

SMOKING CESSATION

You read it here first!

From Mr A. F. Huntley,
MRPharmS

Terry Maguire described my suggestion that a photograph of a diseased lung should appear on cigarette packets as "simplistic scare tactics" (*PJ*, 28 September, p438). It appears that Alan Milburn, Secretary of State for Health, does not agree.

"Milburn steps up war against smoking", says *The Guardian* (November 21). And how is he to do this? "Graphic warnings, which could include pictures of diseased hearts, lungs and brains, will be added to cigarette packets as the European Union and British Government step up action against smoking," the Health Secretary said.

A. F. Huntley
Bristol

COMMUNITY PHARMACY

Public health role is the key to the future

From Mr A. D. Castell,
MRPharmS

I applaud the article by Dr Jill Jesson (*PJ*, 16 November, p725) which so clearly expounds the argument that the North East London Local Pharmaceutical Committee has been promulgating for some years.

This is that the core public health concept of sustainable communities is the key unifying factor in the future of the health service and that, in practically ignoring it, the major professional organisations are excluding themselves from the developing future agenda of health providers.

The Government has attached a high priority to health improvement and put in place many new structures. It has also emphasised that it is a job of every person and organisation to share the massive workload to improve health and work together. We know from our local public's experience that there is a need for health, environment and community development — preferably organised and co-ordinated locally — to work together. We all know that solu-

tions to improving health, environmental and community development are closely intertwined. It means recognising and dealing with the complex links between the social, economic and political factors that play a role in determining the well being of people. For that reason the London Health Strategy has three fundamental principles: that health can only be improved by working in partnership, that citizens and communities need to be actively involved, and that the sharing of intelligence about health and how it can be bettered is essential.

We believe that more pharmacists will feel part of primary care, and what is more important to the public is that the primary care team would be bettered when (i) community pharmacy is integrated with a role in public health, (ii) it is involved in helping to reduce inequalities in health and education (particularly in science) at a local level, (iii) community pharmacists are more involved in establishing new and imaginative partnerships to improve the NHS and (iv) community pharmacists are helped to demonstrate key competencies to improve the health and well being of communities.

What pharmacy needs from the Department of Health is a capital investment strategy to improve pharmacy premises and make them fit for their new purpose, and a new contract that encourages the provision of pharmaceutical care and ensures that pharmacists are appropriately rewarded. For the benefit of local communities, the role of the pharmacy as a local health care resource should be support-

ed. And, by means of suitable legal devices, locality planning must make sure that patient access to this service is maintained.

In the years ahead, in partnership with others, there is much work to do in serving our communities, in saving lives in a modern and dependable way and reducing inequalities in health, education and welfare. However, if LPCs (and there is no one else to do it) do not grasp the nettle of the changing agenda quickly, as advocated by Hemant Patel (*PJ*, 16 November, p714), they will find themselves excluded and will end up being reorganised out of existence by bodies with no concept of their potential.

Alan Castell
Vice-Chairman
North East London Pharmaceutical
Committee

We must avoid past mistakes

From Dr B. P. Curwain,
MRPharmS

Two items in *The Journal* of 23 November attracted my attention: that pharmacist prescribing is getting the official go-ahead and that the Pharmaceutical Services Negotiating Committee is concerned about pharmacists leaving the pharmacy while dispensing is happening. The latter sounds suspiciously like defending yesterday's territory. There are huge uncertainties and significant risks for community pharmacy at present and we must avoid repeating past mistakes.

The questions of skill mix and making better use of both community pharmacists and their staff are high on the Government's agenda for pharmacy. If we do not grasp this opportunity then it will not be there for long. Pharmaceutical input both to the prescribing process and to individual prescriptions can increasingly be provided by pharmacists working in medical practices and for primary care trusts. Shortly, three pharmacists in my PCT will begin seeing patients in medication review clinics. It is easy to see how this service could be extended to include symptom monitoring and dose changes or medication switches.

