Since the inception of the National Health Service there has been an opinion that much minor illness which can be dealt with at home should be channelled into general practitioners' surgeries. As someone who attended Balint groups at the Tavistock Institute for four years I well understand that many patients present with minor illness as a necessary and sometimes covert introduction to a discussion of major importance. Nevertheless, I subscribe to the belief that some patients are genuinely at a loss as to how to deal with minor illness, an attitude engendered if not stimulated by the characteristics of the NHS, and by patients finding that the doctor's surgery is a convenient avenue for advice.

Dr Roberts' paper continues and perpetuates the sociological process which began in the twelfth century, and reached its height in the eighteenth century, at which time apothecaries saw approximately 20 patients for only one seen by the physician. Physicians accused apothecaries of being incompetent while apothecaries complained that physicians were arrogant, unfamiliar with the medicines that they prescribed and made unfair profits. The rivalry continues to this day with physicians gaining the ascendacy, obtaining (and retaining) the control of the 'social object',[1] that is, the drug, and I would suggest that this article reflects the rivalry between pharmacists and dispensing general practitioners.

But there is a different scenario possible in the NHS. We have a stratum of general practitioners, vocationally trained and with full access to investigations, at a time when hospital physicians have become more and more specialized. If general practitioners could devolve many of their patients with minor illness to pharmacies, they could then act in place of the fast disappearing general physicians. Of course, pharmacy students would need better training in clinical pharmacy but this is currently taking place.

One possible result is that outpatients' departments would be able to function more effectively. With fewer patients, waiting lists could be drastically cut and consultants would be able to act in true consultant fashion. This would result in a shift of care from the secondary to the primary field and similarly in a shift of minor illness from doctors' surgeries to the pharmacies. Perhaps general practitioners could then turn their efforts to family care, prevention, health education, and into generally improving the quality of personal contact with patients. This may be cost-effective and as safe as the present system with good training. It would also be vocationally satisfying for consultants, general practitioners and pharmacists. Perhaps the time has come for some lateral thinking.

M.R. SALKIND

Medical Colleges of St Bartholomew's and the London Hospitals
Academic Department of General Practice and Primary Care
New Science Block
Charterhouse Square
London EC1

Reference

1 Denzil NR, Mettlin CJ. Incomplete professionalization: the case of pharmacy. *Social Forces* 1968; **46**: 357.

Sir,

Dr Roberts, chairman of the Dispensing Doctors Association, has a narrow view of the pharmacist's role in the health care team. We would like to present another view of the community pharmacist's current role, one which is closer to reality.

The Nuffield report on the present and future role of community pharmacists[1] accepted that the manipulative skills required to dispense a prescription have been reduced. However, the 'change in nature of drugs has increased the potential demand on a pharmacist's knowledge'. While acknowledging the increasing use made of computers, the report emphasizes the pharmacist's personal involvement in cases which call for the application of pharmaceutical knowledge. In this area, the committee were referring to a service to general practitioners which would enable them to make better prescribing decisions.

A second role was highlighted: to assist patients in the handling of their medicines. This embraces the many and varied aspects of health education. Patients remember just over half of the information provided in a consultation.[2,3] Furthermore, there is evidence to suggest that some prescribers fail to instruct patients fully about their medication regimens.[4-6] Pharmacists are in the unique position of being able to remind patients of important information and reinforce concepts and behaviour strategies suggested by the doctor.

About 25% of all prescriptions written by prescribers, and more than 50% written by ancillary staff, are not complete or have some error.[7] Neither doctors nor pharmacists should be deceived into thinking that the computer will end such errors: the human hand still has to guide the computer — another reason for the

pharmacist in the supply chain.

No pharmacist would disagree that patient records are confidential. However, patients discuss their problems with others, including the pharmacist. Again, two professionals are better than one. It is clear that patients like to discuss their problems with pharmacists, not to challenge the doctor but to reassure themselves that they have understood the message they received.

The pharmacy undergraduate course nowadays includes aspects of pathology and therapeutics which equip pharmacists for the wider role of health carer for minor problems. Pharmacists supply household remedies and provide advice on minor complaints, such as cuts, colds and indigestion. This service is available locally, 10 hours a day, six days a week and in many places, for more than 12 hours a day, seven days a week. Although doctors are on call 24 hours a day, 365 days a year, how many would like to deal with such minor problems outside surgery hours? In fact, how many would feel it was their role to deal with these problems at all? If pharmacists were to disappear, would doctors be able to fulfill these functions, indeed would they want to?

Finally, as does Dr Roberts, we must consider the end user — the public. Pharmacists provide free advice on health subjects during extensive hours of trading. They are not overpaid and are part of the social structure of the community. Society would suffer if they were to disappear.

DEREK BALON
NORMAN EVANS
RUSSELL GREENE

Department of Pharmacy
King's College London
Chelsea Campus, Mauresa Road
London SW3 6LX

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Response to the white paper

Sir,

The majority of general practitioners object to many of the proposals contained in *Working for patients*[1] and to the speed with which the government wishes to implement its plans.

College leaders have a golden opportunity to unite general practitioners and to ensure that the government and patients are aware of their objections. It is clear that this government does not want the proposals to succeed but is aware that implementation will drive many patients to the private sector. When the National Health Service finally collapses the government has its scapegoat ready — the general practitioners who are only concerned about their wallets.

I hope that the College will provide a clear lead and help to preserve and improve the NHS.

DAVID I. JEFFREY

The Health Centre
Merstow Green, Evesham
Worcs WR11 4BH

Reference

1. Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.

Sir,

It is only right that patients should be able to make an informed choice of doctor. It is reasonable that doctors who provide extra services should be rewarded, as should those who take advantage of postgraduate education. It is arguable that this should be at the expense of other doctors.

Of grave concern to all doctors are the government's proposals for family practitioner committees. The local medical committee is to be rendered redundant and local representation is to be removed from the family practitioner committee. A small group of people appointed directly by the government will therefore have far-reaching powers. They will have influence over the appointment of replacement partners; the power to take sanctions over prescribing; the power to monitor referral rates and the reasons for referral; and the power of veto over the general practitioner's place of residence.

There seems to be no obligation for the family practitioner committee to act upon or even take independent medical advice, which they can commission from a varie-