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NEW PROFESSIONAL BODY

## Driving force must be the membership as a whole

From Mr R. Dickinson, FRPharmS

*The Journal* of 7 June brought together a number of important issues related to the future of the pharmacy profession. I refer to Graham Phillip's views on the Privy Council (p687); Douglas Simpson's comments on the Waterloo Group (p688); and the branch representatives' resolution on a pharmacist-only professional body (p698).

It would be reasonable to distil from them a scenario that has considerable merit, ie, a pharmacist-only professional body, operating without a charter and providing services of real value to community pharmacists as well as to those practising elsewhere.

The views at the branch representatives meeting are a significant indication of how the majority of active members probably feel about whether pharmacists should have their own professional body. The arguments for inclusion of other professionals have been well rehearsed. I believe that the least convincing reason for such a decision would be that they would help to make the new body financially viable. Be that as it may, surely the next step is to find out whether or not the majority of individual pharmacists agree with the BRM resolution.

As to the maintenance of a link with the Privy Council through a charter, this was of first importance when the Royal Pharmaceutical Society was acting on behalf of the government in the regulation of the profession. These duties have been forcibly removed from the Society, a decision I deplored. Those pharmacists who welcomed this change emphasised the Society would now be free from any restraints when representing the best interests of pharmacists and that it could now be completely independent. I know from experience that on matters to do with pharmacy the Privy Council works closely with the Department of Health. We have seen how the DoH has tried to influence the development of the new professional body. If it so wishes, the profession now has the opportunity to remove the influence of government from the internal workings of our professional body by severing the link with the Privy Council.

I am not surprised that the minority interest groups within pharmacy have expressed their views through the Waterloo group but the driving force behind the creation of the new body must be the membership of the Society as a whole. It is certainly not time for the Society to take a back seat.

A voluntary membership professional body for pharmacists will only succeed if its planned activities and services support the aspirations of the majority of pharmacists. As in the past, minority groups of pharmacists would decide whether they could function best within such a body or independently. I would hope that the new body would make every effort to create an environment conducive to the work of such minorities.

**Raymond Dickinson**
*Former Deputy Secretary, Royal Pharmaceutical Society*
*Farnham, Surrey*

## We do not need a Charter or lay members

From Mr G. S. Phillips, MRPharmS

I am grateful to Michael Schofield (*PJ*, 14 June, p714) for putting forward the other side of the argument around chartered status and the role of lay members in pharmacists' new professional body. This is the right time to be having this debate and creating such a debate was my prime objective in writing my article the week before (*PJ*, 7 June, p687).

Professor Schofield's arguments in favour of lay input and chartered status are founded upon three assertions:

1. That this will confer greater influence upon the professional body
2. That governance and public confidence will benefit
3. That lay members bring additional skills

I use the word "assertion" purposefully since Professor Schofield, despite the age of evidence in which we live, cites no facts to support his case.

**Greater influence** In my article I listed a series of examples of the Privy Council's unwarranted interference in matters unrelated to regulation. This interference occurred despite the presence of 10 lay members on the current Royal Pharmaceutical Society's Council. This is hardly compelling evidence of their great influence. But the nail in the coffin for Professor Schofield's first assertion is the fact that the Government rejected the arguments in favour of an integrated body and consequently decided to remove the regulatory role from the Society. This was despite considerable and very public opposition from a number of lay Council members. If this is evidence of the greater influence that lay members confer then I suggest we would be doing just fine without it.

**Governance** Professor Schofield provides more assertions but still gives no facts. He quotes the Nolan principles as if they and, by implication, proper governance are the sole preserve of the lay members. I reject these unjustified assertions and resent the implications, which I regard as a slur upon the professionalism of pharmacists. In fact, my experience on the Council was quite the reverse of the picture Professor Schofield paints. Some lay members laid claim to "openness" and "transparency" but some behaviour I witnessed at close quarters appeared far from open, transparent or patient-centred. Professor Schofield himself admits that governance has been difficult at Lambeth despite the lay members' presence.

More generally, I have had the opportunity to be involved in considerable work seeking the views of patients and the public, not only through the Society but also via local primary care organisations and my own pharmacies. Not once has anyone shown a shred of interest or even mentioned governance at Lambeth or the need for lay members. What does interest the public (as the Government's own research as background to the recent White Paper on pharmacy reinforces) is obtaining much more from pharmacists in the crucial areas of public health and medicines management. I want to see our new body deliver on the vision of pharmacists as patient-centred, medicines-focused clinicians. We will need to count on strong patients' voices, a small and dedicated expert staff and a small, visionary and dedicated Council of pharmacists to deliver this. What we do not need is a continuance of Lambeth's lay-led regulatory obsession (let the new regulator deal with that) to hamper our progress.