Where would all this leave community pharmacy? The danger is that, if community pharmacists are prevented by outdated rules and codes of behaviour from fulfilling the extended roles now being developed, those roles will be fulfilled elsewhere than in pharmacy premises. That process has already begun. As community pharmacy staff become more skilled, they will be able to take on a proportion of the pharmacist's advisory and educational roles. Some pharmacists already shun community pharmacy because they have to spend too much time on (important) technical tasks. In order to make the role fit for today's graduates, the rules, customs and practices of supervision will simply have to be re-examined. In surgeries, the process of nurse-led triage demonstrates that only about a third of patients who initially want to see a doctor need to do so. The nurse treats, refers or reassures appropriately. What about similar models for pharmacy?

We risk losing large parts of the community pharmacy network due to pharmacists voting with their feet and PCTs finding other ways to deliver the required services. This would be a great loss since a significant amount of health delivery can and does take place in community pharmacy. More pressure would then fall on the National Health Service and the public would lose a convenient route of access. You have to let go of one trapeze before grasping the next. OK, there is a small chance of missing it but the present one will go ever slower, leaving us dangling in mid air.

Brian Curwain
Chief Pharmacist
New Forest Primary Care Trust

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Letters are accepted for publication on the understanding that they have not appeared anywhere, including electronic media, previously. If the issue is of such significance that the correspondent has simultaneously submitted the letter elsewhere, it is the responsibility of the correspondent to inform *The Journal* at the time.

Letters that are critical of individuals, organisations or companies may be sent to the person or body concerned so that they are given a simultaneous right of reply. In these instances, the authors' identities will not be disclosed until publication, and publication will usually be delayed.

Anonymity will only be accepted in exceptional circumstances. These circumstances will be at the discretion of the editor and the decision made in consultation with the correspondent.

Supervision and absence cannot coexist

From Mr A. O'Shea, FPSI

At the recent General Assembly of European Community Pharmacists of Pharmaceutical Group of the European Union, I listened to the report of the British delegation with disbelief. It was reported that the UK Department of Health proposes a radical review of the so called "skill mix" in community pharmacy such that an enhanced technician grade could operate a pharmacy in the absence of a pharmacist.

The pharmacist in question, supposedly supervising the pharmacy while absent from it, would be visiting patients with special needs or advising general practitioners on rational prescribing, among other things, in their surgeries. Simple logic and plain English tell me that supervision and absence cannot coexist.

In my opinion, this proposal is tantamount to selling the birthright of the pharmacist to hold the legal monopoly over pharmacy supervision at all times. The pharmacist's presence is essential for the level of knowledge and judgement demanded by modern clinical practice. Efficient and professionally effective community pharmacies do require well trained auxiliary staff, whose skills are valued and rewarded. If the National Health Service requires pharmacists to work beyond the confines of the pharmacy, then the solution must not be to devalue the professional control of the community pharmacy, where 99 per cent of daily drug use problems and questions are encountered and solved.

The community pharmacist is at the heart of day-to-day encounters with patients receiving prescribed and non-prescribed medicines, making value judgements based on the bond of trust between doctor, patient and pharmacist. If the NHS also wants journeymen pharmacists acting as district consultants to GPs, then let the NHS recruit them directly while maintaining the professional base of community pharmacy. If the UK wants to enhance the training and skills of pharmacy technicians, that too is laudable within the current supervisory framework.

I appeal to UK pharmacists individually and collectively to

see the evident danger of these proposals, which to some may seem attractive in the short term, but which contain the seeds of extinction for the largest branch of the pharmacy profession. Speak up now before the mandarins of government rearrange your future . . . permanently.

Aidan O'Shea
Cork, Republic of Ireland

MENTAL HEALTH

Pharmacists' role in mental health

From Mrs P. Brown, MRPharmS,
and Mrs K. Kinsey, MRPharmS

In response to the letter, "Develop links with psychiatry" (*PJ*, 9 November, p676), we would like to share the example of a close working relationship that has occurred between primary and secondary care mental health providers in Manchester.

