

■ TRIMETHOPRIM

## Will switching lead to increased resistance?

From Professor R. Finch, and others

The Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) has noted the recent reclassification of trimethoprim and nitrofurantoin from POM to P (*PJ*, 19 April, p459).

ARHAI welcomes the improved roles and responsibilities for pharmacists outlined in the English White Paper for pharmacy. ARHAI and its predecessor — the Specialist Advisory Committee on Antimicrobial Resistance — were instrumental in the recognition of the important role that antimicrobial clinical pharmacists can play in promoting the safe and optimal use of antimicrobials and has given them active support.

However ARHAI considered the reclassification of antimicrobials from POM to P could increase demand, promote the diffusion of prescribing of broad spectrum antimicrobials and contribute to increases in resistance among target urinary tract and other pathogens.<sup>1</sup>

If trimethoprim and nitrofurantoin both become pharmacy medicines this may encourage other applications for POM to P shifts of other urinary tract infection (UTI) agents, for example, pivmecillinam, cefaclor, fosfomycin, norfloxacin. This has potential implications for prescribing in the community.

Nitrofurantoin is recommended for the treatment of lower UTIs due to extended spectrum beta-lactamases (ESBLs). If nitrofurantoin is routinely used in pharmacies this will remove this agent from second-line use by GPs. Indeed, nitrofurantoin may be less satisfactory and may require longer courses of therapy, and thus is considered to be an alternative, rather than a first-line, therapeutic agent for this clinical syndrome.<sup>2</sup>

If nitrofurantoin and trimethoprim are routinely used in pharmacies GPs will inevitably start to use more broad-spectrum antibiotics for UTIs, in the expectation that patients will have already received trimethoprim and nitrofurantoin. This would almost certainly include quinolones and cephalosporins, which are risk factors for increasing community-associated methicillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* and ESBL.<sup>3-5</sup>

Since the first application for change of trimethoprim from

POM to P use three years ago, the prevalence of MRSA, *C. difficile* and ESBLs has increased in the community, making it even more important that use of antibiotic agents in the community is suitably controlled and monitored by robust processes.<sup>3-5</sup>

We would welcome the views of pharmacy staff and, in particular, antimicrobial clinical pharmacists in NHS hospitals who have to deal with targets to reduce MRSA and *C. difficile* infections, and pharmacy staff in primary care trusts who are seeking to address GP prescribing (e-mail [esmita.charani@hpa.org.uk](mailto:esmita.charani@hpa.org.uk)).

### Roger Finch

Chairman

### Jonathan Cooke

Member

### Esmita Charani

Pharmacist Lead

Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections

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2. Garau J. Other antimicrobials of interest in the era of extended-spectrum beta-lactamases: fosfomycin, nitrofurantoin and tigecycline. *Clinical Microbiology and Infection* 2008;14(s1):198-202.
3. Draft guidance on clostridium difficile. Available at: [www.hpa.org.uk/web/HPAwebFile/HPAweb\\_C/1204186175140](http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1204186175140) (accessed 25 April 2008).
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## Trimethoprim is not suitable for treatment in pharmacy

From Dr C. Edwards, MRPharmS, and Dr J. Sarma, MRCPath

We agree with Colette McCreedy *PJ*, 19 April, p459) that changing trimethoprim from POM to P status may not increase its usage, but there are other reasons why trimethoprim may not be suitable to treat urinary tract infections (UTIs) in community pharmacy, even at current levels of use.