**Skills** There can be no suggestion that all the necessary skills reside with pharmacists. Pharmacists' new professional body must work in close collaboration with "internal" stakeholders (non-pharmacist pharmacy academics, pharmaceutical scientists and, of course, technicians) as well as "external" stakeholders (patients and the public, with all that entails) to have a chance of delivering on the vision. The networks to which Professor Schofield alludes would undoubtedly be strengthened by effective public and patient participation. The skills to which he refers (marketing, financial management etc) will be provided by appointing the right expert staff. Thereafter any additional skills required could be provided by co-option or external consultancy.

The profession will decide. On this, if nothing else, Professor Schofield and I are in complete agreement. Hence I am seeking an immediate and public commitment from the Society to consult its members on this issue. The Society has been guilty of paternalism in the past, which has only served to distance it from the members. Now is the chance to promote a vision for our future and thereby to re-engage members' hearts and minds. Time is short. I hope the Council will seize the opportunity

**Graham Phillips**
*St Albans, Hertfordshire*

THE SOCIETY

## Down to earth, friendly and informative

From Miss S. D. Patel, MRPharmS

I have used the Royal Pharmaceutical Society's legal and ethical advisory service on several occasions now. Each time the help I received was practical, down to earth, informative and friendly, making a difficult situation clearer. When talking to other pharmacists I am surprised that many do not even realise the service exists. So, pharmacists colleagues, keep the telephone number handy (020 7572 2304). The service is good.

**Sittal Patel**
*London*

**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

THE PROFESSION

## Pharmacy organisations should support employee pharmacists

From Mr G. Diamond, MRPharmS

I have been interested in recent correspondence regarding the membership of the College of Pharmacy Practice and the political machinations of the Waterloo group.

I have been an associate member of CPP and was surprised to read that such caucusing has been undertaken by pharmacy politicos in various stakeholder groups within the profession.

My opinion of the CPP and its method of attaining full membership is that it is elitist in having a rather complicated if not tortuous procedure. If it wants to encourage people to progress to full membership and attain further subscribers, then it really needs to re-evaluate how it can become more relevant to the needs of the vast majority of employee community pharmacists and their needs as they work long hours in stressful conditions.

The faculties seem to be predominantly for medicines management, cancer care, pediatrics and public health, which are more geared for public sector hospital or primary care trusts.

Unless pharmacy organisations engage actively to support employee pharmacists in community pharmacy to be what they can be, then community pharmacists will vote with their feet.

**Gerry Diamond**
*Manchester*

## 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.

ETHICS

## Grey ethical areas need to be made black or white

From Mr R. I. Dunkley, MRPharmS

I read with more than my usual degree of interest, the results of the "Ethical dilemma" presented in May's *Your Society*, and reproduced in the June issue. It asked pharmacists whether they would allow access to their Controlled Drugs register and patient records to a police officer seeking information about one of their methadone patients. I have experience of this: the chemist officer from the local drug squad has visited on numerous occasions and trawled though the entries in my register, making notes of the names contained within. Stopping a police officer in the course of his or her duties can lead to serious consequences. Thus I had to stand by and let him do it.

A number of points arise from this:

- It is a fundamental breach of patient confidentiality, with the added twist that old Mrs Smith gets her name taken along with the rest. She is there because a record has to be made of each supply of methadone, which her GP deems necessary for control of her pain. No matter, her name is passed into the system. Thus your grandmother's name could be residing on a police computer somewhere.
- I have raised "trawling" on the numerous bulletin boards I subscribe to and colleagues outside pharmacy, but still in substance misuse maintenance, are astounded that something like this can happen.
- The most appalling thing I read in the article is that there was a split in the decision of what action to be taken in the case of such a visit, leading, one concludes, to a difference of opinion as to what should be done. This is surely a case for firm leadership from the Royal Pharmaceutical Society's Ethics Committee; either we allow full access to our records to police officers or we do not.

That the area is still a grey one was demonstrated at a recent Centre for Pharmacy Postgraduate Education meeting on changes in CD regulations, when I asked the very question posed above. To his great credit, the accountable officer under the new CD regulations, who was giving the talk, said that anyone in authority, eg, a police officer, wanting access to the CD register should provide written proof as to the purpose of their examination, and signed by a senior officer. But from what the accountable officer implied, this was not mandatory, just good practice.

