

■ STATUTORY COMMITTEE

### Let off too lightly

From Mr C. S. G. Farry,  
MRPharmS

It is not often I have recourse to doubt the wisdom of the Royal Pharmaceutical Society's Statutory Committee. However, a recent decision to issue a reprimand (*PJ*, 15 December 2007, p698) leaves me somewhat puzzled as to what degree of misconduct is required before any stronger admonishment is dealt out. Here we had a pharmacist who wilfully stole over £9,000 from the NHS by fraudulently claiming for items he had not dispensed. Any member of the public stealing such an amount from an employer or otherwise could reasonably expect a jail sentence at worst. It is indeed an immense breach of trust.

Further to this, dispensing errors notwithstanding, the pharmacist claimed an exemption on a prescription where the patient in question had paid the full fee, thereby putting the patient at risk of a fraud investigation and the distress that would naturally entail.

Does the Statutory Committee really think this punishment will serve as a deterrent to any other who wishes to follow the same path? And what of the public who have read of this in the local press and see the pharmacist in question continuing to practise? This reflects on all pharmacists and does the profession as a whole a huge disservice. The Society has constantly and traditionally said it is there primarily to protect the public and secondly the members. I do not see any evidence of either in this case.

**Conal Farry**  
Leeds

JEREMY HOLMES, Chief Executive and Registrar at the Royal Pharmaceutical Society, responds: It is not the Society's policy to comment on individual cases. However, there are a number of factual errors in this letter, relating to the allegations against the registrant. I refer Mr Farry to the Notice of Inquiry and the Statutory Committee's determinations on misconduct and sanction that can be found on the Society's website ([www.rpsgb.org](http://www.rpsgb.org)).

The determination states:

- "This is an inquiry into allegations of erroneous endorsing and dispensing and the inadequate disposal and

segregation of returned medicines."

- "Dishonesty was not alleged in respect of [this or] any [other] of the allegations contained in the Notice of Inquiry."
- "[The registrant] had received an overpayment totalling £6,467.15 in respect of allegation 1 and £2,966.81 in respect of allegation 2."
- "These sums have subsequently been repaid by way of deduction from the pharmacy account. [The registrant] has not been prosecuted by the police for this matter or indeed for any of the matters contained in this Notice of Inquiry."

As with all such cases, the Society has provided copies of the Notice of Inquiry and transcripts of the determination to the Scrutiny and Quality Division of the Council for Healthcare Regulatory Excellence (CHRE) at First Floor, Kierran Cross, 11 The Strand, London WC2N 5HR. The CHRE has jurisdiction under section 29(4)(a) of the NHS Reform and Health Professions Act 2002 to bring an appeal against a final decision of the Society's Statutory Committee or Disciplinary Committee if it considers that decision to be unduly lenient or otherwise inappropriate. The CHRE also has the ability to issue learning points and guidance to all the regulators over which it has jurisdiction. The Society takes its responsibilities for public protection and regulation seriously.

■ EHC

### Where was pharmacy's voice?

From Mr C. A. Salmen, MRPharmS,  
and Mr P. Mollison, MRPharmS

With regard to widening access to the oral contraceptive and all the recent media coverage of the subject, where was the Royal Pharmaceutical Society's official press release? With the Society's substantial increase in funding why was there no representation on behalf of pharmacists? The coverage in the media was damning and undermined the ability of the profession.

**Chris Salmen**  
Sutton, Surrey  
**Peter Mollison**  
Epsom, Surrey

JEAN-PIERRE MOSER, head of corporate communications and

membership at the Royal Pharmaceutical Society, responds: Issues relating to access to oral contraception and emergency hormonal contraception have made news in recent weeks and the Society worked to ensure pharmacy's voice was heard on both stories.

In December, the *Daily Mail* published a story about EHC being made available to girls under the age of 16, which criticised the provision of contraceptive services through pharmacies. The Society responded with a letter to the editor (available at [www.rpsgb.org](http://www.rpsgb.org)), which highlighted the fact that pharmacists are experts in medicines and that they must make the welfare of their patients their first concern. The letter was published by the *Daily Mail* on 20 December.

