

The **Golden Mortar**



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

Edition 3/ May 2014



THE IMPORTANCE OF THE PSSA AGM AND CONFERENCE

The Pharmaceutical Society's AGM and Conference are usually held concurrently in the month of May. This year is no different and the venue will be the Boardwalk in Port Elizabeth from the 9th to the 11th May.

The procedures that are followed for the conducting of the AGM are dictated by the Constitution of the PSSA. Each Branch of the Pharmaceutical Society has the opportunity and the responsibility to appoint Councillors to represent the Branch at the AGM and Conference. The number of Councillors that a Branch is able to field is determined by the number of paid-up Ordinary members that have been registered by the National Office of the PSSA at the end of January in the year in which the AGM is held. This provides for proportional representation at the AGM and Conference. For example the Southern Gauteng Branch of the PSSA is able to field 25 Councillors at the forthcoming AGM and Conference. However, it is not mandatory for the Branch to field all 25 Councillors – the Branch Committee determines, based on various criteria, the actual number of Councillors that can be funded to attend the meeting. This year it will be fewer than the maximum allowed for reasons of cost, bearing in mind that a limited number of proxies can

be used for the purposes of supporting or opposing motions that may be put forward.

The AGM provides Branches and Sectors the opportunity to propose or recommend activities or actions to be taken by the elected National Executive Committee during the ensuing year.

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The Southern Gauteng Branch delegation plans this year to propose changes to the Constitution that the NEC will be required to investigate, if these are adopted by General Council. For example:

The Branch Committee is concerned at the recent large increases applied by the SA Pharmacy Council to its registration fees and will recommend that the Society endeavour to get a satisfactory explanation from Council as to why this was deemed to be necessary.

In addition, for many years the AGM and Conference have followed the same format despite the multitude of changes that have affected pharmacy in recent years such as, the changing economic environment, the scarcity of pharmacists, the increased

number of conferences and meetings that are organised each year to which pharmacists are invited. A solution needs to be found to rationalise the situation to the advantage of the profession as a whole.

The current Constitution of the PSSA was drafted in the 1990s. Since then many changes have occurred that impact the profession. Is it not time that consideration be given to bringing the Constitution into line with modern trends and demands to the benefit of the profession? Does the federal type governance of the Society still suit the profession - if not what form should it take?

What are your thoughts on these matters? E-mail your ideas to The Editor at pssa@pssasg.co.za

The Southern Gauteng Branch of the PSSA delegation will comprise the following members of the Branch who have agreed to give of their time to represent the interests of the members of the PSSA Southern Gauteng Branch:

Delegates:

Mrs L Terblanche, Branch Chairman; Mr Charles Cawood, Vice Chairman; Mr J Meakings, Branch Treasurer; Mr G Kohn, Mr R Pogir, Mrs G Bartlett, Ms B Lotz, Mr W Mbatha, Mrs V Beaumont, Mr R Barry, Mrs L Baker, Mrs V Clack, Mrs M Cronje, Mr D Sieff, Mr D Gordon, Mr S Mogafe, Ms W Ndlovu, Mr P van der Merwe, Ms Y Peens, Mr T Rabali, Mr A Tannous.

Observers:

Mr N Lyne; Ms J Duxbury, Wits Pharmacy Students Council.



Sector Workshop
Complementary Medicines Legislation
Implications for Community Pharmacists - 8th April

Henriette Vienings

Thanks are due those attendees who completed the Sector Workshop Evaluation questionnaire. The evaluation forms indicated that the majority of respondents found the session to be "Very Satisfactory" or "Satisfactory" in terms of meeting the delegates' knowledge gap. However there were a few delegates that indicated that they would have appreciated more information on the subject.

The session was well attended. Many of the respondents expressed appreciation that the Southern Gauteng Branch of the PSSA arranged the Sector Workshops and Clinical CPD sessions. These sessions were found to be most informative.



