



FACULTY NEWSLETTER

SUMMER 2011

Welcome to the summer newsletter, which features the work of Medicines for Malaria, a not-for-profit organization established in 1999 with the goal of eradicating malaria. Its research portfolio spans all phases of drug development from lead generation through to Phase IV studies, each project reflecting multiple alliances with both the public and private sectors. In his article, Dr Tim Wells, MMV's Chief Scientific Officer provides a fascinating insight into the Foundation's work, provoking reflection not just on the drug development aspects, but also on the success of an organization with a single therapeutic focus, and the practice of pharmaceutical medicine in this context. It's a reminder of the extent to which it is easy to see pharmaceutical medicine solely in the Industry context.

Talking of perceptions, one of the Faculty's concerns has been the lack of awareness of pharmaceutical medicine in the wider medical world, and to this end a working party has been formed under the leadership of Dr Jane Zuckerman to tackle this issue. The winter edition of the newsletter will focus on this area, and we would welcome your ideas and personal experience of what has worked (or not worked, for that matter) in your experience.

Depending on your propensity for social networking, you could choose to share these on the Faculty's new "Linked In" group entitled "Faculty of Pharmaceutical Medicine". We hope that this will provide a new vehicle for more frequent communication and interchange for our members.

One way or another, we look forward to hearing from you.

Liz Clark (Kissanes@btinternet.com)
Jit Solanki (Jit.Solanki@pfizer.com)

The Faculty of Pharmaceutical Medicine

of the Royal Colleges of Physicians
of the United Kingdom

*Advancing the science and practice of
pharmaceutical medicine
for the benefit of the public*



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Faculty News

Office move – staff changes – consultations update – proposed new masterclasses – honoured members – social networking

Faculty office move

The Faculty office and staff will shortly be moving to new premises in the City of London, on Furnival Street, close to Chancery Lane tube station. The new office is currently being re-fitted to our specifications and will be open plan, with a purpose built meeting room. This new arrangement will have implications for Faculty meetings and events: It is envisaged that the meeting room will hold up to 14 people which will mean that most committee meetings will take place on site. Large events, including examinations, will have to continue off-site. Formal details regarding the change of address and other arrangements are inserted with this newsletter.



The new building on
Furnival Street

The relocation of the Faculty office will take place on the 19th and 22nd August and the office will be shut on these days. We will re-open on Tuesday, 23rd August.

New contact details from 23rd August:

Address: Faculty of Pharmaceutical Medicine
3rd Floor
30 Furnival Street
London
EC4A 1JQ

Telephone: +44 (0)20 7831 7662
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Faculty staff changes

The Faculty welcomes Mr Dylan Costello who joins the Faculty staff team as the new Examinations Administrator on 30th August. Dylan, who joins us from the Faculty of Occupational Medicine, will be responsible for co-ordinating all the Faculty's examinations. We wish him well in his new role.

We also say goodbye and thank you to Mrs Laura Cooper who left her role as Examinations Administrator at the end of June following her maternity leave. We wish Laura, Scott and their daughter Sophia all the best for the future.

Consultations update

The Faculty has submitted responses to several major consultations during the last three months. To read the Faculty's submission to these consultations please visit the website

<http://www.fpm.org.uk/faculty/consultations>

GMC: Good Management Practice: Guidance for all Doctors (June 2011)

GMC: Good practice in prescribing and managing medicines and devices (June 2011)

EC: Concept Paper on the revision of the Clinical Trials Directive (May 2011)

EMA: Reflection Paper on the need for active control in therapeutic areas where use of placebo is deemed ethical and one or more established medicines are available (March 2011)

GMC: Consultation on National Postgraduate Professional Examinations (March 2011)

DH: Liberating the NHS: Developing the Healthcare Workforce (March 2011)

DH: Healthy People, Healthy Lives; our strategy for public health in England. White Paper (March 2011)

Faculty members mentioned in the Queen's Birthday Honours List 2011

Professor Sir Kent Woods

Professor Kent Woods, Chief Executive of the MHRA and Honorary Fellow of the Faculty, has been awarded a Knighthood for his services to healthcare.

