



NEW PROFESSIONAL BODY

Society must comply with its gender equality duty

From Mrs H. J. Baker, MRPharmS

At the annual general meeting on 21 May, it was explained that the Royal Pharmaceutical Society's Council will remain as the decision-making body to which the new Transitional Committee (Transcom) will make recommendations.

Our association has been concerned that, in contrast with other healthcare regulators, the Society remains non-compliant with the gender equality duty (GED), which came into force in April 2007.

We are glad to have received assurances from the Chief Executive that Transcom and the Council will be acquainted with their obligations under the GED. In our experience, however, not only do most groups within the profession know little about the duty, most practising pharmacists know little about their GED obligations as employees, or contractors to the NHS.

There are two critical reasons why everyone working to create the new body must ensure they operate in accordance with the duty. First, if the body wants mass membership, it must match its structures and policies to the nature of the pharmacy workforce. The Society has considerable information at its disposal about registration, work patterns and salaries, and it must make proper use of this knowledge.

Second, if the GED is not properly observed, any group in the profession that is unhappy about the outcome of deliberations will have strong grounds for seeking judicial review of the decisions reached. This option is specified in the guidance documents linked to implementation.

Compliance with GED obligations is not a luxury or something that can be added on later. Requirements in England include:

- The duty to assess the impact of current and proposed policies and practices on gender equality
- The need to include objectives to address the causes of any gender pay gap when formulating overall objectives
- The need to consult stakeholders (including employees, service users, trade

unions and others) and take account of relevant information in order to determine gender equality

Furthermore, it must be possible to show how all these duties have been met.

We find it strange that other professional bodies (including many not required to comply with the GED) see this as an obvious mainstream issue, while it seems to have been almost ignored within pharmacy. If the new body is to be truly focused on the needs of its members, things will need to change.

Hazel Baker

President, National Association of Women Pharmacists

MINIMISE ERRORS

Pharmacists should not need to be visible

From Mr C. O. Agomo, MRPharmS

Two articles recently focused on minimising errors (*PJ*, 24 May, p616). Interestingly, the second article — “Double checking medicines may contribute to rather than stop errors” — included a statement that “interruptions were also linked to drug errors”.

The study was conducted using error reports from Bradford Hospital Trust, and one wonders what the situation would be if the same study were to be repeated in community pharmacy, where interruptions by staff and patients are a way of life.

I have always argued that the requirement that pharmacists are always visible to customers — leading to some community pharmacies being designed as open dispensaries — is ill advised. It leaves pharmacists and dispensers open to interruption and, therefore, to errors. It also creates anxiety and stress among staff.

Based on the above evidence, and in the spirit of evidence-based practice, pharmacy bodies and other relevant stakeholders should ask community pharmacy owners to abandon the open dispensary policy.

The argument has always been that open dispensaries enable patients to witness their items as they are being dispensed and also allows pharmacists to observe all that is happening in the pharmacy.

This argument is flawed because when we go to restaurants, none of us insists on witnessing the chef while he or she prepares the meal. If we can trust the chef not to poison us, why can we not trust a qualified pharmacist to dispense our prepackaged medicines out of sight, without unnecessary interruptions?

Is it actually possible for community pharmacists to oversee the entire pharmacy while dispensing patients' prescriptions or counselling patients? One would need to have X-ray eyes to do this. The building of consulting rooms as part of dispensaries in all community pharmacies in the UK, should now be a norm rather than an exception. This is the way forward because it enhances the image of the pharmacy and that of the pharmacist.

I have visited a few major pharmacies in the US and other countries, where it is difficult to see open dispensaries being a common practice. Maybe it is time for those who conceptualised the open dispensary in the UK, to come down from their designing rooms to witness how difficult it is for pharmacists to work in such environments, without making errors and being stressed out at the end of an eight to 12-hour shift (often on their feet all day and many times without a break).

