Celebrating Women in Pharmacy

NAWP Magazine

Founded 1905 Issue 05 - July 2012

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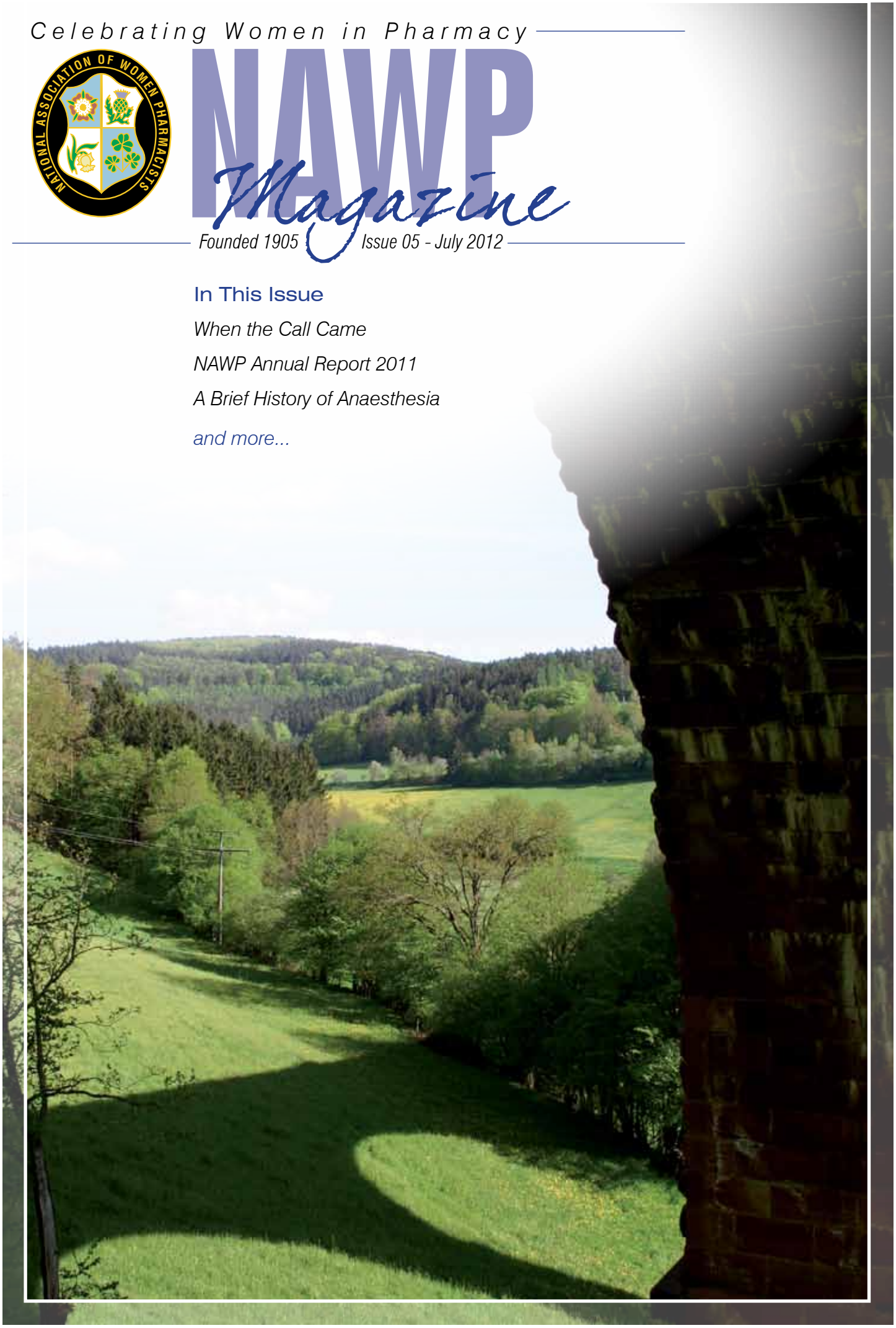

NAWP *Magazine*

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Celebrating Women in Pharmacy

