

WHITE PAPER

A representative body for pharmacists alone

From Mr C. O. Agomo, MRPharmS

It was interesting to read the letter from Derek Swanson (*PJ*, 7 July, p18) in which he argued for the inclusion of technicians in the new professional body for pharmacists. Mr Swanson based his argument on the fact that technicians complement the roles of pharmacists and therefore forming a representative body that excludes technicians will not work because it precludes the use of knowledge and skills available in pharmacy. I completely disagree with him.

The most unacceptable aspect of Mr Swanson's letter was where he mentioned an assumed rivalry that exists between physicians, surgeons and GPs to argue for the inclusion of technicians in the representative body. I would like to clarify that all the three professional streams used in his argument involve the basic bachelor of medicine degree (usually MBBS), which takes a minimum of about seven years (including one year internship) of full-time training to complete. This is then followed by another three to six years (sometimes longer) of full-time training, depending on the specialty and other factors, to become a consultant or a GP. GP training and practice is no longer considered inferior to consultant training. In the past five years or so GP training has become as competitive as the other specialties in UK and, due to its flexibility and better remuneration compared with consultant jobs, many consultants have retrained to become GPs. Again, it is important

to point out that although the GPs, surgeons and physicians are all doctors, they all belong to different royal colleges, with the uniting representative body being the British Medical Association with membership open only to doctors and medical students.

Although I do appreciate the arguments of those who want to include technicians in the college, despite the differences that exist, they forget that pharmacy is not the only profession in this situation. I have looked around and found no reputable profession either here or in other parts of the world that attained its status by inclusiveness in the way proposed by Mr Swanson and others who argue for the inclusion of technicians in our representative body. I implore Mr Swanson to show me just one profession.

The BTEC/NVQ qualification for technicians mentioned in Mr Swanson's letter will not even get a direct entry admission into many of the reputable pharmacy schools around the world without the relevant "O" - and "A" -level qualifications in basic science subjects. Again I recognise the fact that many technicians may be graduates, but this does not make them pharmacists. There is nothing wrong with capable technicians retraining to become pharmacists as done regularly by nurses who train to become doctors, or legal clerks and accounts clerks who become lawyers and accountants, respectively.

It is important to make our profession distinct. Pharmacists must continue to raise the standard of the profession with the changing times. Aiming for a doctorate degree (as is done now in most pharmacy schools in the US, some European countries, some Asian countries and a few universities in

Africa) as the entry point for the pharmacy profession must be our next target if we are aiming to take up some of the services presently provided by GPs and nurses. The pharmacy profession must compete for recognition and this calls for visionary leadership.

Giving technicians full membership of the new royal college will disadvantage both pharmacists and technicians in the long run, lower standards for pharmacists and diminish the identity technicians have been trying to create over the years.

The incredible achievement of nurses was not attained by them forcing themselves into the medical and dental colleges but by believing in themselves and through patience, perseverance, setting goals and nurturing their own representative body and identity.

I encourage pharmacy technicians to follow in the footsteps of nurses and I am certain by doing that they cannot go wrong.

Chijioke O. Agomo
London

PFIZER

How is this system legal?

From Mr P. Walton, MRPharmS

I have read, with interest, the allegations and counter allegations regarding the Pfizer supply system. The one thing that is clear to me is that any pharmacy that cannot genuinely supply a product because of rationing will be harmed. This will not just be at that particular supply point, but if patients have difficulties they will find other pharmacies that can readily supply, and therefore the damage could be long lasting or permanent. If patients do look for other pharmacies then it would be a fair bet that there will be an Alliance Boots or UniChem-owned pharmacy in the neighbourhood willing and able to accept all prescriptions without problems.

If any pharmacy could afford to take these giants in the pharmacy sector to court the damage would already be entrenched by the time a settlement was reached. I will never understand how such a supply system is deemed to be legal.

Philip Walton
Manchester

More in sorrow than in anger

From Mr G. S. Phillips, MRPharmS

In the recent past, as a primary care organisation prescribing lead, I was instrumental in persuading the local health economy to work collaboratively with the pharmaceutical industry to support our prescribing incentive scheme, to improve the quality of our prescribing and benefit some public health aspects of our work. To cut a long story short, my strategy proved effective and we both contained our prescribing within budget and achieved significant gains in the quality of our prescribing.

