abroad (MASTA) with the object of establishing a national network of British Airways travel clinics. Each clinic is able to offer a full range of advice. There is also a retail service for medical accessories for the travellers. The clinics are directly linked by computer to the London School of Hygiene and Tropical Medicine and up to the minute information is therefore available concerning vaccinations and health information in all parts of the world.

Patients may obtain the address and telephone number of the nearest clinic by ringing 01-831 5333. Telephone advice is not available and patients should make an appointment at their nearest clinic.

CAMERON LOCKIE

Green Lane, Alveston
Stratford upon Avon CV37 7QD

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Palliative care: home or hospice?

Sir,

In her editorial (January *Journal,* p.2) Finlay looked at the emergence of palliative medicine as a specialty and how best the profession should prepare doctors entering the field. She placed the emphasis on experience in general practice, where the hospice is seen to provide 'a bridge between community and hospital'. I would like to comment not on the training, but on the general issues concerning the evolution of a specialty which should enable multidisciplinary care in the community to be led by the doctor who is in an ideal situation to do so — the general practitioner.

For too long death has been 'medicalized', doctors having taken over what was the job of clergymen in Victorian times, thus largely protecting the public from death. When caring for the dying we can become engrossed in the science of symptom control, neglecting the other essential factors necessary for good care, particularly communication. Failure here reveals our inadequacy in the face of death and without an open and honest approach the patient is sent away from home where he may prefer to be if he knew what was wrong and what prognosis he had. Unnecessary hospital admissions, which drain hospital beds, could be avoided with benefit to the patients and to their quality of life. It is the general practitioner who usually knows the patient and his family best and therefore is likely to have the best rapport with them. He should use this to his advantage, reversing the trend for death to be hidden in hospitals, and helping death to be once again a 'family affair'.

General practitioners should not be perturbed by the evolution of this new specialty, but stimulated to fulfil their role as family doctors from birth to death, allowing their patients to die peacefully and with dignity, without hospice care unless it is required.

The aim of developing palliative care then should be not so much to encourage an increase in the number of hospices, as to promote a specialty enabling community care by the general practitioner at home. The essence of the problem is not so much the need for a specialist with a place where he can care for the dying but coordination of a multidisciplinary team[2] with the general practitioner as leader.

It is important that the new specialty aims to improve general practitioner care for dying patients at home through research and education, thus attempting to avoid care in an institution. This does not mean that there needs to be evidence of certified experience for general practitioners in the field or the gaining of yet another diploma; but recognition that, as Pugsley describes,[3] there are many who can advise the general practitioner in this role, but none who can perform the task better or with a greater insight into the patient and his family.

The hospice movement is of course essential and to be highly commended. Its main role should be advisory, for education and research and to help in the management of difficult cases.

RODGER C. CHARLTON

Criffel
Dalbury Lees
Derbyshire DE6 5BE

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GPs should not counsel long-term

Sir,

As a general practitioner who is also a trained counsellor, I was most interested by Rowland and colleagues' discussion paper (March *Journal,* p.118).

I have recently been reviewing my work as a general practitioner in the context of the doctor–patient relationship and the client–counsellor relationship and have concluded that it is both difficult and inappropriate for a general practitioner to have a long-term counselling relationship with a patient. Seeing someone for more than one or two counselling sessions outside normal surgery hours fundamentally alters the doctor–patient relationship and it may not be possible for the patient to allow the general practitioner counsellor to continue in the general practitioner role. This conclusion is supported by Kelleher[1] who feels that the general practitioner counsellor may overstep the boundaries of the doctor–patient relationship and confuse the patient.

My answer to the question 'Can general practitioners counsel?' is in two parts. First, counselling skills are an essential tool in the repertoire of all general practitioners for routine work and for short term counselling interventions. These skills need to be taught to doctors at all levels in their training, particularly in the light of the suggestion that 'prescribing anxiolytic drugs (is) no more effective than brief counselling by the general practitioner in treating new episodes of minor affective disorder'.[2] Secondly, longer term counselling is best undertaken with clear personal boundaries in a confidential and anonymous relationship by a 'secure frame'[1] counsellor who lives away from the locality, is not involved in a long term (often literally a lifetime) relationship with the client and who does not allow the counselling process to be compromised by any other relationship.

S.H. COCKSEDGE

The Health Centre
Chapel-en-le-Frith
Derbyshire SK12 6LT

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Importance of legible prescriptions

Sir,

The serious consequences of negligently writing medical prescriptions have been re-emphasized by the court of appeal in the recent case of Prendergast versus Sam and Dee Limited and others. Dr Stuart Miller had written a prescription for Mr

Prendergast, who was asthmatic with a chest infection, prescribing three Ventolin inhalers (salbutamol, Allen and Hanburys), 250 Phyllocontin tablets (aminophylline, Napp) and 21 Amoxil tablets (amoxycillin, Bencard).

Mr Prendergast took the prescription to the pharmacy of Sam and Dee Limited, where it was dispensed by a pharmacist, Mr Peter Kozary. Mr Kozary dispensed the Phyllocontin and the inhalers correctly, but instead of Amoxil he dispensed Daonil (glibenclamide, Hoechst), a drug used for diabetes to reduce the sugar content in the body. Mr Prendergast was not a diabetic and as a result of taking a large dosage of Daonil suffered permanent brain damage.

