

■ ABORTION

A patient group direction too far?

From Mrs L. C. Titcomb, MRPharmS

Discussion at the House of Commons Science and Technology Committee resulting in the report "Scientific developments relating to the Abortion Act 1967" and Pope Benedict XVI's advice to Roman Catholic pharmacists to avoid any involvement, whether direct or indirect, in the supply of medicines used for abortions or euthanasia have raised the profile of issues surrounding abortion once again. Whether we class ourselves as "pro-life" or "pro-choice", the extremely high number of abortions carried out in England and Wales — 193,700 in 2006, an average of 3,725 per week — is a sad reflection of our society's attempts to educate its members in the premise of "prevention is better than cure".

While we are having some success with "stop smoking" campaigns, the Government's answer to the increasing numbers of abortions is to make abortion more accessible by ending the need for two doctors' signatures, allowing midwives and nurses to carry out first trimester abortions, including the administration and supply of abortifacients, and letting women have their abortions at home.

If the latter two proposals become law, pharmacists will need to become involved in the abortion issue once again in the preparation of patient group directions for the supply of gemeprost or misoprostol. They must consider the scenario where a woman, who

could well be in an emotional state, is sent home with a supply of misoprostol, the prostaglandin preferred by the Royal College of Obstetricians and Gynaecologists, with a patient information leaflet explaining that the drug is an anti-ulcer agent which protects the lining of her stomach which she will have been prescribed to heal or prevent ulcers in her stomach or duodenum. She will also read that she should not take the drug if she is pregnant, or trying to become pregnant, because it may cause a miscarriage.

Although patient group directions are permissible for drugs used outside their licensed indications, the Royal Pharmaceutical Society's guidance on this states: "In certain, exceptional circumstances, medicines with a marketing authorisation could be used outside the summary of product characteristics. Areas for consideration might include paediatrics where no licensed version exists. National Institute for Health and Clinical Excellence guidance should be followed to ensure that a medicine used in this way is justified. The PGD must clearly state that the product is being used outside the terms of the SPC and state the reasons why its use is necessary."

With the ever-growing number of abortions, a 4 per cent rise between 2005 and 2006, this will be anything but an exceptional circumstance. Will we have to tackle this PGD too far? In June 2007, 100 members of the British Medical Association voting at their annual general meeting (the whole membership was not balloted) while supporting abortion on demand in the first trimester, did not support allowing trained nurses

and midwives to perform abortions nor relaxing rules on approved premises to allow abortion at home. However, the House of Commons Science and Technology Committee (or should I say the majority of that committee?) has supported the proposal that midwives and nurses be permitted to carry out first trimester abortions. It has also suggested that there is no evidence relating to safety, effectiveness or patient acceptability that should serve to deter Parliament passing regulations which would enable women who chose to do so taking the second stage of early medical abortion at home, or that should deter Parliament from amending the act to exclude the second stage of early medical abortion from the definition of "carrying out a termination" to enable a trial to take place.

In George Orwell's '1984', it was intended that "oldspeak" was to be completely eclipsed by "newspeak" before 2050. This Committee is certainly helping to keep the Government's version of newspeak right on track.

Lucy Titcomb
Stratford-upon-Avon

Advertisement

■ NPA PMI BID

An appalling situation

From Mr A. F. Huntley, MRPharmS

The action taken by the three members who were able to sabotage the National Pharmacy Association Pharmacy Mutual Insurance takeover endeavour appals me (*PJ*, 10 November, p517).

I suggest that NPA and PMI take an advertisement in the *PJ* giving the names and postcodes of these three members in order that on, say, 1 December, 4,300 other members might write to each of this triumvirate pointing out the error of their ways.

Arthur Huntley
Bristol

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

Letters to the editor

Letters for publication can be posted, faxed, or sent by e-mail to 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.

■ RETENTION FEES

Number of resignations may come as a shock

From Mr A. R. G. Calder,
MRPharmS

Finally the retention fees for 2008 have been agreed. Sadly, the opinions and views of the many part-time and semi-retired members have been disregarded.

The Royal Pharmaceutical Society still seems oblivious to the impending staffing crisis that is highly likely to occur in 2008 as many part-time pharmacists decide not to renew their membership, a point I raised in an earlier letter to the *PJ* (25 August, p206).

