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What tasks can physicians delegate to pharmacists?

We are pleased to see how physicians can work with pharmacists in medical practice.¹ As ex-pharmacists and now physicians, we want to suggest the following tasks to be delegated to pharmacists:

1. Monitoring drug therapies: dosing drugs like warfarin, vancomycin, and aminoglycosides can be like chasing your tail. Non-adherence to immunisations is an ongoing public health concern. Pharmacists are trained to perform pharmacokinetic monitoring and intramuscular injections. Why not let those experts monitor patients' drug levels and adherence to therapies?
2. Adverse drug reactions: documented penicillin allergy requires systematic assessment, due to increased risk of MRSA and *C. difficile* mediated by alternative antibiotic uses.^{2,3} Established allergy assessment methods, such as the Naranjo algorithm, are time consuming and may not be achievable during a 10-minute consultation. Why not let our pharmacists aid with adverse drug reaction assessment, which was shown to complement the drug history taken by physicians?⁴
3. Medication reconciliation: medication discrepancies post-hospital discharge are frequent patient safety risks. We have worked in one hospital where pharmacists draft discharge medication lists, and physicians check and co-sign the prescriptions. Why not let community and hospital pharmacists liaise with each other, and provide better communication to dispensaries?
4. Drug coverage: drug counselling and insurance coverage are listed as the most needed tasks where physicians want pharmacists' help.⁵ The NHS is often finding ways to stop funding drugs. Why not ask our pharmacists to find effective, low-cost alternatives for patients?
5. Audit and research: many community pharmacists want to be involved in audit and research, but lack the opportunity. GPs are keen to improve the quality of their ongoing audit and research. Why

not collaboratively perform these projects together?

Physicians are sometimes guilty of 'dumping' work on each other when facing heavy workloads.⁵ The aforementioned tasks may sound tedious to physicians, but are excellent opportunities for pharmacists to optimise patient care. Are there good reasons for physicians to not collaborate with pharmacists?

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A complex consultation

It shocks me that measles is still a threat;¹ it is an eminently eradicable disease, infecting only humans and not mutating; like smallpox, but not quite so deadly. I was proud to read that the UK had eliminated

measles in 2017 and very sorry to read of its return. I want to do my bit, but the editorial is unclear as to how I can practically do this, the reason being primarily, I think, that it is written by non-GPs. It reminds me of the talk I went to by a cardiologist who encouraged us to refer ALL our chest pains to him, because it was impossible to be sure they weren't cardiac. Knowing smirks were exchanged by the GPs present.

If we notified Public Health of all people with a fever, coryza, and a rash, they would be overwhelmed. I thought Koplik's spots were pathognomonic but I now read they are 'an unreliable marker'. In fact, measles may only present as a fever, a cold, and a rash, just like so many children I see every day. If they are ill I admit them; if not I give symptomatic advice. Every day I see these indefinable viral rashes.

If measles is 'going around' I would naturally be suspicious, but I wonder where this information comes from because I don't think it comes from GPs. I don't know any GP who has seen measles for years. Perhaps we have and didn't realise it.

The single best piece of advice in the article was, of course, to establish whether or not the patient has been vaccinated. This should be a routine question and, by asking of a mother with an ill child, it should prompt parents who are holding out to do the right thing by their children.

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