Student numbers reading for various degrees at the University of the Witwatersrand in the Department of Pharmacy and Pharmacology.

by Prof Paul Danckwerts



B. Pharm. First year student numbers. Over the years the number of students reading for degrees in the Department of Pharmacy and Pharmacology has been on a slow increase. There is a large number of students who apply for the Bachelor of Pharmacy degree at the University of the Witwatersrand, but the university is currently restricted by space and human resources. The target maximum is approximately 90 first year students per year. Sometimes there are more or less depending on the number of students who take up the offer of a place.

Many of the applicants also apply for other degrees in the Faculty, with most choosing Medicine and Physiotherapy as their first choices. Statistics have shown that if we make 180 offers during the previous year we get about 90 final acceptances. The final acceptances that we receive each year is normally very late in the year after students have waited for other offers of acceptance to come through. Of the final number of first year students accepted about 40% are Pharmacy first choice students. There are many more students who choose Pharmacy as their first choice, but they unfortunately do not meet the minimum requirements. History has shown us that most students who are below the minimum point cut-off do not make it beyond first or second year. Table 1 shows the number of students according to gender and race classifications that were accepted into first year Pharmacy for 2014.

Table 1. Number of B. Pharm students in the first year according to demographic spread in 2014

Race Description	Female	Male	Total
Black	40	23	63
Coloured	3	2	5
Indian	17	7	24
White	2	1	3
Grand Total	62	33	95

Postgraduate student numbers. The number of postgraduate students has also grown quite dramatically over the past few years. Many students are opting to study further to get ahead in their careers and there are a number of postgraduate degrees being offered by the Department of Pharmacy and Pharmacology. Again, our postgraduate numbers are capped due to limited space, finances and supervision capacity. Table 2 shows the number of postgraduate students per degree.

Table 2. Number of postgraduate students in 2014

BSc Hons Pharmacology	11
M. Pharm Research dissertation	33
MSc Med Research dissertation	23
MSc Pharmacotherapy coursework & research report	10
MSc Pharmaceutical Affairs coursework & research report	19
PhD	15
Post Doctorates	4
Total	115

Interestingly, our racial profile of students shows a direct relationship to the numbers of each race group in the general population of South Africa.



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TREATMENT OF DRUG RESISTANT TB CPD

By Dave Sieff

A recent presentation, "Latest Treatment Policies Relating to Drug Resistant TB" was given by Dr Francesca Conradie, Chairman of the S A HIV Clinicians Society, and Clinical Advisor for Multi-Drug Resistant TB, "Right to Care," to pharmacists in the PSSA Southern Gauteng auditorium.

She began with definitions of the various types of multi-drug resistant (MDR) TB and the agents to which they are resistant, and followed with the phases of the minimum 6

month treatment regimens.

The extent of the problem in South Africa's provinces were compared, and the success rate of treatment outcomes were graphically illustrated, highlighting the disturbing trend of decreasing drug-susceptible cases versus increasing MDR-TB cases, future predictions on the burden of disease, and the treatment challenges presented – including poor evidence of the available options.



Dr Francesca Conradie, addressing pharmacists on Drug Resistant TB

Dumisani Mtetwa, Meriam Ratau and Peter Mohlala attended the Clinical CPD session on 18 March



IN MEMORY OF ANN M LEWIS, OBE, LLB, FRPHARMS, MCPP, MHSM. PAST PRESIDENT AND PAST REGISTRAR/SECRETARY OF THE ROYAL PHARMACEUTICAL SOCIETY OF GREAT BRITAIN

by Ray Pogir

Ann Lewis was the first President of the Royal Pharmaceutical of Great Britain to visit the PSSA. Her visit in 1994 coincided with the year in which this Branch published the history of pharmacy over the previous 100 years. The title of this book is "Pharmacy in The Transvaal 1894 – 1994"

As part of the forward to the book we included her signed Message of Goodwill and her photograph. She was also presented with a copy of the book.

We quote a few sentences from her thought provoking message:

"Leaders must not only look forward in order to advance, but look *backwards* in order to learn from the past".

"The world is watching to see how South African pharmacists are finding their way forward. Those who are true to their professional calling will not waver; to guard and restore health will always remain our primary concern"

Those of us who had the privilege of meeting Anne will remember her as a friendly and gracious lady with deep wisdom, knowledge and dedication to our profession.