Dr Edwin David George McIntosh

Dr David McIntosh, Fellow of the Faculty, has been made Member of the General Division of the Order of Australia for services to medicine, particularly in the areas of vaccines and infectious diseases, as an academic, and to the community through the Glebe Music Festival.

ERRATUM – Annual General Meeting 2010 report

An error has been made in the recently published report from the AGM 2010. On page 7 of the report it states that Prof Kent Woods presented the past-presidents medal to Sir William Asscher. It was actually Dr Frank Wells who presented the medal and who is pictured alongside Sir William. Please accept our apologies for this error.

New Faculty 'masterclasses' for 2012?

The Advocacy Committee of the Faculty is currently discussing the possibility of arranging evening 'masterclasses' for Faculty members. The masterclasses are likely to consist of a drinks reception followed by a ~1.5 hour debate with one or two eminent guest speakers, then supper.

We believe that the masterclasses will provide an excellent opportunity for members to both learn about and debate certain issues but also meet and

network with colleagues and friends. We hope to hold the first masterclass in February 2012 on the subject of 'Keeping clinical research in the UK'. If the first event is successful, the second, possibly on the subject of 'The future of NICE' would be held in May 2012. If you would like to register interest in attending these events, or have any comments on the proposed topics, then please email Ben Cottam (b.cottam@fpm.org.uk). If the first two meetings are successful it is likely that there will be additional and more frequent meetings of this kind in the future.

Social Networking

Do you Tweet? Are you Linked In?



The Faculty is currently in the process of developing a new website and digital strategy. We would like the website to enable us to engage more easily with all members and also allow members to interact with each other. We have just set up a 'Faculty of Pharmaceutical Medicine' *Linked In* group and a 'Pharmaceutical Medicine Trainees' sub-group and would invite members to join these groups.

With the recent growth of websites dedicated to social and business networking (known as web 2.0), many organisations and professionals are starting to use *Twitter*, *Linked In* and similar websites to converse. We are also therefore conducting an informal survey on how much (or how little!) Faculty members use such networking sites in their professional life. Should the Faculty be engaging in this manner or do members prefer more traditional methods of communication. We would be very grateful if you could email Ben Cottam (b.cottam@fpm.org.uk) with your comments. The information we receive will help us to shape the new website into a portal and information source that gives the most benefit to all our members.

Revalidation update

by Susan Paterson, Professional Development Administrator

The Faculty of Pharmaceutical Medicine continues to be actively involved in the preparations for medical revalidation. This is now scheduled to be introduced from the end of 2012 on an incremental basis according to the “state of readiness” of the respective designated bodies of which the Faculty of Pharmaceutical Medicine is one¹.

Revalidation will take place in a 5-year cycle, the basis of which will be an annual work-based appraisal and which will include an evaluation of the doctor’s performance against relevant standards². Doctors will be required to maintain a portfolio of supporting information from their practice to demonstrate that they are meeting the required standards. As each doctor’s practice is unique, the information they collect will vary. The supporting information³ collected in their portfolio will provide the basis for discussion at the annual appraisal. On completion of the 5-year cycle, it will be the responsibility of the Responsible Officer to make a recommendation to the GMC as to whether the medical practitioner should be revalidated.

Revalidation has been piloted through the NHS pathfinder pilots with participants mapping supporting information directly to the 4 Domains and 12 Attributes described in Good Medical Practice. Subsequently, the Faculties of Pharmaceutical Medicine, Occupational Medicine and Public Health received DH funding to pilot the proposed processes with medical practitioners working in non-clinical settings. This culminated in the launch of the Tri-Faculty Revalidation pilot to which over 60 volunteers from pharmaceutical medicine were recruited. This pilot is currently in progress and due

to run until December 2011. The pilot aims to mirror the pathfinder pilots as far as possible.

