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EMERITUS STATUS

Developing proposals for an alumni offering

From Mr H. Patel, FRPharmS

My personal vision for the future professional body for pharmacy is of an organisation that will serve its members from cradle to grave. For me, that would mean welcoming students as associate members from day one of their pharmacy studies and, in particular, it would also mean forging a special relationship with those who have retired from the Register. I think this will be essential if we are to promote a sense of history, status and collegiality within the profession.

In the spirit of this, the Royal Pharmaceutical Society's Council has been working for some time now to establish emeritus awards for its retired fellows and long-standing members. However, responding to concerns raised by the membership, the Council agreed at its February meeting to postpone the creation of these awards until the Society is free from its current regulatory restrictions [see p226].

The restrictions prevent the Council from awarding supportive and meaningful emeritus status. Regrettably, the decision will mean a delay as the emeritus award proposals are passed to the professional body task force, which will be charged with developing the alumni offering as part of the future professional body. I am writing to explain the decision, and what happens next, in more detail.

Readers of the *PJ* letters pages will be aware that senior and highly respected members of the profession have written to point out the lack of tangible benefit associated with the proposed awards (Bruce Rhodes, 17 November 2007, p565, and 1 December 2007, p623; Bill Brookes, 24 November 2007, p588), and correspondence has also been received by the office along the same lines. For example, recipients would not be members of the Society (creating a new membership category would require a special resolution under the Charter and Privy Council approval), would not be on the Society's registers (and so would not be able to call themselves pharmacists) and would not be eligible to use a postnominal denoting the award. One respondent summed this up as follows: "So what is the value of this award in terms of membership? The answer would appear to be 'not a lot'." This comment hit home. I found it hard to disagree, but there seemed little that the Council could do right now to make it better. The Society cannot, while it remains a regulator, offer a form of membership that does not carry the regulatory burden associated with being a health professional, given that "pharmacist" and "member/fellow of the RPSGB" are titles reserved by law to those who are on the Society's Register of Pharmacists.

However, things are changing. The Council took the policy decisions on emeritus awards in August 2006, before there was any suggestion that the Society would change its position as a regulator as well as a professional body. We are now in a different place and, if Government timetables hold firm, regulation will be decoupled from the Society by early 2010 and we hope that a new professional body will evolve. This new body will have the freedom it needs to make these awards meaningful and worthwhile. For example, it could create a new category of membership — perhaps emeritus, or alumnus membership — and there would be no need to restrict the use of postnominals.

The Society has already told the Clarke Inquiry that it believes there is a strong case for expanding the membership of the future professional body to include pharmacists who have retired from the Register. Bill Brookes has written recently (*PJ*, 9 February, p149) to say that he hopes a place will be found for retired pharmacists in the new professional body and a means by which they could still be involved. I wholeheartedly agree.

The Council considered all these points last week and decided that it should be guided by the comments it had received. The issue of emeritus membership is one that Council is taking extremely seriously but the regulatory role ties our hands. The Council wants to introduce something of genuine value to members and it is clear that current proposals are wide of the mark in delivering a meaningful and worthwhile award. It has therefore agreed to postpone creation of the emeritus awards until such time as the Society is free from its current regulatory restrictions. In the meantime, the professional body task force will be asked to develop proposals for an alumni offering as an integral part of the wider work towards a new professional body, in the light of the findings of the Clarke Inquiry. Membership input to these proposals will be vital and I would urge members to e-mail any comments or suggestions to positivefeedback@rpsgb.org.

To me this seems the only sensible solution, given the restrictions we currently face. I hope members will agree with me and I would particularly like to thank those members who wrote in and made us think again.

Hemant Patel
President
Royal Pharmaceutical Society

COMMUNITY PHARMACY

Why does this dangerous state of affairs exist?

From Mr J. M. Brunt, MRPharmS

Casually listening to a pharmacist employed by one of the newer multiples made me glad to be retired and out of it. This man, on learning I had been on the Royal Pharmaceutical Society's Council during the 1980s, told me he supervised some 17,000 prescriptions a month and wondered, quite rightly, what the Society was doing in allowing this dangerous state of affairs to exist and how he had come to be in such a situation with a perfectly good university degree. In my view, nobody can supervise that number with any semblance of safety and this man could be forgiven for thinking his professional society had abandoned him.