I often wonder if the Society works in a similar way to the current Government under its present and its past leader, ie, pretend that a crisis will not occur then, when it happens, wonder why it has and then enter panic mode wondering how on earth it can be dealt with.

The Society should be demonstrating its commitment to reducing administrative costs. Yet this week's *PJ* and the demand for 2008 retention fees each arrived by the same post this morning — hardly a way to prove money-saving measures are operating.

The retention fees demand has an air of financial blackmail about it this time: pay up by 19 December or if we have not got your money in our bank by 1 January 2008, we remove your name from the Register and we will charge you a hefty fee to restore it.

Again, little or no thought has gone into the timing of the demand. Many pharmacists, especially those just starting out on their careers, already find this time of year a particularly hard one financially, especially this year faced with increased mortgage repayments, young families to buy for plus the large rises in fuel costs associated with travelling to and from work, without having to meet the Society's deadline as well.

Many employee pharmacists also have the prospect of having to wait for the December salary to be paid into the bank after Christmas.

I think, as retention forms start to arrive at the Society next month, the scale of resignations will come as a shock but as no surprise to many of the remaining practising members.

Andrew Calder
Leigh,
Lancashire

Forgive me for seeing red but . . .

From Mr A. J. Jukes, MRPharmS

I received an electricity bill and tax demand recently. They were both in black type on a plain sheet of paper. If they were late they would be detailed on a red background indicating they were late.

The recent demand for my professional fees is on a red letter but they are not late. This only serves further to alienate people who are, in fact, professionals.

Andrew Jukes
Brighton

Is the penalty fee a form of extortion?

From Mr D. Lee, MRPharmS

I have just received my retention fee form and noticed on the front that a penalty fee of up to £1,235 is payable if you want to be restored to the Register after removal for non-payment of fees. I find this an incredible statement and it makes me wonder whether this is reflective of the true cost or a punitive measure (ie, a threat of financial violence) to ensure pharmacists pay the extravagant increase in fees against their will.

According to WordNet (2006, Princeton University) extortion is (i) an exorbitant charge, (ii) unjust exaction (as by the misuse of authority), eg, the extortion by dishonest officials of fees for performing their sworn duty, or (iii) the felonious act of extorting money (as by threats of violence). So is the penalty fee a form of extortion?

I struggle to comprehend that the increase in fees is for something that has not been clearly defined and that the Royal Pharmaceutical Society is serving its own interest instead of the interests of its members.

Members have clearly indicated to the Society's Council that this increase is unwarranted and premature. In this instance it is hospital pharmacists who will bear the brunt of this increase more heavily as the NHS does not pay or reimburse the retention fee¹.

I find it hard to believe that it costs as much as it does to maintain a Register when considering the maximum cost in New Zealand is \$495 (approx £180), including the disciplinary procedures. In 2001 the retention fee was £180, which begs the question, what additional services or representation has the

Society provided since 2001?

Other questions that seem relevant is whether the fees will decrease in following years or stay at the same level and whether anyone would be foolish enough to join a Society that flagrantly overcharges for its services. Given a choice, how many current members would stay with the Society as it is being currently run or switch to another organisation that could do the job members want?

Dan Lee
Whitehaven,
Cumbria

'The Department of Health announced in August that it would contribute £38 towards the cost of pharmacists' professional registration (*PJ*, 11 August, p144).— EDITOR.

An appropriate image?

From Mr J. Andrews, MRPharmS

I am sure everyone affected has their own view on the disappointing fees announcement so I will not vent my own anger here, but I just cannot let go of the fact that the "Fee increase — Q&A" document, available on the Royal Pharmaceutical Society's website, has on its front cover the Treasurer Andrew Gush looking as if he is about to burst into laughter.

Was that really an appropriate choice for the first image we see when looking for answers as to why members are now having to cover the cost of the Society's situation.

James Andrews
Surrey Community Health Services

ANDREW GUSH, Treasurer, Royal Pharmaceutical Society, responds: Choosing a photograph can be a very personal choice. Be assured that from day one I have approached my role as Treasurer with a strong sense of duty and with professionalism — and continue to do so.

I acknowledge that the fee change has been an unpopular decision. Members were rightly dissatisfied with such a large and unexpected increase. If there had been alternative actions which offered a similarly sound financial platform to move forward with, they would have been recommended to Council. We are working hard to introduce staged payments to make fee payment more manageable and have taken every care in lessening the impact

on the more exposed membership groups. Extra financial help to part-timers, members with low incomes and retired pharmacists is also being investigated. Delivering financial stability, not financial shocks, must be the way forward.

