

by the Pharmacists' Defence Association.



# Cases for non-referrals to the Investigating Committee

A consultation response by the PDA

**April 2008**

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The PDA's response to this important consultation is split into to several sections;

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- Section 3. Answers to questions posed by the consultation
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## Section 1.

### Executive Summary

1. The exercise being proposed by the RPSGB is an attempt to deal with some of the symptoms of bad regulation and we urge the RPSGB to address the causes.
2. Whilst the regulation of pharmacists is a necessary activity and one which is in the public interest, it should be undertaken in a far more sensitive and appropriate manner than is currently the case.
3. We propose the establishment of a screening committee, which acts to ensure that any cases which are entirely inappropriate are dropped at the outset. For example when;
  - no evidence exists
  - prospect of a finding against a pharmacist exists
  - a complaint has been withdrawn or where no complaint has been made regarding a matter which has come to the attention of the RPSGB and which does not warrant further scrutiny in the public interest
  - where the pharmacist cannot be identified and it is not in the public interest to pursue.

We believe that such screening committees works successfully in other healthcare regulatory systems

4. The investigation of errors must take a wider view and not just seek to try and find a pharmacist upon which to pin the blame. Matters that should be taken into account include;
  - a) location of the pharmacy
  - b) workload – the nature and volume involved
  - c) level and competence of support staff
  - d) were registered technicians involved?
  - e) the presence or absence of aggravating factors
  - f) the presence or absence of any factors caused by the employer which may have contributed to / resulted in the error.
  - g) the presence of adequate systems and procedures.
5. When an RPSGB inspector cannot find any evidence against the pharmacist then he must be given the discretion to conclude the matter at a local level without the need to refer further. The inspector should be given the authority to be able drop proceedings altogether in appropriate circumstances.
6. The list of outcomes issued by the Society (or its local inspectors) must include a 'NO CASE TO ANSWER' determination, which would make clear that the pharmacist did no wrong. In this case, there should be no record made on the pharmacists file.
7. Too many threshold criteria are used and because of this, the vast majority of pharmacists would still be caught up in the full regulatory net. The list of threshold criteria needs to be substantially reduced.

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8. We agree that employment issues, minor NHS terms of service breaches, customer service complaints, restricted titles and fixed penalty road traffic offences should not be dealt with by the Society.

To this list of matters that should not be dealt with by the Society we would add;

- **Disputes over pharmacy contracts**

We believe that the RPSGB should not involve itself in these 'professional rivalry' issues

- **Where a complaint is made against a pharmacist by an employer purely to resolve a contractual issue**

If there is evidently no harm caused to any patients through the actions of an employee or locum, then the Society should not be investigating these complaints which are ostensibly contractual.

9. Where a dangerous working environment leads to an employee or locum closing down a pharmacy, or not turning up for work at a pharmacy, there is often the threat of a referral to the RPSGB by an employer. We would expect the RPSGB to investigate these matters and if it discovers that there has indeed been a dangerous working environment then it would instigate proceedings against the employer.
10. Disciplinary action should never be commenced against any pharmacist where there is little, if any, prospect of a finding.
11. Whether the case is one for referral or non-referral, the evidence used should never be of a substandard basis, such as hearsay evidence.
12. In the absence of any other evidence, the word of a complaining patient must never be given greater credibility than the word of a pharmacist.
13. In the event that a complaint has been made for failure to dispense a prescription from an abusive/aggressive or racially offensive patient, then the RPSGB's policy must be to immediately review its investigation and even consider reporting the matter to the police.

## Section 2. Important Principles

When the scandals in healthcare like the Bristol Royal Infirmary and Shipman occurred, it was widely recognised that an overhaul of healthcare regulation was not only necessary, but was probably long overdue. Although the pharmacy profession had always delivered an enviable standard in regulating its members and protecting the public, it was recognised that pharmacy regulation too would need to fall in line with healthcare regulation generally.

In recognition of the fact that healthcare professions operate in different ways and perform different tasks, a Section 60 Order was produced by the government. This provided a template which could then be used by all healthcare regulators to draft rules uniquely specific to their own profession.

