The Golden Mortar

Nuus van die Suid-Gauteng Tak van die Aptekersvereniging van Suid-Afrika en geassosieerde sektore.

Edition 1 /February 2013

News from the Southern Gauteng Branch of the Pharmaceutical Society of South Africa and associated pharmaceutical sectors.

Report on the new electronic election system

Lynette Terblanche
Chairman—PSSA
Southern Gauteng Branch

The new Branch Constitution allows us to conduct elections for positions on the Branch Committee via electronic means as opposed to the tedious, restrictive and vastly more expensive postal system that had been in place for many years.

After testing the system with staff members and committee members the new **S**hort **M**essaging **S**ervice system was used for the first time recently and the following information may be of interest to members.

1. Firstly, the system relies on the fact that all members own cellular telephones.
2. Secondly, it relies on the fact that members have made the Society aware of their current cell phone numbers.
3. Of huge benefit is the fact that messages will be received and may be acted upon timeously no matter where the member is at the time - you do not necessarily have to be at home or at the office.
4. Members can be assured of confidentiality.
5. Nominations and voting can only be made from the cell phone to which our original messages were sent.
6. The system only accepts a single nomination response and a single vote response from each member.
7. Responses from members, whether correct or not, are acknowledged with an appropriate SMS.
8. The system is auditable should that become necessary for any reason.

The timing for the whole system is still controlled by the Constitution, for example, at least sixty days before the date set for the Branch AGM we have to invite nominations for members willing to serve on the Branch Committee for the ensuing year.

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This was done on the 7th December 2012 after sending a "advisory" message to members to anticipate the call for nominations for up to six names. Members were given five working days to respond and if we had not received a response by the 12th December 2012 a reminder message was sent to members who had not responded. All correct nominations were acknowledged by way of an SMS as were incorrect or late submissions - the closing date being noon on the 14th December 2012.

The result was impressive. We received twenty four nominations of which eighteen were accepted, - some were for non-members, students etc. In the past we have struggled to get the twelve nominations that were necessary in terms of the old Constitution. Acceptance of nomination by the eighteen nominees was confirmed by the Branch Office.

The voting process was very similar to the above and the SMS asking for members to vote for up to six of the eighteen names provided was sent out on the 7th January 2013 giving members five working days to respond. This was in line with the Constitutional requirement of at least thirty days and twenty one days prior to the date of the AGM for voting to be called for and the closing date respectively.

Similar reminder and acknowledgement messages were sent to members and finally we received votes from two hundred and seventy four members. This may not appear to be exceptional given that we have some fourteen hundred members, but it means that more than four times as many members actually participated in this election compared with the number that participated in the old postal system last year.

The result of the voting meant the following members were elected to the Branch Committee;

Lee Baker, Geraldine Bartlett, Johan Bothma, Charles Cawood, Vivienne Clack and James Meakings.

Happily, we have received only positive comment from members regarding the new election process. Aspects that they have highlighted include, "It is so much quicker and easier to use", "I don't have to find a post box to return my nomination/voting paper", and "You have made the process so simple for me that I voted for the first time in ages". We were also grateful to receive some useful suggestions from members that I'm sure will be introduced in the future to make the system even more acceptable.
Perhaps it would be helpful to list some of the simple errors that members made in dealing with the new system.

1. Trying to respond via "reply" rather than to the number that was provided.
2. Responding using a cell phone other than the one to which the original message was sent.
3. Not having their current cell phone number on record in the PSSA membership database.
4. Responding after the cut-off time and date.
5. Not using a full stop as the "separator" for the names & initials of the nominees as instructed.

However, the number of the problems was absolutely minimal, particularly considering that the system was being implemented for the first time.

We are satisfied that the system worked as we had anticipated and we would like to thank all those members who took the trouble to make nominations and to vote. Your interest in our Branch affairs is very much appreciated.

In addition to the six elected members (listed above) the Constitution provides for two members from each Sector to be appointed to the Branch Committee and these are;

CPS. Pep Manolas and Monique Cronje
SAAHIP. Liezl Fourie and Bronwyn Lotz
SAAPI. Lynette Terblanche and Walter Mbatha
Academy. Paul Danckwerts and Deanne Johnston

At the first Branch Committee Meeting held on the 12th February the following members were elected the Honorary Officer positions;

Chairman. Lynette Terblanche
Vice Chairman. Bronwyn Lotz
Treasurer. James Meakings.