Ann Lewis passed away on the 28th of December 1993.

A copy of "Pharmacy in The Transvaal 1894 – 1994" has been made available as a prize by the Southern Gauteng Branch of the PSSA to a member of the Branch who is adjudicated to have written the best short letter expressing their aspirations in progressing their career in pharmacy.

E-mail your entry to pssa@pssasg.co.za and include your contact details. Entries close on 25th July 2014. The winner will be announced in The Golden Mortar 6th Edition, 2014 to be posted at the end of August, 2014.





MEDICINES WEIRD AND WONDERFUL.

By Ray Pogir, FPS

As is well known, the museum has a large collection of historic artifacts used in pharmacies over a few hundred years.

However, there is also a collection of medicines and material which formed part of the stock-in-trade of pharmacies of days long gone by and could well be described nowadays as "Weird and Wonderful".

The photographs on this page represent but a few examples of the attempts by both reputable pharmaceutical companies and pharmacists to satisfy the public needs of the time.

We wonder how many of our readers recall other examples of medicines which also fall into the category of this heading. We invite your comments which may be included in the next issue of The Golden Mortar.

Address: The Editor, Golden Mortar, e-mail: pssa@pssasg.co.za.



Typical Galenical Shelf (early 1930s)
National Pharmacy Museum display



Hormonal contraception-related VTE

By Jacky van Schoor, M. Pharm,
Amayeza Info Services

Concern about venous thromboembolism (VTE) risk of new hormonal contraceptives has, on more than one occasion, resulted in panic stopping of the products in question and a spike in unplanned pregnancies, yet with no subsequent reduction in VTE rates among women of reproductive age.¹ The latest concern raised about drospirenone is another case in point.

The importance of safe, effective and accessible contraception cannot be overstated.² Unplanned pregnancies

remain prevalent in all communities and continue to exert profound health, economic, environmental and societal consequences that pose a global challenge.² Effective and reversible contraception is a critical component of reducing unintended and unwanted pregnancies, empowering women to take control over their reproductive lives and improving their overall health.²

.../continued on page 6



The use of any medicine is associated with risk and the communication of risk versus benefit is a core component of healthcare counselling.³ The safety bar for hormonal contraception is higher than that for most other treatments in medicine, because healthy women use these products to avoid the real and potentially negative consequences of an unintended pregnancy. However, there has not been a case where a woman was considered too medically fragile to use hormonal contraception, but an acceptable risk for pregnancy.³

VTE remains a rare but potentially serious complication of combined hormonal contraceptive use.¹ The condition typically involves thrombosis in the deep veins of the legs or pelvis and the potential for pulmonary embolism.¹ Known risk factors for VTE include advancing age, inherited blood clotting disorders, cigarette smoking, surgical procedures, trauma, immobility (such as that associated with travel or hospitalisation), obesity, pregnancy and the postpartum period.¹ Therefore, there is clearly a background risk of VTE that needs to be taken into consideration. To keep the risk of VTE in perspective, it is worth mentioning that:

- The background rate of VTE in non-pregnant, **non-users** of combined hormonal contraception (pill/patch/ring) is about 4 to 5 per 10 000 women per year.¹
- The rate of VTE in users of combined hormonal contraceptives (pill/patch/ring) is about double that in non-users; about 9 to 10 per 10 000 women per year.¹
- The rate of VTE in women using combined hormonal contraceptives containing drospirenone, gestodene or desogestrel is about 9 to 12 per 10 000 women per year.⁴
- The rate of VTE during pregnancy is about 29 per 10 000 women per year.¹
- The rate of VTE in the immediate postpartum period is about 300 to 400 per 10 000 women per year.¹

In fact, as one of the most widely used and effective contraceptive methods, combined hormonal contraception reduces rates of unplanned pregnancies and decreases the overall rate of VTE in comparison to populations having more pregnancies because of poor access to effective hormonal contraception.¹

Note: Progestogen-only contraceptive methods have not been shown to increase the rate of VTE.¹