"Trawling" has stopped in this part of the world, but the fact that 50 per cent of the sample (n=200+) would allow access to CD registers (including 4 per cent who would give access to computer records as well) means that it is still going on somewhere.

In conclusion, pharmacists should be given guidance about this important matter.

Make that grey area black or white.

**Bob Dunkley**
*Leeds*

PRIYA SEJPAL, head of professional ethics, Royal Pharmaceutical Society, responds: This is an important and sensitive area and I appreciate Mr Dunkley's concern.

A police officer is lawfully able to access any record, register or other documentation in relation to any dealings with Controlled Drugs. You must be satisfied of the person's authority to view patient confidential information, ie, check that they are who they say they are. It would be prudent to check why police officers want to see any record, register or other documentation and confirm that there is a legitimate need for access. They do not have to provide you with written authorisation in order to do so; however you should use your professional judgement to decide if you feel this is appropriate. "Trawling" of registers for no legitimate reason is not appropriate, but looking through registers to ensure that the provisions of the legislation in relation to CDs are being complied with is.

Regarding giving a police officer access to patient medication records, as a matter of routine, police officers cannot access a PMR except in relation to information about CDs. However, there may be other circumstances where a police officer may require access to a patient PMR, for example, the prevention or detection of a serious crime, in which case the request must be made in writing.

The area of confidentiality is unfortunately not always black and white and decisions are made on a case-by-case basis with some general guiding principles; pharmacists are advised to read the professional standards and guidance document for patient confidentiality, which expands on these principles. Further advice can also be sought from the Society's Legal and Ethical Advisory Service (leadvice@rpsgb.org) or 020 7572 2308.

I am pleased that this particular "Ethical dilemma" has created some interest and would encourage other pharmacists to visit myRPSGB on the Society's website to take part in future ethical dilemmas.

PHARMACY IN ACADEMIA

## Society should reduce PhD students' retention fees

From Dr C. T. Gallagher, MRPharmS

I would add my voice to that of Tristan Learoyd (*PJ*, 31 May, p656) in pointing out the contradictory message sent out by a Royal Pharmaceutical Society that, on one hand, wants 333 extra pharmacists undertaking full-time research degrees, while on the other penalises them financially by charging a flat retention fee that does not reflect their diminished income.

Furthermore, I am stunned by the comments of Rebecca Ramsey (*PJ*, 14 June, p717). I wonder if Miss Ramsey, who can survive on £12,000 per annum, has a mortgage, a car loan, or an overdraft accumulated through four years of undergraduate study, like many of her contemporaries in other fields of the profession. PhDs are supposed to attract the best and brightest of pharmacy graduates and, regardless of whether one austere student can survive on breadcrumbs, should have a remuneration package that reflects this.

When I began my PhD (in chemistry), the stipend was £8,400. This was certainly enough on which to survive, but insufficient to attract top chemistry graduates drawn by private sector salaries. Recognising this, the research councils increased their stipends in the range of £12,000–17,000. Since pharmacists are in the almost unique position among life sciences graduates of being able to command starting salaries of £40,000+, it only makes sense that they should seek more than merely the means "to survive" from their funding body. Miss Ramsey erroneously compares the income of doctoral candidates with that of undergraduate students, many of whom are subsidised by their parents, rather than with their professional, adult contemporaries. As a new researcher, she still clearly feels more akin to the former group. I should be interested to have her opinion again in three years' time.

Clearly, the Society is not in a position to affect the amount of PhD funding that it does not itself administer, but surely it can help reduce the financial worries of an additional 333 pharmacists each year by introducing a fair retention tariff.

**Cathal Gallagher**
*St Albans, Hertfordshire*

## A small concession from the Society would be welcome

From Dr E.L. Ferguson, MRPharmS

I was amazed to read Rebecca Ramsey's response (*PJ*, 14 June, p717) to Tristan Learoyd's letter (*PJ*, 31 May, p656) regarding pharmacists in academia. Trying to attract pharmacists to do a PhD is hard enough without ill-conceived remarks like this. Having recently completed a PhD, I believe Miss Ramsey has missed the point that Dr Learoyd was trying to make. £12,000 may be sufficient to scrape by an existence on, but when young pharmacists are faced with the choice of three to four years of studying on a £12,000 salary, or the average pharmacist's salary (£40,000), it is easy to see why few find themselves in academia.

Furthermore, with the introduction of top-up tuition fees for undergraduates (£3,000 per year), students will leave university with increasing debts, making higher paid jobs all the more appealing. Consequently, only the very dedicated and driven pharmacists choose to undertake PhDs, and the Royal Pharmaceutical Society ought to recognise this.