Chijioke Agomo

London

COUNCIL ELECTION

Multiple issues

From Mr J. M. Brunt, MRPharmS

I think Noel Baumber has every reason to be suspicious of Boots's motives (*PJ*, 10 May, p566).

Before the merger with Alliance, it was my perception that Boots was a well behaved company that did not use its muscle and interfered little within the politics of the profession, but I fear those days have gone.

As a past member of the Royal Pharmaceutical Society's Council, though, I came to the conclusion that employees of retail multiples were at a distinct disadvantage when standing for office within the profession because their knowledge and experience appeared invariably to be limited to what the company wished them to know, which was usually very little.

Mike Brunt

Thetford,
Norfolk

THE PROFESSION

Professional title should reflect our value

From Mr J. D. Corlass, MRPharmS

I would suggest that future community and hospital pharmacists should receive a medical qualification and then become pharmaceutical consultants allowed to use the title “doctor”.

At the moment it would appear that general dogsbody might be a more appropriate title.

John Corlass

Scunthorpe,
South Humberside

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.

■ DISPENSING DOCTORS

Time to end the anomalies

From Mr J. D. Thomas, MRPharmS

The financially contentious supply-only function of prescription-only medicines during the weekday-only office hours operated by rural doctors has again reared its head in the details of the White Paper for pharmacy in England.

The Dispensing Doctors Association states that this could spell the end of rural doctors' well remunerated and lightly regulated additional source of income.

Since the inception of the NHS in 1948, rural doctors have manipulated, nurtured and developed this highly profitable non-medical side of their practices, playing the convenience card as their ace.

Over the past two decades, the urbanisation of the countryside and the expansion of rural villages and towns have led to the vast expansion of rural car ownership, with two-car families often the norm. At the same time, community pharmacies have expanded their roles, developing full pharmaceutical services, including complex and free collection and delivery NHS prescription services, which must now surely trump the spurious convenience claim.

That rural doctors can provide a lesser pharmaceutical service than community pharmacies, yet receive more in the way of payments, must now be exposed as poor value for money for the taxpayer.

According to Department of Health figures, rural doctors with dispensing lists of patients are responsible for 11 per cent of items on FP10 forms. The per item dispensing fees payable to these rural doctors can be and are in excess of twice that paid to pharmacy contractors.

Hopefully, the White Paper on pharmacy will expose and address these financial and professional anomalies, and encourage our over-stretched family doctor service to concentrate their efforts and superb medical skills on the nation's health, welfare and benefit in diagnosing and prescribing, and will further community pharmacies' progress in the continuing and furtherance of the provision of pharmaceutical services.

David Thomas
Patshull, Shropshire

■ UNWANTED PREGNANCY

Emergency contraception is better than abortion

From Mr B. Shooter, MRPharmS

Ellie Levenson's **Broad spectrum** article (*PJ*, 17 May, p592) made sense to me.

I have no connections with anti-abortion organisations, but I am convinced that I am not the only reader who feels strongly that the 200,000 terminations carried out in the UK last year are excessive.

If we look at the cost in financial and emotional terms it makes more sense to prevent unwanted pregnancies rather than perform abortions on the mothers.

I agree with Miss Levenson that emergency hormonal contraception should be much more easily and cheaply available from pharmacies for men and women, whenever they think it appropriate.

Somehow we pharmacists must educate patients to ensure that Miss Levenson's website (www.womenarenotstupid.com) does ring true and applies to men too.

Barry Shooter
Aldeburgh, Suffolk

■ THE JOURNAL

Let's not engage in chauvinism

From Mr G. Diamond, MRPharmS

I found Mike Hutchison's letter about *The Journal's* coverage of pharmacy issues in England rather narrow, if not a tad xenophobic towards English colleagues (*PJ*, 17 May, p595). As a Scot living in England, to me it seems a rather churlish putdown that requires a strong rebuttal. In my opinion the *PJ* does strive to provide a balanced representation of pharmacy issues throughout the UK.