Also in December, Lord Darzi announced in the House of Lords, a pilot scheme to make the oral contraceptive pill available to the public via patient group directions. A Society statement was prepared (also available at [www.rpsgb.org](http://www.rpsgb.org)) that broadly welcomed the news. This was issued to all national news desks. The public relations department at the Society also contacted key broadcast media and arranged interviews with the BBC Radio 5 Live, BBC West Midlands, BBC Radio Nottingham and BBC Radio Wiltshire.

It is not only through campaign work that the Society achieves media coverage. The public relations team works hard to maintain pharmacy's presence in national media on key healthcare issues. To help keep Society members informed of this work, a monthly report of PR activity is made available on the Society's website at [www.rpsgb.org](http://www.rpsgb.org).

■ THE PROFESSION

### Poor service

From Mrs A. L. Smith, MRPharmS

Having worked in retail pharmacy for most of my working life, I have always been an enthusiastic supporter of the extended role of the pharmacist. Imagine my disappointment on taking a telephone call last week from my brother, a consultant ophthalmologist, who asked me about availability of Predsol eye drops; he had an irate patient on the telephone who had tried to obtain the drops, prescribed on an HP10, from six different pharmacies. Predsol eye drops were unavailable during December, due to a manufacturing problem, but why did none of these pharmacists pick up the telephone and ask the prescriber for an alternative?

If this is the level of service being experienced by patients and prescribers, who is going to commission extra services from us?

**Anna Smith**  
Exeter,  
Devon

### Direct debit

Sign up to pay your retention fee annually by direct debit. It is quick and easy, you cannot forget to pay and you will not risk being erased. Remember, fees are due and payable on 1 January every year. Contact the registration section and ask for a direct debit mandate (tel 020 7572 2322; e-mail [registration@rpsgb.org](mailto:registration@rpsgb.org)).

### 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.

■ WCPPE

## Questions about the procedure behind director's appointment

From Mrs S. M. E. Cockbill,  
FRPharmS

I am writing to support wholeheartedly the points raised by Colin Ranshaw (*PJ*, 8 December 2007, p655). I, too, was amazed to learn of technician Lesley Morgan's appointment to the position of director of the Welsh Centre for Postgraduate Pharmaceutical Education. I need to emphasise that this is not personal; I have known Ms Morgan for several years and have nothing against her. There are, however, several questions surrounding her appointment which need to be asked. To ensure pharmaceutical credibility among our peers and the other healthcare professions we need a pharmacist at the helm when issues relating to postgraduate pharmaceutical education are being discussed and courses planned. This is simply not a post that should be given to a technician. It is inconceivable that doctors, dentists, ophthalmologists, nurses, etc. would appoint anyone of equivalent status to that of a pharmacy technician to lead their professional postgraduate activities. It simply would not happen.

Why was the appointment not advertised in *The Pharmaceutical Journal* and other relevant publications that would enable pharmacists with an interest in the area to consider applying for this senior pharmaceutical post in Wales? We are led to believe that the position was advertised on the relevant website for appointments within Cardiff University but that it was not considered necessary to advertise it anywhere else. Why? I and several of my pharmacist colleagues failed to find the advertisement when we searched this source so, when, for how long and where did it appear? We know that a Groupwise e-mail message was circulated to a few select people within the Welsh School of Pharmacy. How were these individuals chosen and by whom?

We have become accustomed to openness and transparency and regard for the Nolan principles relating to the seven principles of

public life being the norm when making appointments of this nature. It is regrettable that these principles would appear to have been overlooked on this occasion. If at all possible, I urge those responsible for making this strange decision, to give those pharmacists in Wales who are unhappy with the way in which this whole procedure has been undertaken, an explanation and the reassurance that everything was, indeed, open and above board.

