10 visits over the period, but 20 (1·2%) requested more than 40. Of particular interest, however, are the pairings of certain consultants and general practitioners responsible for more than 12 visits over the period; moreover, several of the individual consultants and general practitioners had similar pairings with more than one person. Unfortunately we are not told anything about the pairers. It would have been interesting to know whether the particular consultants and general practitioners had other associations—for example, through clinical assistantships. A fruitful course of inquiry, made easier by the incorporation of family health services authorities under the umbrella of regional health authorities, might be to visit the general practitioners and establish the reasons for their high request rates.

The recent review by Wilkin and Dornan of general practitioners' referrals has shown how little we understand about the right level of service.[6] The same applies to domiciliary visits, which began with a clear purpose and whose use and value have changed over time. Many general practitioners still seem to think that a "home assessment" is best obtained by asking for a domiciliary visit; others that they have to request a visit to secure a patient's admission. Both views are wrong, but hospitals could do more to make their admission policies explicit. There are now enough examples, particularly in the care of elderly patients, of how a clear statement of what a hospital will and will not do can break down the barriers preventing admission (and discharge). Similarly, general practitioner fundholders will have an influence on domiciliary visits. They will now have a specific budget which will include this service, and when they do request a visit they should be more discriminating because they will have to pay for it. Many potential fundholders are already suggesting that consultants should hold outpatient clinics within their practices. If such clinics are regular and frequent domiciliary visits might be done on the same day, with the general practitioner in attendance, now an uncommon feature of domiciliary visits.

There are also contrary pressures that might stem the downward trend of domiciliary visits: the increased emphasis on day care, shared care, and care in the community and calls on the service from other members of the primary care team, such as social workers. Dowie's interviews with 45 doctors in one district identified several good reasons why general practitioners requested domiciliary visits.[7] These include advising on the management or palliative care of a terminally ill patient who wants to die at home. Another example would be to advise on severe acute back pain, where a consultant's opinion might reassure the patient, relatives, and primary care team. The fact that domiciliary visits do seem to have a place, albeit a limited one, suggests that future studies should concentrate not simply on the minority of consultants who do many visits but on the majority who do only a few, to identify the problems for which they think a domiciliary visit is a good use of everyone's time.

MALCOLM FORSYTHE

Director,
Institute of Public Health,
Tunbridge Wells TN3 0TG

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Extending the role of the community pharmacist

Depends on extending training and regulation

The professional role of the community pharmacist has been largely concerned with preparing and dispensing prescriptions. As a consequence, pharmacists' training has been biased towards pharmacology, pharmaceutics, and pharmaceutical chemistry. Yet, despite the good service pharmacists have given the public, the increasing availability of finished pharmaceutical products from the drug industry and the trend to original pack dispensing have severely constrained the traditional activities of community pharmacists. Over the past few years pharmacists generally have been debating the direction their profession should take.[1-3] The so called "extended" role of the community pharmacist broadly encompasses three activities.

Firstly, pharmacists want to develop their dispensing services.[3] They wish to offer better and more regular advice to patients on how to use prescribed medicines. They see benefits to patients in developing domiciliary services, especially collecting and delivering prescriptions for elderly, mentally ill, and physically disabled patients.[4] They also believe that they could ease some of the burdens, for both the patient and the prescribing doctor, of obtaining repeat prescriptions.[3 5] These activities (which already form part of the conventional work of the pharmacist) seem eminently desirable and should have the support of doctors.

Secondly, at least some pharmacists want to develop diagnostic services. These include growth velocity measurements in children, routine urine and pregnancy testing, and screening for hypertension and hypercholesterolaemia.[2 6 7] There is no absolute reason why pharmacists should not engage in such activities provided that they carry them out in an efficient and well regulated manner and with the support of general practitioners. Whether such activities would, however, have any impact on public health is uncertain, though they might.[6] Consequently, although further carefully designed pilot schemes should be encouraged, it would be premature for community pharmacists to offer these routine diagnostic services.