Feedback from the GMC consultation – Revalidation: The Way Ahead (March 2010) and the NHS pilots suggested that the proposed system was too complex and time consuming. As a result the Academy of Medical Royal Colleges is now working with member Colleges & Faculties and the GMC to produce a streamlined system which should achieve the same outcome as the earlier model whilst reducing its complexity. This version, which requires 6 types of supporting information to be supplied at appraisal at least once in each 5-year revalidation cycle (*see reference below: Supporting Information for Appraisal and Revalidation*), will be trialled within the NHS late 2011.



It is anticipated that the Academy document *Guidance on Supporting Information for Revalidation for Pharmaceutical Medicine* will be posted on the Faculty website mid-August 2011 for consultation. Further information on how to prepare for appraisal and revalidation will follow in late 2011 or early 2012. For additional information visit

<http://www.fpm.org.uk/revalidation/>

Diploma in Pharmaceutical Medicine exam to take place in South Africa

For the first time, the Diploma in Pharmaceutical Medicine examination is to be held outside the UK at the University of Stellenbosch in Cape Town, SA. The 2011 examination will take place on 13-14th October 2011 and will also be held simultaneously in London and South Africa. The deadline for the receipt of applications is 16th September 2011. Please visit the Faculty website

<http://www.fpm.org.uk/examinations/dippharmed> for more information.

¹ Responsible Officer Regulations 2010
<http://www.legislation.gov.uk/uksi/2010/2841/made>

² Good Medical Practice Framework for Appraisal and Revalidation 2011 http://www.gmc-uk.org/GMP_framework_for_appraisal_and_revalidation.pdf 4132696 0.pdf

³ Supporting Information for Appraisal and Revalidation
http://www.gmc-uk.org/Supporting_information_2_.pdf 39974163.pdf

External News

Faculty of Medical Leadership and Management – RCPCH/NPPG Standing Committee on medicines

The Faculty of Medical Leadership and Management

The Faculty of Medical Leadership and Management (FMLM) is a new UK-wide organisation that aims to promote medical leadership, management and quality improvement at all stages of the medical career for the benefit of patients.

The establishment of the FMLM was endorsed by the Academy of Medical Royal Colleges in January 2011. The FMLM will work on behalf of doctors, dentists in secondary care and medical students in the UK, and should be fully operational by the end of 2012. Its main aims are to:

- Promote medical leadership and management.
- Determine and establish the standards and competences for medical leadership, management and quality improvement required for medical students and doctors at all levels, and translate them into educational curricula and revalidation, where appropriate.
- Develop and maintain the good practice of medical leadership and management by ensuring the highest professional standards of competence and ethical integrity.
- Advance medical leadership and management as a profession.

The FMLM is being set up by its Founding Council, which consists of a representative from each College and Faculty in the UK. Dr Malcolm Boyce (FFPM) is the representative of the FPM. Below, he considers the potential impact of the FMLM on pharmaceutical physicians.

“It was clear from the Inaugural Meeting of the Founding Council on 24 May 2011, which I attended on behalf of the FPM, that many of the senior medical managers in the NHS who were present feel somewhat isolated in their jobs, and all are strongly in favour of and committed to the setting up of the FMLM to represent their needs. I was the only representative from the private sector.

So, what might the FMLM offer pharmaceutical physicians? The prospects include: recognition of the medical leadership and management role in the pharmaceutical industry; access to training programmes; help with revalidation; sharing of experiences with NHS counterparts; and the possibility of influencing events in the NHS.

By now, members of the FPM will have had the opportunity to answer an online survey, which members of all Colleges and Faculties represented on the Founding Council were invited to complete, seeking their views and expectations of the FMLM, such as joining it, membership fee, and training. The results will be analysed in the autumn. It will be interesting to learn the views of FPM members.”