The Golden Mortar congratulates all these Branch Committee members and wishes them a successful term in office.

At the same time we express our sincere thanks to outgoing Chairman, Charles Cawood, and Treasurer, Cecil Abramson for their contributions and dedication to the Branch while serving in those two positions.

Tammy Chetty

SCIENCE Revisited

The SAAPI Conference

Tammy Chetty

The SAAPI Executive committee has recently announced the 2013 SAAPI conference programme. The theme of the conference is SCIENCE REVISITED – Quality, Safety and Efficacy: Unpacking current pharmaceutical practices to ensure our products meet the latest requirements. It will be held on 5 and 6 March 2013 at the CSIR International Convention Centre, Pretoria. Topical issues relating to quality, clinical and regulatory aspects will be addressed. International and local experts from Academia, the Department of Health and Industry will present during the conference. In addition there will be a prize draw of FIP membership for one year for one lucky attending delegate.

Topics to be discussed are:

Certificate of Suitability – Recent Advancements - **Dr Helene Bruguera, Head of Certification Division at EDQM** *(European Directorate for the Quality of Medicines & HealthCare)*
Innovative Drug Development - **Prof Oppel Greeff**
Minimising Public Health Risk Posed by Counterfeiting - **Dr Helene Bruguera, Head of Certification Division at EDQM**
Science Revisited: Pharmacovigilance Inspections - Lessons Learned - **Dr Joey Gouws**
Pharmacoeconomics - **Dr Tienie Stander**
Naming and Scheduling Issues - **Mr Andy Gray**
The Role of Sterile Filtration in Aseptic Processing- **Mr Dale Gyure**
API's – Science and Quality - **Prof Douglas Oliver**
Stability Issues and Product Life Cycle - **Dr Ralph Tettey-Amlalo**
Quality by Design - **Prof Rod Walker**
Statistical Process Control in Daily Operations - **Ms Sonya Prinsloo**
ADR Related Issues - **Mr Mukesh Dheda**
Safety Update - **Ms Abeda Williams**
Compiling the CTD - **Ms Henriette Vienings**
CTD and Amendments : New Developments/Experiences - **Ms Joy van Oudtshoorn and Panel**

Registration: To register please visit the website at www.confpro.co.za
For more information please contact Confpro. Email: knel@confpro.co.za Mobile number: 083 445 0480.

Christine Venter
Newly elected Chairman of the CPS of the PSSA

CPS Branch - Committee 2013

Thirteen nominations were received for the sixteen positions available on the Branch Committee so, consequently, no elections were necessary.

At a CPS Branch Committee Meeting held on the 6th February 2013 the following members were elected to hold office.

Chairman - Christine Venter
Vice Chairman - Tshifiwe Rabali
Treasurer - Monique Cronje
Secretary - Pep Manolas.

The other members who will serve on the committee for the year are: Charles Cawood (Immediate past Chairman) Simon Mogafe, Richard Barry, Gary Kohn, Winnie Ndlovu, Dave Sieff, Johan Bothma, John Maklouf and Doug Gordon.

Drugwise - an update

By Johann Kruger
(CPS Pretoria Committee Member)

Many pharmacists will be familiar with the PADA (Pharmacists against drug abuse) program a number of years ago when most of us attended a training course at which we were trained in the intricacies of the dark underworld of drugs and the dangers they pose. All of us, beforehand, thought that we knew everything about drugs and drug abuse – we were experts in drugs because we were pharmacists!!! – how wrong we were!

The Drugwise program was run by the National body of the CPS [body] and successfully trained many pharmacists in the identification, process of constructive confrontation and referral of persons addicted to legal and illegal drugs. Many of us armed with that knowledge, went and made public presentations at schools, churches, parent-groups and many other organisations on the topic of drug abuse. A number of pharmacists started consulting in their pharmacies and set up referral and treatment programs for these people. Pharmacists and Pharmacy were the beneficiaries of a fantastic PR campaign!