There was a time when no company would dare to exploit labour in this manner. That was something the inspectorate would sort routinely but, alas, it seems, no longer.

Mike Brunt
Thetford, Norfolk

DAVID PRUCE, Director of Practice and Quality Improvement at the Royal Pharmaceutical Society, responds: Mr Brunt raises some fundamental concerns about pharmacists' workload. Like Mr Brunt we would be concerned if pharmacists were being placed under pressure to work under dangerous conditions or dangerous levels of work. No one should be placed in a position where they have an unreasonably high workload. It is dangerous for patients and unreasonable for the professional involved.

We deal with this specifically under the code of ethics and the professional standards and guidance documents that support it. These standards address the issue of people in authority and state that they must ensure that "working conditions and practices are lawful and resources, facilities and equipment enable staff to provide services to professionally accepted standards". They also require that staff are able to raise concerns about risks to patients or the public.

We would like to remind employers that they must comply with the code of ethics requirements and that expecting pharmacists or pharmacy technicians to work under potentially dangerous conditions or workloads could form a breach of the code.

The code also says that pharmacists and pharmacy technicians must "ensure that you are able to comply with your legal and professional obligations and that your workload or working conditions do not compromise patient care or public safety". It

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goes on to say that one must "raise concerns if policies, systems, working conditions, or the actions, professional performance or health of others may compromise patient care or public safety". This sets out pharmacists' personal responsibility for ensuring that they do not allow themselves to work under conditions that put patients at risk.

The inspectors address problems that are raised with them. However, pharmacists do need to raise concerns both with their employer and with the Society if they think that patients are being put at risk because of workload. We appreciate that it is not easy to raise a concern in this way and it takes courage to do so. However, we would urge pharmacists and pharmacy technicians to raise concerns rather than simply accepting the situation or leaving a post because of excessive workload. We do take these matters seriously, in the interests of maintaining professional standards and ensuring high quality pharmacy services.

EHC

Defending both stances

From Mr G. Diamond, MRPharmS

Simon Lewis is to be commended as a man of principle with regard to his stance as a Christian pharmacist refraining from issuing emergency hormonal contraception on prescription or a pharmacy sale (*PJ*, 9 February, p149).

However, it is easy to grandstand on the moral high ground with any religious belief. Morality and ethics are not the sole preserve of those that cry "Lord, Lord" but are the domain of every pharmacist, too.

Therefore, I would defend the actions of pharmacists equally as strongly who choose to assist women and their partners to make the best choice for them and their family-planning needs.

Indeed, proposals to help pharmacists provide both long-term oral contraceptive options and EHC services should be welcomed wholeheartedly by the profession and public alike.

Religion in my experience tends to be historically a male dominated club that has given tokens of recognition to women and conspires to persuade believers that personal freedom is gained through compliance with its doctrines.

I have no qualms in helping distressed patients who genuinely need access to EHC in a pharmacy, since I am confident that pharmacists give a valuable and professional service in that respect.

Gerry Diamond
Manchester

Conscience or dogma?

From Mr J. Knowles, MRPharmS

I am sure that most pharmacists think carefully before refusing a service to the public. Those who deny emergency hormonal contraception on religious grounds, however, should not fool themselves into thinking they do so as a matter of conscience. Simon Lewis proudly states that "as a Christian pharmacist" EHC may cause an abortion because it may prevent implantation (*PJ*, 9 February, p149). We could have a lengthy debate about this but there is no point. Positions like his can reflect religious dogma rather than conscience, and unfortunately the Royal Pharmaceutical Society still allows pharmacists to force their religious views onto the public in this way.

I only hope that he displays a prominent sign explaining that he refuses to supply EHC together with the address of the nearest pharmacy that will.