RCPCH/NPPG Standing Committee on medicines

Dr Sue Tansey FFPM

I have been sitting as the FPM Observer on the Joint RCPCH/NPPG Standing Committee on Medicines for just over 6 months and would like to provide a brief update on their activities in order to inform my fellow FPM members. One of the main activities of this committee is to develop, approve and post Medicines for Children leaflets on the website www.medicinesforchildren.org.uk. These free leaflets are intended to provide easily understandable information about medicines which may be prescribed for children, and are particularly aimed at parents and carers. Other activities which the committee is currently engaged in are development of a safer prescribing tool and training package, commenting on various consultations e.g. the recent GMC consultation draft regarding off license and unlicensed medicines and as a conduit for the RCPCH and NPPG to work with the BNF-children to improve the information available to prescribers.

For more information about the work of the RCPCH and the NPPG please visit www.rcpch.ac.uk/medicines and www.nppg.org.uk

Faculty Board summary

Summary of the Minutes from the Faculty Board meeting on the 12th April 2011

Accounts & Annual Report

Following the annual audit, the trustees approved the accounts and report for the period 1 Nov 2009 to 31 Dec 2010, the first period as an incorporated charity. These are now available on the Faculty website.



Appointments & Elections

Ms Suzie Hughes has been appointed as a Lay Trustee. The FPM Board now has two Lay Trustees. Dr Malcolm Boyce has been appointed as the FPM representative on the founding council of the new Faculty of Medical Leadership & Management.

Academy of Medical Royal Colleges

The governance of the Academy has now changed. The Faculty is represented on the Academy's Council by the President who is no longer a trustee. The President could now appoint a deputy to attend and participate. Dr Susan Bews remains as the Treasurer and a Trustee.

The Academy has published standards on the development of in-patient prescription charts – these are available on the Academy's website.

Travel Expenses Policy

The FPM mileage allowance has been increased from 40p to 45p per mile with effect from 6/4/2011. This reflects the change announced by the Government in the recent budget.

RCP Medicines Forum

The forum has been discontinued but on-going work will be transferred to the new group set up by the RCP and ABPI 'Evolving the relationship between the medical community and the pharmaceutical industry'. The FPM will be represented on this group by the President.

Annual Meeting Day – 23rd Nov 2011

The format of the day will be the AGM, Awards Ceremony, Guest Lecture and Annual Dinner. The timings and details will be announced in due course.

FPM Working Parties

Arising from the strategic review at the end of 2010, four working parties will be set up. These are: a) Clinical trials & the environment; b) Raising awareness of the specialty (focus on medical students and foundation doctors); c) New education initiatives and d) Promoting adherence (focus on Patient Information Sheets).

Faculty merchandise for sale!

Faculty head-scarves, ties and paper weights are now available to purchase. Prices include UK postage and package, overseas P+P extra.

Please contact Vanessa Woo, 020 7831 7662

v.woo@fpm.org.uk to order any items.

Head-scarf - £5



Paperweight - £10



Tie - £5



Feature Article:

New Medicines for Malaria Control and Eradication: the Power of Partnerships

Dr Tim Wells, Chief Scientific Officer, Medicines for Malaria Venture



Malaria remains one of the most deadly diseases of our time. Despite huge efforts by many countries, there are still an estimated 700,000 deaths per year, primarily in Africa and primarily in children under the age of five years. Driving these statistics down demands a multi-focused approach including interventions to prevent people becoming infected (bed nets, larvicide spraying and potentially even a vaccine) combined with good case management (diagnostics and appropriate medicines). Since malaria is a parasitic disease spread by insect vectors, medicines are also our key hope to be able to eventually block transmission and break the vicious cycle of infection. To drive this process, new classes and types of medicines are needed. Although historically many pharmaceutical companies invested in malaria research, market failure meant that until recently many had abandoned the effort, to focus on other commercial markets. Over a decade ago, this situation reached a tipping point when the burden of malaria was unacceptably high yet innovation for new medicines was close to zero. It was clear that a new business model for drug discovery in the neglected disease was needed. The story of Medicines for Malaria Venture represents the progress of a determined group of physicians and scientists who set out to address this inequity.

