

■ CLARKE INQUIRY

## Late reflections still being accepted

From Mr N. Clarke

As you know, the formal date for the end of the consultation phase of the of the inquiry into a future professional body for pharmacy passed on 31 January. The inquiry has received a host of responses to the consultation, which we are now digesting; we have been grateful to all those who have taken such time and trouble to consider the wide range of issues that have arisen.

Although the consultation date may have passed, the inquiry is happy to continue to receive any later reflections that pharmacists may have. The website ([www.theclarkeinquiry.com](http://www.theclarkeinquiry.com)) remains open and, as there have been a considerable number of submissions in the final week, pharmacists may want to review some of these and add additional comments. These will all be considered.

The range of formal evidence sessions has also now been completed, as have the public meetings. Although there has been some comment in the pages of the *PJ* about the levels of attendance at these, the inquiry team has found that the debate at all these meetings has been carefully considered and of a high quality, and has been helpful as we consider the responses.

### Nigel Clarke

Chairman  
*The Clarke Inquiry*  
53 Chandos Place,  
London WC2N 4HS

## Finding a place for retired pharmacists

From Mr W. T. Brookes, FRPharmS

I am one of that large majority who neither gave written evidence nor attended one of the meetings organised by the Clarke Inquiry. This does not mean that I have no interest in the future of the profession to which I have belonged for nearly 60 years but from which I have now retired. However, there will be many like me — retired but on the non-practising Register — who will wonder if and where they will fit into the proposed new professional body.

I was, therefore, interested in the statement on p7 of the Royal Pharmaceutical Society's

submission to the inquiry which reads: "There is a strong case for expanding the membership to cover pharmacists who have retired from the Register." I agree. It is appreciated that they are no longer active in the practice of the profession. However many are still involved at local branch and regional level and their input, both locally and nationally, is valued and recognised. This significant minority could well be excluded from the new professional body. It is to be hoped that this is not the case and that a place will be found for them and a means by which they could still be involved.

### Bill Brookes

*Stoke-on-Trent,*  
*Staffordshire*

■ MINOR AILMENT SCHEME

## Issue for pharmacy to consider

From Mrs A. E. Joshua, MRPharmS

Your **News feature** entitled "Making the case for a pharmacy-based minor ailments scheme for England" reported that 18 per cent of a GP's workload was spent on minor ailment consultations (*PJ*, 2 February, p103). The Proprietary Association of Great Britain and the Pharmaceutical Services Negotiating Committee are reported to be proposing that pharmacy should be the sole point of entry for all cases of minor ailments.

Our experience at NHS Direct is that members of the public are aware of community pharmacy as a place to visit for minor ailment advice and support. Many community pharmacists tell us they also provide advice and support via the telephone when they are open. There is a great deal that can be gained for community pharmacy in establishing strategic alliances with other providers of minor illness services rather than trying to promote itself as the sole point of entry. Patients are being encouraged to choose their point of health care access rather than be limited to only one model of service provision.

At NHS Direct we currently take an average of 22,000 calls day through our 0845 4647 number resulting in about eight million calls a year. Just under half of these calls, 47 per cent, are dealt with by NHS Direct as a "home care" or minor illness end point. Most of our calls are received after 6pm and up to midnight, a time when GP

surgeries are closed and pharmacies are closing. The reassurance and support that patients receive from NHS Direct via the telephone is a response to their need at a time when for various reasons the patient chooses this point of access. If, during the course of that discussion, a face-to-face assessment is considered in the best interests of the patient or medicines are required, then patients are advised to visit their local pharmacy, which may have to be on the next day.

The real issues for pharmacy are whether it wants to provide "minor ailments services" as an NHS activity and if it does is pharmacy ready to join with other NHS services so that we can jointly make that process as simple and accessible for the patient as the non-NHS pharmacy minor ailments service is now.

### Anne Joshua

*Associate Director of Pharmacy*  
*NHS Direct*

■ EHC

## As a Christian, I will not supply EHC

From Mr S. J. Lewis,  
MRPharmS

A news item last week entitled, "Complex relationship between beliefs, ethics and knowledge leads to variability in EHC supply" (*PJ*, 2 February, p108), quotes Richard Cooper as stating: "Terminology such as 'morning after pill', and a perception that [emergency hormonal contraception] causes abortion, are unhelpful for a profession seeking to provide a greater public health role."