Otherwise, it would seem that for pharmacists practising in Wales, the unthinkable has happened at a time when the profession needs all the stability and credibility it can muster to engage with other professions to take forward the many Government initiatives currently before us.

I would urge my colleagues and the local branches in Wales to put pen to paper to encourage our Welsh Pharmacy Board to ask questions about the procedure behind this appointment. We need, also, to lobby relevant personnel at the Welsh Assembly who are, ultimately, responsible for the funding of the director's post, and to demand satisfactory answers and reassurance that, despite all appearances to the contrary, the best possible applicant was appointed.

**Sarah Cockbill**  
*Chepstow,*  
*Monmouthshire*

■ CPD

## Lack of realistic engagement

From Dr C. A. Duggan, MRPharmS,  
and others

We were interested in the recent article on continuing professional development and fitness to practise by Dyke and Gidman (*PJ*, 19 January, p48). We agree that there remains a reality gap between rhetoric, the policies and the practice of CPD by individuals. This is exacerbated by the terminology often adopted by policy pronouncements ("doing" CPD, for example, or vague notions that practitioners should engage in "reflective practice" and "lifelong learning"). Despite the plethora of publications, articles, theory and policy on the issue of CPD, there remains a lack of realistic engagement; the heart of the issue is that a significant proportion of practitioners cannot see the everyday usefulness of

CPD. The reason is clear to practitioners, but sadly not to the theorists and zealots, who on the whole have little experience of busy and demanding healthcare work environments. To be relevant and successful, CPD requires a pragmatic, *in situ*, realisation (or "operationalisation"). This can only be achieved, from a fitness-to-practise context, through properly constructed developmental (or competency) frameworks.

The Competency Development and Evaluation Group (CoDEG) has researched "bottom up" approaches towards developing practitioner-owned and workable professional development frameworks relevant to different levels of practice (the "General level framework", the "Advanced to consultant level framework", and now the "Pharmacy technicians' framework" — see [www.codeg.org](http://www.codeg.org)). These are now in widespread use by practitioners and employers, nationally and internationally. Why have these frameworks worked? Because they are the only developmental frameworks to have been tested and shown to work in a way that allies CPD and practitioner development within measurable outcomes.<sup>1,2</sup> Practitioners do not have to struggle with terminology such as "reflective practice" or have to take time out from the workplace to "do their CPD". More recently, the Joint Programmes Board ([www.postgraduatepharmacy.org](http://www.postgraduatepharmacy.org)) has applied this methodology to practitioner development pathways for several hundred junior pharmacists in the south east region, to marked effect. This has enabled both an NHS statement of completion and a postgraduate diploma award to be made on the combined basis of performance and academic attainment. We have good evidence that these same developmental frameworks provide similar practitioner support for all practice settings, with the important issue being levels of practice, not sector-based work environments.

CPD, competency-based approaches and fitness to practise can be successfully married. The crucial step has been the collaborative realisation and application of a work-based model based on equity with the practitioners, the employers (so far, the NHS), the professional agencies (eg, the UK Clinical Pharmacy Association and Guild of Healthcare Pharmacists among others) and the higher education sector.

We have shown that a collaborative ownership of practitioner development can impact on the assured competence and performance of practitioners. There is a lesson here for the current professional debate we are having in the UK.

**Catherine Duggan**  
*Chairman*  
*UK Clinical Pharmacy Association*

**Graham Davies**  
*Head of Programmes*  
*Joint Programmes Board*

**Sarah Carter**  
*Research Lead*  
*Competency Development and*  
*Evaluation Group*

**Ian Bates**  
*Head of Education Development*  
*School of Pharmacy, University of*  
*London*

**John Quinn**  
*Chief Pharmacist*  
*Buckinghamshire NHS Trust*  
**Stuart Semple**  
*Chief Pharmacist and Chairman*  
*Joint Programmes Board*

**Laura Obiols**  
*Research Officer*  
*CoDEG*

## References

1. Antoniou S, Webb DG, McRobbie D, Davies JG, Wright J, Quinn J, et al. A controlled study of the general level framework: results of the South of England competency study. *Pharmacy Education* 2005;5:201-7.
2. Obiols Albinana L, Bates IP, Webb DG, Davies JG, McRobbie D. Validating advanced practice: towards a definition of Consultant Pharmacist. *International Journal of Pharmacy Practice* 2005;13(Suppl):R54.