At that time, persuading the local prescribing advisers and the health authority that the pharmaceutical industry are partners in health care and not some kind of "enemy" to be treated with distrust and disrespect was the hardest part.

So it saddens me now, when community pharmacists are playing increasingly clinical roles, evidenced by the new contract, the development of pharmacists with special interests and the introduction of independent prescribing, to see parts of the industry doing everything they can to undermine the beginnings of trust and damaging recently formed better relationships.

Pfizer's, in my view, disingenuous attempt to use patient safety as a cloak under which to hide their attempts to limit the use of PIs and control the supply chain for their own profit, is short-sighted, lacking in vision and damaging to the reputation of the industry as a whole.

The fact that AstraZeneca has delayed the introduction of a similar scheme can only be good news. Perhaps Pfizer will wake up, smell the coffee, and reconsider. Then we can all get around the table and work for the sort of patient-centred health care to which we all aspire.

Graham Phillips
Member of Council
Royal Pharmaceutical Society

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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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.

■ SUPERVISION

A caveat to the Society's Council

From Mr J. A. Tweed,
MRPharmS

I think that the Royal Pharmaceutical Society should be suspicious of the current Government and its plans for pharmacists. The Government seems hell-bent on spending as little money as possible rather than obtaining best value for money and protecting patient safety. We need to be careful that we are not cast aside at its whim. For example:

- We have just heard that in maternity services, non-qualified staff are performing duties outside their training.
- The Crown Prosecution Service is, I believe, allowing its dedicated case workers (who are not lawyers) to prosecute in the magistrates' courts.
- Policing relies on community support officers, not real policemen.

If we allow remote supervision, how long before the Government decides that technicians can replace pharmacists, to save money? This is not an attack on technicians, but merely a caveat to the Society's Council.

I hope that the Council will be sure to safeguard the profession of pharmacy.

J. A. Tweed
Nottingham

A right to expect a pharmacist in a pharmacy

From Mrs E. E. T. H. Hopkins,
MRPharmS, and others

We wish to express our concerns over the "responsible pharmacist" debate which seems to be being kept secret from many of the profession. But it concerns every pharmacist wherever they work.

The Health Act refers to "responsible pharmacists" but the term "responsible pharmacist" awaits a full definition. When one visits a GP surgery one expects to have a doctor around. Surely the public have a similar right to expect a pharmacist in a pharmacy, not a pharmacy team without the depth of knowledge that is expected of pharmacists to whom they may be referred. Yes, we wish to provide other services, but

getting the right medicines and advice to patients is essential.

We hope that the Royal Pharmaceutical Society gives longer time for consultation. In the meantime we urge all "responsible pharmacists" to get involved in the debate for the sake of the profession and the public, who have a right to a top-rate service.

Ewa Hopkins
Alun Hopkins
Marion Garner-Patel
Rajni Garner-Patel
Harrow, Middlesex

■ COMMUNITY PHARMACY

Half-understood myths

From Mr J. A. Schofield, MRPharmS

David Thomas asks the sensible question of Bharat Nathwani about his assertion that the average pharmacy contractor earns £180,000 net profit from NHS dispensing (*PJ*, 7 July, p16). Mr Nathwani then quotes a Department of Health publication that clearly shows the figure of £180,000 to be a gross figure.

When Mr Nathwani is discharged from hospital (once his gunshot wound to his foot has healed) I would like him to look at the Drug Tariff. He may then, with a pocket calculator, do the sums and work out how many dispensed prescriptions it would take to earn £180,000 gross. I would then direct him to the section which instructs a pharmacy contractor as to how many staff he must employ if he dispenses this number of prescriptions. I might, for information purposes, assist him by saying that accuracy checking technicians today are earning around £20,000 a year and pension costs must be added to that along with holiday cover. He can look in the *PJ* or telephone a recruitment agency to ascertain the sort of salary realistically paid to a pharmacist these days and calculate the cost of locum cover for holiday entitlement and add pension costs. Mr Nathwani is attacking the multiples so it must be borne in mind that a multiple will not be an owner manager situation and the cost of a pharmacist must be factored into his calculation. To continue his convalescence constructively I would invite him to telephone a local estate agent and ascertain commercial rental rates in the various sites that pharmacies are located.

