Prendergast, who was asthmatic with a chest infection, prescribing three Ventolin inhalers (salbutamol, Allen and Hanburys), 250 Phyllocontin tablets (aminophylline, Napp) and 21 Amoxil tablets (amoxycillin, Bencard).

Mr Prendergast took the prescription to the pharmacy of Sam and Dee Limited, where it was dispensed by a pharmacist, Mr Peter Kozary. Mr Kozary dispensed the Phyllocontin and the inhalers correctly, but instead of Amoxil he dispensed Daonil (glibenclamide, Hoechst), a drug used for diabetes to reduce the sugar content in the body. Mr Prendergast was not a diabetic and as a result of taking a large dosage of Daonil suffered permanent brain damage.

In the high court, Mr Justice Auld indicated that a doctor owed a duty of care to a patient to write a prescription clearly and with sufficient legibility to allow for possible mistakes by a busy pharmacist who might be distracted. Having established that in his opinion the word Amoxil on the prescription could have been read as Daonil, Dr Miller had been in breach of his duty to write clearly and had been negligent. Such liability could not be excused by the argument that there had been sufficient information on the prescription to put Mr Kozary on his guard. Dr Miller's negligence had contributed to the negligence of Mr Kozary, although the greater proportion of the responsibility (75%) lay with Mr Kozary.

On appeal, counsel for Dr Miller argued that the word on the prescription standing on its own could reasonably have been read incorrectly. However, various other aspects of the prescription should have allerted Mr Kozary to the fact that something was wrong. The strength prescribed was appropriate for Amoxil but not for Daonil; the prescription was for Amoxil to be taken three times a day while Daonil was usually taken once a day; the prescription was for only seven days' treatment which was unlikely for Daonil; Ventolin and Phyllocontin were well known treatments for asthma and it would have been unusual to have diabetes and asthma treatments on one prescription and finally, all prescriptions of drugs for diabetes were free under the National Health Service but Mr Prendergast did not claim free treatment for the drug. All of these factors should have raised doubt in the mind of Mr Kozary and as a result he should have contacted Dr Miller. Therefore, the chain of causation from Dr Miller's bad handwriting to the eventual injury was broken.

Lord Justice Dillon rejected this argument in the court of appeal. First, it was no defence to Dr Miller to rely on the already established negligence of Mr Kozary when he himself had been in breach of his own duty of care to write clearly and had been negligent. Secondly, those other factors were not enough to make it beyond reasonable foreseeability that Daonil would be prescribed. Therefore, the chain of causation had not been broken.

The implications of this decision are that doctors are under a legal duty of care to write clearly, that is with sufficient legibility to allow for mistakes by others. When illegible handwriting results in a breach of that duty causing personal injury, then the courts will be prepared to punish the careless by awarding sufficient damages. Liability does not end when the prescription leaves the doctor's surgery, even if the doctor has been grossly negligent. It may also extend into and be a cause of the negligence of others.

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The community pharmacist

Sir,

The recent exchanges in the *Journal* on the subject of dispensing and the role of pharmacists in primary care has been illuminating as much for what was not said as for what was.

Rural practice is being given an extremely hard time by pharmacy and pharmacy is being given an almost equally hard time by government. While there are honourable exceptions, the predominant motivation for the pharmacy is money, in exactly the same way as for any other retail shopkeeper. The rural practitioner is not so saintly as to be wholly unmoved by money but something which non-dispensing doctors may not realize is the huge satisfaction that is to be gained from being able to do the whole job of health care provision oneself. The patient has much to gain from dispensing by the doctor, and is acutely aware of it, as may be witnessed by the number of letters that our MP received when this practice was threatened, over 700. The sadness of the fraught atmosphere over dispensing is that patients, if given a free choice, would probably opt to have both a dispensing doctor and a local pharmacist. For the moment at least this is not likely to come about and, in consequence, everyone loses.

The paper by Taylor and Harding (May *Journal,* p.209) is riven with inconsistencies and *non sequiturs.* The sharing of responsibility in the 1982 case cited appears not to have profited the victim. With respect to another case, I venture to suggest that most doctors would not dispense 250 mg of Daonil (Hoechst) tds. A computer would not let such items through.

Compliance with prescribed treatment is hindered by the physically remote dispensing process which is imposed on the majority of clients. Why else would such an enormous proportion of prescriptions written fail to be dispensed?

Taylor and Harding are on much firmer ground when they speak of 'a ready source of drug information' and of pharmacists being well placed to deal with minor ailments. With respect to the latter, how much better placed they would be if they were able to sell more truly effective items and how much better served the public would be if pharmacy were not cocooned by resale price maintenance. However, to state in the journal serving the leading edge of primary care physicians of the UK that 'Pharmacists are the only health professionals to whom there is quick and easy access without a prior appointment and who are willing and able to advise patients on minor health complaints as well as on health education' seems recklessly undiplomatic.

Professor Salkind (letters, May *Journal,* p.214) takes an academic's oblique view of the issue and as a consequence falls painfully astride his own conclusions. Minor ilness can often be managed without the intervention of general practitioners and even more often by no treatment at all. 'Improving the quality of personal contact with patients' is what dispensing by doctors is really all about; that is real 'lateral thinking'.