The program, unfortunately, died a slow death for various reasons and today many [of the] young pharmacists are not aware of the program or how to handle a person entering the pharmacy with such a problem - not only the referral process but also the different legal implications attached to such an incidence.

In 2009, the Pretoria Branch of CPS discussed this problem after a number of requests from member pharmacists were received about the possible availability of the book (which was no longer in print) or the program, which was non-existent at that stage. It was decided to investigate the feasibility of reviving the book when it was discovered that the Branch was the owner of the trade-mark Drugwise and more importantly, that there was a demand for such a book. Geraldine Bartlett (one of the co-authors of the first book) was contacted and she referred us to David Bayever, who is one of the leading experts in South Africa on drug abuse, and he volunteered to take on the huge task of re-writing the book as too many aspects had changed to simply "update" the book. A contract was signed and David then had to endure many phone calls in between his hectic schedule for the next eighteen months regarding "is it finished yet?" After eighteen months we were very proud to hold a book-signing ceremony in Sandton and then launch the book at a prestigious event at the Pretoria Country Club.

Subsequent to that, a media company became interested in the project and members of the Branch were invited to a number of radio interviews which created more public awareness. Media24 then asked us to put together a massive media campaign for December in the Afrikaans newspapers for the December holidays. Dis-Chem came on board as the main sponsor and the end result is a DVD on drug abuse with actor Heike Berg, featuring the pharmacist as a source of information, a CD aimed at the lay person, again featuring the Drugwise book, and pharmacists as a source of help. The next step will be an English media campaign for 2013 that promises to be even bigger!

The important message is that pharmacists should be ready and armed with the necessary information for the envisaged call for pharmacists to be the real custodians of medicine!

By Sumari Davis B. Pharm – *Amayeza Information Services*

Although only around 10% of the world population lives in Sub-Saharan Africa, this is home to approximately 64% of the world population living with HIV infection. In 2009, around 5,6 million (18%) of the South African population were living with HIV.

Over the past two decades, the development of antiretroviral therapy (ART) has changed the perception of HIV and AIDS from a fatal disease to a potentially manageable chronic disease controlled with long-term medication. In the United States, more than 50% of deaths in HIV-infected patients are now related to conditions other than AIDS. With a longer life expectancy, long-term adverse events due to ART as well as age-related co-morbidities and treatment thereof result in greater risks for drug interactions, adverse effects and possible contra-indications. Since the focus of managing HIV-infected patients has moved towards that of managing a chronic disease, the pharmacist now has an increasingly important and complex role to play in the well-being of these patients.

Adherence

The goals of ART are to keep viral loads at undetectable levels. The pharmacist can facilitate this by promoting long-term adherence to treatment, limiting adverse events, avoiding drug interactions, simplifying drug treatment and decreasing cost of treatment. The impact of non-adherence to ART for both public health as well as the patient is much greater than in other chronic conditions. Adherence levels of less than 95% are believed to result in medication levels too low for viral suppression, possibly resulting in drug resistance and treatment failure. The pharmacist is in the ideal position to identify non-adherence by monitoring refill-frequency and ensuring stock availability. The pharmacist needs to counsel the patient in order to identify and adjust medication to best fit the daily routine of the patient. Discuss medication use with emphasis on benefits rather than adverse effects to further improve adherence. Special attention should be paid to treatment of children in terms of splitting of tablets, managing partially ingested doses (spitting or regurgitation) and the ability of the caregiver to understand and manage treatment.

Adverse effects

Although some adverse events may be serious and require discontinuation of treatment, these are relatively infrequent. The more common adverse events can often be treated symptomatically and may resolve spontaneously. In the initial assessment of an adverse reaction, it is important to find out about:

⇒ The signs and symptoms of the possible adverse effect
⇒ When the symptoms occur
⇒ Any concurrent medical conditions
⇒ Concurrent medicine use (OTC, prescription and complementary medicines)
⇒ Adherence
⇒ Duration of therapy
⇒ Recent dose adjustments and
⇒ Allergies.