The reality is, however, that the Society reached a stage where the financial deficit for previous years had to be covered. Even the £3m from the Government towards the transitional costs of setting up the General Pharmaceutical Council has not come direct to the Society: it is held by the body set up by the Department of Health to oversee the creation of the regulatory body. Although I inherited the bulk of these financial challenges, I was not prepared to (or, in fact, in a position to) overlook them.

We have had to address difficult financial circumstances and make extremely uncomfortable decisions over the past few months, but we are not ignoring our responsibility towards the members. We are determined that members will not shoulder the additional costs of the separation and I can wholeheartedly assure readers that we continue to lobby forcefully for full Government funding.

Clarification, please

From Mr R. N. Venkatesh,
MRPharmS

In the *PJ* of 10 November (p542), it is stated: "The direct debit payment and declaration process has changed for 2008. All those making direct debit payments must make a declaration by 19 December 2007. Declarations can be made online via myRPSGB (at www.rpsgb.org) or by signing and returning the retention fee form. The Society says that failure to make a declaration by this time will result in the cancellation of a registrant's direct debit and payment will, therefore, have to be made online or by cheque."

However, the retention fee letter states: "In order to retain your name on the Register of Pharmacists, payment of a retention fee is now due. To ensure your payment and declaration is processed by the statutory deadline of 1 January 2008 please make your return by 19 December 2007."

This suggests that if you pay by direct debit and you fail to make your declaration by 19 December there is no margin for you to pay online by the due date so you will probably have to pay the restoration fee (penalty) plus your normal retention fee. Members

might as well cancel their direct debits and just submit online.

Out of curiosity, why does it take 12 days to clear an online payment?

Roy Venkatesh

Basingstoke,
Hampshire

ANDREW GARDNER, head of registration, Royal Pharmaceutical Society, states: Payments and declarations are due by 1 January 2008 for pharmacists and by 31 December 2007 for pharmacy technicians.

Direct debit payments will be debited from accounts on the first working day of 2008. It takes a minimum of five working days to call for, receive and process direct debit payments and, as the Society requires a declaration with a payment, direct debit declarations need to be received by 19 December 2007. Online payments and declarations reach the Society the day after they are made. The Society recommends all payments and declarations are made by 19 December 2007 to allow time for processing and to resolve any problems before the 1 January 2008 deadline.

Those who fail to make a payment and declaration by 1 January 2008 risk being removed from the Register.

THE SOCIETY

Throwing away 160 years of honourable development

From Mr A. Denholm, MRPharmS

Some interesting points have emerged during the uproar regarding the proposed retention fee rise and I would like to make the following comments.

First, *The Pharmaceutical Journal* is self-funding, so there is no reason, apart from postage why a copy cannot be sent to retired members, out of courtesy, if nothing else. I think a simple "thank you" for a lifetime's contribution to the profession would be an obligation this current Royal Pharmaceutical Society hierarchy might find hard to comprehend, but as an honourable gesture it is entirely correct.

Secondly, all the costs mentioned by our Treasurer as being responsible for this year's unprecedented rise are, as far as I can see, one-off special events. The pension fund deficit will be gone. (The fact that I can be so generous

to people I never knew I was in any way obligated warms the cockles of my cynical heart.) The prior year deficit will be gone. The increased operating costs, national insurance I assume, will not be gone. However if any serious attempt were made to control staff numbers, this increase would be minimal. Therefore can we assume next year the fee will return to less than £300? Of course not. The Society has become bloated on the life blood of the membership.

Was I the only pharmacist who wrote to my MP? Sadly, the reply I received merely illustrated how irrelevant we are to the powers that be in Westminster and how totally ignorant they are of the ramifications on this profession of their ill-informed, Shipman-based knee-jerk response.

However, there is a more serious side to this rise to my mind: the membership protested, wrote letters, filled in petitions, and answered consultation documents, but the fee rise went ahead anyway — £30 pounds less, but it went ahead just the same. So if the membership's views are totally irrelevant to the Lambeth High Street Kremlin, just whom does the Society think it will be representing in 2012 or thereabouts apart from itself, and which of its functions does it think we going to pay for?