Balon, Evans and Green (letters May *Journal,* p.215) also take a tumble in their contribution. I strongly dispute the contention that retail pharmacies are commonly open for the hours described. In our own case, when threatened by a pharmacist opening in the village, we calculated that given the opening hours at his other premises there would be a loss of pharmaceutical provision to the public approaching 75%. Doctors fulfil the function of managing minor illness for 24 hours a day, 365 days per year, even bearing the responsibility for it when the actual work is done by deputies. By contrast pharmacists are only too ready to allow doctors to dispense for many hours every night, at weekends and bank holidays. Where is the commitment to patient care in unsocial hours?

There is no question whatever that pharmacy has a cornerstone role in primary care but that role is not dispens-

ing. The talents of pharmacists should not be so dissipated on such an essentially menial task.

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Dispensing by the GP

Sir,

The government's desire to increase the cost effectiveness and competitiveness within the National Health Service as expressed in the white paper and in the revised contract only heightens the anomaly of the arrangements for dispensing, as was admirably expressed in Dr Roberts' article (December *Journal* p.563).

If general practitioners are encouraged to prescribe generically and cost effectively, while maintaining legal responsibility for a high standard of treatment, they can only do this if they have control of the supply of drugs. The dispensing general practitioner is able to ensure that medicines dispensed from his generic prescriptions come from a reputable source with consistent quality and with appropriate instruction leaflets in English. Those of us who are unable to dispense have no such guarantees nor do we have any recompense if the quality of the dispensing, while being legally correct, is clinically inadequate. General practice has moved a long way in the last 20 or 30 years, with many doctors working in well appointed, purpose built premises and practising high quality professional, scientific medicine. Surely dispensing by the doctor has more in common with this environment than do high street pharmacies, be they chain stores or individual shops, the vast majority of whose trade is in flannels, cosmetics and similar consumer-oriented products.

Is it not time that doctors and chemists should be able to compete on equal terms for dispensing contracts supervised by the appropriate professional bodies and the family practitioner committee? It is extremely surprising that a government dedicated to free enterprise and competition should perpetuate this blatant restrictive practice that presently exists.

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Christian approach to whole-person medicine

Sir,

I was interested in the article by Dr Sheldon on the Christian approach to whole person medicine (April *Journal*, p.166). I am not Christian but I believe in people and it appears that one of the most difficult problems that many of our patients suffer from is not believing in themselves. This is often the result of a number of circumstances including never being given a chance to believe in themselves.

However, the article was spoilt by the second sentence of the summary which talked about the spiritual dimension of 'man'. As a woman doctor I have been talked about as 'he' for 15 years. What about the spiritual dimensions of woman?

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Geriatric day hospitals

Sir,

I read with interest the survey by Dr Williams and colleagues of general practitioners' opinions about referring patients to geriatric day hospitals (November *Journal*, p.498).

In a similar study,[1] just published, we looked at referrals to a geriatric day hospital and likewise found that day hospitals were underused by general practitioners. This is despite the presence of an open access referral system which Williams and colleagues suggest can improve the referral rate. One possible factor is the 'long day hospital day', but more likely (as our study suggests) many general practitioners are not aware of the wide range of facilities of a modern geriatric day hospital.

To remedy this situation, I would suggest that exposure to a geriatric day hospital is made an essential part of vocational training[2] and that general practitioners should arrange a visit to their local day hospital if they are not familiar with the services offered.

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References

1. George J, Young JB. General practitioners and the geriatric day hospital. *Health Trends* 1989; **21**: 24-25.
2. George J, Young JB, Tucker JS. Senior house officer training in geriatric medicine. *Age Ageing* 1987; **16**: 111-114.

Failures of screening

Sir,

The note of caution sounded in Nicholas Hick's paper on misplaced loss of confidence in measles vaccination (April *Journal*, p.151) may be relevant to other preventive activities such as health screening. An analogous problem could arise where a screening test with a sensitivity of less than 100% is applied to a population with the aim of achieving a reasonably high uptake. As uptake increases, unrecognized sufferers in the 'screened: false-negative' group would begin to outnumber those sufferers in the unscreened group and an apparent paradox could later appear: unchecked disease would be commoner in the screened population than the unscreened.

I wonder what would be the public's reaction to such statistics in terms of their faith in screening services?

Is this another twist in the 'health screening can damage your health' debate?

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Sick doctors

Sir,

I am sorry that Dr Ruth Chambers, the writer of your editorial on the health of general practitioners (May *Journal*, p.179), dismissed the National Counselling Service for Sick Doctors as 'at best ... only a crisis intervention service'.

Since the service began in 1985 we have been able to offer help to over 400 colleagues many of whom have themselves taken the initative in contacting us. Sick general practitioners are put in touch in the first instance with one of 60 or so national advisers (many of them nominated by your own College). Where necessary the advisers can call up specialist help through the service.

Many of the problems which present arise from chronic disorders, for example alcohol dependence, depression and other psychiatric ailments which may need intensive and prolonged treatment.

As Dr Chambers rightly points out, doctors are diffident at the idea of consulting local colleagues. One of the strengths of the service is that it can readily provide help from outside the sick doctor's own patch.

Further information may be obtained by writing to me or by phoning our 'hotline' number 01-580 3160.

KEN RAWNSLEY

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