Medicines for Malaria Venture, an eleven year journey

Medicines for Malaria Venture (MMV) was set up in Geneva in 1999, as a not-for-profit organization intended to catalyze the discovery, development and delivery of new medicines to target malaria.

Medicines for Malaria Venture:

“Our mission is to reduce the burden of malaria in disease-endemic countries by discovering, developing and facilitating delivery of new, effective and affordable antimalarial drugs.”

Our vision is a world in which these innovative medicines will cure and protect the vulnerable and under-served populations at risk of malaria, and help to ultimately eradicate this terrible disease.”

The MMV was born from discussions between the WHO (where it was realized that UN bureaucracy and drug discovery were at best difficult bed-fellows) and the IFPMA (the International Federation of Pharmaceutical Manufacturers and Associations). At the time, public opinion of the pharmaceutical industry was generally low, but the IFPMA and WHO together realized that if new drugs were going to be developed, then this could only be done in partnership with academic science and medicine, the pharmaceutical industry and public health bodies. After initial funding from the Rockefeller Foundation, MMV secured an ongoing funding base from a variety of different bodies all motivated by the same need to assure the malaria medicine cabinet remained stocked. These bodies include governments (the British, Irish, Netherlands, United States, Spain and Switzerland), foundations such as the Bill and Melinda Gates Foundation, and the Wellcome Trust, as well as corporations (Exxon Mobil) and individual donors. We currently spend over \$50 million per year,

and this number is more than matched by the in-kind contribution of our pharmaceutical industry partners.

Fixed-Dose Artemisinin Combination Therapies

The mainstay of current malaria treatment is the Chinese natural product artemisinin. A derivative of artemisinin (artesunate or artemether) is always used in combination with a second more ‘classical’

medicine, typically a modern generation of the chloroquine family, such as lumefantrine, amodiaquine, and more recently piperazine (known as artemisinin combination therapies or ACTs). The two drugs are used in combination to protect each other against the emergence of resistance. Artemisinins have a relatively short half-life of around an hour in man, and so the resistance pressure is always on the partner drug. Given that the majority of those that die from malaria are children and the lack of a high quality pediatric ACT, our first challenge at

MMV, in partnership with Novartis, was to develop a child-friendly fixed-dose combination of artemether-lumefantrine: Coartem® Dispersible. This medicine, given twice per day for three days, rapidly disperses and enables the small child to consume the medicine easily. Two years since its launch in February 2009, Coartem Dispersible had treated 64 million children, costing as little as 37 cents for the smallest child.

MMV has been working on two other ACTs. Eurartesim, developed with sigma-tau in Italy, contains dihydroartemisinin (the active metabolite of artemisinin) and piperazine (almost a dimer of chloroquine). It was approved by the European Medicines Agency (EMA) in June 2011, having the advantage of being a once per day treatment with a better ‘post-treatment prophylaxis’. This means a child taking the medicine to treat one episode of malaria is protected against new episodes of malaria 6 weeks