Dr Learoyd also made a point that, as a PhD student, it is often difficult to find time to work as a locum pharmacist to offset the costs of retention fees and indemnity insurance. I struggle to understand how Miss Ramsey has managed to work sufficient hours through demonstrating and invigilating during university term time to pay off these costs, and still have the necessary time remaining to devote to her studies. I suspect this work balance will change as her studies progress. I suggest that, while the PhD stipend may well be sufficient to survive on, a small concession from the Society would be welcome and timely.

**Elaine Ferguson**
*Cardiff*

## Restructuring of retention fee is long overdue

From Mr S. N. Mistry, MRPharmS

I am dismayed by Rebecca Ramsey's comments (*PJ* 14 June, p717) in reply to Tristan Learoyd's observations (*PJ*, 31 May, p656). With the ever rising cost of living, the barriers to attracting newly qualified pharmacists into academia are plentiful. Before income is considered, a degree — especially the more extensive four-year MPharm course — comes with a hefty price tag. I still have a sizeable student loan to pay off five years after graduating. The basic stipend is worlds apart from the income commanded by a full-time pharmacist, especially if the potential earnings of a full-time locum are considered.

As a PhD student approaching the end of my third year, I can assure Miss Ramsey that if and when she progresses past her initial MPhil registration year she will quickly realise that the time and commitment required leave little opportunity for demonstrating and examination invigilation. The few hours one can spare are hardly enough to cover the extortionate Royal Pharmaceutical Society fees and insurance costs.

As the name implies, a full-time research degree is just that; most of my colleagues find themselves sacrificing at least some part of their weekends as well.

At the end of the day the issue is not of income and whether the stipend is enough to live on; it is that it is patently less attractive to go into academia. The non-discriminatory retention fee simply aggravates this situation.

It is time the Society took a more proactive approach to encouraging pharmacists to enter academia and a more realistic structuring of retention fees is long overdue.

**Shailesh Mistry**
*Nottingham*

COMMUNITY PHARMACY

## Benefits of open plan dispensaries

From Mr D. Fernley, MRPharmS

Over 20 years ago, most dispensaries in pharmacies were hidden. Opening them up was a bold move. As a consequence dispensary shelves became tidy, books were put away, coffee cups and kettles went into tea rooms and smokers were banished. In my open plan pharmacy, patients asked to speak to me and rarely interrupted. I had a commanding view of the till and anyone who needed special attention. My checking skills were my forte, regardless of the distractions.

I believe Chijioke Agomo (*PJ*, 31 May, p653) has been working in some poorly designed open plan dispensaries. When planned correctly they enhance the patient/pharmacist experience. I can assure him I do not have the X-ray eyes that he suggests pharmacists should have to achieve an error-free day, just experience.

**Dave Fernley**
*Newark, Nottinghamshire*

Advertisement

COMMUNITY PHARMACY

## I feel like Rip Van Winkle

From Mr R. W. Selfe, MRPharmS

Having been retired for 20 years I felt somewhat like Rip Van Winkle when I read the report "Only two hours' absence to be allowed" (*PJ*, 31 May, p649). Will the "responsible pharmacist" (incidentally would anyone admit to being an irresponsible pharmacist?) have to abandon his home life and sleep under the counter except for two hours out of the 24? The pharmacies I visit today look much the same as they did in my own era and display notices, as I did, relating to arrangements during the pharmacist's lunch break.

And what about this "complicated paperwork" when handing over responsible pharmacist duties two or three times a day? I hate to think how this would have operated during my time at the day and night service in Boots at Piccadilly Circus — even if we could always identify who actually was the "responsible pharmacist".

Some admirable changes have taken place since my day, such as the addition of testing facilities for diabetes, but I do feel that the everyday ordinary requirements of our public get subordinated to the more involved legislation for those trying to attend to these needs.

**R. W. Selfe**
*Benfleet, Essex*

MEDICINES USE REVIEW

## MURs are not simply an income stream

From Mr A. Richards, MRPharmS

I was carrying out locum duties recently at a supermarket pharmacy when a floor manager arrived, who told me that I had to undertake two medicines use reviews that day. His second conversational gambit was to tell me that he was taking me off the company's accredited pharmacy locum list. I think this was a direct result of my telling him what he could do with his first instruction.

Any primary care pharmacist could have seen what was going to happen with MURs. We live in an imperfect world and to use MURs as a means of compensating for revenue lost following the reduction in payment for Category M medicines is ill-considered. We now have a situation where MURs are seen by some as an income stream and valued accordingly.

