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 solutions 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 Commission[3] 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

patient, professions or public purse. It conspicuously fails to make optimal use of the skills of the professions while costing a staggering sum. The benefits which pharmacy can contribute to the prescribing/dispensing sequence are not dependent upon their being provided by a separate contractor.

Lastly, quality assurance and risk management are both hazarded by dispersing an intrinsically unitary process through time, place and unconnected agencies.

STEVEN FORD

Five Stones
Heugh House Lane, Haydon Bridge
Northumberland NE47 6HJ

References

1. Clucas K. *Pharmacy: a report to the Nuffield Foundation,* London: Nuffield Foundation, 1986.
2. Brown P. Are pharmacists necessary? *Scrip* 1994; May: 3-4.
3. Audit Commission. *A prescription for improvement.* London: HMSO, 1994.

Leicester assessment package

Sir,
In their paper exploring the face validity of the Leicester assessment package. Fraser, McKinley and Mulholland use an established but misleading ploy in seeking the views of course organizers: they ask the question 'Do you agree with us?', rather than 'What are your views about what should be assessed and how?'.[1]

Who could possibly disagree with the importance of the criteria listed? However, while agreeing that assessment should form an important part of teaching, I am not sure that the Leicester assessment package represents anything other than a refinement of tools we already possess. These tools may be valid, but they often miss the point.

To ascertain, for example, whether the trainee really has considered 'physical, social and psychological factors, as appropriate' one would need to study their thought processes as well as their behaviour as observed on a videorecording. This seems to be what Neighbour is telling us in *The inner apprentice*, but is something that the medical profession as a whole has not yet addressed.[2]

However, other professions have. In his book *Educating the reflective practitioner* Schon explores at length techniques of teaching that involve assessing how and what trainees are thinking, as well as their behaviour and the outcome.[3] The process of supervision as described by Hawkins and Shohet provides a structure in which to explore cognition as well as action and end product.[4]

In these frameworks for teaching, far from being something one does at specified intervals, assessment becomes an integral part of the teaching process, and all the more valuable for that. Perhaps this is something that the profession as a whole, as well as trainers, should consider.

G A RUTT

42 Heaton Road
Newcastle upon Tyne NE6 1SE

References

1. Fraser RC, McKinley RK, Mulholland H. Consultation competence in general practice: establishing the face validity of prioritized criteria in the Leicester assessment package. *Br J Gen Pract* 1994; **44:** 109-113.
2. Neighbour R. *The inner apprentice.* London: Kluwer, 1992.
3. Schon DA. *Educating the reflective practitioner.* San Francisco, CA: Jossey-Bass, 1986.
4. Hawkins P, Shohet R. *Supervision in the helping professions.* Milton Keynes: Open University Press, 1989.

Sir,
We read with interest the paper by Fraser and colleagues on the reliability of the Leicester assessment package (July *Journal,* p.293). The statistical analysis was elegant but we believe that the concentration on internal consistency may give a misleading impression of what the study actually demonstrated. The study showed that five out of six assessors were able to rank order five doctors with reasonable consistency. The subjects concerned ranged from principals in general practice to a hospital doctor with no general practice experience at all. We suggest that the reliability of an assessment instrument is best assessed by testing it in the context in which it is intended to be used. We are therefore puzzled as to why the authors chose to use subjects of varying experience, thereby introducing a possible confounding variable, whereas in real life the subjects would have similar experience and the assessment process would be used to identify varying competence.

We are also puzzled by the authors' statement that the system can be recommended for use in summative assessment. The essence of a summative assessment process is that it sets out to identify a minimum standard of competence. The Leicester assessment package produces a score which could certainly be used to rank order candidates but the authors do not offer any suggestions as to what score in the package would equate to minimal acceptable competence. If the system relies on rank ordering which would inevitably result in failing a fixed percentage of candidates it is unlikely to be acceptable to a large body of general practice opinion.

L M CAMPBELL
T STUART MURRAY

West of Scotland Committee for Postgraduate Medical Education
University of Glasgow
Glasgow G12 8QQ

Treatment of drug misusers

Sir,
Michael Taylor states that our research work on the treatment of drug misusers[1] 'undermined rather than supported traditional patterns of general practitioner behaviour' and that the inception of new community drug teams served to 'undermine general practitioners' confidence at the very time this piece of research was taking place' (letter, April *Journal,* p.186). Far from disagreeing with such critical comments, we regarded this phenomenon as of such importance that we reported on this inadvertent counter-productive effect in our paper. Such damning criticism should not be dismissed, however disappointing the findings may be.

Research can indeed change that which it purports to be studying, usually through the wider impact of the introduction of a new study condition or the new mechanisms required to collect data. However, in our research it seems reasonable to presume that it was the new community drug teams and their regional structure (and not the evaluation by the university research team) that caused any such effect (only one member of the research team was actively involved in the introduction of the new system of drug services). Artefactual reduced activity may certainly occur as a result of the tail-off phenomenon,[2] which could indeed account for any reduced return of data-gathering forms, as Taylor suggests. However, this fails to acknowledge that the reduced level of activity (as reported in our paper) was also evident in face-to-face interviews with general practitioners.

Finally Taylor makes the important observation that the caseload per worker of his local community drug team is little more than his own individual caseload in his single-handed practice. We have previously reported[3,4] on the significantly higher activity levels of community drug teams with inbuilt medical care and we share Taylor's concern that such new teams can often fail to mobilize local provision, such as Taylor's own activity, and may instead recreate a specialist at the local level. When such a development occurs, then a new approach designed to enable general practitioners to take a more active role, for example through shared-