The Profession
Positive changes have occurred

From Dr A. D. J. Balon, FRPharmS

Perhaps because I am not a political animal, I found comprehension of Tristan Learoyd’s letter (PJ, 27 February 2010, p211) difficult. What point is he trying to make? I am guessing it is that pharmacists’ new professional body should be supported by the profession and we should press for more recognition as stand-alone healthcare professionals.

He appears to question our current standing with other members of the healthcare team. But he also appears to think that our current role is not appropriate. As a pharmacist with some years in practice, I can only reflect on the positive changes that have occurred and wonderwards a vision for the future of our profession.

Despite what Dr Learoyd may think, things have certainly changed. When I started, there was little point even trying to speak to a doctor about a prescription. Nowadays, I find the reverse is true. They willingly take our calls and many telephone us for advice. With respect to the taking of blood pressure, do the vast majority of pharmacists have the knowledge and clinical training to initiate or modify treatment of hypertension? I think that only those who have undertaken extended and additional training have all the necessary skills.

However, most (but not all) do have the ability to review medicines use. It is unfortunate that our primary universal education and preregistration training does not fit us for this task, hence the requirement for subsequent training and “examination” to ensure those who fail this role are capable.

The practice of community pharmacy is as good as the pharmacist who provides the service, within the boundaries set by the rules, the regulations and the resources available. I accept that these require urgent and radical overhaul, as does the financial reward for the services we provide.

I also agree that pharmacists should be given the absolute right to make “adjustments” to prescriptions that are clearly incorrect. They should be empowered to interpret the prescriber’s intentions without referral. For example, we should be able to supply 20 original packs on prescription calling for 200ml of a food supplement. We should end the frustration of having to refer the prescription back merely to have it initialed by the prescriber — a simple but common situation. However, this is different from proposing immediate prescribing rights for all pharmacists.

So what is our future role? I suggest there are two aspects. First, we should be the interface between a drug and a patient. We should not be involved in the mechanics of the dispensing process but use our knowledge in reviewing the clinical suitability of the prescribed medicine for that patient, then providing pertinent information when handing it out. Many years ago, I proposed (in a paper jointly submitted with Jerry Shulman to the Nuffield Foundation report on pharmacy) that all prescribed medicines should be handed out by a pharmacist — no sealed bags. At the time of transfer of the medicine, all aspects of the patient’s health are open for discussion. I am aware that many practitioners will say that this is their current practice but I think they are in the minority.

The second aspect is linked to my previous assertion. We should be available, both reactively and proactively, to provide healthcare — not just advice — to all our clients. Thus we should be providing services, such as blood pressure monitoring, international normalised ratio clinics, sexual health services, diabetes monitoring, asthma monitoring, obesity advice, smoking cessation and minor ailments service (note I refer to monitoring, not initial diagnosis or initiation of drug therapy). However, the current remission system does not encourage this service. The exception to the monitoring function is responding to minor ailments, which should become universal and be financed by the NHS.

I would also suggest our current education and training does not fit us for many of these functions. The profession needs to take a stand on our education. I am aware that academics have some degree of control over our education but the Royal Pharmaceutical Society does have some input and currently it fails in its task. I am also aware that, just like community pharmacy, our academic colleagues need access to entirely different levels of resources if they are to provide “fit-for-purpose” pharmacy education. In a similar manner, the Society also fails in its duty to change the rules of our practice, making them pertinent to practice while being “in the best interest of the patient”. Furthermore, the bodies that negotiate the financial structure of remuneration also fail us.

To this degree, I can agree with the sentiments expressed in Dr Learoyd’s letter and wish him well in pursuing these aims with the committees on which he serves.

Derek Balon
Edgware, Middlesex

Let the readers decide

From Mr G. L. Stafford, MRPharmS

Last week, I detailed my view of the supply chain difficulties (PJ, 6 March 2010, p236). The PJ subsequently reported that the Department of Health has released details of tough new measures to tackle medicines supply problems (see p259). The two analyses could not be more different. It used to be said that you set a thief to catch a thief. The proposals in the news item from the great and the good look to me like using bankers to clear up the banking crisis.

The headline announced that the proposals were tough. For me, they were tough to swallow. Is this ineptitude, greed or stupidity? Readers can decide.

Then, we had the revelation that Tesco now insists its pharmacists take a 20-minute break (see p257). All I can say is it is a good job Bob Cratchit was not a pharmacist or he would be turning in his grave.

I have said it before but I suppose I will have to keep on saying it: a 20-minute break increases the pressure. It does not decrease it. It is simple mathematics because 20 minutes is a paltry minute break argument above the supply chain difficulties (see p259). The two analyses could not be more different. It used to be said that you set a thief to catch a thief. The proposals in the news item from the great and the good look to me like using bankers to clear up the banking crisis.

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So, pulling all these elements together, I want to say that I will do whatever I can to make the work of the Royal Pharmaceutical Society and the English Pharmacy Board interesting to everyone (pharmacist) focused but, until non-pharmacist owners, employer-dominated pharmacy organisations and Whitehall mandarins change their views of the English pharmacy world, it is going to be an uphill struggle against what readers might think is their ineptitude, greed and stupidity.

Graeme Stafford
Morecambe, Lancashire

Mr Stafford is a member of the English Pharmacy Board. The views expressed here are his own and do not necessarily reflect the views of the board. — EDITOR.
Sultan Dajani states (PJ, 20 February 2010, p185) that fears members have about the outcome of the recent national pharmacy board elections are unfounded. Although his assurance is welcomed, members of the new professional body will only be able to believe this when candidates elected to the new board and Assembly give at least as much priority and profile to professional advancement as to the responsible pharmacist regulations.