John Knowles
Lichfield, Staffordshire

Careful consideration

From Mr C. A. Boucker, MRPharmS

I respect Simon Lewis's decision to refuse supply of emergency hormonal contraception on grounds of religious conscience (*PJ*, 9 February, p149) and, although my own opinions differ, I think it is important that we all give careful consideration to our beliefs in this area, rather than just "follow the herd".

I would be interested to know if pharmacists agreeing with Mr Lewis's views have considered their attitude to the supply of hormonal contraception per se? The patient information leaflets for every oral contraceptive list prevention of implantation as a mechanism of action and thus the same objection could be raised.

Also, do we do enough to ensure that patients are aware of these potential issues so that they can make informed decisions?

Colin Boucker
Gloucester

DISPENSING

Consequences of CIP are unacceptable

From Mr U. A. Patel, MRPharmS

I write regarding the "Capacity improvement programme" (CIP), mentioned in the *PJ* of 9 February (p140). Although we understand the need for the CIP, the consequences for contractors are unacceptable.

We are asked to separate all prescription forms where "calendar" packs are not dispensed and where broken bulk endorsements are made. Since there is no definition for a calendar pack and the pack sizes listed in the Drug Tariff vary from four to 180, it is unrealistic to expect pharmacy staff to remember the various products and pack sizes.

The Pharmaceutical Services Negotiating Committee has announced that it is negotiating payment for this extra "regulatory" burden. This is not a regulatory matter and we would rather not sort the prescriptions. This extra cost can be added to the NHS Business Services Authority's Prescription Pricing Division budget — let it do the sorting. Extra payments to contractors have a history of being lost in the global sum.

It is ironic that the NHSBSA is adopting automation while it is imposing a more labour-intensive procedure on contractors.

We understand a scanner is being used. Surely if the scanner can identify the products and strengths, it should also identify quantity prescribed and dispensed as per endorsement. If necessary, the software used by GPs and patient medication record systems should have a standardised format and font. After all, the clearing banks have had a standard format for cheques and pay in slips for electronic scanning for over 25 years.

Also there is concern about the accuracy of the scanner. Several pharmacists have reported that "exempt" prescriptions have been switched to "paid" with consequential loss. I would urge all contractors to check their payments with their records.

Since the accuracy of pricing is of paramount importance to the contractors, we think the PSNC needs to give this matter urgent priority and carry out a thorough audit and inform the contractors.

Uma Patel
Director, Avicenna Plc

THE PROFESSION

There is a need for a real power base

From Mr J. D. Thomas, MRPharmS

It is a sad fact that pharmacy has always had a minority interest among parliamentarians, as it has never had any continuous and effective political representation within the seat of political power when compared with other professions.

Coupled with this stark reality, community pharmacy is not fully recognised as a being a profession within a retail environment. In the eyes of our demanding public and their elected representatives, retail equates to profit and profit is an unacceptable word, giving the perception of excess and greed, as is ever being exposed in the media of large company profits and salary packages. If only community pharmacists had the same perception as a true profession, such as GPs, they would have received a 50 per cent increase in their remuneration as compared with the Category M and future generic clawbacks.

Community pharmacy is constantly having new initiatives thrust upon it due to this Government's emphasis on preventive medicine. This has and will continue to generate greater than inflationary prescription numbers, which is no fault of chemist contractors, who are only the messengers. Unfortunately due to the increase in the total drug bill costs, chemist contractors are being used as a scapegoat that can be easily used to recover some of these monies.

The poor old Pharmaceutical Services Negotiating Committee is not as its name suggests, but merely a consulting committee. From my own personal experience at plenary meetings, meaningful negotiations are not undertaken. But over the years, this committee, contrary to popular belief, has given real value to chemist contractors. The increasing proportion of large multiple ownership, with all the profit images they exhibit, can only be counterproductive in Government pay negotiations. Various legal judgments have made the Royal Pharmaceutical Society impotent in any financial representations, and because of this lack of presence, its efforts to promote our profession as a whole, in my view, have failed miserably. Financial functions have had to be taken over and provided by the National Pharmacy Association, the PSNC and, latterly, by the Company Chemists Association. This apparent lack of unity within the profession has been exploited by Government as a sign of weakness.

