Doctors and pharmacists — working together

THERE are just over 10 000 general practices in the United Kingdom and nearly 13 000 community pharmacies. About a million people see their general practitioner every day and more than six million visits are made to community pharmacies. As about 50% of consultations result in a prescription being issued we can deduce that every day at least half a million patients are seen by a general practitioner and a pharmacist in relation to the same problem. One would have thought that with this degree of shared activity pharmacists and doctors would work closely together as part of the same team. In fact they do not do so, and in cities, in particular, communication is particularly poor.

Should this be of concern to us? There are several reasons why the answer to this question must be yes. First, doctors are often much less accessible to the public than pharmacists. Therefore, when patients require symptomatic relief it is often easier for them to ask for help at the pharmacy than to make an appointment at the surgery. But this is not always appropriate and serious disease can manifest itself initially as minor symptoms. The joint statement by the British Medical Association and the Pharmaceutical Society of Great Britain produced in 1979[1] was a helpful document but it is no substitute for a continuing dialogue on a local basis between colleagues. This dialogue is seen as important when doctors and pharmacists actually meet[2] but more local initiatives are needed.

Secondly, pharmacists are increasingly involving themselves in screening activities. Guidelines for both blood pressure measurement and blood cholesterol level measurement have been published by the Royal Pharmaceutical Society.[3,4] Again these are helpful but are no substitute for local agreements between pharmacists and general practitioners about what should be said and done so that the message received by the public is clear and unequivocal. The underdiagnosis of non-insulin dependent diabetes in the elderly might also be worth attention and the emergence of new screening activities increases the need for us to work together.

For some years pharmacists have stressed the value of their joining the 'yellow card' reporting system to the Committee on Safety of Medicines. The Committee has so far rejected the idea, mainly because of difficulties in analysis. Yet, undoubtedly, patients do complain to pharmacists of symptoms that might be associated with medicines they are taking. A new approach to this problem is described in a paper appearing in this issue of the *Journal*.[5] A notification card was used by pharmacists to communicate with general practitioners. This was welcomed by both pharmacists and general practitioners; patients who were advised to see their general practitioners did so; and a number of potential adverse reactions were identified.

Perhaps the most important reason for doctors and pharmacists to work together concerns the increasing complexity of modern prescribing. As pressure grows on us to monitor the cost effectiveness of prescribing as well as safety a wider range of information systems has been introduced. The *British national formulary* and *Drug and Therapeutics Bulletin* are received by doctors working in general practice and the hospital service. In addition, general practitioners receive PACT (prescribing analyses and cost) and now MeRC (Medicines Resource Centre) information. The one resource available to hospital doctors only is a pharmacist working as a drug information officer. The Nuffield report on pharmacy[6] advocated such a role for community pharmacists. Most community pharmacists would not have access to all the information needed for such an advisory service, apart from information on areas such as cost, packaging and formulation. However, it is certainly time that general practitioners had such a resource readily available and were encouraged to use it. Whether it should be a service provided by the district health authorities or the community pharmacy service is unclear but it adds the most compelling reason for our two professions to work together at a local level.

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Under new management: business as usual

THIS year sees the end of an era for the *Journal*. Dr Graham Buckley, who was only the fourth editor in its 32 year history, has now retired after eight years. These were years in which the reputation of the *Journal* in this country has continued to grow. I think few people would disagree that the standard of the papers published in the *Journal* has visibly improved. This can be measured in terms of the greater competition for a place in the pages of the *Journal* and in the increase in citations in the *Science Citation Index*. The international profile of the *Journal* has also grown with more family doctors overseas subscribing to it and becoming involved in the refereeing of articles. During these years, Graham Buckley has jealously guarded his editorial freedom and by initiating the change of title has helped to signal this independence to the world. His dedication to continuing the *Journal's* principal purpose of publishing original research has helped to consolidate its reputation as one of the foremost academic journals of general practice in the world.

The *Journal* staff who have worked with Graham Buckley have admired him for his patient and gentle style and have found him a popular, conscientious and supportive leader of the team. Authors have found him constructive in his criticism, sustaining, helpful, and prepared to reconsider a decision when new insight was offered. Colleagues have found him steadfast, open to new ideas and always diplomatic and conciliatory in conflict. Graham is now embarking on a new research programme on management and I am certain that some of this work will eventually appear on the pages of the *Journal*. We wish him well in his new endeavours.