EHC works in several ways depending on whether conception has taken place or not. If conception has taken place, EHC blocks normal processes so that the early embryo is unable to implant in the womb and therefore is expelled or aborted. Consequently, EHC may cause abortion if conception has occurred, which means the term "emergency hormonal contraception" is inappropriate and inaccurate.

I am unclear why these facts are unhelpful to us as a profession but they are the reason why, as a Christian pharmacist, I am not prepared to supply EHC, either on prescription or on request.

### Simon J. Lewis

*Hove, East Sussex*

■ WCPPE

## Appointments

From Dr N. S. Doggett, MRPharmS

If the new director of the Welsh Centre for Postgraduate Pharmaceutical Education is a technician whose appointment was not advertised, why do the current vacancies for part-time continuing professional development facilitators/tutors, which were advertised in your pages, specify that the applicants should be pharmacists?

### N. S. Doggett

*Kington, Herefordshire*

#### Telephone number

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

## 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

## My concerns have not been allayed

From Mr C. Ranshaw, FRPharmS

I am grateful to Stephen Denyer for taking time to reply to my letter over my concerns about the appointment of a pharmacy technician to the post of director of the Welsh Centre for Post-Graduate Pharmacy Education (*PJ*, 22/29 December 2007, p711).

I accept that with the proliferation of schools of pharmacy I have not kept myself up to date with the numbers of heads of schools who are, sadly, not pharmacists. Since Professor Denyer is the heads of schools nominee for the Royal Pharmaceutical Society's Council I would expect him to have greater awareness of this situation. However, I have not been reassured by his letter about the appointment of a pharmacy technician, who is one of the elected technician representatives on Council, to the extremely important post of director of WCPPE.

One of my major concerns is transparency of the appointment based upon Nolan principles. *The Pharmaceutical Journal* of 1 December 2007 carried an advertisement for the post of assistant director to the equivalent organisation in Northern Ireland, allowing a wide audience to be aware of it. The Welsh post was advertised somewhere in the ether for internal consumption only. How could the best pharmacists apply for this post if they were not aware of its existence?

In his reply, Professor Denyer mentions the Welsh Committee for the Professional Development of Pharmacy. I have lived and worked in Wales at the grass roots level for about 28 years, and have been involved with the profession helping bring about change over those years. So I am fully aware that the WCPDP commissions work from the WCPPE. Was the WCPDP involved at any stage in the appointment process? Does the work it has already commissioned from WCPPE while it had a director who was a pharmacist need to be reviewed?

Professor Denyer informs us that this is a three-year contract of appointment. I understood that the post was to be an interim appointment only, so three years is surely stretching that definition. Professor Denyer has not allayed my concerns.

At this time of regulation and professional responsibilities for pharmacy and pharmacists being separated, we need a strong pharmacist leader to sit down in meetings to move the pharmacy profession forward. I cannot accept that a non-pharmacist director has the depth of experience that a pharmacist would bring to the table to engage in continuing professional development for pharmacists. The letter from Catherine Duggan and others (*PJ*, 26 January, p82) highlights this lack of realistic engagement in CPD.

I stand by my original letter and my concerns.

**Colin Ranshaw**

*Barry,  
Vale of Glamorgan*

■ DISPENSING

## Patronising not to tell people the costs of their medicines

From Dr P. J. Brown, FRPharmS

I could not agree more with the Public Accounts Committee, Malcolm Furnell and your editorial about the desirability of putting the price of NHS medicines on the packs so that patients make the best use of their medicines (*PJ*, 2 February, p104). But in my experience this idea is not favoured by pharmaceutical manufacturers with whom I have discussed it several occasions.

The manufacturers have expressed a number of concerns. These include (a) the adverse effect on public opinion about fair pricing when branded pharmaceuticals are compared with generic equivalents and (b) price comparisons arising from the dispensing of parallel imports highlighting price differences between EU member states (provided patients know the euro to pound conversion rate). Their overall view is why tell patients about prices when they have not asked for this information — let sleeping dogs lie.

When you speak to patients about the prices of their medicines you find that they have no idea. When informed, they are surprised either because they are "so expensive" or because they are "so inexpensive". Branded versions evoke the first reaction and generics, the second. Interestingly, there are cases when patients ask why they have been transferred to cheap generics suspecting that these drugs are inferior or that they

are being discriminated against. This is commonly raised by elderly patients on repeat medication when the generic version is prescribed in place of the branded following patent expiry.