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Founded 1905

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NAWP *Magazine*

The President's Letter

Dear Colleagues,

It was lovely to see many of you at our weekend conference in Manchester. It might have rained for much of the time, but it certainly did not dampen our spirits. From the moment the social programme started with the tour of Manchester United at Old Trafford and the evening meal at a restaurant in Manchester's Curry Mile there was the buzz that I associate with our conferences that make them so worthwhile. What a pity I was already in the foyer when Bobby Charlton waved to a number of you walking across from the minibus. I can still see Anita at the end of the meal, after counting up our individual payments, collecting an additional £1 from each of us in order to 'balance the books'. Now I know why she is our Treasurer!

A full account of the conference, both the symposium on neurological diseases and the social programme will be published in the next issue, but the quality and variety of speakers on neurological disease was excellent and the presentation by Pharmacist Support, very informative. I would like to thank Joan Kilby, Monica Rose and Anita White for all the hard work they put into organising the conference.

It was lovely to welcome our friends from Germany, the Netherlands and Poland for this combined NAWP and 8TH European Meeting of Women Pharmacists. It is unfortunate that a delegate from Egypt was unable to attend because of last minute visa problems and that on this occasion no-one from Tanzania was able to join us.

It was a pleasure to have Ann Lewis as our guest speaker at the dinner this year; that Martin Astbury, President of the Royal Pharmaceutical Society (RPS) was able to join us and to also have the opportunity to meet the Chair of the deutscher pharmazeutinnen verband (dpv), Karen Neiber; the President of NOVA, Monica Adler; and Monika Zielińska-Pisklak from Poland over dinner. I am also overwhelmed by the money we raised for my nominated charity, Winston's Wish, a total of £427.11.

I believe this is a record sum and I would like to thank all who donated to this charity which helps bereaved children.

Winston's Wish
the charity for bereaved children

www.winstonswish.org.uk

Virginia Watson
National Association of Womens Pharmacists
6 Hollis Gardens
Luckington
Chippenham
Wiltshire
SN14 6NS

24 May 2012

Dear Ms Watson

I am writing on behalf of Winston's Wish to thank you and the National Association of Women Pharmacists very much for your generous donation of £427.11. You donation will help towards our work with bereaved young people.

Every 22 minutes a child in Britain is bereaved of a parent, that's 24,000 newly bereaved children each and every year. At Winston's Wish we believe that the right support at the right time can make a life changing difference to a bereaved child and enable them to face the future with confidence and hope. Thank you for making this possible and helping us to change the lives of bereaved young people across the UK.

"Winston's Wish's capacity for healing is phenomenal. the staff are so skilful and compassionate; they are always on hand to give me a different perspective or to offer an idea as to how to overcome the latest stumbling block". Craig, parent

As a registered charity, we rely almost entirely on voluntary donations to raise the £1.7 million we need each year to maintain our service so every contribution really does count. Please feel free to get in touch if you would like more information about our work and the impact of your support, or visit our website www.winstonswish.org.uk

We would like to keep in touch with news of our work and current campaigns but if you would rather not receive further correspondence from Winston's Wish please let us know so that we can update our records.

With best wishes

Clara Browning
Fundraising Administrator

Mary Gwillim-David has retired from the executive committee (EC) after many years of service and I would like to acknowledge the contribution that Mary has made to our organisation and to thank her for all her hard work and also for the support she has given me. I extend a warm welcome to Elizabeth Nye who has joined the EC.

We continue to receive communications from the Women's Health and Equality Consortium (WHEC) on news items and events. They recently held an event on new emerging health structures and local level engagement in Bristol which I would have liked to have attended, but unfortunately this clashed with another appointment. Their most recent newsletter provides information and links to the Department of Health website on Local Health Watch which will be replacing Local Involvement Networks (LINKs) and will have statutory membership on local health and wellbeing boards.