I welcome this opportunity to start a debate on how far managers — qualified and non-qualified — can go in telling a pharmacist what to do. I would be interested to know the views of superintendent pharmacists regarding this and if they condone interference in the running of a pharmacy. The manager I had dealings with had no idea of my workload, no idea of my staffing level, no precognition regarding the presentation of suitable patients for MURs and, in all probability, no idea of what an MUR is other than it attracts a payment. I believe that this situation is unacceptable and if this culture is allowed to prevail then MURs will lose their credibility with the purchasers (primary care trusts) and with GPs, who have been advised that MURs will have a positive clinical outcome for patients and are not simply designed as an income stream.

**Arwel Richards**
*Winchester, Hampshire*

BREASTFEEDING

## How pharmacists can be involved

From Mrs M. Sharma Kapoor, MRPharmS

I read with interest the **Continuing professional development** article on "Giving advice on breastfeeding" (*PJ*, 14 June, p723), particularly since the recent National Breastfeeding Awareness Week had left me feeling that perhaps we, as a profession, could raise our profile among the general public and other healthcare professionals by getting involved with this annual event.

This year, NBAW ran from 11 to 17 May, with many activities taking place. In Leeds, Breast Buddies (a local community group that aims to promote breastfeeding in public) held an exhibition of posters showing mothers breastfeeding in the city, and the Leeds and Wakefield branches of the National Childbirth Trust held a breastfeeding awareness party at Ikea. Leeds Primary Care Trust held a series of events to highlight the health benefits of breastfeeding.

As pharmacists, we are in a position to be able to contribute to promoting the initiation and maintenance of breastfeeding. We can provide information to patients in terms of what benefits breastfeeding can have for mother and baby. We can advise on management of common difficulties encountered while breastfeeding. We can advise on the importance of a healthy diet while breastfeeding. We can signpost to other healthcare professionals or support organisations. We can provide information on medication and its impact, if any, on breast milk. Finally, we can advise on switching from breast to bottle feeding, either as expressed breast milk or formula milk.

In Leeds, there are several baby cafés across the city. The "You can do it here" guide was published last year, listing all breastfeeding friendly establishments in Leeds. Local National Childbirth Trust breastfeeding counsellors — mothers who have breastfed their own children and undertaken training in order to offer support and information about breastfeeding — are available to talk to mothers and visit them if necessary.

In my experience, pharmacists are not the first (or even the second) port of call for breastfeeding-related issues. By raising awareness of what information we can offer we may be able to reach out to pregnant and breastfeeding women, thus contributing towards raising initiation and maintenance rates of breastfeeding.

**Monica Sharma Kapoor**
*Leeds*

DIABETES

## Pharmacists' interventions are better than nurses'

From Mr M. Ali

A two-year trial[1] published in *The Lancet* recently evaluated nurse-led type 2 diabetes management and reported significant improvement in diastolic blood pressure (1.9mmHg [95 per cent confidence interval −2.88 to −0.94]) and mean arterial pressure (1.36mmHg [−2.49 to −0.23]).

It is interesting that the authors call these "additional, although small, benefits". I am not sure how clinically meaningful an additional decrease of 1.9mmHg in a parameter such as diastolic blood pressure, and with that wide a confidence interval, would be. Moreover, as they demonstrated, this nurse-led intervention was not even cost-effective.

It cannot be said with certainty whether the insignificant effects shown in the trial are related to this particular ethnic group. Nevertheless, we know that general multifactorial intervention in type 2 diabetes significantly reduces mortality (HR 0.54, 95 per cent CI 0.32–0.89), cardiovascular-related mortality (HR 0.43, 95 per cent CI 0.19–0.94) and cardiovascular events (HR 0.41, 95 per cent CI 0.25–0.67) coupled with significant reductions in systolic and diastolic blood pressures, total cholesterol and $HbA_{1c}$ (additional decrease of 15mmHg, 5mmHg, 1.5mmol/L and 1.1, respectively).[2] As we also know from recent meta-analysis[3] that pharmacists' interventions reduce HbA1c by 1.00 (±0.3, $P<0.001$) in contrast with the control, we probably can argue that pharmacists' interventions work better than nurses' interventions in type 2 diabetes management.

However, robust evidence from the evaluation of culturally tailored diabetes services from community pharmacists for South Asians, such as "Umda dawa" in Bristol[4] and other such services by community pharmacists in Glasgow[5] and Edinburgh,[6,7] should provide better comparison.

**Majid Ali**
*Research Assistant*
*School of Pharmacy, University of Hertfordshire*

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