Letters

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Adverse drug reactions: a potential role for pharmacists

I read the editorial by Howe that mentioned the risk to patient safety of medication reconciliation errors between hospitals and general practices.[1] During my placements in hospitals, I noticed one of the most frequent errors is patients' adverse drug reactions (ADR) not being properly documented. Patients are sometimes mistakenly given medications which had caused ADR in the past. It has been suggested that closer collaboration between doctors and pharmacists in primary care prevent ADR.[2] In Oceania, data showed that patients' charts reviewed by pharmacists were less likely to have inadequate documentations of ADR (13.5% versus 29.4%; $P<0.001$).[3]

Being an ex-pharmacist and now a medical doctor, I conducted a study that investigated how many ADRs were missed or incompletely documented in the admission medical notes in New Cross Hospital, Wolverhampton. From September to November 2013, I interviewed 109 consecutive adult inpatients, who were alert and oriented with Glasgow Coma Scale score of 15 (Table 1). Participants were interviewed using a list of questions adapted from a previously published questionnaire.[4] Participants were asked to list any drugs they could not tolerate and describe the nature of reactions. The collected information was compared with the ADR history in the admission notes documented by doctors. Only reactions listed in standard texts (*British National Formulary* and Lexi-Comp®) are regarded as likely reactions.

Table 1. Patient demographics[a]

	n	%
Male patients	57	52.3
Female patients	52	47.7
General ward	23	21.1
Cardiology/stroke ward	16	14.7
Gastroenterology ward	9	8.3
Endocrinology ward	12	11.0
Respiratory ward	31	28.4
Renal ward	18	16.5

[a]*Mean age (standard deviation) 66 (16.4) years*

Fifty-two of the 109 patients (47.7%) reported an ADR to at least one drug. ADR documentation was inadequate in 39 patient notes (35.8%): absent in 20 and without the nature of the reaction in 19. The result in the current study was comparable to the 29.4% of inadequate ADR documentations when pharmacists were not involved found in the Oceanian study.[3] These suggest that pharmacist involvement in drug history-taking and ADR assessment can potentially reduce medication errors. This hypothesis needs to be validated with prospective studies and should include pharmacist involvement and better education in therapeutics and in communication skills. Having more pharmacist involvement in hospital and primary care could improve medication reconciliation.

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Evidence-based medicine and dementia

Claire Hilton describes how NHS policy in the current dementia crusade could distort good clinical practice.[1] I think the departure from evidence-based medicine is even greater than she suggests.

Case finding for dementia was introduced when there was no evidence (beyond anecdotes) that it was beneficial. We have known for a decade that screening for memory loss identifies less than one in five of those who will subsequently develop dementia syndrome.[2] We now have evidence that early psychosocial intervention has no effect on relocation to a care home, patient wellbeing, disease progression, dementia-related symptoms, or caregiver wellbeing.[3]

We have no evidence that memory clinics are the best way to reach diagnoses[4] and grounds for thinking that their resources might be better used to manage dementia's behavioural and psychological symptoms. We do not know that earlier recognition and intervention is harmless,[4] and there seems little interest in finding out. We might be concerned that dementia now overshadows other problems of ageing, like depression and frailty.

We do know that the incidence and prevalence of dementia syndrome appear to be declining in many countries, including Britain,[5] Germany, Spain, Sweden, the Netherlands, and the US.[6] This may mean that prevention of cardiovascular disease is having an effect on brains. GPs' performance in recognising dementia may be under-estimated because of over-estimation of prevalence.

We have seen how poorly-evaluated, short-term projects to provide support or signposting have burgeoned and then disappeared; the familiar NHS disorder of 'multiple projectitis'. And we also know that drug development has failed for a generation, with no symptom modifiers better than cholinesterase inhibitors, no disease modifiers at all, and no prospect of a 'cure' despite lots of 'promising' studies. We do not appear to understand the underlying pathological processes, have over-valued protein unfolding and deposition, and have undervalued the role of neuroprotection pathways.[7]

The Dementia crusade has been endorsed by politicians, particularly the Prime Minister. This has allegedly brought rising 'awareness' of dementia, and has yielded benefits for professionals and charities. Its effects on those with dementia are less clearly visible.

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Competing interests

Member of the Alzheimer's Society; member of the NICE/SCIE Dementia clinical guidelines development