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PROFESSIONAL BODY

What next?

From Mr G. S. Phillips, MRPharmS

We should be grateful to Nigel Clarke and his team for an excellent report (www.theclarkeinquiry.com/papers) against a difficult background and in a short timescale. It provides a helpful platform for debate as the Royal Pharmaceutical Society moves towards demerger.

However, Clarke inevitably failed to achieve "the Heineken effect" (reaching out to the width and depth of our profession). I understand that fewer than 150 pharmacists in total attended his road shows. So he heard from the great and the good (and the vested interests) but not the silent majority.

This will not deliver a professional body that enough grassroots pharmacists will feel inspired to join, and pay for, voluntarily. A high (>70%) membership by pharmacists is crucial. If that is not achieved how will the professional body be financially viable or remotely credible as the voice of pharmacy.

The Society's Council has no plans to simply go ahead and implement Clarke's 60-plus recommendations. This is clearly recognised in the five-minute guide, "Plans for new professional body pick up pace", sent out with last week's *PJ*. So the next step is to inform and then listen to the members.

Pharmacists need to debate, to argue, to discuss, to conclude and, ultimately, to vote on what Clarke recommends and the process has already begun. The Society has all the tools for the job: branches, regions, special interest and sector groups and, carefully enshrined within the 2004 Charter, the democratic process that must be followed for changes on the scale proposed. The use of technology, such as the Society's website, and pharmacist discussion groups, such as Private-Rx, mean that not one of the Society's 48,000 members should be excluded from playing a part in the debate or, finally, from voting on the proposals.

As I noted in the Council discussion, (*PJ*, 3 May, p543) one of the notable absences in Clarke's report is any consideration of alternative options to a chartered body. This, too, must be discussed and agreed with the members.

But time is short: the creation of two shadow bodies (a regulator and a professional body) must be achieved by the end of 2009 if we are to meet the planned timetable of formal demerger of the Society in January 2010. So we must move forward with the process of transition, in parallel with consultation.

This is a professional matter and is, therefore, for pharmacists alone and, logically, must be led by the democratically elected pharmacist members of Council, working with other stakeholder bodies from within the profession.

It will be crucial, while simultaneously consulting the broad membership, to include bodies like the UK Clinical Pharmacy Association, the College of Pharmacy Practice and the Institute of Pharmacy Management International, which have committed themselves to merge with the new professional body. Council must also ensure the Society's national boards play their key role here.

To give the process credibility and to ensure transparency it will be crucial to appoint a neutral chair. Nigel Clarke, and no criticism is intended here, cannot perform this role since, otherwise, the transition process will be seen simply to rubber stamp the Clarke report.

There is an interesting parallel here with the Carter report. Lord Carter's helpful recommendations have been the basis for further debate within and without the profession. But it is Ken Jarrold, not Lord Carter, whom the Government chose to chair the current Pharmacy Regulation and Leadership Oversight Group, which is overseeing the establishment of the new regulator for pharmacy, the General Pharmaceutical Council.

The Society is working hard to get closer to its members. This is a golden opportunity to help achieve this crucial objective.

Graham Phillips
Member of Council and Chairman, Public Affairs Planning Group
Royal Pharmaceutical Society

Time line poses a risk

From Professor H. McNulty

The Institute of Pharmacy Management (IPM) has some suggestions to help the transitional committee take the Clarke report recommendations forward. The following need to be considered by or under the jurisdiction of the transitional committee in addition to the development of a prospectus:

- The business plan and strategy for the new body
- Implementation and project management arrangements and timelines
- Option appraisals of potential models for different income streams
- Risk assessment of these
- New governance and managerial arrangements

IPM believes that given the above, the time lines proposed for establishing the new body pose significant risk to members, to the regulator, to the professional body and to the public. It can take many months to recruit to senior positions and the plans, structure, governance, titles, duties and function of the posts have to be developed and agreed.