Management may include correction of any errors in medication use, substitution or discontinuation of the suspect drug or reduction of doses. Dose reduction of ART is not routinely recommended in patients with normal renal and hepatic function due to possible development of resistance.

General maintenance of health

The pharmacist is easily accessible and can be of great help in counselling patients on their medicines and in referring patients to other professionals to take care of mental health, immunisations, oral hygiene and sexual health. Additional counselling towards smoking cessation, practising safer sex, proper diet and nutrition, prevention of falls and sun protection should also be provided.

Building up a trusting relationship with HIV-infected patients is of utmost importance in the management of this chronic disease and will require the pharmacist to maintain confidentiality at all times. In addition, the pharmacist also has to keep up to date with the latest information and developments in ART.

The following link may be useful in providing more information as well as additional links to websites with useful information on interactions, splitting and crushing of doses as well as general information on HIV.

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3329905/pdf/cjhp-65-125.pdf

Announcements

Government Gazette No 36076 of 17 January, 2013. Basic Conditions of Employment Act: Amendment of Sectoral Determination 9 : Wholesale and Retail Sector, South Africa.

The above Gazette replaces the wage tables 1 and 2 contained in Gazette 32871 of 18 January 2010 . A copy may be viewed on the PSSA website – go to PSSA.org.za then open NEWS and EVENTS . The amendments became effective on 1 February, 2013.

Advertising on The Golden Mortar Envelopes

The Golden Mortar Editorial Board expresses its appreciation to UPD for their advertising support of The Golden Mortar over a number of years by advertising on the distribution envelopes . AlphaPharm Distributors have taken up this advertising opportunity for 2013, which is sincerely appreciated.

The advertising on The Golden Mortar envelopes assists the Branch to defray some expenses relating to the production and distribution of the Golden Mortar to approximately 1650 readers.

The Golden Mortar on the Website

Editions 2 to 8 inclusive of the 2012 The Golden Mortar are accessible on the PSSA website.

Go to Branches and click on publications where you will be able to access the various Editions. We would appreciate any suggestions you may wish to make with regard to content, layout etc, which the Editorial Board could consider for future Editions. Please forward your suggestions to ceciler@pssasg.co.za

FELLOWSHIP OF THE PHARMACEUTICAL SOCIETY OF SOUTH AFRICA

By Ray Pogir

Fellowship of the Society is one the highest awards which can be bestowed on a member of the Society.

It is awarded in recognition of an outstanding contribution made by a pharmacist in the advancement of the profession and the attainment of the objects of the Society.

It also honours the contribution made by a pharmacist in the advancement and service of his community.

Nomination for fellowship is made by colleagues who have evidenced the distinctive career of one of their peers and agreed that such a distinction is deserving of recognition.

Nominations may be made to the National Executive of the Society by colleagues.

Details and evidence of the particular outstanding qualities of the nominee must be submitted in confidence. This will be judged by the Fellows Committee and their decision (in confidence) conveyed to the National Executive Committee.

The constitution of the Society has a provision for Honorary Fellowship. This honour may be bestowed on any person who, not being a pharmacist, has been closely associated with the profession in another capacity which has been of benefit to the Society in attaining its objects.

Fellows of the Society are designated by the letters FPS, and Honorary Fellows by the letters Hon.FPS.

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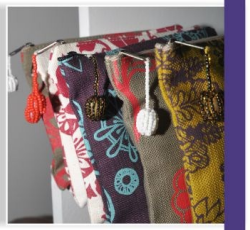
Visit SARCDA International 2013 at Gallagher Convention Centre in Midrand from 7 to 10 March 2013. But before then go online at www.sarcda.co.za to find out more about our exhibitions and register as a trade buyer.



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Ray Pogir –
Curator of the National
Pharmacy Museum

Pharmacy Nostrum Formulae

19th Century examples from the National Pharmacy Museum Collection.

By Ray Pogir, Curator

The pharmacy was the first port of call for common minor ailments and the pharmacist was often referred to as "the poor man's doctor"

Some pharmacies developed a reputation for certain specialties and people would travel considerable distances to purchase, for example, a specific cough medicine, chilblain cure or baby nappy cream. The little "black book" was each pharmacist's record of the tried and trusted preparations.