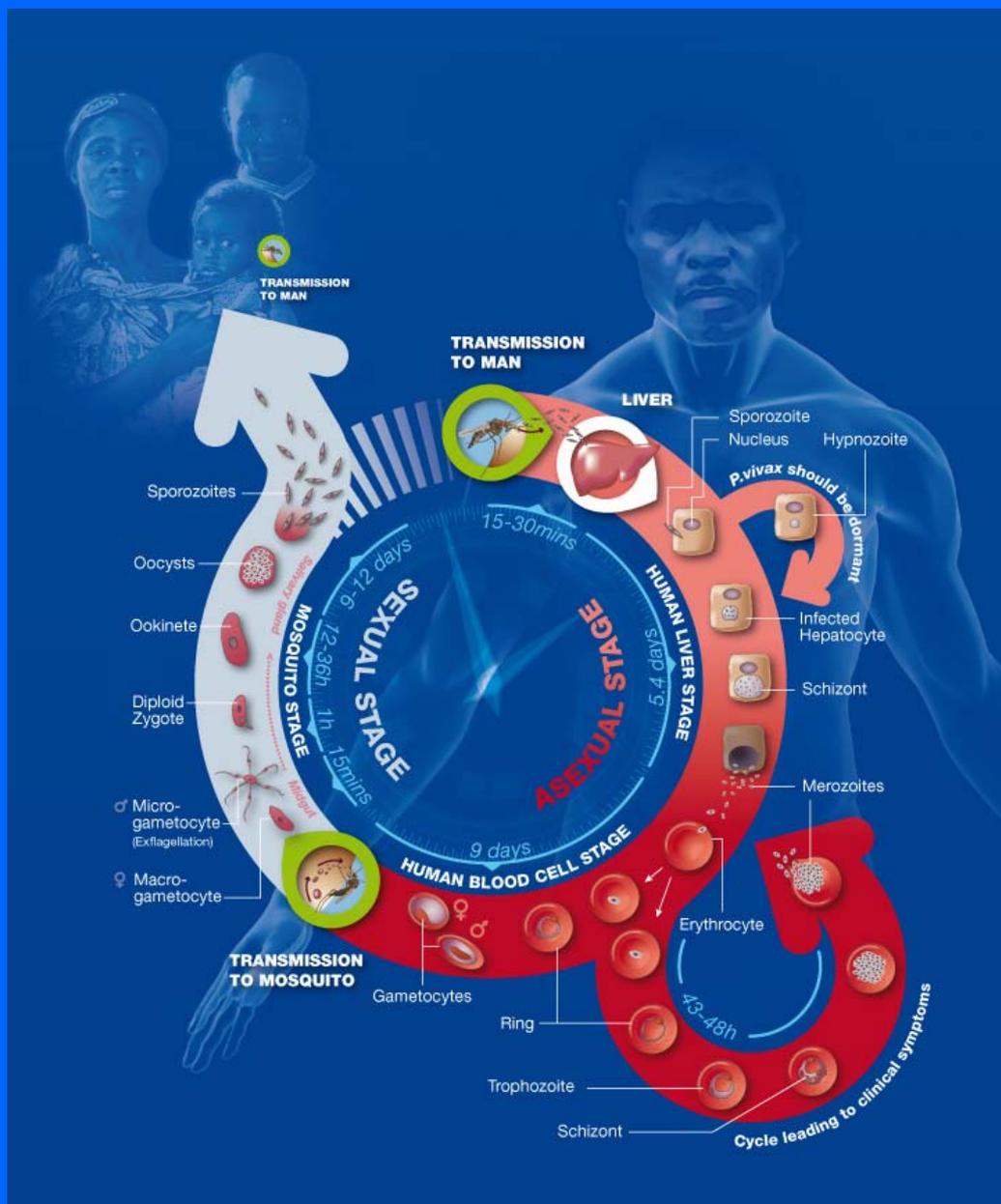


Diagram showing the lifecycle of malaria

later – an important consideration in a country where children have ten disease episodes per year. The clinical program had four key studies, and included 3000 patients in Phase III. Our goal is always to have the highest possible regulatory standard: in this case the approval by the EMA, prequalification by the WHO and inclusion on the standard treatment guidelines for malaria.

Our second new artemisinin combination therapy was developed in partnership with Shin Poong in Korea. It contains pyronaridine (a member of the lumefantrine family) and artesunate. Once approved, this ACT will be the first to be registered for use in both *P. falciparum*, the predominant species in Africa and *P. vivax* malaria, the predominant species in south and south-east Asia as well as in South America. This completed four pivotal Phase III trials, and is currently being reviewed by the EMA under Article 58. This provision allows the EMA to give scientific opinion as to the suitability of the medicine for countries outside the EU, but a positive opinion does not compel the sponsor to sell the product in Europe. We are expecting a final decision from the EMA early in 2012. Both medicines are currently being developed for adults and children, although we plan to register a specific pediatric formulation in each case.