Scientific debate is messy, but ultimately healthy for patient care.³ Unfortunately, the medical literature has rapidly

moved from an exclusive forum for scientific exchange used by healthcare professionals to a source for the lead story on the evening news or as ammunition for litigation.³ However, these media reports rarely report absolute risk and focus instead on relative measures of risk. In other words, they fail to take background risks into consideration. For example, if you double the risk of a rare event, the likelihood of that event is still rare.³

Healthcare providers have the responsibility to interpret science for their patients. This requires counselling patients about the risks and benefits of proposed treatments. When it comes to combined hormonal contraceptives, the European Medicines Agency in 2014 concluded that that the benefits of combined hormonal contraceptives continue to outweigh risks.⁴ The well-known risk of VTE with all combined hormonal contraceptives is small and much smaller than that associated with pregnancy or the immediate postpartum period.^{1,4}

Fear and confusion resulting from media coverage of rare events has the potential to create far greater harm as inadvertent pregnancies are generally the result of panic stopping of combined hormonal contraceptives and these pregnancies themselves carry greater risks for VTE.⁵

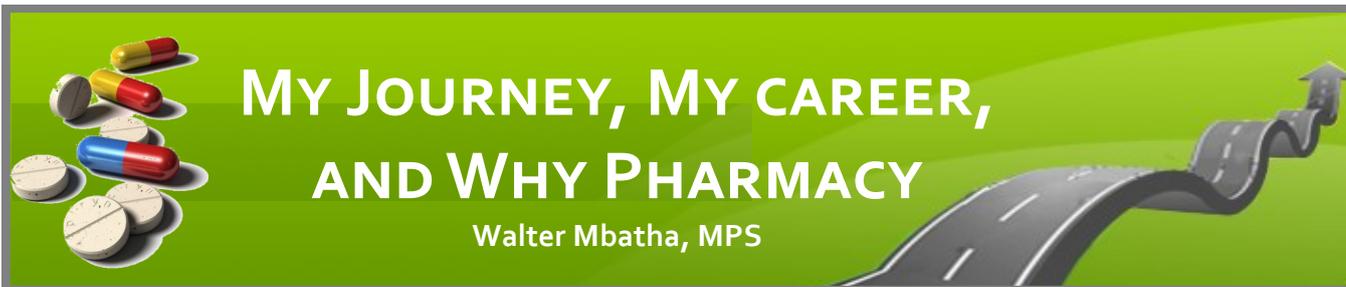
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Accessed 1/04/2014.





MY JOURNEY, MY CAREER, AND WHY PHARMACY

Walter Mbatha, MPS

Let me just start by acknowledging the fact that I have been privileged, honoured and blessed to be to have this opportunity to write this article.

Being a young man and having to grow up in Tembisa (to a certain degree it could be considered as a previously disadvantaged environment) with limited exposure to a wide variety of endless opportunities, one's dreams and aspirations get structured and limited.

Growing up, all I knew was that when I was done with school I could only get to enter one of the four professions to which I was exposed to i.e. Doctor, Lawyer, Nurse or Teacher. In addition, I wasn't much of a soccer player or musician, so the one that seemed to be more appealing to me was being a Doctor.

Having been born from a great man Mr Ephraim Mbatha (a forklift driver) and great woman Mrs Mavis Mbatha (a cashier at KFC – God bless her Soul), I knew that having money to further my studies after Matric was almost an impossible dream. The hunger in me to become greater than my current circumstances made me believe in something greater than myself. I decided to take a leap of faith and apply for Medicine at Wits, and when I went to submit my application I was told that I should also indicate my second and third choices, and that was a very challenging task because all I knew was the above mentioned careers. Luckily, a lady at the enrolment centre told me to put BSc as my second choice, just in case I was not accepted to study Medicine. I would then have something to fall back on and it could eventually propel me into Medicine at a later stage. I took the advice, and yes, I did not get accepted into Medicine but luckily got accepted for BSc.

