

treated her swollen, red, inflamed fingers with an application of 'red nettles, which are better than green ones'. Could their pain relief have been a result of an acupuncture-like effect or caused by a chemical in the nettle? I should be interested to hear from any other general practitioners who have heard of similar cases where arthritic pain has been eased by stinging nettles.

C F RANDALL

Port View Surgery
Higher Port View, Saltash
Cornwall PL12 4BU

Diabetic patients' recommendations for better care

Sir,
It is always enlightening for doctors to hear a frank opinion of what patients think of the service they are providing. In 1993 at a conference of voluntary groups of the British Diabetic Association, some 300 people with diabetes and their carers discussed the motion 'Doctors do not understand what it is like to live with diabetes'. Strong feelings were expressed and helpful recommendations made as to how the service could be improved.

Lack of understanding of the enormous emotional and psychological effects of the condition on both patients and carers, an impression of not trusting patients to manage their own diabetes, and intimidation were common perceptions. Worst of all, perhaps, was the impression that often doctors appeared not to listen. Not surprisingly, these perceptions diminished patients' confidence in the clinician.

However, there was an understanding that for doctors, diabetes care was often only a small part of their clinical work and that it was unreasonable to expect priority for people with diabetes over other patients. People also accepted that individual patients' reactions differed, making it harder for doctors to understand each person's unique needs. Happily, some people reported that their doctors did respond to patients as people rather than cases.

On the organizational side, lack of continuity of care was reported, and a failure to involve family members in the care programme was seen to be a major failing. There were worries that the introduction of mini-clinics might outstrip the availability of general practitioners and nurses with skills in diabetes care, and there was unease that some general practitioners might be influenced by financial considerations to under-refer.

Specialist nurses and practice nurses were generally seen to be beneficial. They were more likely to have greater understanding and sympathy than doctors, but questions were raised about the quality of their training. It was strongly felt that practice nurses and 'ordinary' ward nurses needed to be appropriately trained before working with diabetic patients, and that reception staff would benefit from basic training to enable them to help in emergency diabetic situations.

Better training in 'people skills' was seen to be important, especially as people with diabetes needed to be given information on how to take on the considerable responsibility of their own care. Not surprisingly it was thought that the ideal professional carer really needed to have experienced the condition to understand fully about living with diabetes.

The conference agreed to ask the British Diabetic Association to help improve communications and relationships between doctors and their patients and carers in order to achieve good care for all people with diabetes. The following suggestions were made:

- use of a checklist for patients and doctors to ensure essential aspects of care are covered in the consultation;
- doctors to involve carers more;
- guidelines needed for good care;
- doctors to be informed of the advice in the British Diabetic Association 1992 leaflet *Diabetes care, what you should expect*;
- doctors to be involved with local British Diabetic Association branches;
- training for doctors and support staff in the emotional and psychological aspects of diabetes;
- appointment of more diabetes specialist nurses and better training in diabetes care for nurses caring for patients admitted to hospital;
- general practitioner mini-clinics to be set up only after practices have received all necessary training.

TREVOR GUPPY

MICHAEL HALL

British Diabetic Association
10 Queen Anne Street
London W1M 0BD

Community pharmacy

Sir,
Separating prescribing and dispensing is claimed by various ministers of health or their civil service staff to ensure that the skills of doctors and pharmacists are used to best effect. This is no longer a sustainable proposition. Fresh, consumer-sensitive, risk-reducing and cost-effective solu-

tions are overdue. One thousand million pounds could be released by the integration of pharmacy skills into general practice.

In 1993-94, £747 million will be spent on pharmacy services (Baroness Cumberlege, House of Lords written answer to a parliamentary question, 21 October 1993). 'Pharmacy distribution of medicines costs up to 30-40% of the total medicines bill. Should the public really be paying this amount?' (Parr C, address to the annual meeting of the College of Pharmacy, 1992). Subsidizing over 12 000 pharmacies through National Health Service dispensing is inappropriate; NHS dispensing can be better organized for the convenience of patients, and the funds redistributed.

Two surveys, the first reported by Parr in his address to the annual meeting of the College of Pharmacy in 1992, and the second a National Opinion Polls survey undertaken in 1994, show that 95% and 52% of patients, respectively, want their prescriptions dispensed at the surgery; only 6% currently enjoy this.¹ It appears there is a major unaccommodated preference.

Pharmacist supervision of dispensing is hardly needed.² The Nuffield report observes: 'The dispensing of many prescriptions could be shown... not to have required the personal attention of a pharmacist.'¹

NHS dispensing should be provided in general practice by technicians. Primary care pharmacists as partners (perhaps one between six to 10 general practitioners) would bring the profession properly into integrated primary care, facilitating a one-stop service, maintenance of surgery dispensary standards, audit, interprofessional communication, adverse drug reaction reporting, postmarketing surveillance, formulary creation and maintenance, and budget management.

These changes would reduce costs dramatically. Primary care pharmacy's salary bill (where an annual salary of £30 000 is assumed) would be between £105 million and £150 million compared with current spending of £747 million, suggesting annual savings of up to £642 million. High street pharmacies should be given a separate complementary role outside the public sector.

The £425 million savings identified by the Audit Commission³ could be equalled or exceeded by closer cooperation between pharmacist and general practitioner. The total potential annual savings realizable by adopting the strategy outlined here could exceed £1000 million.

It is demonstrably untrue that restricting dispensing to pharmacies is best for the