Gaps in our armoury against the parasite

Although the ACTs are wonderful medicines, malaria is a complex disease and they cannot address all the treatment needs it presents. The first key gap in our armoury is the ability to protect expectant mothers. ACTs can be used as treatment in the second and third trimester of pregnancy, but following the emergence of resistance to sulphadoxine-pyrimethamine, what we really need is a new prophylactic regimen. Clinical studies in the early part of the last decade showed that a combination of azithromycin (itself a poor antimalarial) and chloroquine works really well even in areas where there is chloroquine resistance. With Pfizer we are developing a new fixed-dose combination of this medicine, which will be given twice during pregnancy. The Phase III pivotal clinical study has started, and will recruit 4000 patients before the end of next year.



The second gap in our armoury is the need for a new drug to prevent the relapse of *P. vivax* infection: this species of parasite has dormant forms, or hypnozoites, which stay in the liver, relapsing from 30 days to several years later and leading to infection in the absence of a new mosquito bite. The traditional cure for this is primaquine – a drug from the 1950s, which requires 14 days of treatment (with predictably low compliance). We are working with GlaxoSmithKline to develop tafenoquine (a second-generation version) which could require just a single dose.

The objective of a single dose treatment is shared by our third ‘advanced project’. Here we are looking for a molecule with the activity of artesunate, but with a half life long enough to support a single-dose therapy. Our front runner candidate, OZ 439 (for ozonide – the active part of the artemisinin), is currently in Phase II trials. If it is successful (we still have to put it in combination, determine the best doses in adults and children, in Africa and Asia, and perform pivotal Phase III studies) it would provide a synthetic alternative to artemisinin.

Breaking the innovation deadlock: successful new paradigms for drug discovery

One of the pharmaceutical industry’s biggest challenges is discovering innovative new medicines. In malaria, however, we have been able to break the deadlock because of dramatic changes in technology. We can now screen live parasites in 384 and 1536

well formats: because of this, whole parasite screening is a hundred times cheaper and faster than even ten years ago. This means that we have been able to 'screen first and ask questions later'. The result has been impressive: we have tested almost six million compounds from 15 companies, and several academic collections, and identified over 25,000 'hits' (compounds that kill the parasite at a concentration of less than one micromolar) – which cluster into families. We've been able to persuade our partners to put most of these in the public domain (they can be downloaded from ChEMBL or the PubChem databases), and from the autumn we plan to make several hundred physically available to anyone interested in understanding their mode of action, or whether they have activities on other parasites (please send your request to malariabox@mmv.org). The optimization of these compounds for use in man runs in parallel with finding the target – with a result that we can rapidly move from screening to the first-in-man – the best being under four years. We can also select early on for the key characteristics needed in a medicine: whether rapid killing, long half life for a single dose cure, or blocking transmission of the parasite. Interestingly, our bottleneck has shifted downstream – we now need more teams for 'hits-to-leads' medicinal chemistry. Here, we again have a new model – teams of chemists in disease-endemic countries such as South Africa and India, supported by experienced Project Managers in house, and a wide

variety of experts, or mentors, many of whom have now retired from Industry.

Conclusion

We have come a long way since the empty malaria R&D pipeline of the 90s, nevertheless, the complexity of the parasite means that our work is not yet done. In recent years, thanks to the generosity of our donors and the investments made by our partners we have seen the launch of several new drugs, and remarkable progress in the overall portfolio of antimalarial medicines. This whistle stop tour of our pipeline shows the progress that has been made in just a few years. What has become increasingly clear over the years, however, is that this progress can only occur through partnerships. No one group of actors alone was able to address the malaria treatment gaps back in 1999, when MMV was established, and that remains the case today. For malaria control and eradication to become a reality, medicines must play their part and they can only do so if we can sustain the wide-ranging collaborations that have brought us this far: collaborations with the many different companies we work with, our academic partners, our funding and scientific and clinical advisers. It is only by working together that we are able to realize the best assets, and bring forward new drugs to our patients who urgently need them.