For his further distraction and amusement he may like to

speculate as to how much the other costs are in running a pharmacy, ie, indemnity insurance, buildings and contents insurance, professional fees, accountancy and legal fees, business rates, heat and light, IT, etc.

Once the costs of running the service are deducted from the gross figure he quotes, a truer picture starts to emerge. However, what is the problem? This is money paid for work done. It has been agreed between the Pharmaceutical Services Negotiating Committee and the DoH. Why the complaint? Multiples work just as hard as individuals to earn this money. They are entitled to it. The disparity comes in the extra money multiples earn from their wholesaling activities and that they keep more of the purchasing profits that they can earn. By all means, raise this as a stick to beat them with but be careful. Their wholesaling activities are legitimate and the wholesaling arms are well run, lawful companies that also supply independents. It would be unfair to take a proportion of income from them when it is lawfully earned.

However, if Mr Nathwani continues to spout half-understood myths as part of his crusade and the purchasing prices of the multiples are those that end up in the Drug Tariff, a queue will rapidly form of independent contractor pharmacists and their staff who will happily reload his gun and pull the trigger for him. Only this time it will not be his foot they are aiming at.

J. A. Schofield
Jarrow,
Tyne and Wear

Are the facts straight?

From Mr B. P. Threlfall,
MRPharmS

I have obviously sold my pharmacies too soon if they could now be making the £180,000 net profit quoted in the letter and response from Bharat Nathwani (*PJ*, 7 July, p17). If my colleagues do not have a clue about NHS payments, what hope do we have that those outside pharmacy can be persuaded to pay more for additional services?

Yes £1,766m was allocated by the Department of Health but this was to pay for the provision of pharmacy services. A pharmacy receiving the average £180,000 will be paying a sum in the order of £20,000 for rent and rates, will

need to employ two pharmacists full-time for about £85,000 (for the year) and at least four other staff for £45,000. There will also be utility and computer bills, etc, of about £10,000 together with bank charges of about £7,000. That leaves about £13,000 as the net profit for the owner of the pharmacy — or under 2 per cent of turnover.

As an ex-independent contractor, I have never been particularly fond of multiples but on this occasion even I have to admit they are not as black as they are being painted by Mr Nathwani. Please get the facts a little straighter.

B. P. Threlfall
Lancaster,
Lancashire

■ ANTIMICROBIALS

Pharmacist prescribing of antimicrobials in secondary care

From Mrs A. Tonna,
MRPharmS

I read with interest the letter from Paul Long (*PJ*, 30 June, p733) in which he expresses his concern regarding the inappropriate use of antimicrobials and the possible global consequences of this. I agree that there is a lack of evidence showing the impact of pharmacist-led interventions in the area, with most studies referring to practice outside the UK, as have been also concluded by a number of systematic reviews.¹ The introduction of pharmacist supplementary and independent prescribing in the UK is likely to provide opportunities and challenges for pharmacists to help ensure prudent use of antimicrobials. It is likely that these opportunities would not be limited to the specialist microbiology (also referred to as "antibiotic" and "infectious disease") pharmacist but would be a role for all ward-based clinical pharmacists.

An ongoing research project is exploring practising pharmacists' views and perceptions of both pharmacist supplementary and independent prescribing of antimicrobials in secondary care. This qualitative study is making use of focus-group discussions in different secondary care settings throughout Scotland. The extent to which pharmacist prescribers are using their prescribing skills varies greatly between hospitals. Some pharmacists report prescribing

regularly, and others are not yet prescribing due to a lack of a hospital policy for non-medical prescribing. Preliminary analysis of transcripts has indicated that pharmacists think that they have a good knowledge base to prescribe and manage antimicrobial treatment, identifying possible opportunities for intervention, and are willing to take on prescribing roles, provided that an initial diagnosis has been made. They have also highlighted barriers to both pharmacist supplementary and independent prescribing of antimicrobials. More detailed analysis of results is currently under way and will be presented at the next British Pharmaceutical Conference in September 2007.

Antonella Tonna

School of Pharmacy
The Robert Gordon University
Aberdeen

References

1. Davey P, Brown E, Fenelon L, Finch R, Gould I, Hartman G, et al. Interventions to improve antibiotic prescribing practices for hospital inpatients. *Cochrane Database of Systematic Reviews* 2005, Issue 4. Art. No.: CD003543. DOI: 10.1002/14651858.CD003543.pub2.