We responded to the Medicines and Healthcare products Regulatory Agency consultation document, which proposed the

reclassification of trimethoprim, in August 2005 and the main points were re-emphasised in a letter to you (*PJ*, 13 August 2005, p193). We think that it is worth reminding supporters of this POM to P reclassification of our main concerns:

- In our experience locally, the resistance of urinary coliforms to trimethoprim from samples in primary care has been rising and is now around 30 per cent. Such a significant degree of resistance makes one question its efficacy as a first-line treatment, whether usage increases or not. Although it may be argued that many urine samples sent to laboratories are from a skewed sample of patients who have failed first-line treatment, there are parallels with amoxicillin, which at one time was first-line choice in the management of UTIs.
- About 50 per cent of urine samples have negative cultures and this throws into question the appropriateness of antibiotic treatment for many patients.
- The MHRA consultation document quoted a report of a working party of the British Society for Antimicrobial Chemotherapy that stated that antibiotics could be suitable for self-medication for uncomplicated lower UTIs, provided they are agents indicated only for UTI. Trimethoprim is not such a drug because, as Robin Howe pointed out in his letter to the *BMJ* (12 April 2008, p787), trimethoprim may be used to treat other infections, including

MRSA. Nitrofurantoin would be a more appropriate choice.

Locally, the level of resistance to nitrofurantoin is about 10 per cent. We think this drug is a more suitable agent for OTC treatment of UTIs.

### Clive Edwards

Newcastle upon Tyne

### Jayanta Sarma

Consultant Microbiologist,  
Northumbria Healthcare

■ PERSONALISED SERVICE

## Funds may not stretch to tailored service

From Mr B. Shooter, MRPharmS

I was pleased to read Steve Tomlin's *Agenda* article (*PJ*, 19 April, p475) "Pharmacists should dispense information".

He echoes the theories of Michael Porter, of Harvard Business School, who states that to maximise success we should strive to differentiate the product and service. Tailored information on medicines is a good example.

If we could provide personalised information our profession would be striving for excellence rather than the mediocrity of the standardised leaflets we supply now.

However there is a problem. I can buy a ready-to-wear suit for around £150, but a bespoke outfit from Saville Row costs around £4,000. Will our paymasters pay the premium for a tailored service?

### Barry Shooter

Aldeburgh, Suffolk

## Letters to the editor

Letters are welcome from all readers. 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 and registered pharmacy technician correspondents should supply their membership numbers, and a contact telephone number should always be given.

All letters are considered on their merit and 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. Further to a recommendation by the Journal Oversight Board (*PJ*, 1 March 2008, p244), pharmacists and pharmacy technicians whose names appear on the non-practising part of the relevant register are asked to make their status known.

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.

## ■ SHAMBOLIC PROCEDURES

### Penalty for providing unpaid services

From Mr A. R. Korsner, MRPharmS

It was tragic to read of a pharmacist being struck off for the crime of providing, what are often, unpaid NHS services. ("Shambolic" procedures lead to striking-off, *PJ* 19 April, p487). It never has been possible or made economic sense to provide a compliance aid service for free.

This is clearly not a service to offer lightly and not one to be underestimated. To allot the time and space required and take the associated risks requires that a, not unsubstantial, fee be attached to the service.

When I did costings on behalf of several local pharmaceutical committees in 2004 it became clear that only by receiving a fee of about £200 for assessment and set-up costs and £400 per patient per year would a professional service be viable.

It was difficult to convince pharmacists of the need to spend adequate time in setting up and keeping the paperwork up to date

and the dangers of just muddling through.

On the basis that you get what you pay for (and I do not know whether this particular pharmacist was receiving a payment from his primary care trust, but I will wager it was not as calculated as above) I am deeply saddened for the pharmacist concerned, but not surprised.

I am fortunate to be in the position of offering this service to my elderly mother. By the time I have checked the prescriptions, popped the medicines out of the foils, filled up the Dosette box and checked each compartment for "jumpers" the best part of an hour has passed.

What kudos or appreciation does the profession gain from being seen to have been involved in such a case and how can it be expected to be taken seriously in this and other ways?

The latest professional innovations seem to be taking us towards being GPs' assistants (second class) instead of professionals in our own right. In my thoughts this is because we are not funded properly (less than £1 professional fee for a prescription, with all its responsibilities) and thus

corners are inevitably cut. Only if we receive viable calculated fees for services should they be done.