Did you notice the feature in the Sunday Times on 6TH May? I was not aware that the Women's Library is under threat of closure as London Metropolitan University seek to make annual savings of £1,000,000. Some of you may recall the visit that we had to the Women's Library in September 2010 and the treasure trove of information that is held there. Our NAWP newsletter is one of the many periodicals that are held by the library. Over 10,000 have signed an online petition to the Education Secretary, and if you would like to add your support to saving this national archive, then the petition can be accessed on http://www.thepetitionsite.com/925/128/986/save-the-womens-library-at-london-metropolitan-university.

NAWP featured in the Spring edition of Welsh Chemist Review and we have been given permission to reproduce this article on page 9 - 10. There are plans to introduce an English Pharmacy Review in June/July and Joan Kilby and I were interviewed by them last week.

At the Manchester conference we piloted an abstract and presentation competition for pharmacy students, which we hope will become an annual event. I am delighted that Joy Nicholls and Sarah Tait have agreed to have their abstracts published in this issue of our magazine. Congratulations to both of them on their achievements as winner and runner-up. I welcome them as student members of NAWP and hope that we will see them at future events.

I am also very pleased that we have a contribution for this magazine from Aaminah Haq, a student member of the Medical Women's Federation (MWF). I met Aaminah when I went along to the MWF autumn meeting where we found ourselves working together during a workshop. Her article on the history of anaesthetics is excellent.

I would also like to draw your attention to the 10TH Anniversary meeting of the dpv to be held in Germany in September (further details on the back cover).

We continue to receive notification from the RPS of many consultations and if anyone is interested in learning more or would like to participate by providing input to NAWP responses, please get in touch.

Virginia Watson

President of the National Association
of Women Pharmacists

NAWP *Magazine*

When the Call Came

I had been anticipating this for several months, but when the letter arrived at the beginning of February there was that moment of panic. Was this the moment to retire from the register! Along with other pharmacists in the south west of England, my CPD records had been called for review.

Like so many pharmacists, my CPD records were far from ready to submit. I had several boxes of CPD materials, certificates of attendance and notes made whilst in the pharmacy of CPD - related activities. I had some handwritten CPD entries on forms I had printed off the computer a few years ago and I even found a memory stick where I had downloaded some entries on the very first version of electronic CPD records which I had asked the IT department to set up on my computer.

But, where to start?

Fortunately for me, since returning to the pharmaceutical industry in 1996 it was necessary to keep training records which had to be available for inspection during company, sponsor or Medicine and Healthcare products Regulatory Agency (MHRA)/ Food and Drug Administration (FDA) audits. Not only did I have a detailed list of dates of all industry-related training, but I had included all pharmacy –practice related professional development. This provided me with an ideal starting point especially as working across two sectors of the profession I wanted to select CPD activities from both.

Within days of receiving my letter, I had an email alert from my Local Practice Forum (LPF) offering support if necessary and providing links to information on the Royal Pharmaceutical Society (RPS) website. This was very useful and practical.

It took a couple of evenings to locate all the relevant material and then it was time to start writing up the entries. There was a choice of submitting paper or online records. I decided to go for the latter, but found it a very slow and laborious process. The earlier electronic and paper entries had to be revised or expanded, in order to use the preferred terminology. The database was not very user friendly, was slow and periodically dates I had entered defaulted to the current date, so I had to keep checking this at every stage. I tried setting up folders to file the records by year, but if I mistakenly filed a record in the wrong folder there was no way I could move it. There was one day when for no apparent reason when I corrected text or a spelling all subsequent letters or text were deleted and I found myself having to retype whole sentences. I checked the settings on my computer which were fine so it must have been a setting on the database. By the next day however the problem had disappeared. The print was too small to read on screen which necessitated printing out every entry to proof read. I was ready to submit when I re-read the instructions and discovered that abbreviations/ acronyms were not to be used as the reviewers were not pharmacists; so I had to go back and define all abbreviations used in each entry. Granted I should define GCP or NAWP, but is it really necessary to write MUR and NMS in full?

I think it took me the best part of 3 days to complete all the entries. Submitting entries online however was simple, fast and I could access acknowledgement of receipt almost immediately. Within a week I was able to access the outcome online. This is in contrast to those who submitted paper copies where two or three months elapsed before they were provided with feedback.