An analysis of what the various healthcare regulators have produced, having all been given the same basic template, makes interesting reading. Not only is the language, style and tenor of the rules for pharmacy disappointing, when it is compared with that used by other healthcare regulators in their rules, it is the view of the Pharmacists' Defence Association (PDA), that the rules as drafted for pharmacy, largely at the hands of the Royal Pharmaceutical Society of Great Britain (RPSGB) are the toughest of their kind and unnecessarily so.

The result is that today, a practitioner is more likely to be involved in a professional disciplinary episode as a pharmacist, than any other healthcare professional. The Society's recent annual report on pharmacist regulation which was presented to the RPSGB's Council by the Fitness to Practice directorate on April 2nd and 3rd demonstrates clearly that the over-regulation of pharmacists has reached crisis proportions. During the year 2007, a total of 1359 disciplinary incidents were being handled by the RPSGB, of which 523 were concluded during the year in question and a further 836 were still being investigated.

When considering that virtually all of those involved in a RPSGB disciplinary episode in 2007 are practicing pharmacists residing in the UK, this represents, at least theoretically, a staggering 1 in 27 of practicing pharmacists.

Taking into account that the vast majority of complaints relate to community pharmacy, the odds are even more dramatic for pharmacists in that sector.

It is the view of the PDA, that this level of regulation is unnecessarily disproportionate and highly damaging to both the professions and ultimately the public's interests. It is stifling innovation and inhibiting pharmacists when making professional judgments which are to the benefit of the public. We have evidence that numerous experienced and long serving pharmacists are cutting their careers short as a consequence of being submitted to unnecessarily excessive and humiliating treatment. Ultimately, if this situation is left unchecked, then judging by the comments being made to the PDA by significant numbers of its members, then it will discourage future pharmacists from entering the profession.

One might expect that a Pharmacist Defence Association would occasionally be at odds with the pharmacy regulator, however, evidence of the RPSGB's overt regulatory approach can be found in several places. Notably, the governments own Chief Medical Officers report entitled '**Building a safer NHS for patients**' describes healthcare regulation in terms that would be at odds with the RPSGB's style of approach. The highly respected Institute of Medicine's report '**To err is human; Building a safer Health system**' is clearly not on the reading list for those involved in pharmacy regulation. These are just two examples- there are many more.

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section two

What should ideally be an exercise which whilst protecting the public, also allows professional colleagues to learn from the mistakes of others in an environment of support, learning and improving standards, has become instead an exercise of punishment and retribution. This has resulted in widespread resentment, distrust and defensive practice.

Typically, at the start of an investigation, a pharmacist usually will be involved in a conversation with a Society inspector, this may involve a taped interview under the Police and Criminal Evidence protocol (PACE), but frequently, it is much more like an informal conversation. Unfortunately, even what seems like an informal conversation with an inspector, can result in evidence being taken and used to lead a case against a pharmacist without any legal safeguards being in place – as would happen in a PACE interview.

When the investigation is concluded, the pharmacist will receive a very substantive (often more than 100 pages) legalistic parcel which is difficult to fathom without recourse to specialist and expensive legal advice. This occurs whether the complaint is serious, or whether the complaint is trivial (or even vexatious).

Either way, it causes anxiety, bewilderment and can lead to health issues for the pharmacists involved. It should be pointed out that sometimes, receipt of such a bundle is the first that the pharmacist will know about the alleged incident.

During the process, what starts off as fear and anxiety, turns into anger and frustration as many of the pharmacists involved recognise that they have done very little wrong or even that there is no case to answer, however, they are being treated like suspects in a serious criminal investigation by their own professional body.

Their employers are informed by the RPSGB that they are being investigated for a Fitness to Practice matter and if locuming then all of their employers are informed. This will occur whether the accusations can be substantiated or not.

Even if the outcome of the investigation which can take up to one year shows that they have done no wrong, rather than be told that they have **no case to answer**, instead they are told that there will be **no further action taken at this time**. This strongly gives the impression that some form of action was taken, but that this was deemed sufficient. Indeed, a record of the episode is placed onto their professional file.

The process uses language and an attitudinal approach which is deemed by all those who have experience of it as being particularly arrogant, abrasive, patronising and unnecessarily difficult.

The justification that is often offered to the PDA is that the RPSGB is worried about what the Commission for Healthcare Regulatory Excellence (CHRE) will say if the RPSGB is too lenient. In reality, it is a fact that CHRE concerns itself predominantly with the decisions of the disciplinary (statutory) committee and therefore this argument is largely irrelevant.