In August 2001 a group of long-term, mentally ill day patients were required to move out to a community setting. A crucial issue to consider was how these clients would manage their medication. We were involved in a project team to develop and involve community pharmacy in Manchester.

Over 45 community pharmacists expressed an interest in the project and 30 were called to attend the Centre for Pharmacy Postgraduate Education course on mental health. The remaining pharmacists were trained six months later. After the initial training the community pharmacists attended a training session that explained how to manage the clients, how to respond and look out for signs of relapse and where to refer problems. The training was attended by a local user group, community mental health team and had input from the North West Psychiatric Pharmacists Group. The community pharmacists were given the task of monitoring eight needs areas around issues such as compliance, over-the-counter purchases, lifestyle advice and explanation of the side effects of medication. Information was shared with the pharmacies regarding care plans, diagnosis, relapse signatures, previous non-compliance, and all contact details necessary to allow concerns to be raised with the appropriate individual. They were also

tasked with ordering repeat prescriptions and to respond to any changes in medication communicated from secondary care. The trained pharmacists were given the title of "mental health resource pharmacists".

The work has continued for one year with positive results. We have been able to demonstrate that community pharmacy has a place in managing the most difficult patients with regard to compliance and with clear lines of communication they can feed back information about the patient's well being. One of the primary care trusts has now funded this service.

Petra Brown
Citywide Mental Health
Pharmacist

Kate Kinsey
Community Liaison Pharmacist
Manchester

Support available for pharmacists

From Miss W. Ackroyd,
MRPharmS

I agree with Martin Nasr and Dr Joseph Guirguis (*PJ*, 9 November, p676) that it is time that there were stronger links between community pharmacists and community mental health teams. Merely acknowledging this does not give any indication of how to proceed or why links are not there in the first place. As a hospital pharmacist working in psychiatry I have been dismayed by the lack of interest or enthusiasm in mental health issues in my community colleagues. Taking a step back gave me a clue why.

In my days as a community pharmacist I would not have thought my undergraduate training would prepare me for offering my services to a community mental health team. Neither would completing the Centre for Pharmacy Postgraduate Education pack on mental health, as interesting as it was, have encouraged me to participate in the way that perhaps a similar pack on hypertension or diabetes might have. Hypertension and diabetes are nicely measurable, I could clearly see where I might have an input and having read the various guidelines I could feel confident that I might make a measurable difference for which, perhaps, I could clearly identify a "fee" (after all I am in business).

As a community pharmacist I was nervous about this huge area of mental health which I believed I knew little about. Perhaps I did not know whom I could contact for support, or to refer to if I came across something I could not answer. Luckily I know now that there are enthusiastic people working in pharmacy in psychiatry who are happy to direct their community colleagues to the people they need to talk to, and advise on the kind of things they could do to improve links between community pharmacy and mental health services and people with mental health problems. There is also the UK Psychiatric Pharmacy Group, an organisation that pharmacists can join if they are working in any area with an interest in mental health. It can provide access to training, support and the experience of 400 or so other pharmacists (www.ukppg.org.uk).

Perhaps the missing link is really that between the secondary care specialists and the community pharmacists.

We are often more willing to take a step into the unknown if we know there is support available.

Wendy Ackroyd
Senior Pharmacist — Psychiatry
Dumfries and Galloway Royal
Infirmary

REMUNERATION

Emperor's new clothes approach

From Mr M. A. Cormack,
MRPharmS

I have decided to offer my staff a 4 per cent pay increase this year. I am not increasing their hourly rate but, if I use the Pharmaceutical Services Negotiating Committee/Government formula, they are going to work an extra hour and a half a week. Overall, at the end of the year, they will be 4 per cent better off. Will they go for it?

This is what I call the "emperor's new clothes" approach — do 4 per cent more work at the same rate and you will have 4 per cent more money at the end of the day.