DISPENSING ERRORS

Type of error and response of pharmacist that matters

From Mr M. Randerson, MRPharmS

I write with reference to the Law and Ethics Bulletin (*PJ*, 30 June, p781) on medication error logs. The criteria for referral of a single dispensing error to the Investigating Committee all make perfect sense in defining a potentially poorly performing practitioner — “cover up, failure to co-operate, no attempt to learn from”, etc. — with one noticeable exception, in my view. I understand that “the potential for, or evidence that, the dispensing error caused moderate or severe harm or death” is of obvious interest to patients and the public in general and might be thought by them to equate to a poor practitioner. However, I fail to see why the different potential consequences of, for example, dispensing incorrect strengths of two prescriptions, one for a drug with a narrow therapeutic window and one for a drug much less toxic, should result in different fitness-to-

practise processes and decisions by the Royal Pharmaceutical Society. Surely it is the type of error and the response of the pharmacist to making the error that matters — not the intrinsic toxicity of the drug involved.

Mark Randerson

Scarborough, North Yorkshire

RECALLS

Class 1 alerts

From Mr I. Holloway, MRPharmS

Anne Rickard (*PJ*, 7 July, p19) suggested that it is unacceptable to fax class 1 recalls to hospitals at a busy time of the week. We have always taken the position that only class 1 alerts are sent out on Fridays and all other classes are withheld until the following Monday. Public safety has to be considered paramount. I take exception to the comment that this is a frequent occurrence. We have sent out eight class 1 drug alerts in this calendar year but only two of these have been on a Friday.

Drug alerts have to be distributed to many other groups

in addition to hospitals and more than one distribution system has to be used. In addition to hospitals, we had to fax to overseas regulators, UK wholesalers and use Public Health Link to contact primary care as well as posting the information on the Medicines and Healthcare products Regulatory Agency website. In all the recent cases we distributed to hospitals first to try to minimise the local impact.

Ian Holloway

Manager
MHRA Defective Medicines Report
Centre

ONLOOKER

A hard act to follow

From Mr A. Low, MRPharmS

May I say how sad I am that “**Onlooker**” is retiring. I have learnt such a lot from him and his page has often been the first one I have read on picking up *The Journal*. He will be a hard act to follow. I wish him well.

Andrew Low

Harrow

Advertisement

■ CPPE

Why not a hard copy version?

From Mr P. Melnick, MRPharmS

I write to express my annoyance and frustration at the Centre for Pharmacy Postgraduate Education's decision to issue an exclusively e-learning pack on the subject of pharmacogenetics.

This is a rapidly expanding topic about which I know almost nothing. Sure, I have heard of fast and slow acetylators. Certainly, I am aware of cytochrome P450 enzyme systems with confusingly similar and instantly forgettable names that would not look out of place in a space observatory.

I can think of no subject more likely to bring the most profound changes in the ways in which we think about and use drugs in the near future. Without doubt it has the potential to change the working lives of the next generation of pharmacists. Here was a real opportunity to put them all in context.

And yet the CPPE chooses to exclude luddites such as me from accessing its expertise.

Surely there are many of us who would experience great difficulty using e-learning during the working day, which would not be the case with hard copy. Similarly, when I am stuck in traffic, or at home, or in bed, I prefer to read printed text. It is what I have always done and it remains the most accessible and practical of choices by far.

I accept that it is cheaper for the CPPE to use an electronic format and they could argue that the information could be downloaded, but they can take it from me that a collection of any unspecified number of papers is just not the same. The subject is far too important for this exclusive treatment and I wonder if the CPPE directors might be prevailed upon to reconsider their decision.

Perry Melnick
Ilford, Essex

CHRISTOPHER CUTTS, director, and PAULA HIGGINSON, senior pharmacist learning development, both from the Centre for Pharmacy Postgraduate Education, respond: We are pleased that Mr Melnick recognises the potential importance of pharmacogenetics as a subject area for future generations of pharmacists. This is one element of a portfolio of over 100 learning

programmes that are currently available from CPPE. And, overall, we offer a balanced portfolio of approaches through workshops, print-based open learning, computer-based and now e-learning.

This meets the range of formats that pharmacists and pharmacy technicians choose to use as they learn. Increasingly we find that the newer generations of pharmacists, accustomed to blended learning approaches through their undergraduate programmes, expect that their postgraduate support will be available through similar routes.

