J. Thompson, MRPharmS

I would like to comment on the article by Toni Orr (*PJ*, 7 April, p398).

First, monitored dosage systems are a core service in England. The contract states: "Under the Disability Discrimination Act 1995, pharmacies as service providers have a duty to make reasonable adjustments to enable someone with a disability to utilise the service. Reasonable adjustment may include the provision of an auxiliary or compliance aid to enable a person, who is disabled, to take their medicines. In determining what is reasonable, consideration needs to be given to the individual circumstances of the patient and the pharmacy, and a judgement made by the service provider, the pharmacy." The "reasonable adjustments" are funded under the contract.

Second, although Mrs Orr alludes to how labour intensive the filling of such compliance aids is,

she neglects to mention what a high-risk process it is. Any community pharmacist who has checked an MDS containing 19 different "little white pills" will be fully aware of the errors just waiting to happen. Then there is the risk to the patient. Patients often do not have the dexterity to open the small openings and often use sharp objects to achieve this. They do not know which tablets are which, so if a medicine is stopped they do not know which one it is and are less likely to spot errors.

Finally, social services carers can administer or prompt medication from original containers. The Commission for Social Care Inspection supports this. In Leeds, there have been incidents where medicines that cannot go in an MDS blister (eg, soluble tablets or *prn* medication) have not been administered and patients have suffered because of this.

I acknowledge that patients need help in taking their medicines in a domiciliary setting but I think that MDS is not usually the best way to provide this. Community pharmacists would be well placed to provide training and or information to groups or

individuals providing care to such patients.

Sarah Thompson

*Medicines management and prescribing manager
Leeds Primary Care Trust (NW Area)*

Toni Orr was writing from Scotland, where, *The Journal* understands, MDS provision is not currently a core service under the community pharmacy contract. — EDITOR.

Main thrust for providing MDSs in the community comes from carers

From Mr D. V. Nandha, MRPharmS

Toni Orr makes a strong case for the provision of monitored dosage systems to be a core service (*PJ*, 7 April, p398). Tony Schofield counters this viewpoint (*PJ*, 21 April, p458), with some equally pertinent points and spells out the perils of choosing to go down this route, a view I am compelled to concur with.

It is clear that the main thrust for providing MDSs in the

community comes from carers, who seek to off-load their own responsibilities onto pharmacists, often for their own convenience, rather than for the benefit of the patient. Under the Disability Discrimination Act, pharmacists are required to make “reasonable adjustments” to help patients who have a genuine disability. Unfortunately, too many carers, and some nurses, view MDSs as a panacea for all the patient’s problems without regard for a proper assessment, which could identify a range of simple solutions.

To provide a well managed MDS service for patients is, of course, a time-intensive operation, requiring robust procedures in the pharmacy, in terms of accuracy at time of filling, regard for tamper-evidence, consideration for the production of accurate medication charts with descriptors highlighting the form, colour and code of the relevant medication and the provision for patient information leaflets, as well as the maintaining of a pharmacy system that records batch numbers and expiry dates of the preparations used.

These components are the bare minimum, for clinical governance purposes, for safeguarding

pharmacists and patients alike. However, MDSs place huge and often unrealistic demands on pharmacists in their attempt to enable an “adjustment” to be made, for which there is either little or no evidence, or which pharmacists frequently make because they feel obliged to.

While MDSs may be considered a solution to aid compliance in patients who are confused, they have been known, paradoxically, to add to confusion since many common pharmaceutical preparations which are unstable or unsuitable cannot be placed into such a system and have to be dispensed separately. Therefore, the patient for whom such a system may have been deemed appropriate still has to juggle between medicines in original containers and an MDS, which must be, at the least, self-defeating for the patient.

It seems absurd that family members who are able to take on the role of carers can support their loved ones at home by administering medicines direct from original containers, whereas carers, trained or otherwise, cannot or refuse to do so. Administering medicines from original containers

remains the safest option, so when developing core services, it may be more expedient to press for the administration of medicines by carers as a core requirement of their job.

Dipak V. Nandha
London

■ ONLOOKER

Dandelions in the southern hemisphere

From Mr C. London, MRPharmS

Having just read **Onlooker** (*PJ*, 14 April, p430) I felt I had to put pen to paper about his comments on dandelions. I have lived in New Zealand for about 11 years and if the vast numbers of yellow flowers with dandelion clocks growing in my gardens are not dandelions then I do not know what they are. It may be that they are not native to these parts and were introduced by early settlers, but they are certainly present in this part of the southern hemisphere now.

Chris London
Milton, New Zealand

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