The case for putting the price of medicines on the pack is part and parcel of the need to ensure maximum transparency about the whys and wherefores of healthcare costs. Tax payers are aware that billions of pounds are spent annually on the NHS and are being told that there is considerable wastage. The more they know about what their medicines cost, the more likely will they appreciate what they are getting for their tax pound, which will lead to more responsible use, whether it is reducing wastage or ensuring compliance.

At the most basic level, putting prices on the packs of medicines can be justified by the argument that good decisions can only be made on the basis of having good information: the better the information, the better the decision. Ignorance may be bliss, but is it not extremely patronising to keep people in a state of ignorance about the price of what they are getting, particularly if they are paying for it?

**Phillip Brown**

*Weybridge,  
Surrey*

■ COMMUNITY PHARMACY

## We try to help patients in spite of the hurdles

From Mr U. G. Patel, MRPharmS

In response to Anna Smith's letter regarding the poor service a patient might have received (*PJ*, 26 January, p81), I would like to point out how this could have happened.

A patient needing an item which has a manufacturing problem rushes into a pharmacy and demands to know if the item is in stock since he has already been to a few pharmacies and found the medicine to be unavailable. Before the pharmacist can explain about the manufacturing delay or how he or she can telephone the prescriber and request an alternative preparation, the patient walks out saying he will try somewhere else. Even if the pharmacist is able to convince the patient, the patient wants what the doctor prescribes and thinks that the pharmacy is substituting a lesser drug.

Of course this depends on whether the pharmacist can even

contact the prescriber, who may have long left the surgery and no longer be contactable.

The telephone call Mrs Smith suggests would take over 15 minutes and this would be in middle of dealing with other waiting patients. And then time would be needed to explain to the prescriber that a new prescription is needed for the alternative suggestion.

In spite of all these hurdles we still try to help the patient if he or she is willing to tolerate the long wait.

**Umesh Patel**  
Hastings, East Sussex

■ PSNC

### With friends like these . . .

From Dr G. E. Spurgin,  
MRPharmS

I have just received the latest edition of *Community Pharmacy News* from the Pharmaceutical Services Negotiating Committee. Chief executive Sue Sharpe has written about medicines

distribution and the piece includes the following statement: "We will be working to agree with the Department of Health changes that remove or at least reduce dispensing at a loss." What a wonderful starting point for negotiations. With friends like this who needs enemies?

**Gareth Spurgin**  
Birmingham

■ DRUG ADDICTION

### The decision is the responsibility of the abuser

From Mr J. S Tait,  
MRPharmS

I write in support of R. C. Jacob (*PJ*, 2 February, p120). Fraser Harvie (*PJ*, 19 January, p59) states that in addiction the organ is the brain and the causal agent is stress. Unlike diabetes there is no organic or genetic link to stress, and therefore addiction does not fit the disease model.

Stress is merely one of several factors in the motivational mix and every person exercises his or her

own free will to start. Surveys reveal interrelated causes such as: boredom leading to experimentation with drugs; lack of domestic discipline; no sense of responsibility in this permissive society; affluence in a search for new thrills; rebellion against authorities; peer pressure; escape from living in a competitive society; unemployed with time to spare; and a spiritual vacuum with no meaning or fulfilment in life.

Essentially, the drug abuser is an unstable, maladjusted personality who has emerged as the product of disorganising forces from the family or environment causing him persistently or periodically to resort to excessive use of drugs as a means of assuaging his sense of malaise or frustration experienced in the world of human relationships. Other drug abusers simply succumb to the pandemic drug culture through experimentation or having tried drugs for kicks. Clearly, the decision to choose is the responsibility of the abuser.

The late Sir Derrick Dunlop, past chairman of the Committee on Safety of Medicines, observed that, of the biological species, (unlike rats) *Homo sapiens* is unique

in his persistence to resorting to drugs in the management of everyday affairs. What is the nature of man? No age has learnt so much about man and no age has learnt so little about who man is.

The drug culture must be challenged and changed by zero tolerance, this expressed in no uncertain terms by the Government, media, sport authorities, social services, the arts and the professions. Our fractured society must be mended by allocating top priority to marriage, responsibility and domestic stability.

