

Dear Sir,

I thank Dr Arce for her comments on the preliminary results of the first EAHP Survey of Hospital Pharmacy Services in Europe. Dr Arce is eager to defend the concept of 24-hour unit-dose dispensing, but a few points need to be made in reply.

I accept Dr Arce's statement that unit dose dispensing is also widespread practice in Spain, but I was writing only in the context of the EAHP Survey. The Spanish Society of Hospital Pharmacists did not participate in the Survey at the same time as all other countries, so there was no data available from Spain. In the Survey, 24-hour unit-dose dispensing was found to be widespread only in the Netherlands. The overall incidence of unit-dose dispensing in the Survey was 6.5%, which is very little.

Dr Arce accuses me of drawing unwise conclusions in relation to the relative safety of floor-stock dispensing and unit-dose dispensing, based on one published study. Far from drawing conclusions, I was drawing attention to a paper which challenges the conventional American belief in the 24-hour unit-dose dispensing system. [1]

More recently, McNally et al showed that in an Australian hospital, a unit-supply individual patient dispensing (USIPD) system reduced the number of medication errors compared with a ward stock system. However, to operate USIPD system it was necessary to extend pharmacy opening hours to 12 hours per day, seven days per week. Although a reduction in medication errors was reported, no attempt was made to assess the clinical significance of these errors [2].

If hospital pharmacists in Europe introduce 24-hour unit-dose dispensing, they will only do so after rigorous cost-benefit analysis. A weakness of previously published studies on error rates in various drug distribution systems has been the failure to assess what the outcomes for patients were as a result of errors. The pharmaceutical care philosophy demands that we focus on patient outcomes in our analysis of the medication use process. Drug distribution systems are no exception. The work of Deans et al shows us that we cannot necessarily accept long-held beliefs without question. The work of McNally et al indicates that considerable additional investment in pharmacist manpower will be needed to move from floor stock system to USIPD or 24-hour unit-dose distribution. If a large investment in packaging, people and automation is to be made, those who would make that investment have a responsibility to prove that the result is better, safer drug distribution.

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References

- [1] Deans BS, Allan EI, Baber ND et al. Comparison of medication errors in an American and a British hospital. *Am J Health Syst Pharm* 1995; **52**:543-9
[2] McNally KM, Page MA, Sunderland VB. Failure-mode and effects analysis in improving a drug distribution system. *Am J Health Syst Pharm* 1997; **54**:171-7

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