article was to detail flaws in one particular method of rationing that is such—namely, agism.

Lilford writes about two patients in an accident and emergency department. At triage (which this effectively is) it could be acceptable to treat the younger person, but this should not be extrapolated to become a general policy.

Lilford asks whether age should be an acceptable criterion for rationing. I have shown that the arguments for adopting agist policies are flawed. I accept that age (unlike race, for instance) may occasionally be a relevant factor in decisions about the allocation of scarce resources, but it should not be used as the sole reason for denying someone treatment. Lilford also implies that I am not offering guidelines for doctors. On the contrary, I am putting my head firmly above the parapet by saying (and backing this up with strong and convincing arguments) that agism is untenable and should not be practised.

With regard to Bill Bytheway's letter, why is referring to "elderly people" being agist? My whole article attacked agist assumptions. Bytheway writes that "all of us are affected by the introduction of rationing on grounds of age." Maybe; but, as far as I am aware, elderly people are the only group who are refused treatment as a policy.

On reflection, it would have been better for me to ask how we justify spending funds on a population that is "nearer to death" rather than on "those who are dying." I accept that another of my phrases was agist and should not have been used.

I cannot understand why Bytheway thinks that the demographic explosion that I refer to will cause problems only "if society chooses to make them so." The increasing number of elderly people will force us to question how to distribute our finite medical resources fairly. The choice that society has is how to make the distribution; my contention is that it should not be decided on the basis of age alone.

MICHAEL M RIVLIN
Research student

Department of Philosophy,
University of Leeds,
Leeds LS2 9JT

Integrating pharmacy into the primary care team

"One stop clinic" has advantages for patients

EDITOR,—We agree with Steven Ford and Kevin Jones that the policy of integrating pharmacy into the primary care team has much to recommend it.[1] Genitourinary medicine clinics have pioneered the concept of "one stop care," with on site medical, nursing, laboratory, pharmacy, counselling, psychology, and social work facilities. With the ever increasing numbers of patients with HIV infection attending, these in house services have increased to include dietetic, dental, and ophthalmic care.

Integrated pharmacies have had a key role in the provision of services in genitourinary medicine clinics from the beginning. There is a satellite dispensary in many larger clinics, staffed by a full time pharmacist, who is responsible for all prescriptions. In other smaller units prepacked drugs are dispensed direct by medical or nursing staff from an in house pharmacy, although this system is not ideal.

Integrated pharmacy has many advantages for patients, as shown by a study carried out in an HIV outpatient clinic to assess clients' experience of outpatient dispensaries versus distribution of drugs in clinics (D G Webb *et al*, scientific meeting of Medical Society for the Study of Venereal Diseases, Dublin, June 1992). Distribution based in clinics was perceived to be superior in terms of waiting time, quality of advice, availability of information leaflets, and confidentiality, and the overall satisfaction ratings for the service were high. These factors are especially important for frail, sick patients such as those with HIV infection, but they would also be appreciated by people with busy work schedules, mothers with babies, and many other groups of clients. The benefits to medical staff should not be forgotten and include help with difficult management problems, drug interactions, and drug resistance and the provision of other specialised drug information. There are some disadvantages with this system, in that small clinics and primary care surgeries may not be able to afford the service of a full time pharmacist, but this could be overcome by having a pooled pharmacist covering several small units. Integrated pharmacies have served a useful purpose in genitourinary medicine clinics for many years, and their incorporation into primary care settings should be seriously considered.

G CROWE, Senior registrar
G E FORSTER, Consultant in genitourinary medicine
C J HARRIS, senior pharmacist
B T GOH, Consultant physician
Infection and Immunity Clinical Group,
Ambrose King Centre,
Royal London Hospital,
London E1 1BB

1 Ford S, Jones K. Integrating pharmacy fully into the primary care team. *BMJ* 1995;**310**:1620-1. (24 June.)

Freedom from the dispensary is essential

EDITOR,—I was pleased to read the title of Steven Ford and Kevin Jones's editorial, "Integrating pharmacy fully into the primary care team,"[1] as I work full time in a fundholding general practice as a primary care pharmacist exactly as envisaged by Marinker and Reilly.[2] On further reading, however, I was disappointed to learn that the authors envisage just salaried dispensing pharmacists to save money on the nation's drugs bill because dispensing fees would be abandoned.