If only all pay disputes were settled this way, what a happy Government we would have.

M. A. Cormack
Norwich

Manufacturers should provide extra leaflets

From Mr S. Whitaker,
MRPharmS

In response to Stephen Lutener's answer to a letter from G. J. Weaver (*PJ*, 23 November, p744), it ought to be pointed out that most community pharmacies do not have internet access and will be unable to download patient information leaflets.

Among those who do have access to the internet, only a minority will have a high definition printer (inkjet or laser) capable of printing out the documents they download. Most pharmacies still operate entirely on dot matrix printers.

Although few pharmacies have internet access, even fewer have photocopiers. Many pharmacies have fax machines capable of rudimentary copying, but copying on to thermal fax paper is far from ideal, because the print fades when exposed to light or heat.

I am sure that most readers will realise the futility of trying to encourage prescribers to prescribe only pack size quantities. Clearly, allowing us to "round up" is the only realistic solution to this problem, although I acknowledge that, sadly, it is probably the least likely.

A suitable interim measure would be for manufacturers to include extra PILs in their packs. This happens now with many bulk packs, but there needs to be a realisation among manufacturers of "pseudo-patient packs" such that packs like the Bucestem mentioned by Mr Weaver can be split.

Simon Whitaker
Bicester,
Oxfordshire

Where was the Society?

From Mr D. L. Coleman,
FRPharmS

I was pleased to see the large number of pharmaceutical bodies that have made representations against the Medicines Control Agency proposals which suggest the photocopying of patient information leaflets. I

notice the Royal Pharmaceutical Society is not included in that list. This I am sure must be an oversight.

If, incredibly, the Society has not objected I am at a loss for words. Is it conceivable that in a year or so the Society in its regulatory function will be overseeing the photocopying of leaflets by pharmacists and reprimanding those who fail to do so? And in that light, is it conceivable that the Society has not objected?

The whole issue of split and snipped packs has been rumbling on for over a decade. It is a professional matter. It is a matter in which all bodies in pharmacy must say to the Government, "You have had enough time, you are jeopardising patients interests, you are making a laughing stock of our pharmaceutical supply service and all you can come up with is photocopying patient leaflets". On reflection I guess if we wait a bit there will be arrangements to photocopy the original pack (which has the batch numbers and expiry date on it) and even the split tablet foils.

David Coleman
North Walsham, Norfolk

A united front would have been better

From Mr M. P Smith,
MRPharmS

I was pleased to see *The Pharmaceutical Journal* acknowledging the joint response to MLX 285 (*PJ*, 9 November, p666). However I would like to make the following comments. First, the National Pharmaceutical Association, the Company Chemists Association and the Pharmaceutical Services Negotiating Committee are not and never have been wholesalers or manufacturers of pharmaceuticals. It would have been more accurate to report that the majority of the bodies representing the pharmaceutical profession endorsed the document.

This brings me to my second point that the only body whose support was absent from this joint response was the Royal Pharmaceutical Society. As you quite rightly report, the reply of the Association of the British Pharmaceutical Industry and the joint response was based on patient

safety considerations. It is therefore difficult to understand why the Society believed it could not put its name to this document.

I am sure that the response of the rest of the bodies representing pharmacy will carry weight, but it would have been better for the whole of the pharmaceutical profession to have presented a united front on this ill-conceived document.

Mel Smith
Chairman
Industrial Pharmacists Group,
Royal Pharmaceutical Society

STEPHEN LUTENER, head of professional conduct, Royal Pharmaceutical Society, replies: The Society is in a different position from the other bodies that signed the joint letter in that it is also a regulatory body and, crucially with respect to the consultation, it has an enforcement role under the medicines legislation. It could not, in those circumstances, sign up to the whole of the response.