In respect of this, I look to the new Assembly to ensure at least equivalent support, profile and energy is given to professional service provision and to the Practice Development Group work Carol Evans, head of professional development at the Royal Pharmaceutical Society, has ably undertaken. Catherine Duggan, director of professional development and support at the Society, now builds on with Ms Evans. This may provide some of the evidence David Miller (PJ, 19/26 December 2009, p680) and others may be looking for that a single issue will not get undue priority.

However, I sense Mr Miller’s assertions may not be unfounded since much of the success of many elected candidates was, I believe, founded in heavy marketing and support by the Pharmacists’ Defence Association to progress its perspective on the responsible pharmacist regulations. Trade unions should do what trade unions do best: represent their members on terms and conditions of service.

It is a sad reflection on its ability to do this if it has to support candidates for election to a professional body. When such things happen, it is not unreasonable to have fears that the new professional body may not give due priority to advancing professional practice when many of us believe our democratic processes have been hijacked.

R. G. Pate
Kinver, West Midlands

From Mr V. S. Mithani, MRPharmS

The recent case of Stafford Hospital, where managers pursued targets to the detriment of patient care, should be a salutary lesson to us in our pharmacies.

The burden to show written evidence that a pharmacy is complying with ever-increasing demands is taking away our main focus — patient care.

The latest is NHS Information Governance. It has to be completed by the end of March 2010. It is a 64-page document. Independents have limited staff, time and financial resource. How long and how much can one go on robbing Peter to pay Paul? I hope our Peter is not our patients and the care.

It is difficult enough to obtain important medicines on a day-to-day basis to make sure our patients do not come to any harm. So, I wonder how much my informing faceless bureaucrats that I am complying with their 64-page document tells them how hard I am working to keep my patients safe on a daily basis.

Incidentally, in my case, an annual 100-patient satisfaction survey has to be completed by the end of March 2010. I hope I get a satisfactory response. I know I have done my best.

V. Mithani
Camberley, Surrey

Letters to the editor

Remuneration model destroys the viability of some pharmacies

From Mr D. R. Kent, MRPharmS

Has anyone noticed the irony in the new slogan for pharmacy dreamed up by the Pharmaceutical Services Negotiating Committee — “Pharmacy: the heart of our communities”?

This is strange because the shameful remuneration model put in place by the PSNC in 2005 has done more to destroy the viability of those pharmacies truly in the heart of communities, those in the back streets, secondary positions or on estates. These pharmacies, as a consequence of their placement, dispense lower prescription numbers than their prosperous high street colleagues and are penalised heavily by the PSNC for this.

Sue Sharpe, chief executive of the PSNC, in 2004–05 lauded the current remuneration arrangements as mowing pharmacies away from remuneration based on prescription numbers. Perhaps she also thinks pigs can fly?

David Kent
Banter, Hertfordshire

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OVERSEAS PHARMACISTS

Demands are out of proportion

From Mr P. G. M. Murphy, MRPharmS

I am New Zealand-qualified pharmacist who has been registered and practising in the UK and Ireland over the past four years. It was with a sense of “I told you so” that I have read in the PJ and elsewhere about the shortage of band 6 pharmacists in the NHS, with almost a quarter of the positions unfilled, rising to 40 per cent in Scotland (PJ, 5 December 2009, p607). I believe some of these posts would have traditionally been filled by antipodean pharmacists who were mobile and keen to fulfil workforce requirements.

I am still at a loss as to the justification behind the extensive retraining programme for overseas-trained pharmacists put in place following the end of the reciprocity arrangements. This bewilderment has been refreshed by these recent reports of the shortage of junior pharmacists (PJ, 19/26 December 2009, p669, and 13 February 2010, p149) and recent comments from a customer I served regarding the language problems of a European Economic Area pharmacist. The current situation for non-EEA overseas pharmacists is a year of university training, preregistration training and examination before registration can take place. By comparison, the General Medical Council requires overseas doctors to complete a two-part examination before registration, as does the General Dental Council. The Nursing and Midwifery Council requires overseas nurses to complete 20 days of protected learning and a period of supervised practice, where appropriate.

I believe the demands on overseas pharmacists are way out of proportion, especially considering some work visas are only valid for two years. Accordingly, the flow of non-EEA pharmacists has all but stopped, with only 166 non-EEA pharmacists beginning their preregistration training under the overseas pharmacists assessment programme in 2007–08.

A mobile workforce benefits all parties and is still facilitated in these other healthcare professions by quick entry onto the register. This has been the way for generations of pharmacists before. In the early stages of a pharmacist’s career, working in other cultures and systems is hugely beneficial. Young pharmacists stay for a year or two, work in areas that may otherwise have had difficulty attracting workers, then go back home. These hard-to-staff areas could be the same ones now reported to be at staffing levels endangering patient safety.

There needs to be a review of this registration policy that is hampering the development of young pharmacists and the profession. If competency absolutely must be tested then let there be a registration examination, not some long-winded repeat preregistration training and university training. I hope that, with the establishment of the General Pharmaceutical Council, there may be an opportunity to review this in line with the best interests of both patient safety and the profession.

Philip Murphy
London

FLU VACCINATION

Vaccine not safe or effective

From Mr A. F. Huntley, MRPharmS

In a News story (PJ, 20 February 2010, p181), you reported that there appears to be little reliable evidence that routine influenza vaccination in the over 65s and others may be either safe or effective.

It is timely that this chimera of 40 years standing has been challenged by a Cochrane review in light of the flu virus mutating in the period between vaccination and the onset of the flu season. Now in my 85th year I have, for some 20 years, resisted attempts to be persuaded to have an annual flu injection. What a sad loss of remuneration for my own GP.

A. F. Huntley
Bristol

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