IPM Council is very pleased to see that the Clarke report believes "that the case that management advice is a legitimate area for consideration by the professional body is a compelling one". IPM suggested a broader role than the management advice. IPM Council proposes a modification of recommendation 26 for consideration by the transitional committee: "The professional body should work closely with IPM (which might become an integral part of the organisation) to ensure that its members have better access to management qualifications, appropriate standards, education, training, CPD support and advice."

IPM Council recognises there are organisations interested in or providing management support and would be pleased to hear from groups that share a similar vision. IPM looks forward to working with the transitional committee, The Royal Pharmaceutical Society and other organisations to help meet the challenges and demanding targets for both business planning and the management proposal.

Howard McNulty
General Secretary
Institute of Pharmacy Management International

TERMINOLOGY

Use correct professional name for colleagues

From Mr M. Randerson, MRPharmS

Despite disappearing from the professional dictionary of the NHS many years ago, the term chemist still persists with reference to community pharmacy in the columns of the lay press.

Somewhat less common is the use of the term by non-pharmacist healthcare professionals and NHS managers, more often than not due to misunderstandings over correct terminology. It does not help that a small number of pharmacists do not always use correct professional term for colleagues working in the community. I suspect the reasons for this may be rooted in some small-minded professional snobbery.

Pharmacists who use slang terms in front of other NHS professionals do little to enhance either their own professional image or the image of the pharmacy profession as a whole.

Mark Randerson
Crossgates, North Yorkshire

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 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.

OPHTHALMOLOGY

Confusion over eye drop prescriptions

From Captain R. Blanch, MB ChB

In our hospital's ophthalmology department there is a current policy that prescriptions for community pharmacies are given where possible; hospital prescriptions are reserved for those circumstances where a prescription for a community pharmacy would lead to an unacceptable delay. I have encountered the following problem. I frequently prescribe eye drops to be given one hourly or two hourly (notation 1° or 2°) for a period of, say, two weeks. The notation "2°" has caused confusion when it has been interpreted as 2 per cent.

I understand that it is standard practice for only a single bottle of eye drops to be dispensed for each prescription. Given that a standard bottle is 5ml and a drop averages 50μl, with one hourly application one could expect this to last a maximum of seven days. In practice it lasts slightly less than this. As a result, several patients have run out of eye drops before their review appointment.

When they queried the quantity with the dispensing pharmacist, the patients were informed that I had "only prescribed one bottle". I had specified dose, frequency and duration — from which a total quantity could be calculated. I have now modified my practice to specify number of bottles to be dispensed.

Is there a place for guidelines to cover dispensing of ophthalmic medicines?

Richard Blanch
Specialty Registrar in Ophthalmology, Sandwell General Hospital, West Bromwich, West Midlands

SCIENCE PROGRAMME

Educational initiatives need to be affordable

From Mr A. R. Korsner, MRPharmS

I was delighted to receive news of the Royal Pharmaceutical Society science programme in my e-mail this week. What a shame, however, that the prices charged seem prohibitive for the rank and file membership.

The Society has lost an opportunity to give educational assistance to its members in a manner that could justify the new and much higher retention fee.

At £125, plus locum fees and travel, I should not think many will take up what could otherwise have been a valuable resource, providing an opportunity to get some continuing professional development under the belt.

A nominal fee, to cover the lunch and a bit extra, for members only, would have been an excellent public relations gesture.

Adrian Korsner
London

JULIE CHURCHILL, Science Programme Manager responds: The Society has run an active and vibrant science programme for many years, in collaboration with the Academy of Pharmaceutical Sciences and the Joint Pharmaceutical Analysis Group. It has always been an aim of the programme to run one-day symposia at a competitive rate.

Indeed, the rates we charge for our one-day symposia compare favourably with other membership bodies, such as the Royal Society of Chemistry and the Society of Chemical Industry. However, unlike most other membership bodies, we include full course notes in the price.