Reflecting on the CPD process I have learnt that there is plenty of support provided by the RPS and LPFs, and when records are called by area, it is a topic of conversation and of mutual support between colleagues.

It is obviously much easier if you have written up your records as you go along, but even then I discovered that many felt revisions to the original entries were necessary before submission. If you submit paper copies, you need to request a special pack and follow the specific instructions carefully. At the time that the call went out in this area there was a contradiction, between the letter and the instructions within the pack, on the number of entries required, but I assume this has now been rectified.

I don't know if it was necessary but I felt that with each entry I had to relate it to either industry or community practice or both, which meant defining this each time in 'planning' and 'evaluation'. Being of the older generation, and having practiced for many years, automatically doing what we now call CPD without even thinking about it, I got exasperated with having to explain how I had implemented learning into practice and how it would change my practice in future. I am afraid that my long- suffering husband bore the brunt of these outbursts. However, I can now understand the necessity for this as the General Pharmaceutical Council need to monitor compliance with CPD for the purposes of reporting statistics to higher authorities. I assume that this is achieved by ensuring all fields on the CPD form are completed. Are the entries checked for accuracy or relevance? – I don't know but I would like to think that at least a proportion are.

Submitting CPD records is not something to be dreaded, nor does it need the tears shed by a young pharmacy technician that I know. Times change.

Virginia Watson

NAWP *Annual Report* 2011

For many years NAWP has held its Annual Conference the second weekend after Easter. In 2011 this proved problematic due to the lateness of the Easter Break. This was further compounded by the announcement that the Royal Wedding would take place on the Friday of our chosen weekend and led to the decision to cancel the weekend school. However to comply with the NAWP Regulations it was still necessary to hold an AGM and this took place on 6 April 2011 at the Royal Pharmaceutical Society (RPS) Cymru, in Cardiff.

NAWP has continued to strive to raise awareness of the needs of women not only in our profession but also in the wider population. To this end NAWP, in conjunction with the Medical Women's Federation (MWF) and the RPS embarked on a joint event 'Blue Pill, Pink Pill – Does Gender Matter?' This was held at the RPS HQ in Lambeth in November. On this occasion representatives from industry, academia and the Medicines Healthcare products Regulatory Agency (MHRA) joined members of the two professions. Such was the impact of the meeting that the Lancet addressed one of the action points within two weeks of the event. NAWP is working with a number of agencies to address the many other action points that resulted from the discussions held on that day.

NAWP has continued its links with our European colleagues and 8 members, from the UK, attended the 7TH meeting of European Women Pharmacists in October which was held in Warsaw, Poland. This was the first time that this gathering had been held outside of Germany. Hazel Baker and Sid Dajani were among the speakers presenting at the Polish Conference.

NAWP has maintained its links with both the General Pharmaceutical Council and the RPS and a representative of each organisation sits on the NAWP Executive Committee (EC). Further to this Christine Heading has been nominated to represent NAWP on the 'Equality, Diversity and Inclusion (EDI) Reference Group' and NAWP has, along with other special interest groups, signed a partnership agreement with the RPS. This will allow all partners to work more effectively together whilst still maintaining their independence.

Over many years NAWP has enjoyed 'free' room hire when using the RPS HQ for its EC meetings. Whilst still wishing to maintain its links with the RPS, NAWP has been forced to look at other options such as changing the meeting day, from a Wednesday, to either a Monday or Friday which are 'free' days at the RPS or finding less expensive venues for a proportion of the EC meetings.

NAWP receives, via email, information on numerous consultations and draft proposals and the EC has endeavoured to respond to those it deems relevant to NAWP and its members.

In January 2011 our oldest member, Edith Spivak, reached her 100th birthday. Miss Spivak made a significant contribution to NAWP, especially during the Centenary year. Sadly Edith died in January 2012, shortly before her 101ST birthday.

NAWP continues to acknowledge the input of Phoenix in producing and mailing the Newsletter, which from January 2011 was re-launched as the NAWP Magazine.