English people, in my experience, are tolerant. Pharmacists in England have always expressed an interest and even an envy, in some cases, as to how Scots pharmacy services are at the leading edge in both the community and hospital sectors.

I hope that jingoistic and chauvinistic expressions about any part of the UK are consigned to the bin in future correspondence.

Gerry Diamond
Manchester

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■ THE JOURNAL

Can we be different and in harmony?

From Mr A. R. Cox, MRPharmS

Mike Hutchison complains about *The Journal's* focus on the English national plan for pharmacy (*PJ*, 17 May, p595) and states: "We are not at all interested in what is happening in Englandshire."

In February 2002, the *Journal* had a front cover illustrating the newly launched strategy for pharmaceutical care in Scotland, accompanied by a leading article and extensive news coverage.

If an English pharmacist had complained about coverage by saying "We are not interested in what happens in Scotlandshire", he might be considered a xenophobe who only spoke for himself.

Anthony Cox
Sutton Coldfield,
West Midlands

■ PHARMACY ROBOTS

The debate is behind the technology

From Ms S. Bloom

Until recently I was programme manager for the North West Hospital pharmacy automation programme, a collaborative programme to implement pharmacy automation in hospitals. Between 2005 and 2008 I was responsible for co-ordinating the collaborative procurement and installation of 23 pharmacy robots across the North West.

I was disappointed to read the article on hospital pharmacy (*PJ*, 17 May, pp599–602). I agree that too little has been written about pharmacy automation and its benefits and was therefore, at first, heartened to see an article on the subject in your publication. However, I think that the article is out of date and factually incorrect.

I draw attention to what it said about systems available in the UK. The information appears to have been taken from a 2004 article and therefore is four years out of date. That is a long time, considering the speed of development of these systems. Functionality has increased since then. For example, the Mach4 system now has automatic loading and refrigerated modules.

The article mentioned two systems that are no longer marketed in the UK and made no

mention of several systems that are being actively marketed.

RoboPharma has a channel-fed dispensing system that is installed at Whiston Hospital and P@P Picking Systems has a high-volume picking system suitable for large-volume orders, such as ward supplies. It is currently installed at Kent and Canterbury Hospital. Siemens Logistics and Assembly Systems changed its name to Dematic in 2006, and currently has six installations in the UK.

The NHS Purchasing and Supply Agency (PASA) keeps a fairly up-to-date list of UK installations as well as other useful automation information on its website that can be accessed from their robotics and automated dispensing page.

Perhaps the most worrying comment in the article was the assertion that "the recognition rate of barcodes is 70 per cent and therefore less useful as a source of information for storing and selecting products". Barcodes are fundamental to pharmacy automation, but if the recognition rate is only 70 per cent how can installation be justified? I acknowledge that the reading of some barcodes is problematic due to print quality, colour or product packaging and is a cause for far too many products being unsuitable for automation. However, barcodes have high reliability. Accuracy rates of one error in 1.7 million have been cited (see www.ent.ohiou.edu/autoid/research.htm), far more reliable than manual human intervention and are the reason why installing automation has been shown to reduce or even eliminate product selection errors.

I was commissioned by the PASA (www.pasa.nhs.uk) to write a toolkit on implementing hospital pharmacy automation to share the learning that has been gathered from the NW Pharmacy Automation Programme. Should any of your readers wish to obtain more up-to-date advice on implementing automation they can download the toolkit from the PASA website's robotics and automated dispensing page.

Shoshana Bloom
Independent Pharmacy Automation
Consultant
Stockport, Cheshire

STEPHEN GOUNDREY-SMITH, author of the article, responds: The focus of my article was a discussion and evaluation of the potential benefits of automated dispensing, and whether those benefits have been realised in the

UK. This necessarily entailed a review of published literature, some of which was not of recent date. It was not my intention to provide a detailed description of current robot functionality.