We are aware that not all of the membership can attend our symposia and meetings, and are looking at other ways of making these events more accessible. One new initiative we have introduced for members in 2008 is a special £25 rate for delegates attending the British Pharmaceutical Conference on Sunday 7 September. For more information and bookings go to www.bpc2008.org.

GPHC

Why does the GPhC need a presence in each country?

From Mr D. Lee, MRPharmS

The pharmacy regulation and leadership oversight group (PRLOG) says that there needs to be a physical presence for the General Pharmaceutical Council in each of the UK's four nations (*PJ*, 22 March, p325). Why? What will a physical presence add? How much will it cost and who will bear that burden — current or future pharmacists? We are centrally (London-centric anyway) administered. Does this mean the current system is not ideal? How does this change benefit people who live and work rurally?

Dan Lee
Whitehaven, Cumbria

KEN JARROLD, Chairman of the Pharmacy Regulation and Leadership Oversight Group, responds: The PRLOG has been set up by the Department of Health as an advisory, not an executive, group and its role is to be the "guardian" of professional regulation in pharmacy during the period of separation from the professional body, and to advise Ministers regularly of progress in the transition period.

The group has 21 members from all four countries in the UK. The PRLOG's aim is to ensure the best regulatory system is delivered for the public, patients, carers and the profession. It is working with stakeholders to make sure the establishment of the GPhC happens efficiently, safely and effectively by 2010.

I would like to highlight that the final decision on establishing a physical presence in all four countries, (subject to final decisions from Northern Ireland ministers) will be for the GPhC when it is set up in shadow form in mid 2009.

However, the PRLOG has advised that it believes there are benefits to the new regulator having a presence in all four countries. Of course, this presence can be achieved in a variety of ways. We would expect the new regulator to consider these benefits and also the impact of the associated cost on registrants before making its decision.

EUTHANASIA

Relative concepts of right and wrong

From Mr M. D. Worsley, MRPharmS

The argument for euthanasia usually revolves around man being just another animal and, therefore, the "rights" of animals should be conferred on humans. This is based on the concept of the common ancestor between man and ape. As there is no direct evidence for this, it is merely a point of view.

There is an opposing belief that man and animal are separate, and so what is done by or to animals does not necessarily transfer to mankind.

What constitutes human rights infringements is debatable. In Eritrea, for example, some religious people and politicians who fall foul of the government have found themselves held in corrugated iron freight containers, for indefinite periods. I do not see this happening in Britain.

Not all secularists agree with euthanasia. Richard Dawkins in 'The God delusion' concurs with those who say that some people might kill their grandparents for their money if euthanasia were made legal. An atheist friend of mine does not like euthanasia because he observes that man is capable of murder, while animals generally kill for food or defence.

The argument for relative concepts of right for one and wrong for another are meaningless without a common standard. Is it choice for the individual (secular materialism) or what is best for all? How would pharmacy operate without the existence of a standard like 'Medicines, ethics and practice', which all pharmacists have to abide by whether they want to or not?

Mike Worsley
Wirral, Merseyside

TRAINING

Preregistration year, why is it so tough?

From Mr M. A. Alvi

After working all day at the pharmacy, I am completely drained and feel tired mentally, which affects my concentration and motivation. Most of the time, I am involved in pharmacy practice-based tasks, and there is no or little time to gain all the clinical knowledge required.

The integration of preregistration with the MPharm degree mentioned in the White Paper is a fantastic idea and should have been done years ago.

One way of making things easier for preregistration trainees is to cut down their working hours in the pharmacy, which will provide them extra time to improve their clinical knowledge. They should also be given some weeks off

Broad spectrum
The Broad Spectrum feature is open to any reader. Contributions of around 1,100 words commenting on topical issues should be sent to graeme.smith@pharmj.org.uk for consideration

before their preregistration exam so they can prepare better for it.

Mohammad Ayub Alvi
Birmingham

MINORITY LANGUAGES

Responsibility must rest with the pharmacist

From Mr B. E. Black, MRPharmS

Gerallt Jones, writing from New Zealand, (*PJ*, 3 May p537), may be correct to highlight the benefits in speaking a patient's language as a protection against the onset of the symptoms of dementia. In both Wales and New Zealand it would be correct to be familiar with the rudiments of Welsh and Maori, respectively.