Hopefully, with the forthcoming and long overdue changes to our Society, the proposed new body can catch the imagination of our profession and provide a real powerbase to promote and drive our profession to its full potential.

J. D. Thomas
Patshull, Shropshire

Ownership changes

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

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

A coalition for change

From Mr G. Hall, MRPharmS

In her **Broad spectrum** article (*PJ*, 9 February, p148), Catherine Duggan makes some important points.

We have an unprecedented opportunity between now and 2010. This opportunity could unite the profession as never before and allow us to move away from the narrow politics and self-promotion of the past.

We need fresh faces on the Royal Pharmaceutical Society's Council: practitioners who care about promoting pharmacy and who will work together in such a coalition for change. The profession needs this leadership within the inner circle of the Council in order to engage with change, whatever the outcome of the Clarke inquiry.

In addition, there is opportunity for a change in the way Government wishes to remunerate community pharmacists for their services. The historical differences between pharmacists working in community and hospital could disappear with enlightened leadership. Clinically oriented pharmacy service is the future and many existing organisations have demonstrable experience in this field, capable of developing practitioners and services to enhance patient care. Practitioners from these organisations could play an invaluable role in moving the agenda forward and should consider standing for Council.

These considerations will be extremely important when the Council election papers are distributed. I would appeal to all pharmacists to vote with this new agenda in mind and seize the opportunities that present themselves.

After the debacle of the fee increase and a history of over regulation and a poor relationship between the Society and the membership, I would hope to see record numbers of pharmacists voting this year, voting for a break with the past, voting to make a difference and a coalition for change.

Graeme Hall
Leicester

MANUFACTURING

Tablets within capsules — unwelcome and inconvenient

From Dr S. Carey, MRCPsych

As health care professionals, it may be easy at times to view the internet and patient power as added burdens, but when viewing the world from the perspective of a user things may well seem different. I have been prescribed omeprazole capsules containing enteric-coated granules by my GP for a number of years. I have always adjusted the dose to the minimum required by removing some from the capsule (and recycling the excess, of course). I have recently discovered that my recent "capsules" do, rather oddly, contain one smallish, brown tablet inserted into a significantly larger capsule shell, which makes such titration impossible. The label on the box indicates that they are made by Almus, but the leaflet carries the Dexcel Pharma logo. My internet searches on this have found the helpful letter from Lynne Woodburn highlighting this issue and its associated response (*PJ*, 26 May 2007, p610). I note the current BNF54 indicates on p49 that capsules, in the case of omeprazole, contain enteric-coated granules and I suspect often for the good reason that swallowing may be difficulty for some with the conditions for which they are commonly indicated.

The BNF lists one "tablet within a capsule" of omeprazole made by Dexcel (Mepradec) under "tablets" on page p50, but does not mention any product made by Almus. I have a few of the old capsules left in a suitcase upstairs which gives me a week to try to sort this out, but this discovery is unwelcome and inconvenient. How can it be reasonable to brand medicines as capsules in this way? I would like to think that we, in psychiatry, do not often repackage our therapies in this way — but maybe we do. As Rabbie Burns might say: "O wad some Pow'r the giftie gie us To see oursels as others see us."

Stephen Carey
Consultant Psychiatrist
Stratheden Hospital

SUPPLY

Out-of-hours supply plan for Cornwall

From Mr N. Cameron, MRPharmS

From an outsider's perspective, one of the peculiarities of working in rural (rustic) Cornwall some years ago was that the we had dispensing doctors 300 yards down the road — they provided most of our prescriptions.

These doctors kept abbreviated hours, closed for the weekend at lunchtime on a Friday and had various other half days off during the week.

The pharmacy was open for much longer hours, the result being that those who ran out of medicines had to visit the pharmacy and request an emergency supply. If the other GP branch was open they could drive seven miles to obtain their medicines. Otherwise the problem fell to the pharmacy.

The out-of-hours emergency supplies plan for Cornwall (*PJ*, 8 December, p636) is an excellent initiative and it will be interesting to observe its implementation.

Neville Cameron
Coromandel, New Zealand