The published wording of the section on automated dispensing systems available in the UK suggests that the detail of this section is entirely from Swanson's 2004 paper. This is not the case; I am grateful to various pharmacy automation suppliers for information on recent robot developments. Current developments with the ARX ROWA systems and the Mach4 systems are mentioned. I approached representatives of ARX, Mach4, Swisslog and Baxter while researching the article earlier this year. I was unable to make contact with a representative of RoboPharma within the timescale of preparing this article, although every effort was made to do so.

I am grateful to Ms Bloom for providing information to *PJ* readers on the current UK activities of Dematic, RoboPharma and P@P Picking Systems. Unfortunately, there does not seem to be any information on UK hospital pharmacy

applications on their respective websites, and centres where these systems have been installed have not, to my knowledge, published their experiences in the professional literature. This lack of disseminated information on developments in automated dispensing is one of the points made in my article.

Ms Bloom indicates that barcodes may not be readable because of print quality, colour or product packaging. I am aware of anecdotal evidence from work in medicines management software analysis that a proportion of medicinal product barcodes are not machine readable, due to data anomalies in the barcodes. I concede that the rate of barcode recognition of pharmaceutical products is probably now higher than 70 per cent, but it is by no means 100 per cent.

I am not suggesting the process of product identification by barcode is not accurate when the barcodes are correctly machine readable. However, I would be interested in any information that readers have on this issue in a UK context, either from research they are aware of, or from official sources.

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■ LOCUM PHARMACISTS

Bad image is not deserved

From Mr H. S. Badwal, MRPharmS

Since embarking on my career as a locum pharmacist one thing is clear: a lot of tarring with the same brush goes on.

I hear stories of pharmacists who have vanished back to their homeland before a booking, have arrived at work with wet hair and a hairdryer and that, too often, we have a minimalist approach in the dispensary.

I would like to speak up for the hardworking locum who covers days off and who strives to leave the dispensary as tidy, and often tidier than it was when he or she arrived.

As someone who works in a different dispensary every day I appreciate a pharmacy that has stock in date, support staff who know how to use their computers and an idea of their dispensary's standard operating procedures.

My more serious point is that each pharmacist has a right to professional discretion. I often have to complete a prescription or do work that I take some exception to. In these cases I believe it is a locum pharmacist's duty to complete work on behalf of the pharmacist in regular charge, with minimal disruption to patient care. However, I would say that the quality of locum pharmacists willing to return to the pharmacy for a day is directly related to the quality of the pharmacy and its support staff, not the hourly rate we are paid.

Hardeep Badwal
Derby

■ PHARMACY IN ACADEMIA

Pension deficit will lead to PhD deficit

From Dr T. P. Learoyd MRPharmS

It is interesting to note the discrepancy between policy and reality in the Royal Pharmaceutical Society's direction on the recruitment of pharmacists into academia. It is also interesting to note that the Society chooses to lobby governments rather than sort out its own "backyard" (news release, 29 January). I refer the reader to the pensions deficit debacle and the Society's reluctance to give pharmacy postgraduates, who undertake

research degrees, and young academics any break from the exorbitant hikes in the retention fee.

The Society should recognise that the pay in academia is not on a par with the private sector. And if the Society wants to have a future representation in pharmacy schools I suggest it does more to help such members out financially, rather than ask the Government to do more.

How can the Society expect an extra 333 pharmacists to be recruited to full-time research degrees (*PJ*, 23 February, p205) when it sends out questionnaires to its membership asking if they would pay a fee of £600 per year?

Furthermore, how can a newly qualified pharmacist be expected to pay a retention fee (of a projected £600 per year by 2010) and professional indemnity insurance (of over £150 per year), and then settle for a stipend in the region of £12,000 per year (Biotechnology and Biological Sciences Research Council, 2006)?