Hazel Baker

ASSOCIATION

Women working together with the NAWP

As the National Association of Women Pharmacists prepares for its 107th annual conference, WCR takes a close look at the work that the association does.

The Conference, which is to be held in April at the Chancellors Hotel and Conference Centre in Manchester, gives female pharmacists around Europe the opportunity to get together and share best practice.

'The National Association of Women Pharmacists (NAWP) is an independent organisation within the profession in the UK and represents women in pharmacy,' said Past President, Monica Rose, who helped to organise the academic elements of the Conference. 'Its mission is to enable all women pharmacists to realise their full potential and raise their profile by being educationally, socially and politically active. Branches hold informal meetings with guest speakers covering a variety of subjects. Some branches also provide successful and informal networking and mentoring and may organise locum work in their area. Membership is open to all pharmacists and pharmacy students, regardless of age, race or gender.

'NAWP members have been attending the European Meeting of Women Pharmacists for the past seven of its eight years, and have formed strong friendships with many of its members, from Germany, Norway, The Netherlands and Poland in particular.

This year the two conferences have been combined, providing not only an extensive social programme but also a worthwhile day of information.

'The Association aims to enable all women pharmacists to realise their full potential by contributing to debate within the profession and healthcare; representing pharmacy amongst women's organizations; addressing career and CPD issues; providing networking and fellowship opportunities and examining women's healthcare issues.

'The Association has active links with many organisations and we meet with women pharmacists in many EU countries (especially Germany), liaises with women's

policy-forming groups in the UK, and participates in numerous consultation exercises affecting pharmacy in the UK. Members can enjoy a range of benefits including events such as the Association's educational weekend Conference, which provides a learning atmosphere which is both friendly and reassuring. This can be particularly welcomed by individuals who work as locums or part-timers and others whose work environment does not provide much in the way of professional support. Those returning to practice or changing their areas of practice can also find membership helpful.'

After spending a varied career in pharmacy, Monica now works as a locum in a small independent pharmacy in rural wales.

'The Cardiff branch of NAWP has given me much support over the years and is greatly appreciated both by myself and others for friendship. Some of our meetings are held in association with WCPPE and - until its recent demise – WCPDP (the WCPPE steering committee) which represented the interests of the locum pharmacist. We also provide support for pharmacists who wish to return to practice by offering job shadowing. For many years the branch has held a list of locum pharmacists, who are available for duty in South Wales and our list coordinator can help find locums in any eventualities.'

Monica's views on the benefits that the Association can bring its members are reiterated by Newport-based pharmacist, Hazel Baker, who joined in 1989.

'I knew others who were members and it was their influence and the benefits that they had received from the Association which encouraged me to join,' Hazel told WCR. 'The Association is invaluable in terms of the support, networking, job opportunities and social interaction, which it provides to its members. The Cardiff branch – to which I belong - meets three or four times a year in addition to the annual dinner and we also join forces with other branches in the UK and similar groups across Europe once a year.


Hazel Baker

'Our membership isn't very big – the Cardiff branch has only around 40 members – but I firmly believe that more female pharmacists could benefit from joining the Association in terms of what it provides. I think one of the reasons why the membership has remained quite low is because people have - over the years - found other ways of gaining support through media such as electronic networking.

It goes without saying that the issues surrounding women in pharmacy now are very different from those of the first members who joined in 1905. As with all aspects of healthcare and medicine, women pharmacists are treated much more equally now and this is reflected in the increasing number of professional support groups which are available now. With increased media, mobile phones and freedom of travel, pharmacists are not quite so insular as they once were.

'I think the Association provides particularly good value for people, who are returning to practice, perhaps after a career break when they've raised their family. We offer support to them by providing social networking and possible work shadowing opportunities; giving them ideas of where they can, for example, get job placements and we've already helped to place quite a few in work areas.'