Now the challenge was to try and raise the registration fee, I remember my mother used to have a small gas stove at home which was unused, so I borrowed it and I started selling boerewors rolls at Wits during the Orientation week to try to raise enough

money for registration, and yes through the grace of God I managed to raise enough money to register before the classes commenced. Later, I was fortunate enough to be granted a study loan from NSFAS to cover my fees for my 1st year of studies. By virtue of being at Wits, it presented opportunities for me to meet people who would eventually impact the direction of my career life. One of such individuals is a gentleman by the name of Melusi Magele who was a 1st year pharmacy student at the time, he told me how fascinating the career was that he was studying towards (obviously being a 1st year himself he didn't possess much information) so I decided to do my own research about this so called Pharmacy profession. I then embarked on the journey to walk into pharmacies that I came across, and started interviewing different Pharmacists. I posed as a student who was doing a school research project on Pharmacy as a career option. Through the outcome of that research project a new dream emerged.... I now had found my calling.

One of the greatest motivators for me to do pharmacy was the fact that I was able to work from my second year of study, which to me at the time was a great financial relief and I could actually afford to get myself through varsity. I applied for pharmacy for my 2nd year of study and by God's grace I got accepted for B-Pharm 2nd year. I received credits for my 1st of BSc. While I was busy with my 2nd year studies my biggest worry was fees since NSFAS took longer to approve my loan for that year, so one day on my way to Tembisa (Home) from Joburg, the Taxi I was travelling in passed by Bruma. Sitting in the Taxi I saw a big blue and white sign written BRUMA PHARMACY, so I decided to get off and walk into the pharmacy and ask for a JOB. I met a gentleman by the name of Nick Cetinich, MPS, who was the owner of the Pharmacy at that time. Nick was the man who launched me into this career of mine, which I get to enjoy now. He hired me on the spot, he was just God sent. Nick wherever you are I thank you for all the belief you had in me.

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Don't ask me how I managed to pass my 2nd year B-Pharm (Anatomy and Physiology were just a nightmare) at times I think I still suffer from a post-traumatic stress disorder which was caused by these subjects.

In 3rd year B Pharm I decide to join WPSA – Wits Pharmacy Student Association (currently known as WPSC) that was the BEST DECISION of my career. I was elected as the President of WPSA. I got an opportunity to be invited to attend my 1st CPS meeting. In that meeting I was privileged to meet some of our great leaders in this profession. One man, who to me was the highlight of that meeting was the gentleman, Doug Gordon.

This is the man who became my father in this profession and my mentor (without him knowing it), a man who gave me opportunity to dream big. I guess any man who you meet for the 1st time as a president of the students and who offers to give you financial assistance for our WPSA projects, would be a superhero. Shortly after that I was invited for my 1st PSSA-Southern Gauteng branch meeting, and that was even a greater platform for me to realise that I could be a part of the force to drive the future of this profession. That year there were a few challenges which the profession was facing, one being the introduction of Single Exit Pricing of medicines. I remember leading a protest of Wits Pharmacy students to the Gauteng Department of Health to submit a memorandum to the MEC.

Later that year another blessing in disguise came my way - I failed Pharmacotherapy. This gave me another year of being a student (what more could one wish for?). Yes, I'm normal after all! The following year, only doing one subject, gave me even more time to involve myself in professional politics. I was elected as the SAPSF – South African Pharmacy Student Federation president, and also became vice - president of the Health Science Student Council (Wits). As president of SAPSF I was invited to my 1st of many PSSA conferences, what an opportunity to create a name for myself. At the end of that conference I had leaders from different sectors of the Industry willing to offer me jobs as soon as I graduated, I knew from that time that my career prospects could improve.

I remember when I took office as SAPSF president, SAPSF was no longer a member of IPSF – International Pharmacy Student Federation. We had to raise money to repay the debt that SAPSF owed IPSF. We also required money to apply to renew membership and to send someone to Australia to represent SAPSF and to motivate to the IPSF congress to reinstate the

SAPSF affiliation. At the PSSA conference with a help of a pledge which was made by a gentleman by the man of James Meakings, chairperson for PSSA-SG branch committee, we managed to raise enough money for SAPSF to send one person to Australia to attend the IPSF world congress. I was fortunate enough to be nominated to represent SAPSF and we were successfully readopted back into IPSF. Also, one of the great highlights of the congress when I was nominated to be the World TB day coordinator for IPSF.