The irony is that whilst pharmacy has historically been one of the least problematic healthcare professions in terms of episodes that could cause public harm, it is now the most highly regulated healthcare profession. The tragedy, is that this has been inflicted upon pharmacists largely at the hands of its very own professional body – the RPSGB.

The PDA measures the problems caused by excessive regulation in human terms; the large numbers of pharmacists who have had their professional lives either badly shaken or terminated early through de-motivation, the families of pharmacists who in the vast majority of cases have had their lives disrupted through the disproportionate actions of the

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RPSGB. Not forgetting the patients who sometimes wait for more than a year to get a simple answer from the regulator, because the RPSGB is too busy dealing with unnecessary cases.

It is apparent, that the RPSGB is proposing these new measures because of financial considerations and not out of the public interest or because of its concern about the impact that the current process is having upon its members. Suddenly, the cost of excessive regulation has led to a re-think at the RPSGB.

The key to this conundrum has always been in the hands of the RPSGB, it has both caused this crisis with its overtly burdensome rules and their application, and it could always have prevented the crisis by applying its own rules more sensibly. Under Article 49 of the Pharmacists and Pharmacy Technicians Order 2007, it states that **'The Registrar shall, except in such cases and subject to such conditions as the Council may prescribe, refer the matter..... to the investigating committee.'** As the RPSGB's own consultation document has stated, this means that the Council can make rules as to which cases need not be referred.

The current initiative to consider which types of cases not to refer, could have been conducted prior to 2007, when the current rules became operational and this could have saved literally hundreds of pharmacists involved in trivial, irrelevant or impossible to conclude cases having to run through the entire panoply of the RPSGB's overwhelming regulatory machine.

The worrying rise in the number of referrals to the (previous) Infringements Committee prior to 2007, should have alerted the Society to the problems that would be encountered if it (substantially) continued with the same referral criteria as were previously in place.

It is the view of the PDA that whilst regulation of pharmacists is a necessary activity and one which is in the public interest, it should be undertaken in a far more sensitive and appropriate manner than is currently being done. Several current examples of 'more appropriate' approaches to healthcare regulation do exist.

The exercise being proposed by the RPSGB is an attempt to deal with the symptoms of a bad regulation, what it should be doing instead is addressing the causes.

Consequently, whilst the proposal to consider matters that need not be referred to the Investigating Committee is a step in the right direction, what is really required is a comprehensive root and branch overhaul of pharmacy regulation and mindset change at the RPSGB.

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## Section 3

### Answers to questions posed by the consultation

#### PART A: Non-referral of single one-off dispensing errors

##### Question A1

Do you think that single one-off dispensing errors are suitable for non-referral to the Investigating Committee (subject to threshold criteria; see Panel 2)?

##### **YES**

The single, one off dispensing error needs to be applied in the widest sense of the word. See answers to question A3.

However, we have some concerns about the threshold criteria which we have described in the answer to Question A2 and B3.

##### Question A2

Do you think that the threshold criteria (see Panel 2) for single one-off dispensing errors need to be amended and/or added to in order to ensure that they are adequate to protect the public?

##### **YES they need to be amended**

##### Fourth Bullet point states;

**There is evidence that the individual departed from agreed safe protocols or standard operating procedures and in doing so took an unacceptable risk.**

However, this argument is based on a supposition that the standard operating procedures were indeed safe in the first place. It is the experience of the PDA that not all such protocols are. Furthermore, this approach is too inflexible as there will always be times when a pharmacist will knowingly depart from an SOP because the situation dictates that it makes sense to do so. Consequently, the PDA proposes an amended bullet point 4 which now reads;

There is evidence that the individual without justification departed from safe agreed protocols or standard operating procedures (which have been previously accredited as safe practices) and in doing so took an unacceptable risk.

##### Eighth Bullet point states;

**No attempt has been made to learn from the incident.**

We are concerned about this criterion because it is one that would be difficult to objectively prove or disprove. Additionally, an acknowledgement from a pharmacist that an incident could have been handled differently, has on occasion been used by the Society to attempt to prove that the pharmacist did wrong in the first place.

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Eleventh Bullet point states;

**There has been a failure to co-operate with an investigation carried out by the Society's Inspector or other investigatory body.**

Surely, this would need to be qualified by two factors firstly, the investigation or its approach would need to be deemed reasonable – the experience of the PDA shows that this is a very relevant point as we would take issue with some of the tactics used by the RPSGB in investigations.