Thirdly, community pharmacists wish to pursue their advisory role in health care, and, particularly, in treating minor self limiting conditions. Such activities are, of course, not recent: pharmacists have been giving therapeutic advice for many centuries. Moreover, as there is a specific class of drugs that only pharmacists can provide (as opposed to general retail outlets) it is inevitable that consumers will seek advice on their purchase. Community pharmacists are also available to the public throughout the working day with no appointments, no receptionists, and no direct charges. They are therefore readily available to provide advice on health care, and there is clear evidence that they offer a service that many general practitioners and consumers both value[8-11] and

use.[12] Nevertheless, there are grounds for concern about the quality of advice offered. Reliable studies tell a consistent story: although there is a wide range, traditional symptomatic treatment at pharmacies is too often inadequate; pharmacists are too often unable to identify symptoms that require referral to a doctor; and too much of the advice is given by counter assistants rather than by qualified pharmacists.[13 14] The findings of Goodburn and others (p 440) are therefore broadly (and disappointingly) in line with the results of previous work.[15]

Although the Royal Pharmaceutical Society is clearly concerned about the competence of community pharmacists, it is time to be rather more robust about improving standards of these aspects of pharmacy practice.[16 17] Practical therapeutics is being gradually introduced into the undergraduate pharmacy curriculum,[17] but is this enough? Is it sensible to allow newly registered pharmacists to practise in the community, entirely unsupervised, without any further training? What steps will the profession take to ensure the quality of the service its members deliver? And, finally, if much of the advice given in pharmacies is to be provided by counter assistants should not they themselves be trained?

That there is an extended role for the community pharmacist is accepted by the government and many other bodies, as well as the pharmaceutical profession itself.[3] The profession's leaders have a considerable responsibility, however, in ensuring that the potential is fulfilled.

MICHAEL D RAWLINS

Professor of Clinical Pharmacology,
Wolfson Unit of Clinical Pharmacology,
The University,
Newcastle upon Tyne NE1 7RU

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Immediate reporting of fine needle aspiration of breast lesions

Needs an experienced aspirator and breast cytopathologist at hand

Although widely practised elsewhere, fine needle aspiration of breast lesions with immediate reporting of cytological findings has been slow to catch on in Britain.[1-3] Immediate reporting has several advantages. Unsatisfactory aspirates may be repeated immediately—thereby increasing diagnostic yield—and discussion of the diagnosis is possible with the patient on her first visit. Importantly, immediate reporting of the cytological findings does not seem to reduce the accuracy of the technique.[1-3] The obvious disadvantage is that a technician and an experienced cytopathologist have to be available to stain and report the findings.

Immediate reporting of fine needle aspiration need not be restricted to palpable lesions. Stereotactic fine needle aspiration of non-palpable mammographic abnormalities is now widely practised, and results are improving.[4 5] The advantage of having immediate reporting available is that multiple passes through such lesions—usually required to obtain a diagnosis—may be kept to a minimum if a cytopathologist is able to inspect the material aspirated on each pass. The fewer the number of passes, the less the discomfort of the procedure.

Why is "best practice" not the rule in Britain? The main reason is that in countries that provide fine needle aspiration with immediate reporting cytopathologists usually perform the aspiration, report the results, and inform the patient of the diagnosis.[6] In Britain, surgeons mostly aspirate breast lumps in their outpatient clinic. Unless a technician and a cytopathologist are on hand the report is usually not available for 24-48 hours.

The technique does not have a sensitivity of 100%,[1 3 6 7] and to ensure that breast cancers are not missed fine needle aspiration and cytological examination should be combined with clinical examination by an experienced clinician and, in women over 35 years, by mammography reported by an experienced radiologist.[7] Mammography should be performed before fine needle aspiration as haematomas may produce mammographic appearances resembling those of breast carcinoma.[8] Mammography is also considerably more painful when performed after fine needle aspiration. Not having the reported mammograms available when fine needle aspiration is performed means that some patients with impalpable suspicious mammographic lesions will be inappropriately reassured.

Currently, many busy surgical outpatient clinics need to defer discussion of the diagnosis and its implications for the 36-48 hours it takes to obtain the results of cytology, the delay resulting in needless anxiety for patients whose lesions are eventually found to be benign. With immediate reporting of cytological specimens patients with benign aspirates and no clinical or mammographic suspicion of malignancy may be reassured and an unnecessary biopsy avoided.[3] Often patients can be discharged after their first visit. Being able to offer immediate reassurance to patients with benign disease referred from screening centres should minimise the psychiatric morbidity from screening.[9]

In Scandinavia fine needle aspiration of breast lesions is performed and reported by experienced staff.[4-6] Studies from Britain have shown clearly that the technique depends on the aspirator and that results improve with experience.[7 10 11] Fine needle aspiration with immediate reporting should therefore be practised only in centres where experienced aspirators and experienced breast cytopathologists are available.

J MICHAEL DIXON
Senior Lecturer in Surgery

University Department of Surgery,
Royal Infirmary of Edinburgh,
Edinburgh EH3 9YW

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