One of my career aspirations when I was a student was to have the opportunity to do my internship in the pharmaceutical manufacturing industry. I remember at that time it was a bit difficult to get an internship in industry since there was a limited number of companies willing to offer internships to students. During my final year Adcock Ingram Healthcare (PTY) LTD came to our Varsity to recruit four students for their Internship program. But at that time I was in Australia attending the IPSF congress and thus I missed that recruitment opportunity. Shortly after returning from Australia I was contacted by Adcock Ingram and told that someone has highly recommended that they should interview me before they made their final decision for the internship program (Now that's what I call the power of networking!).

During my internship I was nominated by PSSA-SG branch to be their representative at the PSSA National Executive committee from 2007-2008. After my internship at Adcock, I completed my community service at Hillbrow Community Health centre, then Adcock offered me a permanent position as production Pharmacist. Three years later I moved to Sandoz to become a Production Manager. Later I moved from Sandoz with a view to venture into other different fields of pharmaceutical business, to widen my experience. This is one of the advantages of this profession of mine (one degree can open endless opportunities).

I'm currently serving on the PSSA – SG committee as a Student Liaison officer, nothing gives me more pleasure than trying to get young pharmacists involved in Professional Politics because I believe it takes more than just a degree to become a greater Pharmacist. I believe that, we as young pharmacists have the responsibility to influence the environment in which we practice to improve the circumstances in which we practice, and to carve the future of our profession. As pharmacists, we need to acknowledge the fact that we cannot thrive independently, but as a unit we can be the best profession we ought to be.



Leaving fingerprints behind

by
Hester Coetzee, Pharmacist



I have a friend who was blessed with amazing artistic talent. She painted, drew and decorated her home in extraordinary ways. She also loved to travel. You can see from the National Geographic magazines which she has collected what her travel preferences were. She has left her mark. It is as if her '*fingerprints*' are everywhere because of the things *she* created, things she changed.

My friend turned 60 last year. Her husband and children held a meeting last week to discuss the rapid deterioration of her memory.

I am currently reading a book about an American pharmacist; a consulting pharmacist. He reviews old age home prescriptions and makes suggestions on alternative medicines to be used or the adaptation of doses, for example. People very often consult with him when they have prescriptions with ten items and they have lost total control of their medicines. Sometimes he is consulted when people experience severe adverse effects from their medication, or when they (or their children) are simply at the end of their wits. In his book he discusses the medicines he found to harm the elderly and also impaired their memory. Medicine we think to be harmless, which are mostly harmless when younger people take them—medicines he believes the elderly should better go without because they do more harm than good.

When we talk medicine, the elderly includes anyone older than 65 years of age. Facts are that the elderly very often experience memory loss, fall, move with difficulty or may become depressed. Very often some of these effects are attributed to the use of medicines. These problems are very often overlooked because these people *have been taking these medicines for years* and never experienced any problems. But, we forget that the patient's renal function and blood flow to the liver have decreased over time and that the same dose now, perhaps, reaches toxic levels in the body. Some of these medicines include the first generation antihistamines, pain killers, sleeping tablets....

Let us briefly discuss a few examples. Increased sensitivity to hypotensive and sedative effects of medicines is to be expected in the elderly. Any anticholinergic medicine like tricyclic antidepressants (TCAs)

or the first generation antihistamines will increase constipation, difficulty urinating, blurred vision, confusion, short term memory loss and cardiac arrhythmias. TCAs can cause *serious* cognitive problems. Cimetidine is also not a good choice for the elderly. Normal adult doses can be used unless renal function is markedly impaired. However, we should expect impaired renal function in the elderly, which can then lead to cimetidine-induced confusion, dizziness, slurred speech, hallucinations and seizures. *Also remember*, that cimetidine inhibits many enzymes that probably metabolize other medicines that the elderly take and should thus best be avoided in those patients, due to these risks.