I realise this may be seen as a retrograde step, but anyone working at the coal face will know how official "extended services" have impacted on their income so what is the point? My experience is that the word "shambolic" best describes many service payments from PCTs, like minor ailments. Even if we get them we can rarely check them against our submissions and we just have to trust to luck. If we are underpaid, tough luck, but if we overclaim, we are in trouble.

As a profession we should stop the infighting and rivalry, stop offering incentives for professional activities (free collections and delivery) and we just might regain the professional pride we had 20 odd years ago.

**Adrian Korsner**  
*London*

## ■ WHITE PAPER

### There is a way forward for pharmacy

From S. M. Burman, MRPharmS

There is much talk about the English pharmacy White Paper being only a rehash of the ideas set out in the new contract that have never materialised.

As a community pharmacist, I am not surprised that we find ourselves in this situation. Any community pharmacist will tell you that they would love to be involved in more professional services, but while we still have the millstone of the final accuracy check around our necks, we cannot take on any professional roles unless we can train our staff to do most of it.

They do a great job, but it is not extending the role of the pharmacist or making full use of the four-year degree course we are all required to complete. Reluctance from primary care trusts to provide funding and from pharmacists to take on a role they know they do not have time for has resulted in nothing much happening.

If it were a requirement for all pharmacies offering professional services to employ an accuracy checking technician (ACT) for a minimum of 20 hours a week, this would release the pharmacist to become properly involved in the professional role and would generate a lot more enthusiasm to

do so. It would also improve the career structure for dispensers, who are such a valuable part of the pharmacy workforce.

The additional cost of this is easy to calculate (just over £10,000 per year) so it would be up to PCTs and pharmacists to negotiate between them the quantity and quality of professional services pharmacists were required to do for this sum.

**Sue Burman**  
*Salisbury,  
Wiltshire*

## ■ WORKLOAD

### We need more support staff

From Miss R. J. Ellis, MRPharmS

The recent correspondence about pharmacy workload has focused on the high workload experienced in community pharmacy, but this is not the only place where too few people are trying to do too much in too little time. The dispensary of a large teaching hospital is a busy place, and the on-call service also has a high demand placed on it.

Hospital pharmacy has three main areas of expenditure: staff, drugs and gases. Unfortunately, when money is tight, the staff are the first to go (or not be replaced) and it is the patients who suffer. I have yet to hear of a dispensing error that has been dealt with beyond department procedures, but it is only a matter of time.

When the Royal Pharmaceutical Society takes some positive action on the matter of workload, will it remember to include hospital pharmacies? It would be helpful to have the Society's weight behind calls for more support staff in all sectors.

**Rebecca Ellis**  
*Sheffield, South Yorkshire*

## ■ PATENTS AND GENERICS

### Consequences to the NHS of the switch

Mr H. Modi, MRPharmS

I wish to respond to the recent news article about the launch of Servier's perindopril arginine salt preparation (*PJ*, 29 March, p352). The switch of patients from the tert-butylamine salt that is available generically to the patent-protected arginine salt, raises important issues for patients and the NHS.

Advertisement

Current UK sales for perindopril tert-butylamine salt are £100m per year. Following patent expiry, the use of generic versions has generated considerable savings to the NHS, and will continue to do so by price reductions and clawbacks on generics' reimbursements.

If the switching strategy by Servier, which includes changes via GP software suppliers, is successful and prescriptions are mostly generated for arginine salt, there will be little or no market for generic perindopril tert-butylamine salt. This would remove competition, and commit valuable NHS resources for a further long period.

Experience has shown that altering the appearance of packaging and tablet strength causes confusion among patients and wastes health professionals' time for no good reason or cost-saving to the NHS.

This action of Servier has no clinical or financial benefit to anyone except Servier, which makes the pharmaceutical industry's rhetoric of wanting to work with NHS sound rather hollow.