Contact the Faculty...

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Charity number: 1130573

If you have recently moved or are planning to move, please notify the Faculty by phone, post or email of all changes of address.

This newsletter is published by the Faculty of Pharmaceutical Medicine of the Royal Colleges of Physicians of the United Kingdom. Opinions expressed in articles do not necessarily represent those of the Faculty or its parent Colleges or their policies.

Faculty events 2011...

September

1st – Certificate in Human Pharmacology examination
16th – Closing date for applications for Diploma in Pharmaceutical Medicine examination
27th – Prescribing without Evidence conference (RCP London)

October

13th and 14th – Diploma in Pharmaceutical Medicine examination
19th – Faculty Board Meeting

November

23rd – Faculty Annual Meeting and Dinner

President's update

by Dr Richard Tiner PFPM

New Offices

You will already have seen that the Faculty is moving from the RCP London to new accommodation just within the square mile of the City of London. These will be modern open plan offices with a self-contained meeting room, so that our reliance on the RCP will considerably diminish and enable us to become more independent but also to develop closer links with other Colleges and Faculties many of whom are located nearby. Nevertheless, I should like to thank the RCP for being such considerate landlords over the past 21 years and allowing us to go beyond our lease whilst we finalised our move.

Diploma Exam

I am delighted to confirm that the GMC last week approved the removal of the essay paper from the Diploma. This change will take immediate effect i.e. the 2011 Diploma will consist of a slightly longer MCQ, a Short Answer paper and a Critical Appraisal paper. I should like to thank Alan Boyd and Steve Pawsey along with Konrad Obiora for all the work they put in to achieve this excellent outcome. For the first time, the Diploma will have an overseas centre in Cape Town as a pilot. If successful, we hope to expand the number of centres in 2012. For those of you intending to take the Diploma in October 2011, I hope that you are hard at work revising. Just a couple of tips from previous examinations: in the MCQ some of the questions will have been derived directly from ICH and EMA guidelines so do include them in your revision; with regard to the SAQ, unanswered questions will automatically lose marks as will missing out a part of a multipart question. I wish all candidates well over these next two months as you prepare.

Update from the GMC

In the last newsletter, I reported that the GMC required doctors entering PMST after 31st October 2012 would have to take the Diploma as part of the training programme even if they had already passed it. I am pleased to report that the GMC have recently extended the timeline to 31st October 2013. I think it highly unlikely that they will extend it further, therefore if you have passed the Diploma and intend to do PMST, you must have enrolled by 31/10/13.

Faculty Events

Advertised elsewhere in the newsletter are the two events coming up in the Autumn. Firstly, our Annual Symposium "Prescribing Without Evidence": the Ethics Committee and our partners the British Pharmacological Society have put together a very interesting programme and so I hope to see many of you there on Tuesday 27th September. Many of the medicines with which you are involved are prescribed by clinicians off-label to patient groups for whom there is little evidence for their use i.e. the elderly, children and pregnant women. There is a need to discuss these issues and this conference will provide that opportunity.

Secondly, the AGM, Awards Ceremony at which there will be a prestigious lecture and the Annual Dinner on Wednesday 23rd November. Do try and come for the whole event but if that isn't possible, do try to attend some of it and support your colleagues who will be receiving their well-earned awards and then network over drinks and a relatively informal dinner. I aim to finish by 10pm so that you can get home as it is midweek.

Congratulations

I should like to add my congratulations to both Sir Kent Woods and David McIntosh on their awards in the Queen's Birthday Honours List.

Best wishes for the rest of 2011 and I hope to meet many of you at our two autumn events.