Secondly, such an approach could not override protections provided under the International Human Rights Conventions. In other words, a pharmacist who consistently refuses to attend a pre-arranged appointment with an RPSGB inspector will have failed to have co-operated with a reasonable investigation. However, a pharmacist who attends such an interview, but then exercises his/her right to make no comment, should not then be accused of failure to co-operate with a reasonable investigation.

Fourteenth Bullet point states;

**There is relevant history within the last three years.**

Virtually all of the research conducted on dispensing errors points to the fact that all practicing pharmacists will make some kind of dispensing error at some stage. The fact that some will come to light and then will be investigated is more to do with luck than with good regulation. Consequently, the threshold of three year relevant history is virtually meaningless. This point demonstrates why the use of an inflexible list of threshold criteria is in itself not fit for purpose. In the answer to Question C2, the PDA recommends the use of an experienced screening panel. This panel, composed of experienced pharmacists with appropriate lay representation would constitute a far more appropriate mechanism for ensuring that cases deserving a higher level of discipline should be referred further.

## Additional criteria

First Bullet point states;

**There is a demonstration towards a patient or customer, or a prospective patient or customer, of attitudes or behaviour from which that person could reasonably be expected to be protected.**

The general position of the National Health Service towards patients who have violent or aggressive tendencies towards NHS staff, is one of zero tolerance. However, the experience of the PDA, is that the RPSGB appears to pay little regard to whether the patient has been abusive, aggressive, violent or racially abusive to the pharmacist, the pharmacy staff or even to other customers in the vicinity when investigating a complaint from such a patient. In the event that a pharmacist acts in such a way as to protect staff, property, other customers or even himself in a situation where there is violence or abusive behaviour, then the Society must not consider this criterion to be appropriate.

Consequently, the PDA proposes an amended bullet point 1 under Additional criteria which now reads;

**There is a demonstration towards a non violent or non abusive patient or customer, or a prospective patient or customer, of attitudes or behaviour from which that person could reasonably be expected to be protected.**

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Third Bullet point states;

**There are controlled drugs involved.**

This statement is simply too broad. This could encompass a patient who has received the wrong medication in a bag, in which controlled drugs were otherwise correctly supplied. It could include a simple bookkeeping error where the Controlled Drug was entered on the wrong page in the register. Neither of these matters should be deemed to be suitable for escalating an investigation to a full referral to the Investigating committee.

## Question A3

Do you think that the remit of single one-off dispensing errors should encompass errors made during the dispensing process, from receipt of prescription through to supply of dispensed medicine to patient, e.g., errors made in delivery of medicines?

### YES

The notion that an error which involves the transposition of two labels on two separate containers is actually two dispensing errors and not one, is a notion that suggests a substantial lack of insight into the realities of pharmacy. A single one-off dispensing error should be an episode where a patient has received the wrong medication. It is highly likely that when this has occurred, more than one specific thing in the process will have gone wrong.

Additionally, the investigation of such an episode, must take a wider view and not just seek to try and find a pharmacist upon which to pin the blame. Matters that should be taken into account are;

- a) location of pharmacy
- b) workload - the nature and volumes involved
- c) level of support staff
- d) were registered technicians involved?
- e) the presence or absence of any aggravating factors
- f) the presence or absence of any factors caused by the employer which may have contributed to / resulted in the error
- g) The presence of systems and procedures and their appropriateness.

## Question A4

Do you think that the proposed course of action to be taken in cases involving single one-off dispensing errors is appropriate?

### YES - However

The proposed course of action is only suitable if a pharmacist genuinely commits and then admits to an error and is prepared to accept a letter of advice from the inspector. However, this only provides a resolution in a limited number of scenarios.

One routine situation is where the pharmacist believes that he has not committed an error and/ or there is no evidence to show that such an error has been committed. The pharmacist will therefore not accept any wrongdoing. We recommend

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that if an inspector cannot find any evidence against the pharmacist then he must be given the discretion to conclude the matter at a local level without the need to refer further. The inspector should be given the authority to issue a **No Case to Answer** verdict and be able drop proceedings altogether.

Our recommendation will help to ensure that the RPSGB's centrally operated procedures can concentrate on the more serious cases.