■ PREMISES FEE

## Call for a more realistic apportionment of costs

From Mr R. Darracott,  
MRPharmS

I cannot let the Treasurer's further repetition of his claim that the members of the Royal Pharmaceutical Society "subsidise" the premises fee (*PJ*, 8 December 2007, p654) go unanswered. In the cost recovery model submitted by the Society in support of its claim for a 56 per cent rise in the premises fee for 2008, revenues are set against the costs of collecting the fee, the full costs of 18 of the Society's inspectors (with an associated overhead), and an apportionment of the costs of significant elements of the Society's Fitness to Practise Directorate, including 35 per cent of the costs of all investigations and the Society's statutory committees

### E-mail

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

(including disciplinary and health). Sticking purely to the financial modelling, I do not accept that the Society incurs £3m costs annually related to the collection of the premises fee or its enforcement activities related to premises. Inspectors undertake a variety of duties over and above those related to premises. And given that I could find only one Statutory Committee Notice of Inquiry in 2006 that includes any reference to problems with "premises" in the citation, I am struggling to see how 35 per cent of the costs of investigation, prosecution and adjudication borne by the Fitness to Practise Directorate — or almost £1m annually — can justifiably be linked to premises. And why is the cost of collecting the premises fee forecast to more than double between 2006 and 2008?

I suggest that the application of a more realistic apportionment of costs would remove the Treasurer's "subsidy" and might even mean that premises fees are a net contributor to the Society's coffers.

#### **Rob Darracott**

*Chief Executive  
Company Chemists' Association*

ANDREW GUSH, Treasurer of the Royal Pharmaceutical Society, responds: Mr Darracott has had the advantage of having seen the detailed financial analysis we supplied to the Department of Health to support our argument for a substantial increase in premises fees. I am surprised therefore at the inaccuracies contained in his letter.

The Society does not, as Mr Darracott argues, "subsidise" the premises fees but our members do, any shortfall in recovery of our costs which we feel justifiably attributable to the regulation of premises have to be made up by a higher retention fee paid by pharmacists.

The costs attributable to premises regulation have not doubled between 2006 and 2008. The analysis supplied indicated an increase, based on our budgets for 2008 of 34.7 per cent. The fee proposed for 2006 of £243 represented an increase of 62 per cent over the corresponding fee for 2006 of £150. The higher increase in fees than the rise in costs results from our desire to eliminate the subsidy paid by our members that has existed for many years.

Mr Darracott remarks that there is only one citation (a Statutory Committee Notice of Inquiry) in 2006 that made reference to

premises. In doing so, I believe he has been rather disingenuous. The premises fee is paid by the owners and operators of pharmacy premises. In these days of consolidation, the dominance of multiples and corporate responsibility it would seem appropriate that owners take responsibility for safe operating procedures, the provision of appropriate staffing levels, the appointment and supervision of suitably skilled and qualified staff rather than, as they would seem to argue, that the consequences of any failures should fall entirely on the shoulders of the pharmacist who in many cases could well be a self employed locum.

I have the privilege of quoting from detailed statistics for 2008: The Disciplinary Committee ordered the removal from the Register of 12 pharmacists, three superintendent pharmacists who were directors, four sole proprietors and four joint owners of pharmacies; it also issued reprimands to 12 pharmacists, four superintendent pharmacists who were not directors, four sole proprietors and one limited company.

During the same period, the Disciplinary Committee heard applications for interim orders against five pharmacists and two superintendent pharmacists who were not directors, while the Health Committee imposed interim suspension orders on two pharmacists and one superintendent pharmacist who was not a director. I am sure that I do not have to remind Mr Darracott that superintendent pharmacists must be appointed by the owners of pharmacies which trade as limited liability companies.

