The special resolutions invoked for the introduction of the two new membership categories have not been handled optimally and we are faced with a simple choice: vote “yes” and accept poorly constituted membership categories that may not then meet the representational needs of those we want to join our professional body; or vote “no” and ask for a more inclusive and far-reaching debate to ensure that our future aspiring pharmacists — be they preregistration trainees or students — are properly valued and then rewarded for their aspirations, with better thought-through proposals that will help deliver a strong and membership-driven professional body for pharmacists.

Kareol Pazik
Aylesbury, Buckinghamshire

Absorption into UCL not a new idea
From Dr P. J. Brown, MPharmS

As Lord Clement-Jones’s predecessor as chairman of the council of the School of Pharmacy, University of London, I welcome the school’s decision to defer any conclusion about its future until after March 2011 (PJ, 20 November 2010, p579).

In March, the Higher Education Fund for England will make known the university grant arrangements for the coming academic year. Only then can the financial viability the school as a standalone entity be known with any degree of certainty. However, it is my understanding that, based on a student fee level at around £7,000 a year, the school will be able to operate in surplus.

Lord Clement-Jones has noted that strong feelings have been expressed in favour of the continued independence of the school. I, too, favour this state of affairs. It is also the case that many of the school’s academic staff have opposed the idea of a takeover and, indeed, have worked with the university and college union to organise the “SavingOurSchool” campaign, which has been instrumental in bringing the issue to a wider audience through advertisements and its website www.savingourschool.org. In the coming months, this website will continue
to provide a public platform for debate.

The absorption of the school into University College London is not a new idea. On three occasions in the 1990s, the provost of UCL, Sir Derek Roberts, expressed a strong desire to take over the school. The case for such a move was examined carefully by the school’s council and, on each occasion, was rejected. The council concluded that it was far better, academically and financially, for the school to remain independent and thereby free to collaborate with whoever made common cause in research and teaching. At this time, the school’s academics do, indeed, collaborate widely, including with UCL, to the financial and academic benefit of the school.

It should also be remembered that the School of Pharmacy is unique among schools and departments of pharmacy in having a Royal Charter that defines a wide range of functions, procedures and objectives. I am advised that, if the school were to be taken over, the Charter would have to be surrendered, providing the case for surrender met with the direct approval of the Queen-in-Council. I suggest that, at a time when the pharmacy profession is undergoing a fundamental change in its organisation and objectives, the last thing pharmacists would want would be for one of its leading academic institutions to end a special relationship with the Crown.

The arguments for continuing independence of the school will be aired over the coming weeks. What one wants to see from the debate are creative ideas not only about the future of this important institution but also about the direction of pharmacy education and research. I urge all interested parties, whether they are alumni, fellows or honorary fellows of the school, or pharmacists who simply have a passion for the profession, to join the debate and so contribute to the greater cause.

Philip J. Brown
Weybridge, Surrey

Opportunity lost

It is an incredible shame that chlamydia testing and treatment has been canned in Scotland (PJ, 23/30 October 2010, p459), but this is completely understandable. On the whole, the pharmacy’s provision of chlamydia screening services has been underwhelming and there are many other ways to get greater numbers of young people tested, such as through school and college campaigns or at festivals.

That being said, I still strongly believe that chlamydia screening services should be available from pharmacies, particularly pharmacies that provide emergency hormonal contraception. [Some] young [women] who visit a pharmacy for EHC are demonstrating that they have not been practising safe sex and should be encouraged to take a test as soon as possible. In addition, many of these young people may not be accessing other sexual health services and it is important to make access to screening, advice or even contraception methods as easy as possible. I hope that other commissioning groups can fill the gaps that this loss of service leaves.

Richard Taggart, Liverpool

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1 Ginzburg L, Present DH. Alcohol is well tolerated in IBD patients taking either metronidazole or 6-mercaptopurine. American Journal of Gastroenterology 2003;98(Suppl):S241.

COMMUNITY PHARMACY

Best approach is to work with GPs and the new GP consortia

You reported that NHS Choices and community pharmacy services can reduce unnecessary GP visits (PJ, 13 November 2010, p540).

However, the assertion that this can save the NHS massive sums of money is, sadly, at variance with the facts.

Removing work from GPs does not save money since GPs are paid whether we consult them or not. There is, at present, no mechanism to move money from the GP pot to follow activity to other providers. I regard this as something of a flaw in their remuneration system but that is the way it is.