Who is going to sign up to the voluntary membership society? Will it possibly be the hospital pharmacists sitting in their cold garrets counting their 1.5 per cent pay rise? Will it be the major chains, to which the Society has just presented a bill for many hundreds of thousands of pounds, which will be passed on to the Chancellor as a business expense? Will it be proprietor owners, who have also just presented the Chancellor with a tax write-off for business expenses which also will run into many hundreds of thousands of pounds. This remains the question the Society needs to ask itself.

In my view the Society has just thrown away 160 years of honourable development and will succeed only in splitting the membership into a series of professional camps, in what is probably the greatest political misjudgement and mismanagement since Mr Chamberlain returned from Munich.

Roll on retirement so I can join another irrelevant group — the pensioners.

Alan Denholm

Keswick, Cumbria

■ THE SOCIETY

Not much value in emeritus status

From Mr W. T. Brookes, FRPharmS

The Official Notices in the *PJ* of 13 October, which caused my good friend Bruce Rhodes to ask a number of questions about the proposed emeritus status of (former) members and fellows (*PJ*, 17 November, p565), had also prompted me to put a series of similar questions to Jeremy Holmes, the Royal Pharmaceutical Society's Chief Executive and Registrar.

I have just received his reply, for which I am grateful. However, it causes me to question the value of the award as outlined since those such as Bruce and me had understood it would be a means of remaining on the Register.

To quote Mr Holmes, "the awards of emeritus fellowship and emeritus membership of the RPSGB will . . . be new categories of Society distinction that will recognise the distinction of . . . fellows and members who have retired from the Register and who have previously been on the Register for 50 (total not necessarily continuous) years or more. To be clear, emeritus fellows and members will not be on the Society's Register." He goes on to say that they will be offered the privilege of a reduced price subscription to the *PJ* of £30 per annum but will not be able to use any form of post-nominal designation.

In addition, presumably, although this has yet to be clarified, they will not be able to attend the annual general meeting or the branch representatives' meeting or hold office at branch or regional level.

So what is the value of this award in terms of membership? The answer would appear to be "not a lot".

Bill Brookes

Stoke-on-Trent, Staffordshire

■ THE COUNCIL

We want to know how Council members vote

From Mr D. J. Livingstone, MRPharmS

The reply from the President, Hemant Patel, to the issues raised by Paul Breame (*PJ*, 17 November, p562) is wholly inadequate.

Mr Patel states: "We will continue to plan ahead to design a professional body based on the needs and views of our members . . . encouraging members to vote in Society elections." Mr Patel and his fellow Council members should be aware that I and, I believe, most members of the Royal Pharmaceutical Society do wish to know how individual Council members vote on such issues as the fees increase. This should not take any debate; we paying members should have an unequivocal right to know. Mr Patel talks of collective responsibility — as far as I am aware the Council is supposed to act like a parliament with free debate which should be open to scrutiny. It would appear that the President takes a different view and sees the Council as his cabinet. Few members currently vote in Council elections. When we see our views being ignored by an anonymous majority of the Council, it is a source of wonder that any vote at all.

Duncan Livingstone

Lancing, West Sussex

■ COMMUNITY PHARMACY

Non-professional dispensing set a bad precedent

From Mr P. J. Francis, MRPharmS

As I understand it doctors have the legal right to allow non-qualified staff to dispense in surgeries without any checking by the doctor. The doctor is not required to be present in the dispensary when dispensed medicines are given out. The legality of this was challenged several years ago by a major pharmacy body. The judge decided in favour of the dispensing doctors. The basis of his judgment was that a pharmacy could be owned by a company. The judge appeared to ignore the fact that dispensing surgeries are often also run by doctor-owned companies. There was, therefore, room to appeal the decision given the double standard applied. The decision was not appealed, leaving the situation whereby doctors can employ anyone to dispense without supervision.

What is the relevance of this to pharmacy? The Department of Health will no doubt have thought that if it is legal for non-qualified persons to dispense unsupervised in doctors' dispensaries, then there is no reason why the same should not happen in normal pharmacies — and at a fraction of the cost to

the DoH. Perhaps it is time to reconsider avenues of appeal of that highly anti-pharmacy precedent.