The Society is acutely aware that the legislation surrounding pharmacy premises is old and in urgent need of overhaul. We hope that the forthcoming legislation that will establish the General Pharmaceutical Council will address such matters. In the meantime we hope that an adult debate on the why and how of regulation can take place with a view to promoting high standards in the operation of pharmacy premises for the protection of the public and the pharmacists working therein. We believe that every responsible and professional pharmacy owner has a vested interest in ensuring that premises regulation is maintained at a high standard and that those premises which fall below the high standards of the majority of community pharmacies are not allowed to

undermine the reputation of community pharmacy as a whole.

#### ■ RETENTION FEES

### Cost of restoration to Register

From Mr U. A. Patel,  
MRPharmS

In his reply regarding retention fees (*PJ*, 15 December 2007, p680), Jeremy Holmes, Chief Executive and Registrar of the Royal Pharmaceutical Society, mentions a figure of £753 as the cost of restoration to the Register of Pharmacists.

A pharmacist is paid about £23 per hour and if say another £23 is added to cover "head office costs", ie, rent, rates, heating, pension, etc, this comes to a total of £46 per hour. The cost of restoration equates to 16 hours of work. Does the Society expect us to believe that it takes that long to restore a name?

Can we please have a breakdown of what amounts to this figure? It is not surprising that pharmacists are disillusioned by the finances of the Society.

#### **U. A. Patel**

*Northwood, Middlesex*

JEREMY HOLMES, Chief Executive and Registrar at the Royal Pharmaceutical Society, responds: The £753 fee for restoration to the Register of Pharmacists applies where an individual who does not pay the relevant retention fee as and when required is, as a result, removed from the Register by the Society and subsequently wishes to restore his name to the Register.

It takes account of the increased administration costs involved where the Society has been obliged to pursue registrants who have failed to make retention fee payments, the costs in issuing a final demand for payment and the subsequent Society process for removal from the Register.

In considering the proposition in this letter, readers may also wish to note that pharmacists can voluntarily retire from the Register as part of the retention fee exercise. If this option is exercised the cost of being restored to the Register is £191.

#### ■ Telephone number

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

## ■ RETENTION FEES

**Initiatives to assist the lower paid**

From Mr E. S. Maule, MRPharmS

I read with interest the news item regarding General Medical Council's announcement that its retention fees will rise this year (*PJ*, 15 December 2007, p668). Its fees have risen for the first time in six years (in contrast to the annual fee increases of the Royal Pharmaceutical Society) and doctors on low incomes are entitled to a 50 per cent fee reduction. I wonder if Andrew

Gush, the Society's Treasurer, has considered similar initiatives to aid the lower paid NHS and part-time pharmacists to cope with this year's fee increase?

**Ewan Maule**  
*North Shields,  
Tyne and Wear*

ANDREW GUSH, Treasurer of the Royal Pharmaceutical Society, responds: I welcome this letter because helping low income members is a priority for me, but as Treasurer I must establish that the majority of members share my view before this help can be put in place.

The General Medical Council has just announced its intention to raise its fees to £390. The fee was raised by £100 from the previous level of £290. The Society's 2008 fees increased by £108, from £287 to £395. The GMC offers a 50 per cent discount on its annual fee for those whose incomes in the relevant year would fall below £21,391.

As a result of the consultation on the proposed fees for 2008, it was clear that a low-income fee was a concession that some members desired. The Society will therefore be consulting with members on such a concession during 2008 with a view to its

possible introduction in 2009. It must, however, be borne in mind that any concession given to those on low income will imply a subsidy by those paying the full fee. The acceptability of such a subsidy will, of course, form part of that consultation. Members are invited to make their views known by replying to this forthcoming consultation.