The Society has, though, responded in similar terms to the consultation document on photocopying of patient information leaflets. The Society's position is that patients should have access to patient information leaflets, in order to be fully informed, but that photocopying leaflets is not a practicable means of complying with the 1994 Regulations.

Mr Smith and Mr Coleman can be assured that there has been no oversight and that the Society will continue to co-operate with the other bodies, the Medicines Control Agency and the Department of Health to resolve the problems pharmacists face in providing patient leaflets.

DRUG TARIFF

More information on fees

From Dr G. L. Geddes,
MRPharmS

My response to the letter from Tessa Jenns (*PJ*, 23 November, p743) was incomplete. The complete response follows:

Fees related to threshold quantities were introduced with effect from 1 September 1987 to offset the discontinuation of differential on-cost. At that time the Pharmaceutical Services Negotiating Committee became

increasingly aware of the tendency of medical practices in some areas to issue repeat prescriptions for longer treatment periods — up to six months in some cases. This practice was not uniform throughout England and Wales. Before the introduction of a flat on-cost rate (and its eventual disappearance) a switch to longer-term prescribing had been partially offset by a higher on-cost rate. Thus a fee related to the treatment period became a PSNC objective.

A treatment period specific to a prescription could only be determined by relating the quantity to the daily dosage when this is stated. Dosage information is not captured by the Prescription Pricing Authority but fortunately a solution in the form of a threshold quantity based on the average quantity emerged. The list in Part IIIA 2H of the Drug Tariff is derived from the 1,200 most popular solid oral dosage formulations. The threshold quantity is set at the average quantity prescribed plus 34 per cent. This formula is arbitrary but was designed to pay out a small proportion of the global sum at an initial rate of a 30p fee.

I agree with Mrs Jenns that the list is in need of revision. However, the effect of a revision results in more monies being allocated from the global sum. Recently the PSNC made a decision to leave threshold quantities untouched until more information is available regarding the quantum of the standard professional fee and the effect on average quantities following the introduction of repeat dispensing schemes.

I should be pleased to discuss the history of threshold quantity fees with Mrs Jenns outwith these columns. However, I hope that this necessarily lengthy reply will not put her off browsing through the Drug Tariff — an activity I recommend to all readers!

Gordon Geddes
Head of Information and Technical
Services
Pharmaceutical Services
Negotiating Committee

SEARCH THE JOURNAL

The *Pharmaceutical Journal's* website, *PJ Online*, contains a fully searchable archive. Visit www.pjonline.com to see how easy it is to use. The archive starts from August 1999.

Be vigilant about methotrexate toxicity

From Mr M. F. Hannon,
MRPharmS

I read with interest the letter regarding the confusion between folic acid and methotrexate tablets (*PJ*, 16 November, p712). Within our hospital we have had similar anxieties about this type of confusion occurring in one of our dermatology outpatients clinics and we have had two near misses of which we are aware. Our analysis suggested that although the colours and shape of the two agents are similar, we need to pay much more attention to the strength of the methotrexate tablets prescribed (dispensed) and their dosing frequency.

Therefore, about 15 years ago, we took action to stock only one strength of oral methotrexate (2.5mg tablets) in the hospital pharmacy. This decision was driven by a consultant dermatologist and myself and we organised it such that all our dermatology outpatients on oral methotrexate would, for reasons of safety and continuity, always get their drug from the hospital pharmacy. The consultant argued forcefully that with the drive by the Government to encourage generic prescribing and dispensing, changes in tablet presentation, colour, etc, happen so frequently that patients often "miss" the obvious warning signs when something is dispensed wrongly. He reasoned that for a drug such as methotrexate where the therapeutic index is so low, we needed to ensure that the patient was trained adequately and that the supply and the identity of the drug could be guaranteed. Therefore we purchased only branded, identifiable methotrexate tablets 2.5mg and patients in the clinic knew what to expect. This initiative soon spread to patients in other clinics and so far we have had no problems.