In the museum there are five examples of such books. One dated 1850, another 1876 and the others are undated. They contain a wide range of hundreds of fascinating formulae and the stains on the pages show that they were often prepared.

The contents can roughly be divided into four main categories.

1. *Medicines for internal and external use.*
   Each has a range of formulae for the popular Dutch medicines of that time, also many medicines for common minor ailments such as mixtures for coughs, indigestion, diarrhea, cold and "flu etc.
   One has a range labeled "Huis Apotheek"- a complete home medicine chest. There are various remedies for tape-worm, gout and constipation.
2. *For External Use.*
   There are formulae for embrocation, cold cream, vanishing cream, deodorants, depilatory lotions, (one is marked-excellent results!) black-eye paste, hair dye, freckle cream ,Eau de Cologne and many others.
3. *General Household Products.*
   These consist, amongst many others, of methods for preparing varnishes for wood, sealing wax, writing ink, vanishing ink, battery solution, metal polishes and mosquito oil.
   There are also recipes for ginger beer, lemonade, coca wine, curry powders.
4. *Veterinary Products.*
   Included here are biliary fever cures, horse balls, mange ointment and "wolvegif" - (poison for wolves).

The contents of these personal formularies represent a fascinating insight into the practice of pharmacy before the advent of the current wide ranges of patent medicines and commercial household products.

In the oldest formularies the handwriting is in classical copperplate and many of the products have a wide range of ingredients and detailed instructions for preparing the final product.