## PART B: Consideration of other cases for non-referral to the Investigating Committee

### Question B1

Do you think that further categories of cases should be considered for non-referral (subject to threshold criteria; see Panel 2)?

#### YES

We have examined the case types proposed by the RPSGB in Panel 4;

We agree that employment issues, minor NHS terms of service breaches, customer service complaints, restricted titles and fixed penalty road traffic offences should not be dealt with by the Society.

However, we have concerns about the handling proposals made over some of the other case types described.

#### 1. Attitude and Behaviour

There is a significant demarcation line between a customer complaint on a service issue and one that involves an element of professional impropriety. The RPSGB must take great care in ensuring the appropriate application of its regulatory powers.

#### 2. Failure to dispense a prescription for abusive/aggressive patients

Even the NHS terms of service formally permit pharmacists NOT to dispense prescriptions for patients that are abusive/ aggressive or violent. The RPSGB must adopt the zero tolerance stance taken by the NHS towards abusive or violent patients. In the event that a complaint of this nature is found to have been made by a patient who has been aggressive, violent or racially abusive – then the RPSGB's policy must be to immediately review its investigation and even consider reporting the matter to the police.

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## Question B2

Do you think that the further categories of cases proposed (see Panel 4) for non-referral should be amended and/or added to?

### **YES - they should be added to**

Some of the categories of cases described in panel 4 indicate that the RPSGB would intend not to deal with them at all. We would add some additional categories to this list to include;

- **Disputes over pharmacy contracts**

Experience shows that NHS contract applications can attract untoward complaints to the RPSGB by interested parties about pharmacists who are applying for NHS contracts. Those who complain know full well that if they can engineer a situation where a contract applicant is under investigation by the regulator, then the local PCT may be disinclined to issue them with a NHS contract. There has been at least one statutory committee case that has dealt with a dispute over an NHS contract application in the recent past. We believe that the RPSGB should not involve itself in these 'professional rivalry' issues.

- **Where a complaint is made against a pharmacist by an employer purely to resolve a contractual issue.**

Recently, the PDA has dealt with a case where an owner has informed a locum that whilst on duty, he did not put away £1000 worth of fridge lines and as a result they had to be thrown away. The employer then told the locum that unless he refunded the £1000 to the owner that he would report the pharmacist to the Society for professional negligence. In the experience of the PDA, such threats from employers intent on securing some form of leverage over employee's or locums is not unusual and could be illegal under the Administration of Justice Act. If there is evidently no harm caused to any patients through the actions of an employee or locum, then the Society should not be investigating these complaints which are ostensibly commercial.

- **Where a dangerous working environment leads to an employee or locum closing down a pharmacy, or not turning up for work at a pharmacy.**

Employees and more typically locums are often placed in very vulnerable situations because they are working in pharmacies whose environments they do not control, as these are controlled by the employer. The PDA has faced situations where the environment in which pharmacists are working has become so chaotic and dangerous, that allowing the pharmacy to continue in operation in the short term would constitute a danger to the public.

In some instances, when the pharmacists have contacted management to tell them that they would be closing the pharmacy, or that they would not be coming in to work the next day, they have been told that if they did so, then they would be immediately reported to the RPSGB for being responsible for failing to provide a pharmaceutical service. In these situations we would expect the pharmacists who have acted in the public interest to receive the support of the regulator and not be subjected to discipline. We would expect the RPSGB to investigate and deal with the poor working environment as opposed to the pharmacist who closed down the pharmacy.

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## Question B3

Do you think that the threshold criteria (see Panel 2) for the non-referral cases need to be amended and/or added to in order to ensure that they are adequate to protect the public?

### YES

We believe that there are far too many threshold criteria and because of this, the vast majority of pharmacists would still be caught up in the full regulatory net. The list of threshold criteria needs to be substantially reduced. Additionally, the RPSGB inspectors in having to comply with these threshold criteria are having a significant amount of discretion taken away from them. This leads to a lessening of the benefits of being able to apply their undoubted experience to the job of regulation. It turns the regulatory process into little more than a legal 'join the dots' exercise where experience of pharmacy is not needed and could even be a hindrance.

## Question B4

Do you think that the proposed course of action to be taken in cases involving the further categories of non-referral cases is appropriate?

### No

See the answer to Question A4.