One of my colleagues in another trust asked me whether our patients and pharmacy staff eventually become "desensitised" to the risks of oral methotrexate. I hope that this never happens but given the growth in the use of oral methotrexate in other specialties (immunology, oncology, rheumatology), it is possible that methotrexate could become "just

another drug". Patients, for instance, expect to take their tablets every day and weekly dosing is relatively infrequent in pharmacy practice so complacency can creep in. However, anyone who read the recent report on the fatality with methotrexate (see www.canibs-ha.nhs.uk/publications/pdf/methotrexate-toxicity.pdf) can be left in no doubt as to its potential toxicity.

The pharmaceutical industry could, with better packaging, do much more to help eliminate the hazard. But given the range of doses that we dispense in our hospital (from 2.5mg up to 22.5mg once weekly), it could prove to be difficult to get a standard pack. Until there are further controls on oral methotrexate (see *Pharmacy in Practice*, September 2002, p277), perhaps the only safeguard for patients and pharmacists is more information and better education. As pharmacists we must remain acutely aware of the risk posed by this drug if it is taken daily instead of weekly.

M. F. Hannon
Principal Pharmacist
Royal Victoria Infirmary
Newcastle Hospitals NHS Trust

CANNABIS

Treat BLF report with caution

From Ms A. Sandford

Claims by the British Lung Foundation that cannabis is as hazardous as tobacco (*PJ*, 16 November, p704) should be treated with considerable caution. The comparison between cannabis use and tobacco is flawed because the report does not address patterns of consumption nor does it examine the most common health impacts.

The two studies on which the claim that cannabis causes as much harm as tobacco is based only examined a limited range of symptoms and did not estimate the risk of lung cancer and chronic obstructive pulmonary disease, the main fatal lung disease caused by smoking tobacco.

Secondly, the report fails to address one of the most important factors in lung disease risk, namely years of lifetime exposure. Because nicotine is so addictive, it is not unusual for a smoker to consume 20 cigarettes a day for 40 years. But such heavy

and sustained cannabis use is rare. Any comparison of risk should include the different ways the substances are used over a lifetime. The three cannabis joints to 20 cigarettes ratio cannot be substantiated.

No one is arguing that cannabis is harmless but when comparisons are made between tobacco and cannabis it is important to keep the harm in perspective.

Amanda Sandford
Research Manager
Action on Smoking and Health

FOOD SAFETY

Medicines Act affects public confidence

From Mr J. H. Verrall,
MRPharmS

For some time the public has not had confidence in food safety and this is due in no small part to the existence of Section 118 of the Medicines Act 1968. This "confidentiality clause" covers all information submitted in a product licence application and prevents open discussion on food safety issues. There appears to be little justification for such information to remain confidential (except perhaps for such things as details of a manufacturing process) and, since some data submitted by companies have not been peer-reviewed, there is every reason for it to be open to scrutiny and debate. That information relating to the safety of food is "proprietary and confidential", as suggested by some organisations, is unacceptable.

At Veterinary Medicines Directorate/stakeholder meetings, it has been established that the industry as well as the VMD are in favour of the repeal or amendment of Section 118 and, in the past, the House of Commons Select Committee on Agriculture has recommended "an early repeal of Section 118".

The Food Standards Agency, created by the Government because of the significant lack of confidence in food safety following "mad cow" disease, has also expressed support for the section's early repeal in the hope that "it will bring about greater transparency of the approval process".

The lead for such action is to be taken by the Medicines Con-

trol Agency and I understand this is to be implemented on the back of the Freedom of Information Act which, in a diluted form, received royal assent on 30 November 2000. However, the Lord Chancellor has said that the Act will not be implemented in all public authorities until January 2005 at the earliest. One wonders why there is such a delay and why it has to be implemented in all public bodies at one time.

What would appear to be an unnecessary delay in the repeal or amendment of Section 118 is to be regretted. Only when this is undertaken can public confidence in food safety be renewed.