For more information visit www.nawp.org.uk

PROGRAMME:

20-22 April 2012
107th Annual Conference of the National Association of Women Pharmacists in association with the 8th European Meeting of Women Pharmacists

Chancellors Hotel and Conference Centre, Manchester

Friday 20 April
NEUROLOGICAL DISORDERS

2pm	Visit to Manchester United Football Ground
7pm	Evening meal at a restaurant along the 'Curry Mile'

Saturday 21 April
NEUROLOGICAL DISORDERS

8.45am	Coffee and registration
9.15am	Welcome and introduction
9.30am	Overview of more commonly encountered neurological diseases and their diagnosis Speaker to be confirmed
10.30am	Coffee
11am	Management of Stroke and other Neurological Diseases from a Physiotherapist's Perspective (Claire Rose)
11.45am	Novel Therapies in Parkinson's Disease – the adenosine receptor (Prof Karen Nieber)
12.30pm	Parkinson's Disease – The view of an Expert Patient (Sheila North)
1.15pm	Lunch
2pm	Abstracts as submitted by students from Manchester University School of Pharmacy
3pm	Pharmacy Support – Help given to patients with MS (Members of the Pharmacy Support Team)
3.15pm	Tea/coffee
4.30pm	Development of a Pharmaceutical Service for Psychiatric Patients in Germany (Dr Martina Hahn)
5.15pm	Close of Conference
5.30pm	NAWP AGM
7.15pm	Reception
8pm	Conference Dinner

Sunday 22 April
NEUROLOGICAL DISORDERS
Optional guided walk of Manchester in the morning

Student *Abstracts*

In February 2012 NAWP piloted a new competition whereby pharmacy students were given the opportunity to share with a wider audience, pharmaceutical investigations or developments that they have been involved with.

As the competition was a pilot it was restricted to fourth year pharmacy students (male and female) at Manchester University.

Students were asked to submit a 400 word abstract of information that could be reported in a 10 minute presentation. The best entries were invited to present their work at the 8TH European Meeting of Women Pharmacists in Manchester and as a result two students – Joy Nicholls and Sarah Tait attended to present their work.

The standard of work presented was high. After much deliberation the first prize was awarded to Joy Nicholls.

Prevalence and nature of dispensing errors *impact of electronic ordering*

Joy Nicholls: I was born in Australia but when I was two my parents decided to move back home to England where I grew up in the Lake District. I have undertaken two summer placements with Boots as well as placements in hospitals and am due to start my pre-registration year at Salford Royal in August. (My study is a clinical audit undertaken at University Hospital of South Manchester)
Email: joynicholls@hotmail.com

Background

Electronic prescribing is a strategy used by physicians to reduce prescribing errors. In the pharmacy department at University Hospital of South Manchester (UHSM) electronic ordering of in-patient medication has recently been introduced. This is a similar idea to electronic prescribing with the same goal of increased patient safety, and is now being used in a bid to reduce dispensing errors.

Aim - To determine how electronic ordering impacts on the prevalence and nature of dispensing errors

Objectives

1. To quantify the number of dispensing errors that occur at each stage of the dispensing process
2. To categorize the errors that occur during dispensing
3. To compare the incidence and nature of dispensing errors, when medication is ordered electronically and on handwritten orders.

Methodology

A data collection form was designed to determine the prevalence and nature of dispensing errors within the pharmacy department at UHSM. The study focused on in-patient orders made through both the electronic and handwritten systems. The data was collected for 3 weeks. Information regarding actual dispensing errors that occurred was collected as well as information regarding potential errors.

Novelty

Electronic ordering of medication is a system that has been used since August 2011 at UHSM whereby a pharmacist or technician orders medication required electronically for an individual patient. No studies to date have any baseline data regarding the impact that electronic ordering has on the nature and prevalence of dispensing errors and this is why this research was carried out.

Results

The prevalence of dispensing errors when using the electronic system was 0.38% for actual errors and 0.38% for potential error. When using the handwritten ordering system the actual error rate was 1.15% and the potential error rate was 1.92%. All errors occurred in the first two stages of the process: the ordering and labelling stages.