The time pressures while committed to a doctorate are such, and the opportunities to commit to locums so few, that the postgraduate would be lucky to break even after a year's membership. I suggest that the Society is doing little to get pharmacists into academia and that it needs to review its fee structure vigorously.

Tristan Learoyd
Hatfield, Hertfordshire

■ ADVERSE REACTIONS

Protect patients from harm

From Mr C. Spence, MRPharmS

I write to share my concerns about the potential for harm to patients taking anticoagulants when they are prescribed or advised to buy miconazole oral gel, as raised by Sonia Baker (*PJ*, 15 March, p308).

During my own experience of running international normalised ratio monitoring clinics, I have encountered several similar instances of the potentiation of INR by miconazole oral gel. These have largely been due to GPs issuing a handwritten or acute prescription, without adequate reference to BNF interactions or to interaction prompts from their surgery computer systems. As a result, I provide advice and education to surgeries, include interaction guides and discussion time with trainee GPs and nurse prescribers.

I am aware of a number of interventions made locally, by diligent community pharmacists, having detected such co-prescribing and have been thankful for this. However, I, too, recently encountered an instance where a previously stable patient's INR was elevated to dangerous levels (7.7), after the OTC sale of miconazole oral gel, while away from the area on holiday.

This was disappointing because the patient had asked to speak to the pharmacist and asked if this treatment was OK for her, as she took warfarin. The patient acted as I counselled; however the same cannot be said of the pharmacy. A critical incident report has been completed.

Fortunately, no harm came to this patient, as her high INR was detected at clinic, shortly afterward and corrective measures taken. At first, I was unable to explain this reading, despite thorough discussion with the patient. However, as I use the surgery patient medication record system, I was reminded that nystatin oral suspension had recently been prescribed. This allowed me to prompt the patient to reveal that she had sought further treatment for a recurrence of the complaint, while on holiday.

I would not like patients to be denied access to effective treatments such as miconazole oral gel from pharmacies, but I agree this is an area that should be studied. My suggestions would include further local training and the expanded use of minor ailment schemes to allow the supply of non-interacting treatments such as nystatin and, hopefully, in future the connection of community pharmacies to GP patient records as part of the national programme for IT, to allow efficient safety checks and monitoring.

Craig Spence
Practice and INR Pharmacist
Sunderland Teaching Primary Care Trust

■ MINORITY LANGUAGES

Develop multi-language communications

From Mr K. P. Moseley, MRPharmS

In his letter (*PJ*, 17 May p.595), Bernard Black mentions the difficulty in communicating effectively with patients whose first language is not English.

In one pharmacy I work in, the pharmacy manager sourced a

printed list of WWHAM questions translated into Polish, which was useful for his Polish patients.

I am also aware of the excellent Translabel website (www.translabel.co.uk), which enables pharmacists to translate a selection of commonly used dosage instructions into one of 14 languages. When used for patients whose command of English is not strong, there are opportunities for risk minimisation by being able to print accurate and understandable instructions to accompany the dispensed medicines.

Has any pharmacist ever had an experience of developing or using a multi-language communication tool, perhaps with key words/phrases and pictures (such as body parts), which could be used easily in over-the-counter pharmacy consultations?

Kevin Moseley
Bath

■ THE SOCIETY

Excellent service at Society dining room

From Mr M. P. Shepherd,
MRPharmS

The interview with Bernard Kelly (Director of Finance and Resources) in the May issue of *Your Society* mentions proposals to upgrade the dining room on the top floor of the Royal Pharmaceutical Society's London headquarters.

My partner and I recently had lunch there. The meal and service were excellent, but the dining room looked tired and in need of refurbishment.

With the reasonable cost (bearing in mind its central location) and fantastic views we were surprised that we were the only diners present. The catering staff provided us with a top quality meal and the front of house staff a very enjoyable experience. I would encourage other members to take advantage of this facility.

I wish the plans for the refurbishment and opening in the evenings every success.

Martin Shepherd
Dorchester

Telephone number

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