

■ RETENTION FEES

## Reasons for the lower technicians' fee

From Mr A. C. Gush,  
MRPharmS

In response to B. S. James's letter (*PJ*, 28 July, p100) concerning retention fees it should be noted that pharmacy technicians currently pay a lower registration fee than practising pharmacists as they do not benefit from the full range of services offered by the Royal Pharmaceutical Society. These services include use of the Society's library and the potential to receive support provided by the Society's Benevolent Fund and Listening Friends scheme.

The cost of regulation is based on the risks involved. Pharmacists' practice is inherently more risky than that of pharmacy technicians and is becoming more so with the growth of prescribing rights and increase in clinical services. There might be an argument for equal fees for pharmacists and pharmacy technicians if we were receiving the same number of fitness-to-practise allegations for both groups and we were involved in accrediting courses, for example, for advance practice for pharmacy technicians, but we are a long way from this position at present.

Pharmacists and pharmacy technicians are registered with the Society regardless of the number of hours they work — the standards they are expected to uphold operate seven days a week. There is provision for both pharmacists and pharmacy technicians to register as non-practising in appropriate circumstances should they wish. The Society has adopted a policy of ensuring all costs incurred in

registering technicians, together with an appropriate allocation of overheads, are recovered from the fee charged. This allocation of costs includes a charge for supplying *The Pharmaceutical Journal*.

**Andrew Gush**  
*Treasurer*  
*Royal Pharmaceutical Society*

■ WHITE PAPER

## Employee community pharmacists not represented in new group

From Mr R. Gartside, FRPharmS

We must all welcome the announcement of the Professional Regulation and Leadership Oversight Group (PRLOG) and hope that it marks the beginning of the end of a period of acute uncertainty, although there must be doubts concerning the make up of this new group. There must also be a little apprehension when Keith Ridge, chief pharmaceutical officer at the Department of Health, announces that regulation may need to be "reframed" so as to apply tighter control since tighter regulation is not known for producing an atmosphere conducive to innovation.

Normally, extreme care is taken in ensuring balance and fair representation when important government committees are set up but both Dawn Primarolo, the Minister of State for Public Health at the Department of Health, and Dr Ridge were at pains to point out that the members were appointed on the basis of their skills and experience, not as representatives of any particular

section of the profession. Fair enough, but an examination of the membership of this group shows no one with current or recent experience as an employee community pharmacist.

There is no doubt that the experience of being a proprietor community pharmacist is different to the experience of being an employee community pharmacist and, in fact, the pharmacists with community connections in this group lead extremely busy lives and one may entertain small doubts as to the proportion of their time taken up by actual hands-on community experience.

Since employee community pharmacists make up by far the largest part of pharmacists on the Register, this is a strange omission. The past few short years have seen large changes in community pharmacy: training and use of accredited checking technicians; a huge increase in helping patients to manage their repeat prescription requests; an equally huge increase in deliveries of medicines to patients; medicine use reviews; diabetes, blood pressure monitoring and cholesterol testing; smoking cessation provisions; supply of emergency hormonal

contraception — the list is almost endless. All of these make it imperative that PRLOG has access within itself to active hands-on practitioners in order that its deliberations are fully informed.

This is not to denigrate the worthy community pharmacists appointed to the group, merely to point out that their very eminence may distance them from the rough and tumble of everyday practice.

Another noteworthy omission from this group is pharmacists with practical contemporary knowledge of everyday mishaps gained from dealing with insurance and other claims. Neither the National Pharmacy Association nor the Pharmacists Defence Association are represented and yet between them they provide professional liability insurance cover for a large majority of pharmacists and have an unrivalled up-to-date knowledge of the mishaps and contretemps which occur on a day-to-day basis.

Perhaps these shortcomings will be addressed when PRLOG begins its consultation process, but the future is certainly misty.

**Bob Gartside**  
*Caernarfon, Gwynedd*

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## Letters to the editor

Letters for publication can be posted, faxed, or sent by e-mail to [letters@pharmj.org.uk](mailto:letters@pharmj.org.uk) and should not normally be of more than 400 words and should cover one topic only. *The Journal* reserves the right to abridge letters and to edit them for clarity and style. Pharmacist correspondents should supply their membership numbers and a contact telephone number should always be given. Women correspondents should specify a preferred title otherwise "Ms" will be used.

Letters are accepted for publication on the understanding that they have not appeared anywhere, including electronic media, previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform *The Journal* at the time.

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

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

## ■ WHITE PAPER

**An iniquity that must be redressed**

From Mr J. A. Schofield, MRPharmS

The proposed split of the Royal Pharmaceutical Society into a representative body and a Government-appointed regulatory body has commenced and the Professional Regulation and Leadership Oversight Group (PRLOG) has been constituted. Not one member of that group has been drawn from the ranks of employee or locum pharmacists. This is not right.

The Company Chemists' Association has a representative and there are four community pharmacists who are owners, managers or employers or who fit that description. Although I accept that at least one of those individuals can probably be trusted to remember what it was like to be an employee, I think it is a scandal that those who are currently employee pharmacists and working in the current conditions have no representation.

Employee pharmacists will be held accountable for the work that will be expected of them yet they have no voice at the table around which this will be decided. They will have no input into the process where the excesses of some of their employers could meaningfully be addressed. This is manifestly unfair.

Employee and locum community pharmacists make up a large proportion of the register, ie, those to be regulated. Regulation is not equitably possible under the current arrangement — even technicians have better representation on the oversight group. Writing letters to pharmacy publications will not be sufficient — our leaders and opinion formers must do all in their power to redress this iniquity.