The escalating drug scene, inter alia, is inversely proportional to our spiritual maturity.

**John Tait**  
Inverallochy,  
Aberdeenshire

#### 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](mailto:graeme.smith@pharmj.org.uk) for consideration

Advertisement

## ■ THE SOCIETY

**Why no cheques?**

From Mr J. E. Balmford, FRPharmS

I cannot believe that the Royal Pharmaceutical Society's Council has decided to cease the acceptance of payments by cheque. Electronic payment may be the way forward, but not all pharmacists, especially the elderly, have the means to pay in this way. I assume that this idea has come from the staff who now seem to run our Society. I would like to know what the problem is in accepting cheques. It cannot be the extra work involved because whenever I visit the Society, there always seems to be plenty of staff. It is just another idea that has not been thought through.

When the activities of the Society are split up, the new professional body will need all the members it can attract, and when you realise the length of time some of our members have been on the Register, this may well be yet another reason to cease membership.

It is my intention, next year, to pay my membership fee by cheque. If and when it is refused, I will not attempt to pay by any other means. I would ask as many members as possible to do the same so as to show the finance department that they cannot ride rough shod over members.

**John E. Balmford**

*Past President  
Royal Pharmaceutical Society*

HEMANT PATEL, President of the Royal Pharmaceutical Society, responds: I would like to assure Mr

Balmford that the decision to remove payment by cheque was only made after careful consideration.

In 2005, a strategy paper was developed by the Society's Financial Controller which looked at financial processes and identified which "hidden costs" could be eliminated. Although the removal of payment by cheque was, at that point, a little ahead of its time, the Council agreed that, with a communication plan and the appropriate systems in place, this should be implemented in 2008. In the past two years we have seen many companies and organisations follow the same approach and it is becoming more difficult to have a cheque accepted in our everyday life.

Although a majority of members now use MyRPSGB to make payments on line, we still retain a number of other methods for payments by members. These include:

- Direct Debit. Members can provide their bank details to the Society by completing a direct debit mandate. The Society will notify each member in advance of the date which payment will be taken from their bank account.
- Online. For those members wishing to pay online without access to a personal computer, libraries and internet cafes all offer use of computers and will provide support for using the internet.
- Telephone. In addition, a facility is currently being set up for members to pay their fees over the telephone. A telephone system will talk the member

through how to make a payment by either debit or credit card. We will be communicating details of this service, including providing a user guide nearer the time.

With regard to the number of staff employed, the introduction of MyRPSGB has seen the number of staff reduced by 4.5 for the period of the retention fee process. This, together with other associated costs, has resulted in a cost saving of over £60,000 enabling further investment in membership services.

Mr Balmford is correct that the Society wants to retain all members within the professional body. However, in order to do this, we need to demonstrate that the membership fee represents value for money. This does require us to continue to look for efficiencies and ensure we keep our administration costs at their lowest for the benefit of each member.

**Put out by pro-forma letter**

From Mr J. B. Nutt

Having retired and had two years on the non-practising Register I finally decided that I would resign from the Royal Pharmaceutical Society. On receiving the notification of my resignation from the Registrar, I was put out, to say the least, by the final paragraph of the letter.

I quote: "Some members retire after many years of service to the pharmacy profession. If you are one such member, may I take this opportunity to thank you and to

wish you the very best for the future."

I served 39 years and six months as a pharmacist. Yet it appears the Society cannot be bothered to look at someone's record to see length of service and adjust a standard pro-forma letter. Or are so many resigning that they are overwhelmed with work?

**John Nutt**

*Aylesbury,  
Buckinghamshire*

JEREMY HOLMES, Chief Executive and Registrar, Royal Pharmaceutical Society, responds: It is always helpful to have feedback from members, and I appreciate the letter sent to members resigning from the Register may seem impersonal, especially after long service to the profession. The Society is already changing the way it communicates with its members, and I hope members will see improvements over the coming months. I would like to take this opportunity to thank Mr Nutt for his 39 years and six months service to pharmacy, and I hope he will stay in touch with the Society.

**Closing down?**

Closing your pharmacy? If you are closing down a registered pharmacy premises, remember that the details on the Register of Premises need to be updated.

Contact the Royal Pharmaceutical Society's registration section (tel 020 7572 2322; e-mail registration@rpsgb.org).