John Verrall
Battle,
East Sussex

ALZHEIMER'S DISEASE

Missing the point

From Mr M. Campbell,
MRPharmS

The report by Shubra Mace and David Taylor (*PJ*, 9 November, p680) makes for interesting reading but I suspect tells us little about the quality of care for people with Alzheimer's disease, of which a key prerequisite is the availability of old-age psychiatry services. The Royal College of Psychiatry's annual workforce census (www.rcpsych.ac.uk/publications/op/op54.htm) shows that, for 2001, 72 out of 512 old-age psychiatrist posts (14 per cent) in England were filled by locums or were vacant. Even including these, this is less than one whole time equivalent old-age psychiatrist per 1,000 people with dementia (based on 412 whole time equivalents and an estimated 700,000 people with dementia [National Institute for Clinical Excellence guidance]). Although other specialties are involved in the management of dementia, most services are led by old-age psychiatrists and I suggest that the shortage of trained specialists rather than drug funding arrangements, is the rate-limiting step in access to treatment for Alzheimer's disease.

Moreover, the title of the paper is misleading. Only a detailed clinical audit would tell us whether clinical practice is in line with NICE guidance and no such data are presented. Unfortunately, similar surveys of prescribing advisers and directors of public health are commonly used

to determine if health authorities and primary care trusts are funding a particular drug and therefore “complying” with guidance. The crudeness of such approaches misunderstands the complex nature of the National Health Service and its commissioning processes in particular. As commissioners of services, PCTs might, for example, provide additional investment for cost pressures arising from NICE guidance but it would rightly be for hospital trusts to prioritise and allocate these extra resources.

Mark Campbell
Programme Director — Clinical
Governance
Bury Primary Care Trust

THE SOCIETY

Back to the drawing board?

From Mr A. J. Rogers, FRPharmS

I seem to recall that when the Royal Pharmaceutical Society embarked upon its “modernisa-

tion” programme, it took advice from the same management consultants that had recently guided Boots on its future strategy. Boots has just announced that its initiatives have not been successful, and has consulted another company on its future direction. Let us hope that our masters (no, servants) in Lambeth have the sense to admit a similar failure, and return to the drawing board.

A. J. Rogers
Ewell Village,
Surrey

Do industrial pharmacists get value for their retention fees?

From Mr J. D. R. Jolley,
FRPharmS

I am unable to agree with Nigel Graham’s response to Mike How’s letter (*PJ*, 16 November, p713); his statement that the Royal Pharmaceutical Society’s practice division devotes considerable time to the industrial

pharmacist is not true. The time spent in administering applicants to the Qualified Persons’ register is paid for in the £500 application fee; the only other support is the administration of the Industrial Pharmacists Group committee, which has now been cut back to three meetings per year (requiring only a quarter a person time per year).

Even the newsletter, *Industrial Pharmacist*, has to be paid for now by sponsorship from industrial companies.

What is more, there is little chance of things improving since, despite considerable lobbying from the IPG committee, the Society’s Council has decided to give priority to regional representation in place of representation from the major sectors of pharmacy. Even pharmacy technicians will have representation in the new Council structure.

This is a clear message from our Society that there is no intention to give support to the industrial pharmacist, and we should all consider what value do we get from our annual retention fee.

John Jolley
Norwich

Excalibur was pulled from a stone

From Mr A. P. Bolt, MRPharmS

I beg to differ with Stephen Jones (*PJ*, 23 November, p746) about the origins of Excalibur.

According to some the name Excalibur comes from the Latin *ex calibre* (ultimately from the Arabic *kalib*) “from the mould”. It was an early bronze age sword made by pouring molten bronze into a stone mould and so ultimately came “from the stone”. Such swords signalled the beginning of the bronze age. They were rare and prized by kings and great warriors.

The Arthurian legend has become so mixed that it is unclear if there were two swords, or one sword with two mythical origins.

Alistair Bolt
Norwich

Correspondence about Excalibur is now closed.—EDITOR.