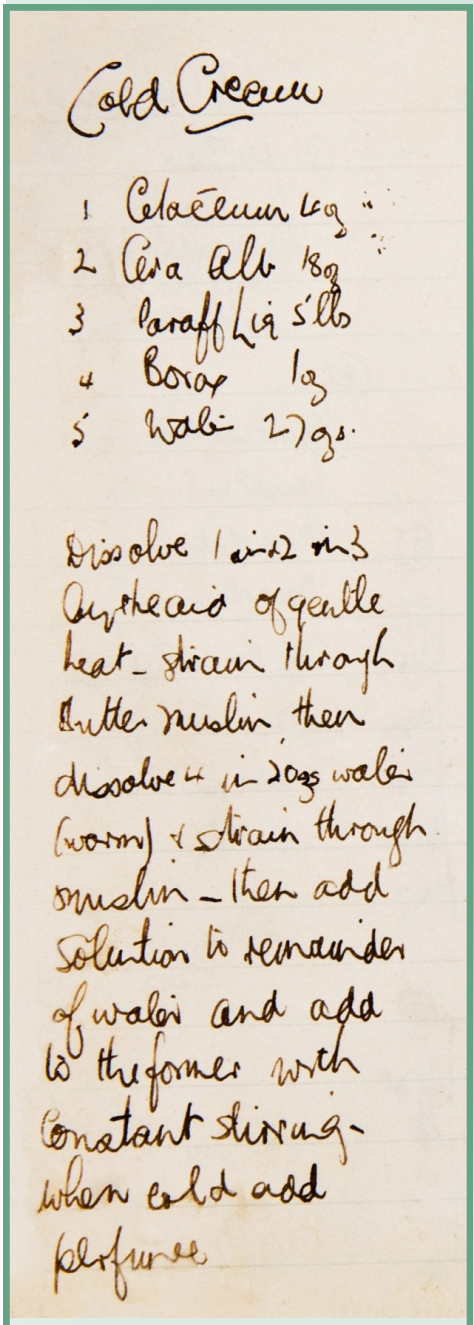
Pictures on Page 9

Did you know? - By Trevor Phillips

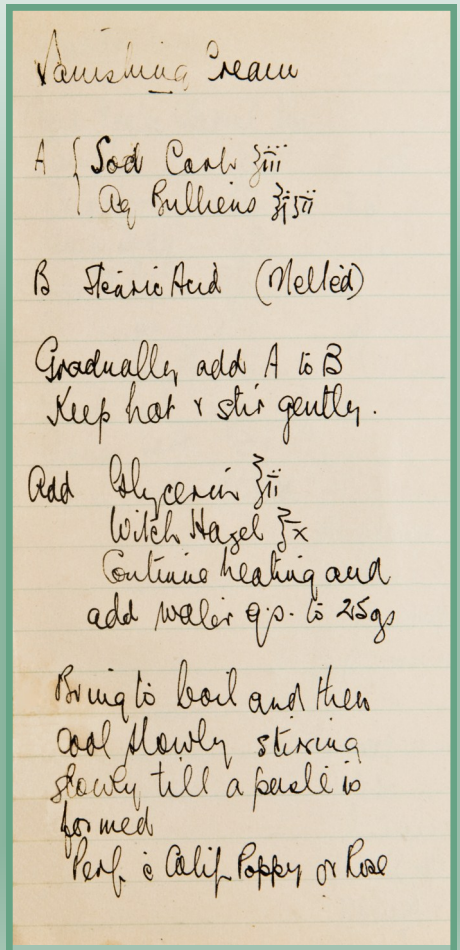
The global pharmaceutical biological drug market is one of the fastest growing sectors. They generated revenue of some USD 115bn in 2010. This corresponds to just over 15% of the total global pharmaceutical market.
There is a large lucrative demand for lower cost biological medicines worldwide.
In 2011 the global *biosimilars* market was worth over USD 1300m just 1.1% of the global biological medicines market. Globally the biosimilars market is expected to experience a rapid growth throughout the period 2012 to 2022, especially in Japan and the US. Growth in developing countries is also expected to grow rapidly.
'Biosimilar' or 'Follow-on Biologics' are terms given to manufactured biological molecules. However, due to the complexity of the biologics, the product made can only be similar, not identical to its reference molecule.
Owing to the complexity of this type of product there are many issues such as immunogenicity, developmental, registration guidelines, patents and many more to overcome, especially in countries where authorities lack capacity and technical skill.

EXAMPLES OF NOSTRUM FORMULAE

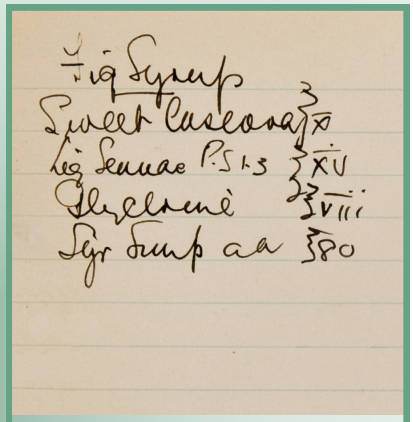
FROM PERSONAL "BLACK BOOKS" IN THE MUSEUM



Pharmacy Nostrum – Cold Cream
Photo: Nikki Faria



Pharmacy Nostrum – Vanishing Cream
Photo: Nikki Faria



Pharmacy Nostrum – Fig Syrup
Photo: Nikki Faria

A QUIZZ Question

By Liezl Fourie

You must dispense a 10 % (m/v) intravenous glucose solution. You have 200 ml glucose 5 % (m/v) intravenous solutions in stock and 50 % (m/v) dextrose ampoules. How many milliliters of the 50 % (m/v) dextrose ampoules should be added to the 200 ml (5 %) solution to prepare a 10 % m/v solution?

There are no prizes offered but the answer to this question will be published in The Golden Mortar Edition 2 2013.

Rhabdomyolysis and the role the pharmacist should play

By Hester Coetzee

Rhabdomyolysis is the rapid destruction or disintegration of skeletal muscle resulting in the release of myoglobin. This released protein enters the blood and is then excreted via the urine, eventually leading to renal failure. The most common causes of rhabdomyolysis are drugs and toxins, including lipid-lowering agents, alcohol, and cocaine. Trauma and overexertion are also relatively common causes. The majority of patients have more than one etiologic factor, and less than 10% has no identifiable cause. You as a pharmacist play a very important role in preventing serious injury due to rhabdomyolysis in patients receiving statins and other drugs.