Most importantly, we believe that the list of outcomes issued by the Society must include a 'NO CASE TO ANSWER' determination, which would make it clear that the pharmacist did no wrong. In such a case, there should be no record made on the pharmacists file.

## PART C: General

### Question C1

Do you think that the records maintained as a result of action taken in non-referral cases should form part of the fitness to practice history of the registrant?

### YES

We have no problem with this approach, in the event that a pharmacist has genuinely erred, has accepted that he did wrong and has accepted a warning letter. However, we believe that the resultant file entry should be erased after a certain period of time – the recommendation of three years would be acceptable. However, what we object to is what we have been told by the Fitness to Practise Directorate, that any such records or even general correspondence would be kept on a pharmacist's professional file in perpetuity.

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## Question C2

Do you think that cases subject to non-referral should be dealt with via the Society's inspectorate?

### **Yes - however**

We have publicly argued that the inspectors should be given back their general authority and should be allowed to exercise their discretion. However, what is being proposed is a long way short of that. We would urge the Society to reconsider this central issue.

We propose that what should be put in place is a screening committee, which acts to ensure that any cases which are entirely inappropriate be dropped at the outset. For example were;

- **no evidence exists**
- **no prospect of a finding against a pharmacist exists**
- **a complaint has been withdrawn or were no complaint has been made relating to the matter which has come to the attention of the RPSGB and which does not warrant further scrutiny**
- **were the pharmacist cannot be identified and were it is not in the further public interest to pursue.**

We believe that such a screening committee works successfully in other healthcare regulatory systems.

## Section 4 Further Comments

### General comments about non-referral

The basic foundation upon which the non-referral initiative is built is that of a heavy reliance on threshold criteria and this is largely because of the substantial systemisation of the entire regulatory process. However, this systematic 'join the dots' approach to regulation does not superimpose itself easily onto a profession whose greatest benefit to the public, is the ability of pharmacists to make professional judgments.

So either pharmacists need to become more systemised and SOP driven to ensure that they fall in line with the regulatory approach – the cost of which will be the diminution of the role of the professional judgment, or the regulatory system has to become more intuitive, so that it can enable pharmacists to make professional judgments without the fear of reprisal because they have not strictly followed fixed procedures. Since life is never a standard operating procedure, arguably, it is the latter of these two approaches that is more relevant and therefore of greater benefit to the public.

What this means, in relation to the current proposals on non-referral, is that the inspectors should be given far more latitude and independence in being able to resolve issues locally. Furthermore, even if the complaint needs to be referred on to the Investigation Committee, then the processes that it uses need to be substantially overhauled.

### Additional remarks

- Some errors do not in any way imply that a pharmacist's fitness to practice is impaired. This would indicate, that for some errors, there should be no need for a full investigation, simply a letter of advice from a local RPSGB inspector who has the experience to know when an incident is not suitable for onward referral.
- Early experiences have shown that the new Investigating Committee appears to have little insight into the realities of community pharmacy in particular. The problem of there being a lack of contemporary practising pharmacists being appointed to this committee needs to be addressed.
- Disciplinary action should never be commenced against any pharmacist where there is little, if any, prospect of a finding.
- Proportionality and consistency have been lacking in some cases handled by the Investigation Committee. This has led to several cases being rejected by the Disciplinary Committee and one case in particular where costs were awarded against the RPSGB. We anticipate further examples of these cost awards in the future.
- Whether the case is one for referral or non-referral, the evidence used should never be of a substandard basis, such as hearsay evidence.
- In the absence of any other evidence, the word of a complaining patient must never be given greater credibility than the word of a pharmacist.

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## About the Pharmacists' Defence Association (PDA)

The Pharmacists' Defence Association (PDA) is a not-for-profit organisation and Pharmacist Union which aims to act upon and support the needs of individual pharmacists and, when necessary, to defend their reputation. PDA currently has more than 13,000 members.

The primary aims of the PDA are to:

- Support pharmacists in their legal, practice and employment needs
- Represent the views and concerns expressed by members
- Provide insurance cover to safeguard and defend the reputation of the individual pharmacist
- Seek to influence proactively the professional, practice and employment agenda to support members
- Lead and support initiatives designed to improve the knowledge and skills of pharmacists in managing risk and safe practices, so improving patient care
- Work with like-minded organisations to improve further the membership benefits to individual pharmacists

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