When I was commissioning primary care services for a primary care trust, the General Medical Services (GMS) funding system made the argument about saving GP time entirely unpersuasive from a financial point of view. I wished that things were different. Maybe in a PCT where GPs are scarce and practices overwhelmed with work it might carry some weight, but that is not the normal situation.

Probably the best approach for us is to work with GPs and the new GP consortia, which will enable pharmacy- and pharmacist-provided services to be a part of GMS and thus access their funding in that way. This will be easier than simply trying to take some of their money away or bidding for ever decreasing sums currently available from PCTs and their successors.

Brian Curwain
Chichester, West Sussex

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Brian Curwain
Chichester, West Sussex

PPRS demonstrated

The buffer role of the National Institute for Health and Clinical Excellence is not primarily between patients and their doctors (PJ, 6 November 2010, p507). It is between the Government and the electorate, so as to take healthcare rationing out of the forum of political debate. In other words, to provide a process and a set of technical criteria by which unpopular decisions on NHS funding can be made without politicians having to be directly involved in making them.

As for the much-maligned Pharmaceutical Price Regulation Scheme, although large companies might need to employ specialists to forecast their annual financial returns under the scheme, its principles and methodology are fairly simple for all to understand.

The stabilising effect of PPRS has been clearly demonstrated this year at a time when many other European countries have enacted cuts to drug prices and distributor margins in response to the global economic crisis. Yet we have been told the PPRS is on its way out and to be replaced by value-based pricing. There are already elements of value-based pricing in the current PPRS and, post-2013, I would expect the new value-based pricing to contain a good few parts of the old PPRS.

Donald Macarthur
Global Pharmaceutical Business Analyst
Haywards Heath, West Sussex
Clarifications about the Society’s history

From Mr S.W.F. Holloway

Briony Hudson’s brief Article on the history of the Royal Pharmaceutical Society of Great Britain (PJ, 18 September 2010, p310) contains a few errors. My comments follow the order that the issues are raised in the article.

1. The Pharmacy Act 1868 gave the Society the power to prosecute not only the registered but, more importantly, the unqualified.

2. The Jenkin (“without an ‘s’) case is important because the doctrine of *ultra vires* was applied for the first time to a chartered body. The powers of the RPS today are circumscribed by the wording of its current Charter but otherwise the Jenkin case is as dead as a dodo. It became irrelevant to the Society’s powers when the Charter was revised in 1953. Since then, the Charter has been revised twice and trade union law has undergone fundamental change. I dealt in detail with the Jenkin case in an article in the *PJ* (8 June 2002, p811).

3. The decision of the House of Lords in the Dickson case prevented the Society from implementing its strategy of raising the professional image of retail pharmacy within the NHS. It was a policy that had the overwhelming support of the Society’s members, so many of whom turned up at the annual general meeting in 1965 that no vote on the relevant motion could be taken. Instead, a special general meeting to discuss the issue was arranged to be held at the Royal Albert Hall.

Robert Dickson, a director of Boots Pure Drug Company, tried to prevent the meeting being held and initiated an action in the High Court, claiming that the Society’s motion was outside the scope of its powers and, if implemented, would be a restraint on trade. At the SGM held on 25 July 1965, the motion supporting the Society’s policy was passed by 5,026 votes to 1,346. After a series of legal battles, the House of Lords ruled against the Society on the grounds that the motion was *ultra vires* and that the restrictions proposed were in restraint of trade and had not been justified.

4. The British Pharmaceutical Conference was, for its first 59 years, completely independent of the Society. Its activities were not designed primarily to encourage pharmacists, whether in London or the provinces, “to take a more active part in the Society”.

5. Until the Pharmacy and Poisons Act 1933, the law relating to the practice of pharmacy was not differentiated from that relating to poisons. In both cases, the Privy Council was the central authority and the Pharmaceutical Society exercised the control. By the 1933 Act, the Home Secretary became the new central authority for poisons. The Privy Council retained its position for pharmacy, which it had held since the 1868 Pharmacy Act.

Sydney Holloway
Leicester

FROM PJ ONLINE

Negative marking

I write in response to Sadia Naeem’s blog about negative marking for the MPharm course at the University of Manchester. I study at Queen’s University Belfast and we [use] negative marking as well. I did not realise [that this is not the case] in every other school of pharmacy. For every multiple-choice question we get wrong, we lose a full mark (not just a third). Negative marking does prevent [students guessing answers] but, [in order to make it fair], it should be enforced across all schools of pharmacy.

Lola Clements, Pharmacy Student, Queen’s University Belfast