Paul Francis

Brisbane, Australia

■ HEALTH CARE REGULATIONS

Let pharmacy not be at the forefront

From Mr M. A. Walker, MRPharmS

At the start of summer, Keith Ridge, the chief pharmaceutical officer for England, proposed to reframe pharmacy regulation at the College of Pharmacy Practice's annual meeting (*PJ*, 21 July, p61). I am concerned that pharmacy regulation might be considered in isolation instead of within the wider framework of health care regulation. I thought that the White Paper envisaged that health care regulation would be common across the various professions.

I hope that the All-Party Pharmacy Group will scrutinise the recently introduced Health and Social Care Bill and the related secondary legislation and ensure that pharmacy is regulated with the same scope and manner as other health care professions. The pharmacy profession would definitely benefit from being regarded and regulated as a mainstream health care profession and I hope that the APPG can deliver this. After decades of pharmacy regulation being a special case let us not repeat this error when creating the General Pharmaceutical Council.

Dr Ridge may have been thinking that all health care regulation should be reframed.

That is a much wider topic than pharmacy regulation, and doctors, dentists, nurses etc will need to be consulted in that debate. However, pharmacy will be better served by being a follower and not the leader in any "reframing of regulation" that may occur in the future.

Mark Walker

Oxford

■ MEDICINES DISTRIBUTION

Supply of Prograf

From Mr G. A. Largue, MRPharmS

With reference to Ross Ferguson's letter (*PJ*, 6 October, p382) regarding supply problems with Prograf capsules, I have also found the availability of this product to be sporadic, with both my two main wholesalers regularly out of stock.

I telephoned Astellas Pharma on a Friday to order Prograf because Phoenix and Munro were out of stock. I was told that I would receive the order by courier on Monday, and that I would be invoiced through my normal wholesaler. However, I was also asked for my UniChem account number, the account number that I use only for my Pfizer products. When I asked why this was required I was told that the Prograf capsules might be delivered via UniChem. When my Pfizer order arrived on Saturday morning there was also a bag containing the Prograf capsules that I had ordered, although they will still be invoiced via my normal first-line wholesaler. I have also been told by one of my wholesalers that some of their customers have been told that Prograf is only available via UniChem.

I would like to ask Astellas Pharma Ltd the following questions:

- Is it only supplying pharmacies via UniChem?
- If so, why has it not made it public knowledge and let other wholesalers and pharmacies know?
- Why do we have to telephone its customer services department every time we need to order?

This convoluted and opaque supply chain causes delays in supplying essential medicines to patients, wastes time that should be spent on our patients and is unprofessional. This is at a time that the Government and pharmacy representatives are working to deliver a contract that is focused on

A4 certificates

At the request of members performing locum duties, the Royal Pharmaceutical Society has made available an A4-size registration certificate. Any member wishing to take advantage of this facility should write to the Society enclosing their current registration certificate together with a fee of £10.

It is a requirement of the Medicines Act 1968 that the certificate of registration should be displayed at the premises at which the pharmacist is working.

getting pharmacists off the telephone to suppliers and out talking to patients.

Gordon Lague
Huntly,
Aberdeenshire

AMIT MAKWANA, managing director, Astellas Pharma Ltd, responds: Timely and reliable supply of all medicinal products is critical and it is particularly vital that transplant patients receive their prescribed medicines regularly.

I can confirm that we have appointed UniChem, with its service and coverage expertise, as our sole distribution logistics service provider in the UK for all our transplant medicines. This announcement was communicated publicly on Monday 12 November and before that date we advised key stakeholders of our decision.

This change has been made in response to reports from UK pharmacists that they have had difficulties obtaining Prograf for their patients from their wholesaler. When we learnt that transplant patients were experiencing problems getting their medicines, we had to take immediate interim measures and set up an emergency delivery service. These reports escalated quickly and we therefore took urgent action to distribute all our transplant medicines direct to pharmacists and other dispensing points with effect from 26 November.

This change only applies to our transplant medicines. All other Astellas Pharma products can be ordered in the usual way.

The vast majority of dispensing sites are already ordering some, or all, of their medicines through UniChem and will be able to order our transplant medicines (Prograf and Advagraf) through their existing accounts. UniChem will be contacting all customers shortly to confirm the ordering processes. Any dispensing site that does not currently have a trading account with UniChem and wishes to obtain our transplant medicines from 26 November should contact UniChem immediately by telephoning 0800 389 3455 or e-mailing sales_customersupport@unicem.co.uk.