In the high court, Mr Justice Auld indicated that a doctor owed a duty of care to a patient to write a prescription clearly and with sufficient legibility to allow for possible mistakes by a busy pharmacist who might be distracted. Having established that in his opinion the word Amoxil on the prescription could have been read as Daonil, Dr Miller had been in breach of his duty to write clearly and had been negligent. Such liability could not be excused by the argument that there had been sufficient information on the prescription to put Mr Kozary on his guard. Dr Miller's negligence had contributed to the negligence of Mr Kozary, although the greater proportion of the responsibility (75%) lay with Mr Kozary.

On appeal, counsel for Dr Miller argued that the word on the prescription standing on its own could reasonably have been read incorrectly. However, various other aspects of the prescription should have allerted Mr Kozary to the fact that something was wrong. The strength prescribed was appropriate for Amoxil but not for Daonil; the prescription was for Amoxil to be taken three times a day while Daonil was usually taken once a day; the prescription was for only seven days' treatment which was unlikely for Daonil; Ventolin and Phyllocontin were well known treatments for asthma and it would have been unusual to have diabetes and asthma treatments on one prescription and finally, all prescriptions of drugs for diabetes were free under the National Health Service but Mr Prendergast did not claim free treatment for the drug. All of these factors should have raised doubt in the mind of Mr Kozary and as a result he should have contacted Dr Miller. Therefore, the chain of causation from Dr Miller's bad handwriting to the eventual injury was broken.

Lord Justice Dillon rejected this argument in the court of appeal. First, it was no defence to Dr Miller to rely on the already established negligence of Mr Kozary when he himself had been in breach of his own duty of care to write clearly and had been negligent. Secondly, those other factors were not enough to make it beyond reasonable foreseeability that Daonil would be prescribed. Therefore, the chain of causation had not been broken.

The implications of this decision are that doctors are under a legal duty of care to write clearly, that is with sufficient legibility to allow for mistakes by others. When illegible handwriting results in a breach of that duty causing personal injury, then the courts will be prepared to punish the careless by awarding sufficient damages. Liability does not end when the prescription leaves the doctor's surgery, even if the doctor has been grossly negligent. It may also extend into and be a cause of the negligence of others.

KENNETH MULLAN

Department of Public Administration
and Legal Studies
University of Ulster
Jordanstown
Northern Ireland

The community pharmacist

Sir,

The recent exchanges in the *Journal* on the subject of dispensing and the role of pharmacists in primary care has been illuminating as much for what was not said as for what was.

Rural practice is being given an extremely hard time by pharmacy and pharmacy is being given an almost equally hard time by government. While there are honourable exceptions, the predominant motivation for the pharmacy is money, in exactly the same way as for any other retail shopkeeper. The rural practitioner is not so saintly as to be wholly unmoved by money but something which non-dispensing doctors may not realize is the huge satisfaction that is to be gained from being able to do the whole job of health care provision oneself. The patient has much to gain from dispensing by the doctor, and is acutely aware of it, as may be witnessed by the number of letters that our MP received when this practice was threatened, over 700. The sadness of the fraught atmosphere over dispensing is that patients, if given a free choice, would probably opt to have both a dispensing doctor and a local pharmacist. For the moment at least this is not likely to come about and, in consequence, everyone loses.

The paper by Taylor and Harding (May *Journal,* p.209) is riven with inconsistencies and *non sequiturs.* The sharing of responsibility in the 1982 case cited appears not to have profited the victim. With respect to another case, I venture to suggest that most doctors would not dispense 250 mg of Daonil (Hoechst) tds. A computer would not let such items through.

Compliance with prescribed treatment is hindered by the physically remote dispensing process which is imposed on the majority of clients. Why else would such an enormous proportion of prescriptions written fail to be dispensed?

Taylor and Harding are on much firmer ground when they speak of 'a ready source of drug information' and of pharmacists being well placed to deal with minor ailments. With respect to the latter, how much better placed they would be if they were able to sell more truly effective items and how much better served the public would be if pharmacy were not cocooned by resale price maintenance. However, to state in the journal serving the leading edge of primary care physicians of the UK that 'Pharmacists are the only health professionals to whom there is quick and easy access without a prior appointment and who are willing and able to advise patients on minor health complaints as well as on health education' seems recklessly undiplomatic.

Professor Salkind (letters, May *Journal,* p.214) takes an academic's oblique view of the issue and as a consequence falls painfully astride his own conclusions. Minor ilness can often be managed without the intervention of general practitioners and even more often by no treatment at all. 'Improving the quality of personal contact with patients' is what dispensing by doctors is really all about; that is real 'lateral thinking'.

Balon, Evans and Green (letters May *Journal,* p.215) also take a tumble in their contribution. I strongly dispute the contention that retail pharmacies are commonly open for the hours described. In our own case, when threatened by a pharmacist opening in the village, we calculated that given the opening hours at his other premises there would be a loss of pharmaceutical provision to the public approaching 75%. Doctors fulfil the function of managing minor illness for 24 hours a day, 365 days per year, even bearing the responsibility for it when the actual work is done by deputies. By contrast pharmacists are only too ready to allow doctors to dispense for many hours every night, at weekends and bank holidays. Where is the commitment to patient care in unsocial hours?

There is no question whatever that pharmacy has a cornerstone role in primary care but that role is not dispens-