Pharmacogenetics is a relatively new concept in learning and is currently changing rapidly. Any print-based programme would become dated quickly. We made the deliberate decision to build pharmacogenetics as an e-learning programme.

We can easily maintain the currency of the learning programme and include small addenda to the programme as developments occur.

We recognise that there are challenges in practice for many who wish to access e-learning programmes, understanding that some of the multiple pharmacies actively prevent their employees from accessing the internet during their work hours. However, the most recent OfCom report states that over 50 per cent of homes now have broadband internet access, local libraries and gyms offer access and there continues to be a growth in internet cafes.

In summary, the CPPE will continue to develop e-learning programmes alongside our traditional approaches. We appreciate the concerns that Mr Melnick has raised and will continue to seek ways to meet the differing needs of all of our users. However, pharmacogenetics is a rapidly changing and developing area of practice. It does not make sense for us, as a learning provider, to offer a print-based resource for this topic.

■ RECYCLING

Recycling without compromising patient safety

From Mrs Y. H. Taylor, MRPharmS

The "Live Earth" concerts around the world last weekend have focused on recycling. In reply to the letter from Barry Shooter (*PJ*, 7 July, p17), the intentions of my

original letter (*PJ*, 30 June, p773) need some explanation.

First, a manufacturer would need to be sourced which could design prescription baskets with side flaps that could be folded over the top of the baskets once medicines had been checked.

A red basket could be used by pharmacists for prescriptions that might lead to a medicines use review or intervention, a yellow basket for accredited checking technicians and other technicians and a white basket by counter staff. The shelves in the dispensary may need to be widened to accommodate the baskets that could be stacked on the shelves.

Secondly, the recycling bags or semi-rigid containers, similar to wine boxes used by supermarkets, would be used solely by the customer for collecting their dispensed medicines. Again a manufacturer would be sourced which could supply the bags or containers of three or four sizes depending on the number of medicines collected.

These would be issued to the customer from the pharmacy and reissued after a suitable interval, eg, six months.

Hopefully, having addressed these concerns, the pharmacy profession might be able to recycle without compromising patient safety.

Yvonne Taylor
Shoreham-by-Sea, West Sussex

■ RETENTION FEE

Unfairly treated

From Ms C. Schweizer, MRPharmS

Exactly that same thought went through my mind when I read the note about the announcement by Hemant Patel in the *PJ* (26 May, p624). I completely agree with Paul Breame and the points he raised in his letter (*PJ*, 16 June, p706).

The retention fee has risen "substantially" already over the past few years.

I personally think that newly registered pharmacists, those who work part-time or who are having a career break, eg, those on maternity leave, are treated unfairly by having to pay the same fee as everybody else. During a recent update session on pharmacy legislation, I asked a representative of the Royal Pharmaceutical Society the same questions about

why the fee cannot be paid monthly and why it cannot be a percentage of the salary. After all, we live in a democracy, ie, people who earn less pay less tax and contribute to society according to their means. I was told that, for legal reasons, the fee must be paid in full and at the beginning of the year.

Furthermore, I was told that every member gets the same support from the Society and must therefore pay the same fee. I imagine that the support includes continuing professional development, ie, the provision of a website to record CPD and the checking of compliance with CPD requirements. If that is the case, why not, hypothetically, split the fee into a set CPD contribution, a set payment for the *PJ* and the actual registration fee, which is determined according to the earnings of the individual pharmacists? After all, before the introduction of CPD it was possible to set different levels of fees taking into account the earnings.

In other European countries, eg, Germany it is possible to pay the fee quarterly.

As a pharmacist working for the NHS, I feel disadvantaged even further as my employer does not pay my fee unlike some private pharmaceutical employers do.

Cornelia Schweizer
Bangor, Gwynedd

Ownership changes

When buying a pharmacy business the purchaser must contact the Royal Pharmaceutical Society prior to taking over the business to obtain the necessary "Application for transfer of ownership" form. Until this form is completed and returned to the Society, the Register will continue to show the premises as registered by the previous owner.

A legal problem could arise from the new owner not advising the Society of a change of ownership. Section 76(3) of the Medicines Act 1968 provides that the existing registration automatically becomes void at the end of 28 days from the date on which a change of ownership occurs.