**Broad spectrum**

Contributions of around 1,100 words commenting on topical issues should be sent to [graeme.smith@pharmj.org.uk](mailto:graeme.smith@pharmj.org.uk) for consideration

**Drug interactions****Drug interactions that can occur with St John's wort**

Good quality information regarding drug interactions with herbal medicines is generally lacking, although the number of studies available is growing. The pharmacokinetic interactions of one herb, St John's wort, are well characterised, but drugs and herbs may also interact by pharmacodynamic mechanisms, and this type of interaction seems to be less well recognised. The following case will be used to highlight some of the interactions of St John's wort.

**Case study**

A patient taking gabapentin for nerve pain and using the contraceptive pill was admitted to hospital after a car accident. She was given three doses of intravenous pethidine followed by regular paracetamol and tramadol for pain from a broken leg. Within three days she developed tremors, fever, confusion and visual hallucinations. The serotonin syndrome was suspected and so tramadol was withheld and cyproheptadine given. When the patient was quizzed regarding her recent use of medicines, illicit drug use and non-prescription medicines, she mentioned that for several months she had been taking St John's wort. On discussion with the pharmacist she was told that St John's wort can affect the efficacy of hormonal contraceptives, and so she decided to stop taking the herb. A pregnancy test proved negative. St John's wort is an inducer of the cytochrome P450 isoenzyme CYP3A4, predominantly in the gut, and can therefore increase the metabolism of drugs that are CYP3A4 substrates. Case reports and studies suggest that St John's wort reduces the levels of drugs

including ciclosporin, hormonal contraceptives, imatinib, indinavir, oral midazolam and verapamil by this mechanism. Usually dose titration of the affected drug would adequately manage these interactions. However, the interacting constituent of many herbal medicines is unknown and therefore not standardised. Its potency could vary widely between different products and batches of the same product. Therefore managing the interaction safely and consistently becomes difficult.

Furthermore, decreasing the levels of drugs that are being given for serious conditions can be extremely hazardous, and it is for these reasons that St John's wort is generally considered to be contraindicated with ciclosporin and indinavir (and other protease inhibitors).

**Serotonin syndrome**

Serotonin syndrome is thought to arise from over-stimulation of serotonin receptors in the brain. It usually develops when two or more serotonergic drugs are given together. Drugs implicated in this reaction include lithium, metoclopramide, opioids (pethidine, tramadol), sibutramine, selective serotonin reuptake inhibitors, tricyclic antidepressants, triptans and venlafaxine. St John's wort has also been implicated in cases of serotonin syndrome (with venlafaxine and sertraline). Therefore, in the case above, serotonin syndrome may have been caused by a pharmacodynamic interaction between St John's wort and tramadol or pethidine. Caution is generally advised if several drugs with serotonergic effects are given. In practice this probably means being alert for symptoms of the serotonin syndrome,

which include altered mental status (agitation, confusion), autonomic dysfunction (diarrhoea, fever, shivering) and neuromuscular abnormalities (hyperreflexia, tremor). The problem usually resolves within about 24 hours if both drugs are withdrawn and supportive measures given. Non-specific serotonin antagonists (such as cyproheptadine) have also been used for treatment. Most patients recover uneventfully, but there have been some fatalities.

**Interactions with antiepileptics**

The final potential interaction in the case is that of St John's wort and gabapentin. It had been predicted that the metabolism of antiepileptics such as carbamazepine would be increased by St John's wort, but studies suggest any effect is not clinically significant. Nevertheless, the Medicines and Healthcare products Regulatory Agency has received reports of possible interactions with antiepileptics, resulting in reduced antiepileptic effects. These reports have included those antiepileptics that would not be expected to have a pharmacokinetic interaction, such as lamotrigine. The mechanism of this effect is currently unknown. Recent guidance from the MHRA suggests that patients with epilepsy should be advised to avoid St John's wort. At this stage it is unclear whether this advice extends to those taking antiepileptic medicines for conditions other than epilepsy, such as gabapentin for nerve pain. However, some caution would seem prudent. — *Karen Baxter, editor, Alison Marshall, staff editor and Jennifer Sharp, staff editor, Stockley's Drug Interactions*