1. *Recognize the symptoms* of rhabdomyolysis. These include muscle aches and pain, stiffness, and muscle weakness. It may cause a darkening of the urine - red or cola colour.
2. *Listen* to what your patients say when they complain. "I have been taking simvastatin for the past two years. For the last year, I have had severe leg cramps and aches. My doctor prescribed ibuprofen. I can't take it any longer…."
3. *Know which drugs* are known to cause rhabdomyolysis. In addition to alcohol, users of heroin, cocaine, amphetamines, angel dust (PCP), methadone, LSD and solvents are at risk of developing rhabdomyolysis. The prescription drugs most commonly responsible are antipsychotics, followed by statins, SSRIs, zidovudine, colchicine, lithium, antihistamines like doxylamine, and several others drugs.
4. These drugs cause rhabdomyolysis through *several different mechanisms*. Statins and colchicine are examples of drugs that are direct myotoxins. In addition, statins can increase the risk of rhabdomyolysis in patients with other predisposing conditions, such as hypothyroidism or an inflammatory myopathy. Sometimes multiple mechanisms may contribute to muscle damage; as an example, rhabdomyolysis with alcoholic binges may result from a combination of hypokalaemia, hypophosphatemia, coma, agitation, and direct muscle toxicity.
5. *Consider the risk factors* of developing rhabdomyolysis. Make suggestions on when you think the patient should best temporarily withhold the therapy (such as statin therapy) that can cause rhabdomyolysis. This could include anyone with an acute, serious condition suggestive of myopathy or predisposing to the development of renal failure secondary to rhabdomyolysis (e.g., sepsis, hypotension, dehydration (like when hypokalaemia caused by potassium loss from sweating occurs), major surgery, trauma, severe metabolic, endocrine, and electrolyte disorders, or uncontrolled seizures).
6. Prevent rhabdomyolysis due to drug use by *monitoring for possible drug-to-drug interactions*. As an example: some inhibitors of CYP3A4 like macrolides (e.g. erythromycin), cyclosporine and some protease inhibitors used in the treatment of HIV infection, can cause elevated plasma levels of the statins that are CYP3A4-substrates. With higher plasma levels of these substrates (the statins), there is an increased risk of myopathy or rhabdomyolysis. The higher the dosages of the statin, the larger the risk. The higher the dosage of the CYP3A4-substrate, the larger the effect expected. With atorvastatin caution is advised when exceeding doses larger than 20 mg daily. The lowest statin dose necessary should be used. This interaction is classified as an interaction of great significance with major severity. Severe cases of drug-induced rhabdomyolysis may lead to acute renal failure and severe electrolyte imbalances. Myalgia and elevated creatinine phosphokinase usually develop within 5 to 21 days after starting the strong inhibitor. Always try to *make safer choices* for your clients.

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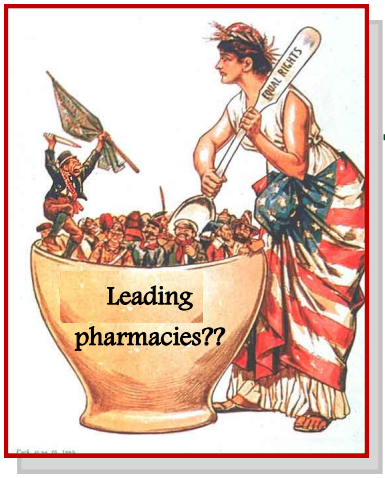
7. *Warn and inform the patient* that takes statins (or any other drug that can cause rhabdomyolysis) of the symptoms and to report when such symptoms are experienced. Very often we repeat and repeat a script, failing to advise the patient when to have his renal functions or liver functions monitored. Decreased renal and/or liver function can lead to higher levels of the drug in the blood, increasing the risk. Advice the patient to take Co-enzyme Q10, as this might help to prevent muscle pain or provide moderate, short-term relief of statin-induced muscle pain. Instruct patients to report any signs of muscle weakness, pain and body aches.