A pharmacist needs to be freed from the dispensary to achieve real integration. My present activities include domiciliary visiting and counselling of patients; running an anticoagulant clinic; audit; developing a formulary; monitoring prescribing analysis and cost (PACT) data; repeat prescribing; and answering a constant stream of queries from patients, partners, staff, community pharmacists, nursing and residential homes, etc. I could not run a dispensary as well.

As a result of my work the practice's latest PACT report shows that its costs are currently 19% and 11% below the average for the family health services authority and the national average respectively, although I like to think that the improved care that patients receive is more important.

MARIAN BRADLEY
Practice pharmacy manager

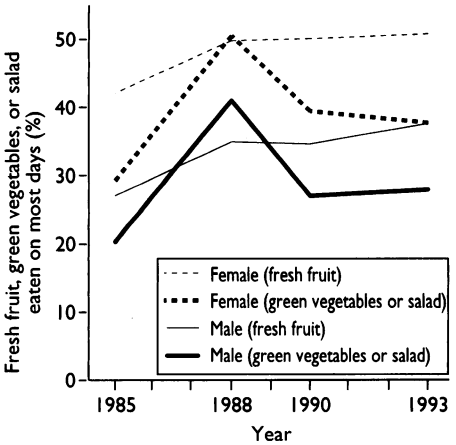
Northgate Medical Centre,
Aldridge,
Walsall WS9 8QD

1 Ford S, Jones K. Integrating pharmacy fully into the primary care team. *BMJ* 1995;**310**:1620-1. (24 June.)
2 Marinker M, Reilly P. Judging rational prescribing. In: Marinker M, ed. *Controversies in health care policies, challenges to practice.* London: BMJ Publishing, 1994:89-110.

Healthy eating in Wales

EDITOR,—Health Promotion Wales supports efforts to produce unambiguous and scientifically based advice on fruit and vegetable consumption for the public and agrees that accurate information on current intakes is needed. Carol Williams is incorrect, however, in stating that there were no national numerical goals for fruit and vegetable consumption before the Committee on Medical Aspects of Food policy published its report in 1994.[2] In Wales a population target for the consumption of green vegetables and salad was adopted in Health Promotion Wales's "health for all in Wales" strategy in 1990.[3] Furthermore, we have monitored progress towards most of our health targets through lifestyle surveys conducted every two to three years since 1985.[4]

The data from Wales support the conclusion that fruit and vegetable consumption is considerably lower than the "five a day" advice that is advocated but that we are moving in the right direction from our baseline of 1985 (figure).



Percentage of population eating fresh fruit and green vegetables or salad on most days of week (six or seven days), Wales, 1985-93.

Further progress towards achieving the dietary changes recommended in health for all in Wales, the Health of the Nation, and the Scottish diet will be achieved only by adopting a coordinated and consistent approach to nutrition messages for the public across the United Kingdom.

CHRIS TUDOR-SMITH
Director of research and development
JOHANNA CLARKSON
Senior development specialist

Health Promotion Wales,
Llanishen,
Cardiff CF4 5DZ

1 Williams C. Healthy eating: clarifying advice about fruit and vegetables. *BMJ* 1995;**310**:1453-5. (3 June.)
2 Department of Health. *Nutritional aspects of cardiovascular disease: report of the cardiovascular review group, Committee on Medical Aspects of Food Policy.* London: HMSO, 1994. (Report on health and social subjects 46.)
3 Health Promotion Authority for Wales. *Health for all in Wales. Part C. Strategic directions for the health promotion authority.* Cardiff: HPAW, 1990.
4 Health Promotion Wales. *Health-related behaviours in Wales, 1985-1993: findings from the health in Wales surveys.* Cardiff: HPW, 1994. (HPW technical reports No 8.)

Misleading meta-analysis

EDITOR,—In their response[1] to our editorial on misleading meta-analysis[2] A Perry and R Persaud state that we ignored the degree of heterogeneity among different studies. We examined the case of intravenous magnesium in acute myocardial infarction, a treatment recently shown to be of no benefit in a trial.[3] We argued that the asymmetrical funnel plot (a plot of the estimates of effect sizes against the sample size) should have alerted meta-analysts to the possible presence of bias. The erroneous conclusion that magnesium treatment represents an "effective, safe, simple and inexpensive" intervention could thus have been prevented.[4,5]

Perry and Persaud argue that, rather than funnel plots being used, a statistical test of homogeneity should be performed to help decide whether the results of meta-analysis of small trials should be