Astellas hopes readers understand that this decision was not taken lightly. Our responsibility as holders of the UK marketing authorisation for Prograf and Advagraf is to ensure the supply of these vital medicines to pharmacists and their patients in the UK.

ETHICS

How can confidentiality and patient care be reconciled?

From Mr S. D. Morgan
MRPharmS

I read the article by Joy Wingfield on confidences (*PJ*, 10 November, p533) with interest. The "real life situations" contained an example where a young man who was collecting a prescription on behalf of his grandmother asks: "Can you tell me which one is for what, because she gets rather confused these days?" The suggested response (at www.pjonline.com.CPD) states that as you cannot presume consent to disclosure you should "politely refuse" (Code of Ethics — standards of confidentiality). This type of situation is a common, indeed a typical scenario. Just as many prescriptions are collected by relatives or representatives as by patients themselves. Obtaining explicit consent from a non-present patient is often not possible. In the example given, one would presume at least that the patient has consented to the grandson collecting her prescription, but even this cannot be proved.

Elsewhere in the Code of Ethics we are reminded that we must "make the care of patients your first concern" and "encourage the effective use of medicines and be satisfied that patients, or those who care for them, know how to use their medicines". Where a new medicine is prescribed, a dose of an repeat medicine is changed, or where there is potential confusion I would consider that it is therefore my first concern to explain the proper use of the medicine.

Giving out medicines to representatives in a sealed bag does not assure confidentiality. If we are sufficiently satisfied to dispense the medicine to the grandson, then we should be satisfied to give supporting advice.

We could protect ourselves and refuse to issue the prescription as well as refusing to disclose any information to representatives, or we could apply discretion and common sense in determining the relative risks.

Confidentiality is important but so is patient care. How do we reconcile the two concerns in these common circumstances?

Simon Morgan
St David's,
Dyfed

■ LOCUM PHARMACY

Can "Spanish practice" survive influx of practising Spaniards?

From Mr M. J. Tobyn, MRPharmS

David Sevege (*PJ*, 10 November, p531) suggests that pharmacists set a rate of locum pay based on a notional sense of "worth", rather than what the market will bear in their area. Of course, if this sense of worth is more than a couple of pounds greater than the local going rate Mr Sevege will have all the time outside school holidays and influenza epidemics to ponder his economic importance.

It would be interesting to see if this particular "Spanish practice" survives a new influx of practising Spaniards (and Poles, Portuguese and Greeks) who discharge their responsibilities with competence, but more cheaply.

Mike Tobyn

*Wirral,
Merseyside*

Locums provide a valuable service

From Mr S. Elliott, MRPharmS

I can empathise with almost all of the financial and administrative pressures Harnek Singh Chera describes (*PJ*, 20 October, p438) since I, too, am a director of an independent pharmacy. However, as a self-employed locum pharmacist I would like to refute his assertion that locums are "holding contractors to ransom".

Market forces and competition will naturally influence the fees that locum pharmacists are able to charge, but I consider that the fee which Mr Chera mentioned of £23 per hour is certainly not excessive, especially when taking into account the lack of paid holidays and responsibility for one's own retention fees, indemnity insurance, pensions, injury/illness-type insurance etc. Assuming an average 40-hour week for 48 weeks per year (most employee pharmacists would receive at least four weeks' paid holiday entitlement), £23 per hour would equate to just over £44,000 per annum, which I think would be comparable to, or less than, the salary of experienced pharmacist managers (who may also receive bonuses, profit sharing schemes etc from their employers).

It must also be kept in mind that a locum is not "guaranteed"

work for a set number of hours or weeks per year and may have to make considerable effort to obtain sufficient work to earn a reasonable wage, or may need the help of a locum agency, adding an additional cost to the contractor and possible losing some of the freedom and flexibility offered when dealing direct with clients. During "quiet" periods of the year locums may also have to travel greater distances than usual, adding extra time to their working day and a financial penalty if travelling expenses are not fully reimbursed.

As mentioned previously in a **Broad spectrum** article (*PJ*, 29 September, p348) and **Letters** (*PJ*, 13 October, p401), there is an increasing necessity for locums to become accredited for various enhanced and advanced services offered by their numerous places of work in order to attract premium rates of pay and possibly, in the future, to obtain sufficient work as contractors may become less willing to use locums who cannot maintain the pharmacy's usual range of services. The locum must be able to adapt to each pharmacy's standard operating procedures and working style and can pass on examples of good practice from one to another, if appropriate.