#### Has Modi

Superintendent Pharmacist and  
Managing Director  
Jardines (UK) Ltd  
Milton Keynes,  
Buckinghamshire

FREDERIC GIRARD, chief executive officer, Servier Laboratories Ltd responds: Perindopril was a discovery of Servier research. Perindopril-based products have a substantial evidence base, having been used in such landmark studies as PROGRESS, EUROPA, ASCOT and ADVANCE. Servier continues to support research using perindopril-based products to decrease the mortality and morbidity associated with cardiovascular disease, and even in orphan diseases such as muscular dystrophy.

Generic perindopril erbumine (tert-butylamine) has been available in the UK since July 2007 and generic products represent 90 per cent of perindopril supplies today. Our changes to Coversyl proprietary products are independent of the generic market. The generic tariff price has remained relatively high and thus has not produced the "considerable" savings alleged by the author. We refute any allegation made by the author that we have acted inappropriately when notifying information providers

and healthcare professionals of our intended changes to our Coversyl products. We have been open and clear in all our communication.

Perindopril arginine is a discovery of Servier research that improves the stability of the active ingredient and therefore increases product shelf-life and enables consistent quality all around the world, whatever the climate conditions. The launch of the Coversyl arginine products is part of a global strategy that has already proven to be well managed by Servier as evidenced by their smooth introduction in a number of other countries including Australia, South Africa, Denmark, Netherlands and Ireland.

Servier UK (as the subsidiary of the Servier Research Group) continues to maintain its investment in UK personnel and UK research as a responsible partner of the NHS and the UK economy. Servier regularly invests more than 25 per cent of its annual turnover in research and development, which is significantly higher than the industry average. Servier develops truly innovative drugs to meet unmet medical need and has launched two true innovations in the recent past with a third anticipated to be launched in early 2009 (subject to regulatory approval).

■ LEARNING@LUNCH

### An opportunity to update skills

From Mr J. S. Persaud, MRPharmS and Mrs A. Noot, MRPharmS

We recently attended a Centre for Pharmacy Postgraduate Education (CPPE) facilitation training day in Birmingham for pharmacists and technicians who are intending to facilitate the use of the Learning@Lunch programme in their hospital trusts.

The learning events were developed after feedback from the national evaluation that CPPE undertook late last year.

Learning@Lunch offers a range of clinical topics at a level that is challenging and relevant to the "generalist" hospital pharmacist and clinical pharmacy technician. Learning@Lunch helps pharmacists and technicians to keep up to date with topical subjects at no cost to the department. It provides high quality training for staff at their local department. The latest Learning@Lunch modules include diabetes, mental health, smoking cessation, asthma and child health.

The CPPE produces three booklets for each module: for pre-reading, for the training session and for post-session use. Each session is designed to be run within a lunch hour. The booklets include case studies, related questions and multiple choice questions enabling participants to expand their learning after the lunchtime session. The post-session follow-up activities can be easily adapted to meet local priorities. There is also a facilitator's booklet with additional background reading and material that helps support an in-house facilitator to deliver these sessions.

Since the Royal Pharmaceutical Society and Knowledge and Skills Framework competencies are listed for each topic, participants can include these reflective activities in a portfolio of evidence of continuing professional development.

We found the facilitation training day a worthwhile investment of our time. We are now equipped with the knowledge and skills to deliver these sessions in a practical, realistic and timely manner. There are places available on future facilitators' training days (details are on the CPPE website) at venues around England, and we would urge hospital-based colleagues who are responsible for education and training to consider attending one of these sessions.

#### John Persaud

Deputy Head of Pharmacy  
Sandwell and West Birmingham  
NHS Trust

#### Anne Noot,

Education and Training Lead  
Pharmacist  
Dudley Group of Hospitals NHS  
Trust

■ MINORITY LANGUAGES

### Benefits of speaking a patient's language

From Mr G. Jones MRPharmS

I read with interest the research on the provision of pharmacy services in Welsh in Wales (*PJ Online*, 22 March). Having lived in New Zealand/Aotearoa for some years I have seen parallels between Te Reo Maori and Welsh: both languages have suffered from linguistic imperialism and are making a slow but steady recovery (Maori television has recently been launched).