However, the onus must rest with patients to learn the dominant language of the country in which they reside. In some areas of the country it would be impossible for pharmacists to learn all the spoken languages of patients. In one week in my pharmacy in east London, I recorded patients from 47 different countries. The number of countries represented in the whole of Greater London is even higher.

In order to learn this number of different languages to meet the needs of patients, one would need to have the skills of a professor of linguistics, rather than those of a community pharmacist.

Bernard Black
Stanmore, Middlesex

COMBIVENT

A well managed discontinuation

From Mr P. Jerram, MRPharmS

I agree wholeheartedly with Erol Ali (*PJ*, 19 April, p472) in wanting to compliment Boehringer Ingelheim on the manner in which the company sought to remove Combivent metered-dose aerosol inhaler from the market.

As early as September 2007 I recall receiving a letter from Boehringer, advising of the future discontinuation of the product. Since then, I have received further letters confirming the likelihood of stock running out by June and the Combivent inhaler now has a flash on its pack advising patients of its discontinuation.

This has facilitated the phased switch of patients away from Combivent to appropriate alternatives. While realising that it may be accused of discontinuation in the knowledge that it may benefit from patients being switched to other more lucrative products in its chronic obstructive pulmonary disease portfolio, Boehringer has, through its timely issue of warnings, ensured that no patient is put at risk and that clinicians have had ample time to consider the implications of the discontinuation.

I have no financial or other affiliation with this company.

Paul Jerram
Head of Medicines Management, Isle of Wight Primary Care Trust

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

PATENTS AND GENERICS

Ask patients how to spend money

From Ms M. Yassaie, MRPharmS

Is the new perindopril formulation an innovation o

r patent extension? I have read Has Modi's letter with interest and the reply from Frederic Girard, the chief executive officer of Servier Laboratories Ltd (*PJ*, 3 May, p537).

I do not see the innovation in the new formulation, only patent extension. If the changes in the new formulation are going to be dictated by changes in the GP software, I believe we need to ask patients what they would like their money to be spent on — a new expensive formulation of perindopril of the same efficacy or a change to a different angiotensin-converting enzyme inhibitor, equally effective but more cost-effective? I know which one I would go for.

Maha Yassaie
Chief Pharmacist, Strategic Lead, Medicine Management, Berkshire West Primary Care Trust

MISS TRACY'S MIXTURE

Stood the test of time

From Miss M. P. Tracy, MRPharmS

I was recently surfing the internet and to my surprise found Miss Tracy's Mixture (lidocaine gel 1 per cent and nystatin 50,000 units). I was aware that the treatment was prescribed locally, but had no idea it was used as far away as North Staffordshire.

It was originally prescribed at the Southampton Children's Hospital. At that time chemotherapy was in its infancy and one side-effect was the development of very sore mouths. The consultant asked me if there was a suitable treatment available. Because I could not find one on the market I prescribed one of my own — that was at least 45 years ago.

Mary Patricia Tracy
Southampton

FOUR NATIONS

Make the coverage more balanced

From Mr M. B. Hutchison, MRPharmS

Upon receiving *The Journal* last week (*PJ*, 10 May), I had a quick glance at the front cover to see what the interesting news was in pharmacy that week.

The main cover story was about the Department of Health's plans for the English White Paper. The news feature was on Dawn Primarolo defending the government over the English White Paper and the interview — "Turk Speaks Out" — was with John Turk, the National Pharmacy Association chief executive, speaking about the English White Paper.

Now, personally, I cannot wait for Scotland to be an independent country with its own Scottish Pharmaceutical Society, but until that happens please can we have coverage that is a bit more of a balanced.

We are not all interested in what is happening in Englandshire.

Mike Hutchison
Alloa,

Problems?
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