The treatment of rhabdomyolysis depends on its cause and severity. If a cause for rhabdomyolysis is identified, it is addressed; for example: discontinuing the medication causing it, replacing electrolytes, or treating an underlying muscle disease. In more severe cases, or if home therapy is not possible, hospitalization may be required. Prompt initiation of hydration with IV fluids, in addition to the removal the provoking factor(s), is an essential part of the treatment of rhabdomyolysis. Monitoring and managing kidney dysfunction, correcting any disturbance in the electrolytes, and monitoring the muscle enzyme levels (CPK, SGOT, SGPT, LDH) are most effectively done in the hospital when rhabdomyolysis is severe. Severe cases of rhabdomyolysis may be associated with kidney damage and electrolyte imbalance and hospitalization and even dialysis can be required.

The overall prognosis of rhabdomyolysis is favourable *as long as it is recognized and treated promptly*. Most causes of rhabdomyolysis are reversible. If you know what it is about, you can most certainly play a very active role in preventing serious harm due to rhabdomyolysis. As a pharmacist you should be managing your patients' medications.



Stirring the Pot

….and another thing, what are "other leading pharmacies?"

I hear and see this reference almost daily on radio and television - some or other product that they are promoting is available at *XYZ* "and other leading pharmacies".

Where are these places? Is there a register of such pharmacies? Is there some kind of test that has to be taken or application made to qualify as "a leading" pharmacy? Who can I discuss this with?

I happen to believe that all pharmacies are leaders in the provision of medicine and the attendant advice and counseling that goes with it.

Perhaps, to be a "leading pharmacy" you have to carry a great big range of non-pharmaceuticals as well - pots and pans, kettles, vases, cosmetics etc. etc.

While we're about it, can anyone tell me whether, in addition to "leading pharmacies", there are any leading doctors or leading hospitals or leading nurses that I should know about?

Pharmacy Perspectives

Here's a challenge. Are you prepared to make a meaningful New Year's resolution and carry it through this year? A resolution that will provide you with a real sense of satisfaction and make a positive difference to you, your patients, your business and possibly even to the profession.

There are many problems for us to deal with on a daily basis and we all know what they are. No matter which sector of the profession we are active in there are things that we are unhappy about and that seem to be so illogical, not to mention unfair. Frustratingly, there seems to be little that we can do to effect change as individuals, but even when our Society becomes involved it takes time to reach resolution.

As a consequence, it isn't surprising that many of us have become a bit disillusioned. Unfortunately this results in a negative approach to so much of what we do. What is even worse is that we don't or can't hide this negative frame of mind and it affects those around us – our patients, our staff and our family.

My challenge to you is this – let's change this mindset and become more positive about everything that we do this year. How?

Well, the one thing that you, as an individual, will always have complete control over is your attitude. Only you can decide what your attitude is at any given time, in any given circumstance and only you can decide whether you need, or are prepared, to change it.

As a pharmacist with a tertiary education and a qualification you have already proved that you are blessed with the power of reason, otherwise you would never have qualified. From reason comes understanding and once you have understanding you start caring. Out of this caring comes love, – love for virtually every aspect of your life, – your job, your family, all of those around you and life itself.

The quality of your life is brought about by the quality of your thinking, so if you want to change your world you need to change the way that you think.

Come on – I dare you to make a RESOLUTION right now to change the thinking that will change your life.

The Chairman of the Editorial Board is David Sieff and the members are Cecil Abramson, Johan Bothma, Liezl Fourie, Doug Gordon, Neville Lyne, Trevor Phillips, Ray Pogir and Miranda Viljoen.
The Board apologises for any errors or omissions which may occur.
We welcome controversial contributions and as space permits, these will be published, abridged if necessary. It could be however, that the content of *The Golden Mortar*, or the insertions, or advertisements, will not reflect the views of the branches, sectors, the Editorial Board. Therefore the aforesaid cannot be held liable.

The Golden Mortar
P O Box 2467, Houghton, 2041
Tel: 011 442 3601, Fax: 011 442 3661
nevillel@pssasg.co.za

Your SG Branch Chairman	Lynette Terblanche
Your PSSA Southern Gauteng Branch Sector representatives are:	
Community Pharmacy:	Pep Manolas & Monique Cronje
Hospital Pharmacy:	Liezl Fourie & Bronwyn Lotz
Industrial Pharmacy:	Lynette Terblanche & Walter Mbatha
Academy	Paul Danckwerts & Deanne Johnston

Contact them through the Branch Office: Tel: 011 442 3601

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