At a superficial level one could argue that there is no need to provide services in indigenous languages where a common knowledge of a second language

exists. However, knowledge of a patient's language (even at a minimal level) earns respect from the patient and builds their confidence in one as a health professional. Surely the "they can all speak (insert dominant language) there anyway" attitude is now anachronistic and outmoded. Correct pronunciations of names and addresses of patients is a start. Every day, I hear the verbal mangling of beautiful Maori place names by people who have made no effort to learn even the basics of the indigenous language.

I am aware of the difficulties of learning a new language as an adult. On arriving in Aotearoa I had great ambitions of becoming fluent in the Maori language, but I am still at a basic phrase-book level. Here, as in Wales, there needs to be more support for people to learn the language in a healthcare setting. A start would be to offer a course during employment.

This approach could easily be incorporated in NHS hospitals. How interesting and challenging it would be for a recent graduate to work in a hospital gaining a clinical pharmacy diploma and a qualification in Scots, Gaelic or Welsh or other minority language depending on locality. The challenge is hard in community pharmacy, but not insurmountable.

Another challenge is to have a dictionary of pharmaceutical terms in the indigenous language. I am aware of such terms in Welsh as *gwrthfotig* (antibiotic) or *poenladdwyr* (painkillers) but would not know what the Welsh is for "transdermal absorption". It would be interesting to see how speakers of other minority languages respond to the challenge of updating vocabulary of a specialised/technical nature in their languages. However hard the challenges, they are worth addressing if we are to retain our linguistic heritage. Surely, the aim for the future will be the retention of one's indigenous language in addition to a common global language (whichever that may be). Readers who are not convinced by the linguistic argument might consider a recent Canadian study that showed that bilingual people showed symptoms of dementia four years later than monolingual people.<sup>1</sup>

#### Gerald Jones

New Plymouth, New Zealand.

#### Reference

1. Bialystok E, Craik FI, Freedman M. Bilingualism as a protection against the onset of symptoms of dementia. *Neuropsychologia* 2007;45:459-64.

 DOMAIN NAMES

## Society fudges issues that involve the business world

From Mr J. A. Schofield, MRPharmS

I was interested to see the complaint by Ashok Jhalley (*PJ*, 12 April, p437) where the name of his pharmacy had been purchased by one of his local competitors. Presumably this was not an act of charity on behalf of the competitor. My naturally suspicious nature leads me to believe it is likely that the process was instigated to prevent Mr Jhalley fairly competing via the internet. If there is an honourable intention that I have overlooked I apologise.

Mr Jhalley has been afforded a response from Jeremy Holmes, Chief Executive and Registrar at the Royal Pharmaceutical Society, and it is full of useful information about how Mr Jhalley may seek redress by negotiating with the domain name purchaser or commencing legal action or arbitration proceedings. Mr Holmes provides the names of suitable bodies Nominet and ICANN each of which offers dispute resolution services.

However, my attention is drawn to the last paragraph of Mr Holmes's contribution in which he states: "The Society is of the view that the registration of domain names in the circumstances outlined does not breach guidance in 'Medicines ethics and practice'."

Who in the Society decided that the purchase of what might be considered Mr Jhalley's identity, possibly for the purpose of securing a commercial advantage over him, but also leaving open the possibility of all manner of nefarious activity, was not an ethical matter and was adequately dealt with in the current MEP?

My own view is that Mr Jhalley has good cause to be concerned and, should it happen to me I would be outraged at yet another example of the Society fudging issues that involve the business world.

**Tony Schofield**  
Jarrow, Tyne and Wear

JEREMY HOLMES, Chief Executive and Registrar, Royal Pharmaceutical Society, responds: It is unfortunate Mr Schofield takes the view that the Society "fudges issues that involve the business world". I would like to assure members this is not the case.