The growing number of multiple and supermarket pharmacies may impact upon locum fees as they could gain the upper hand in negotiations with self-employed locums if there are fewer opportunities to work in the decreasing number of independently owned pharmacies. I currently provide services to both independent and multiple pharmacies and I think it is fair to charge a consistent fee across the board for offering the same level of service to all of my clients.

In short, I believe that locums provide a valuable service to contractors and deserve fair

remuneration to reflect this. I feel sure that many contractors would agree with this sentiment and appreciate the "peace of mind" of leaving their businesses in the care of a trusted and reliable colleague.

Simon Elliott
*Bishop Auckland
County Durham*

Locum rates in Northern Ireland

From Dr I. ab I. Davies, MRPharmS

David Sevege (*PJ*, 17 November, p531) should move to Northern Ireland where he would find that the going rate for locum fees is less than £20 per hour.

Iolo Davies
*Ballygowan,
County Down*

■ REMUNERATION

Plumbing as a paradigm

From Mr A. R. Cox, MRPharmS, and Mr C. Anton

David Sevege (*PJ*, 10 November, p531) revives the use of plumbers as a comparator for pharmacists' remuneration. We noted that plumbers commonly appear to be the comparator of choice for pharmacists when complaining about remuneration, and decided to test this by searching the online version of *The Pharmaceutical Journal* for references to plumbing. Since 2000, 23 letters have been published using plumbing as a comparator. Two of these concern the effect of professional regulation on pharmacists' ability to work, one was concerned with comparative attractiveness to the opposite sex, while the remaining 20 used the plumbing profession as a bench mark for pay levels. Other trades mentioned in these letters were car mechanics, electricians, chefs, landscape gardeners, and painters and decorators. Professional groups (such as dentists) with comparable training were rarely mentioned in these letters.

Example comments included "It now takes five years to qualify as a pharmacist, and when one gets there one is paid less than a plumber and is treated as an Untermensch" and "It is surely time we were charging for our knowledge and expertise. We all know how much an emergency

plumber or car mechanic charges." Notably similar comparisons have been noted in academic studies of female community pharmacists' views on remuneration,¹ and have also been made by members of the Royal Pharmaceutical Society's Council.

Although plumbing is arguably at least as old as pharmacy, and sanitation was recently voted the greatest medical advance in 150 years by readers of the *BMJ*,² the comparison is used to imply that pharmacists are undervalued. Complaints that pharmacists are underpaid using plumbers could be viewed as selective, when a typical community pharmacist manager's salary is likely to be close to the 90 percentile gross national salary.

The other basis for the comparison is also the claim of pharmacy to be a profession, and is an attempt to differentiate pharmacy from a mere trade. The plumbing comparison perhaps reflects a concern that pharmacy is not valued as profession, or may indicate a lack of confidence of the profession itself.

We suggest that plumbing is a poor comparator for the profession of pharmacy, due to plumbers' remuneration being directly linked to a market scarcity of plumbing skills rather than a valuation of its professionalism. More useful comparisons could be made with fellow professionals such as dentists, physicians or specialised nursing staff. The focus should be on the valuable contribution that pharmacists could provide using their specialist skills to ensure the safe and effective use of medicines in the population. If society does not place a value on such activities, then it is up to the pharmacy profession to ensure that its role is more clearly marketed and recognised. The paradigm of plumbing serves this cause badly.

Anthony Cox
Christopher Anton
*Pharmacy Department
City Hospital,
Birmingham*

CONFLICTS OF INTEREST
ARC is a pharmacist who recently refitted his own bathroom. CA has recently paid a large amount of money for a new boiler.

References

1. Gidman W, Hassell K, Day J, Payne K. Let's get practical: does it pay for female community pharmacists to work? *The Pharmaceutical Journal* 2007;278:645-9.
2. Ferriman A. *BMJ* readers choose sanitation as greatest medical advance since 1840. *BMJ* 2007;334:111.

Ownership change?

Transferring the ownership of a registered pharmacy premises? Remember that you have a legal obligation to update the Royal Pharmaceutical Society. Contact the Society's registration section (tel 020 7572 2322; e-mail registration@rpsgb.org) for an application form or download a form from the registration section of the Society's website (www.rpsgb.org/pdfs/regpremb.pdf).