



Dear Sir,

Following publication of the preliminary results of the first European Survey [1], first presented at the first EAHP Congress of Hospital Pharmacy, we would like to ask one question related to the conclusions which the author, the ex-secretary of the EAHP Board, offers as a preliminary overview of the results.

Development of the unit-dose distribution system in Europe has only taken place relatively recently. 'The 24-unit-dose dispensing system was found to be widespread only in the Netherlands' and in very different rates in other countries — Spain reaches 57% of hospitals with 100% beds under unit-dose dispensing procedure — and this situation is influenced by three factors:

1. Market conditions
2. Staff levels
3. Efficacy of the system for preventing errors

We would argue about the relationship between these factors and the unit-dose dispensing system and propose that there is at least a fourth, and even more powerful, factor which is related to willingness of staff pharmacists.

Market conditions can be changed through dialogue. In our experience in Spain, almost 60% of drug presentations are in unit-dose form: we can obtain cooperation in obtaining this presentation if we explain to industry the security aspects of handling its products. Generally, it does not make sense to relate a low rate of unit-dose presentation to the non-existence of a large and strong market because this kind of presentation can be sold only to hospitals, and the hospital market is of very small size in relation to the total drug market in any country.

If we examine staff pharmacy, we can easily identify important differences between Europe and the United States, but we think this is also an argument for promoting unit-dose dispensing. It is true that it is a labour-intensive method of drug distribution, but it is the best way to provide individual information and individual therapeutic records. That means that short-staffed pharmacy departments will need a system for recording

therapeutic evolution of patients without the need for running all over the hospital. LDS Hospital, Salt Lake City, Utah [2] has 20 people to develop patient care, 10 of them are pharmacists, with a fully computerized working procedure. Routine activities can be automated, but it is not possible to mechanize pharmaceutical intervention and for improving that we need the patient's clinical information updated.

Finally, we really think that it is not wise to present conclusions based on one single study that makes a comparison between two procedures of drug-dispensing and their relationship with the prevention of medical errors [3].

We still defend the need for unit-dose dispensing, within patient-oriented drug distribution systems. We also would like to establish more widely the concept of close links between unit-dose dispensing and the professional improvement of hospital pharmacists. It is probably necessary to deal with our staff rates, and it is likely that the pharmaceutical industry has to help in achieving this important goal, offering more unit-dose drug presentations, but we have learnt that our future is linked with clinical information and advisory techniques, and to progress this way we need the unit-dose distribution system.

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#### **References**

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- [2] Personal Communication. Pestotnik SL, Coordinator pharmacy informatics. LDS Hospital, Salt Lake City, Utah, USA, December 1995.
- [3] Deans BS, Allan EL, Barbe ND, Barker KN. Comparison of medication errors in an American and a British Hospital. *Am J Health-Sys Pharm* 1995; **52**(15): 2543—9.