Based on the information contained in Mr Jhalley's letter, the Society took the view that this was a commercial dispute between two parties. The registration of the domain names in these circumstances does not breach the Society's Medicines, Ethics and Practice (MEP) guidance. Having said that, the Society has looked to provide Mr Jhalley with useful information about how this matter might be resolved.

Members who have concerns about possible breaches of the content of the MEP guidance should contact the Society's fitness-to-practise team, who will be able to deal with the complaint formally. The team can be contacted by writing to the Society's London office or via e-mail at ftp@rpsgb.org. FTP also provide an information service to members which can be accessed by telephoning 020 7572 2408.

 PUBLIC RELATIONS

## Obsession with "c" word should be put in context

From Mr J.-P. Moser

Responding last week to Alan Rogers's **Broad spectrum** article, "Would you trust a chemist to check your health? We must deliver" (*PJ*, 19 April, p470), Neal Patel the National Pharmacy Association's head of communications offered some useful insights into the challenges faced when talking to the national media. The fact is that when giving quotes to reporters we can never be 100 per cent certain that they will be used in full or in context. Equally, no matter how many times we use the word "pharmacist" or "pharmacy" we can never guarantee that the words will not be replaced by the term "chemist".

Alan Rogers is clearly frustrated by the use of the "c" word but, in my opinion, it should not be seen as a barrier to communicating effectively with the media and the public on pharmacy matters.

In all its communications the Royal Pharmaceutical Society is consistent in using the terms "pharmacist" and "pharmacy". However, for a public that has grown up with familiar names such as Boots The Chemists, the "p" versus "c" word argument will be seen as largely irrelevant. When, as a profession, pharmacy has organisations called the Company Chemists Association and publications such as the *Chemist and Druggist*, insistence on use of

the "p" word by the national media becomes a hard point to argue.

The key to changing perceptions about community pharmacy will be to ensure that the media and public understand the changing role of the profession. A good example of how this can work to positive effect was demonstrated last week with BBC Three Counties Radio.

When the station reported on the Society's hay fever campaign on 14 April the presenter of *The Breakfast Show*, Stephen Rhodes, questioned whether the public could visit a pharmacy without an appointment and get advice on hay fever or other minor ailments. He argued that this was not in line with his own experience, and told listeners that he doubted that pharmacists would be able to provide substantial advice to patients as they would be too busy with dispensing medicines.

The Society's PR team followed up this report and worked to change Mr Rhodes's view. With help from the Bedfordshire branch, the team arranged for him to visit Lloydspharmacy in Wigmore Park, Luton, where David Rose, the pharmacy manager, was able to explain first hand the range of services offered by a modern community pharmacy.

Fresh from this new experience, Mr Rhodes included a 10-minute pharmacy feature on his 23 April show, which included a live interview with Graham Phillips, Hertfordshire pharmacist and a member of the Society's Council.

The interview can be heard in full at [www.digitalnewsagency.com](http://www.digitalnewsagency.com) — sign in under the password and user name "rpsgb1" and go to the Society's virtual press office and then to hay fever coverage.

**Jean-Pierre Moser**  
Head of Corporate Communications and Membership  
Royal Pharmaceutical Society

## Promote profession tirelessly

From Mr A. G. B. Jones, MRPharmS

Neal Patel, head of communications at the National Pharmacy Association, highlights the problem pharmacists have when trying to get their message across in the media to improve the public's understanding of the profession (*PJ*, 26 April, p507).

It is inevitable that, over time, comments will be misquoted, shortened and used out of context. This is a problem for everybody,

not just for pharmacists, and highlights the need to build up relationships with journalists at local and national levels to improve the media's understanding of the issues that affect the pharmacy.

Our professional bodies need to be relentless with the messages we promote to the media and opinion formers. We may have heard the messages many times before, but the general public has not.

Rather than argue among ourselves about how an article has been written in a particular newspaper, we need to be outward facing and committed to broadening the public's understanding of pharmacy and that of opinion formers.