**Tony Schofield**  
Jarrow, Tyne and Wear

**Formation of the professional body**

From Mr G. S. Phillips, MRPharmS

I was encouraged to read Alan Rogers's letter in the *PJ* (28 July, p99) calling for members to engage with the White Paper debate. Member apathy will be our greatest enemy so it was good to see his views expressed in such a passionate way. It is for the membership to decide the future of

a professional body for pharmacy and although the timelines are tight they are not so short as to require the Royal Pharmaceutical Society to act in haste.

What has been particularly encouraging in recent weeks has been the change in the Government's attitude to the formation of a future professional body. Lord Hunt, speaking at the recent All-Party Pharmacy Group meeting, made it clear that such a body should be built on the "fantastic work" that the Society has done over many years. The mood music has also changed inside the profession with pharmacy organisations recognising the benefits of building on the foundations of the Society.

Clearly the Society must not be complacent and the Society's Council is aware of the sensitive nature of the work that is required if a new pharmacy body is to be established. We are looking to strike a difficult balance in terms of seeking the views of our members and, at the same time, not being perceived as leading the profession by the nose.

The Opinion Leader research that has been commissioned is an exploratory piece of work that will be idea forming, with the findings used to help inform a formal business model. The first stage of the research will last up to six weeks and involve a series of focus groups from around the UK. This work will be followed by a number of one-to-one, in-depth interviews that will look to build on the findings of the focus groups.

Looking to the future there will come a time when the Society will need to go out to wider membership with firm proposals for a professional body. But before we reach that stage we must first clarify what members will want from such an organisation in order that they will be prepared to join it.

**Graham Phillips**  
Member of Council  
Royal Pharmaceutical Society

## ■ ATHENA

**Challenging statement regarding mosquitoes**

From Mr J. A. Parry, MRPharmS

Your columnist, **Athena**, has made the most incredibly challenging statement (*PJ*, 21 July, p78) asserting that the mosquito *Culex pipiens* "is the most common transmitter of malaria". It is, to my

mind, essential that this serious allegation should be repudiated immediately. If it were true, then malaria would be endemic throughout the UK, because *Culex pipiens* is overall the most abundant mosquito of our land, being overtaken only by *Aedes cantans* and *Aedes rusticus* in some wooded areas.

Malaria is caused by species of the protozoon genus *Plasmodium*, of which there are many species. These parasites each have two hosts, one of which is a bloodsucking insect and the other a vertebrate, such as an anthropoid, bird, lizard or other. In anthropoid (ie, human, simian) malaria the parasite is carried only by one or more of the many species of anopheles mosquito. The parasite is passed between the two hosts alternately.

Anopheles mosquitoes may be recognised by their characteristic resting position in which the body, wings and proboscis are aligned in a forward-sloping position as opposed to the horizontal stance of culicines. The only British species, *Anopheles maculipennis*, does occur commonly in this country, most frequently in salt marshes, where in earlier times sporadic outbreaks of malaria (then known as "ague") did occur. The wings of *A maculipennis* are dark-spotted, the only other indigenous mosquito that has spotted wings being *Theobaldia annulata* (and sometimes in the Scottish Highlands *T alaskaensis*). Both these are much larger.

*Culex* species, including *Culex pipiens*, have never been implicated in the transmission of anthropoid malaria. A telephone call to the London School of Hygiene and Tropical Medicine will confirm this.

This mistake would not in itself appear to be important, but journalists from the tabloids do peruse professional journals for juicy titbits and if the statement should be taken seriously, every open stretch of water from garden water butts to Windermere might be covered by a thin film of liquid paraffin or engine oil in order to kill all mosquito larvae and eradicate this "pest". This of course has happened in areas of Africa such as Gambia (where the worst form of malaria, quaternary malaria, caused by *Plasmodium falciparum* is endemic), with catastrophic consequences for the local aquatic wildlife. It is important, therefore, that the statement is refuted at once.

There is a form of malaria called avian malaria, also caused by a plasmodium, which is indeed carried by culicine mosquitoes. It

does not appear to be endemic in the UK, but it could explain how this misunderstanding may have occurred.

I am much surprised that this error was not noticed by *The Journal's* editorial team, or by any other pharmacist on the staff, because I should have thought that by now all pharmacists would have become aware of the causal organisms and vectors of malaria.

**John Parry**  
Tenterden,  
Kent

ATHENA responds: Ronald Ross won a Nobel Prize (1902) for demonstrating the existence of plasmodium in the wall of the midgut and salivary glands of a *Culex* or common house mosquito (1898). Indeed the life cycle of the plasmodium was researched extensively in this species. However since then, research has shown that the anopheles mosquito is the most common transmitter of malaria in humans. It has been suggested that the increasing numbers of *Culex* in the domestic environment could lead to an increase in feeding on humans (as adverse to birds, their preferred targets) and transmission of disease. *Culex* is also a transmitter of West Nile virus, filariasis and Japanese encephalitis. I offer my apologies for the wording in the article, which may have misled readers.

## ■ THE JOURNAL

**Not to be fought over or rationed**

From Mr M. J. Naylor, MRPharmS

I must take issue with Keith Baxter (*PJ*, 21 July, p72) on the subject of the "wasted" *Journal* since I too belong to a two-*Journal* household, but I look on the postman's arrival as a chance for my wife and I to study and discuss together, with the minimum of delay, the latest news and developments which are so relevant to community pharmacy today. Such a riveting read should not be fought over or rationed. These are exciting times for pharmacy, we are told, and I believe Mr Baxter and his wife should not look a gift horse in the mouth but seize the opportunity to enhance their job satisfaction to even higher levels.

**Michael Naylor**  
Presteigne,  
Powys