β-blockers can cause cognitive problems in older patients, including depression, insomnia, confusion, anxiety and short-term memory loss. Narcotic agents can cause confusion, disorientation, auditory and visual hallucinations and persecutory delusions – even tramadol can cause confusion. Meprobamate's adverse effects include drowsiness, dizziness, unsteadiness (will increase the risk of falls and fractures), cognitive impairment, memory loss and addiction. Neuroleptics cause movement disorders, delirium, confusion, depression and sometimes cardiac arrest and death.

Hundreds of statin-induced cases of memory loss and transient global amnesia have been reported. Statins, as a class, cause memory loss. But often an adverse effect of a statin (e.g. pains and cramps in the large leg muscles and back), leads to the diagnosis of restless leg syndrome. Now follows a prescription for a dopamine-agonist (DA-agonist) which exacerbates the problems with memory and cognition. Here the medicine cascade begins.

Sedative hypnotics should never be prescribed to the elderly if only because they increase the risk of falls by 70%. The chronic use of benzodiazepines heightens the risk of cognitive impairment (and falls) even in younger patients. Zolpidem is often called 'the amnesia drug', but all the sedative hypnotics can put an older patient on the road to cognitive impairment. Did you know that the FDA now recommends that women (of any age), and any person older than 65 years of age should not take more than 5mg of Zolpidem!

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Fluoxetine is probably totally inappropriate to be taken by the elderly. Not only is the half-life too long, it (like other selective serotonin reuptake inhibitor (SSRI) medicines) causes hyponatraemia, which can cause symptoms such as drowsiness, confusion, muscle twitching and convulsions. People over 65 are especially susceptible to hyponatraemia. SSRI-use can also lead to anorexia and insomnia. In 2011, the results of a study were published in the British Medical Journal where it was found that selective serotonin re-uptake inhibitors (SSRIs) were not as safe for the elderly as they thought. Patients in this study were all older than 65 years of age. These patients were more likely to die, suffer a stroke, fall, fracture bones, have a seizure, or experience other adverse effects than those not taking them.

These are just a few examples of common medicines that can cause cognitive problems in the elderly. There are many more. Any number of medicines or medicine combinations can lead to false positives for Alzheimer's disease and other cognitive impairments. As a person ages, the adverse effects of any medicine becomes more pronounced. Polypharma-

cy complicates everything.

We should take more time to evaluate the medications that the elderly take. We should listen to their complaints and what they try to tell us. All I am asking is for you to pause a while and consider the possibility of medicine-induced mental impairment. What if we don't listen? How many people will continue to lose so much of their lives? But, what if each of us could give someone their life back? What if somebody that was totally impaired because of the medicines they took could suddenly drive themselves to the pharmacy and to bowls and live a meaningful life once again?

I hope a simple explanation is found for my friend (or anybody else's friend's) impaired memory. Perhaps they'll link the memory loss to hypothyroidism. Or, if we are lucky, a therapeutic intervention can make all the difference to their lives. Hopefully they are among those who can get their lives back. Maybe we (being pharmacists), should, while we still have the time and mental abilities, start leaving our *fingerprints* - let us enable more people to live their lives better.



To the Editor

Comment on Hester Coetzee's Articles



The articles deal with a number of issues of great importance to us as Pharmacists and to the public that trust us as the "guardians of medicine":

In the days before all the knowledge that is available to us now we also knew that a number of the substances which we dispensed had the potential of causing serious consequences for our patients. These were mainly overdoses of so-called Division 1 or 2 "Poisons" or interactions between the ingredients in the prescription.

Handling these problems was relatively easy when compared with the complicated and highly sophisticated chemical entities which we dispense nowadays.

Besides having to memorise the maximum dose of the poisons, the bottles containing such items were ribbed and coloured green as a further warning to the dispenser.

Interactions mainly concerned the ingredients of mixtures and one quickly learned the reactions which would take place in mixtures which were acidic or alkaline or when precipitates occurred and were observed

during dispensing.

Hester's articles emphasize the important difference. The interaction now takes place within the patient. The effects are too late to correct and the patient either dies or suffers serious consequences.

The public sees the role of the "Guardian of Medicine" as someone who counts out the number of pills which the doctor has ordered and sticks on the label. Unfortunately this is supported by the image which many pharmacists project in their pharmacies.