**Graham Jones**  
Lambourn, Berkshire

 NEW PROFESSIONAL BODY

## This change is not just about rebadging

From Mr R. A. Cattell, MRPharmS

It is clear that pharmacy has a once-in-a-lifetime opportunity to secure a professional leadership body that will be all that we hope for. The Clarke Inquiry gives us hope that, generally, the profession is clear that it wants this new body to be competent, representative of the individual, vocal and to operate to the highest corporate governance standards.

Central to the creation of this new professional leadership body must be the full involvement of the current organisations in the profession. The members of those organisations will justifiably expect their representatives to deliver the required vision and leadership at this time of great change.

The Guild of Healthcare Pharmacists agrees with Nigel Clarke's report that the Royal Pharmaceutical Society has an important role to play in facilitating the creation of a transitional committee and supporting structures for the new body, but it must not simply be a rebadging of the old one. It will be vital that this process includes those inside and outside the profession who understand all the profession has to offer and who have the skills (and political nous) to deliver a

 E-mail

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

new organisation in around 18 months, and who will ensure the process is transparent and keep the individual member at the fore.

To this end, I urge all pharmacists and technicians to use their votes in the current Society elections, and vote for those candidates who will make the Council deliver on the agenda set by Clarke and demanded by the profession. If we fail to use our vote we will be left with what we currently have; a vacuum of profession leadership part filled by myriad smaller groups.

#### **Richard Cattell**

*President  
Guild of Healthcare Pharmacists*

#### **What value will new body offer?**

Mr C. D. Pilkington, MRPharmS

I have just taken part in the Royal Pharmaceutical Society's survey on its new role. I am not terribly politically inclined and perhaps I have missed a significant discussion that explained it to me but I am unsure what is left once the regulatory function is removed.

The survey mentions a number of key functions that the new body could serve and asks me to rank their importance. At first glance the list does contain some important functions, such as the provision of clinical and legal advice, help with continuing professional development and the supply of discounted insurance and services.

I started to rank them all as high importance and then realised something. They are of high importance to me but I do not currently get them through the Society. The National Pharmacy Association? Yes. The Pharmacists' Defence Association? Yes. The Welsh Centre for Postgraduate Pharmaceutical Education? Yes. The Society? No.

The only item on the list that I expect the Society to provide is to lobby, on my behalf, the Government, the media and other professions. I am not convinced that it is very good at it. The survey then goes on to ask how much I would pay for this? I thought no more than £50.

What worries me is that the survey ends by asking if the combined fee for joining both bodies (regulatory and professional body) were £395 would I be likely

to join? What about £495? What about £595?

Perhaps I am being unreasonable, but I do not envisage paying an extra £100–£200 pounds on top of the current fee for its representation. I realise this survey is to canvass opinion and perhaps the Society will discuss the results, but unless something changes I can see this shiny, new professional body representing about 10 per cent of the workforce — unless, of course, my employer offers to reimburse my fee...

#### **Chris Pilkington**

*Llandudno,  
Gwynedd*

#### ■ THE SOCIETY

#### **Losing members**

From Mr P. M. W. Clarke, MRPharmS

The profession is going through uncertain times, and nothing highlights it as much as the loss of members.

I found it most disconcerting to see the list (*PJ*, 29 March, pp378–81), of more than 500 members who have not paid the annual fee

and have been expelled from membership of the Royal Pharmaceutical Society.

Whatever their reasons, and they must be heartfelt, it seems different from the attitude of members decades ago, when they seemed proud to belong to an honourable society. In those days a good proportion in community pharmacy were or aspired to be proprietor pharmacists.

Nowadays, a high proportion of active members are employees, with less influential input, locally, to the profession to which they belong.

Apart from resentment about the expense involved to remain a member — and many of the 500 expulsions seem to have addresses abroad — I can only wonder if there is a widespread dislike or fear at the way the pharmacy profession is heading.

#### **Peter Clarke**

*Naumur, France*

#### **Telephone number**

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