The leaders of the profession have the responsibility of telling the public that these pills which the pharmacist dispenses have the potential of causing as much harm, probably much more harm, than the bullets sold by gun dealers.

I ask the question; **Whose role is more obvious to people - the gun dealer or the pharmacist? Whose fault is that?**

Ray Pogir, FPS





The 2D barcode and Health Awareness Days

During 2013 the Branch was requested by the National Executive Committee of the Society to investigate possible ways of promoting the Department of Health's Health Awareness Days with particular emphasis on specific days, including Pharmacy Week. The following subjects and months were proposed and accepted:

- March:** **Vaccination Week**
May: **Hypertension Day**
September: **Pharmacy Week**
November: **World Diabetes Day**

The use of the 2D barcode has been shown to be widely accepted as an effective way of distributing information to the public. This is a major boon for the Community Pharmacist, in particular, as it enables the pharmacist to communicate cost efficiently with his or her selected audience/s. The density of mobile phones in South Africa is very high and this means of communication is a prime means for all sectors of our population, but particularly younger persons, to access information. Mobile phone literacy in Africa is also high and basic internet data services are available wherever there is a cellular signal, which pretty much covers the whole of South Africa.

While 2D barcodes are relatively new. You may have noticed examples of these in magazine adverts or on packaging and wondered what they were.

These tags can be scanned by any smart phone or feature phone - the only requirements are a camera, data access and an application to be loaded on the phone - which is free of charge.

We encourage members to acquaint themselves with and actually experience the system first hand because it is the intention to use it more widely than simply promoting Health Awareness Days.

In order to do this, you need to download the application to your particular phone.

Go to <http://trustatag.mobi> or to <http://gettag.mobi>

The system will detect the type of mobile phone and will prompt the user on how to download and install the application. Once completed, you should scan this tag to access the brochure that we have developed entitled "What you should know about taking medicine" .

This will give you a good idea of how simple the system is to access and to use - and at no cost.



While we have missed the proposed Health Awareness Days for March and May this year we would like to know that a large proportion of our membership is acquainted with the means of accessing the Tag referred to above in preparation for Pharmacy Week, this year.



PHARMACY

PERSPECTIVES

By David Sieff



Pharmacists employed by corporate community pharmacy groups do not appear to participate actively in either the established representative bodies of so-called organised pharmacy, nor do they seem to have established a collective association of their own. There is a growing feeling that this situation should be greatly improved to the benefit of both "factions."

The corporate groups obviously have their own jealously guarded trading and business strategies, but there are certainly professional aspects of common interest that could and probably should be jointly discussed around a table. Immediately coming to mind are matters such as public health campaigns; Pharmacy Week and other Health Days promotions; indemnity insurance; submissions/comment to the authorities on draft legislation that will inevitably affect all of us. Surely, speaking with a single united voice on these issues would have far greater impact.

Cooperation at this level should not and need not be a contentious issue and could be a basis for further "toenadering" between the independent, private pharmacy owners and individual pharmacists operating in the corporate pharmacy chain environment.

There should be clearly defined lines of responsibility and action between the bodies that purport to represent the professional interest on the one hand and the business or commercial interests of community pharmacy on the other, to avoid the inevitable duplication of effort, waste of resources and treading on toes.

Since the corporates are unlikely to want or need commercial advice and protection for their pharmacies, it would make a lot of sense for an organisation looking after the pharmacists' professional

interests (such as CPS) to reconsider meaningful membership benefits to community pharmacists in *all* spheres of community pharmacy if they wish to remain relevant in a rapidly changing pharmacy environment.

The current community pharmacy environment is so different to that of, say, ten years ago that this would be a good time to really take stock of the current situation and consider new and meaningful membership benefits to all pharmacists occupied in this demanding pharmaceutical sector.



The Chairman of the Editorial Board is David Sieff and the members are Doug Gordon, Neville Lyne, Jan du Toit, Ray Pogir and Miranda Viljoen.

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We welcome all contributions and as space permits, these will be published, abridged and edited if necessary.

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