Most errors made were discovered in the following stage of the dispensing process. The most common type of error made when using both types of ordering systems was wrong directions on the label. Handwritten orders were also found to have other important patient information missing from the order form, and this was a frequent potential error. Handwriting contributed to errors made on handwritten errors in 22.22% of actual errors made and 60% of potential errors that could have been made.

Conclusion

Electronic ordering of medication has shown to decrease the prevalence of errors made when compared to handwritten orders. The most common type of error made was the same for both ordering systems; however the handwritten system has shown to have the potential for important details relating to the drug or information regarding the patient to be incomplete.

Application of the NICE *medicines adherence guideline* by hospital pharmacists

Sarah Tait: I was born and schooled in Lancaster. I am a fourth year undergraduate student, studying at the University of Manchester. I will be undertaking my pre-registration year at the Royal Lancaster Infirmary and hope to pursue a career in hospital pharmacy once I have completed my pre-registration year.
Email: sarah_tait12@hotmail.com

Background

Medicines adherence is defined as, 'the extent to which the patient's action matches the agreed recommendations'.[1] According to the National Institute for Health and Clinical Excellence (NICE), 'between half and a third of all medicines prescribed for long term conditions are not taken as recommended. The estimated drug cost of unused or unwanted medicines in the National Health Service (NHS) is around £100 million annually'.[2] Poor adherence may lead to reduced benefit of medication, treatment failure and deterioration of health.

The NICE Clinical Guideline 76 entitled, 'Medicines Adherence: Involving patients in decisions about prescribed medicines and supporting adherence' was published in January 2009. It is aimed at all healthcare providers involved in the prescribing, dispensing and reviewing of medicines.

Aim

Determine the awareness of the NICE Clinical Guideline 76 on Medicines Adherence among hospital pharmacists working in NHS Trusts across the North West region.

Objectives

1. Examine the level of awareness of the NICE guideline among hospital pharmacists
2. Investigate application of the guideline principles during working practice

Methodology

A survey tool was developed to investigate the level of awareness of the NICE guideline on medicines adherence. The questionnaire was sent electronically to all hospital pharmacists working within the 28 NHS Trusts across the North West. The questionnaire was piloted to a small sample of the study population, with the main survey conducted in February 2012. The results were collected, interpreted and analysed descriptively.

Results

A total of 45 completed questionnaires were collected, giving an estimated response rate of 5.5%. Two thirds of respondents were aware of the guideline prior to the survey, with the most common method of awareness being via communication from NICE. The results showed varied levels of local guidance relating to medicines adherence being published, both prior to and in response to NICE's guideline. Only 13% of respondents had untaken additional training as a result of the guideline, with the majority feeling confident and adequately trained to address adherence issues.

The main themes highlighted in respondents' comments and suggestions were; need for further guidance to aid implementation, increased education, and improved communication of national and local guidance published.

Conclusion

The guideline principles were already being applied in practice, despite the lack of awareness of both national and local guidance published. Hospital pharmacists felt sufficiently trained and confident in their ability to address medicines adherence among patients, believing it has always been a central role of their practice even before the publishing of specific guidance.

Awareness of the guideline could be improved by a combination of approaches by both NICE and individual hospitals and departments. The guideline requires major cultural and behavioural changes from all healthcare professionals, which will ultimately take time to develop.

References:

1. *Horne R. Compliance, Adherence, and Concordance: implications for asthma treatment. Chest. 2006;130(Supplement 1):65-72.*
2. *Excellence NIfHaC. Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence. Full Guidance CG76. London: National Institute for Health and Clinical Excellence; 2009. p. 364.*

Corrigendum

On page 12 of the January 2012 issue of the NAWP Magazine, the statement under the copy of the front cover of The Lancet should read:

Reprinted with permission from Elsevier (The Lancet 2011, volume 378, November 26 – December 2)

Welsh Pharmacy Conference 2012

'Today knowledge has power. It controls access to opportunity and advancement'

This was the quote at the top of the folder accompanying the papers for the inaugural Welsh Pharmacy Conference, held in Cardiff on 26 April 2012. The conference was held in the City Hall and commenced at midday with a substantial buffet and an opportunity for networking. This was followed by the opening address given by Mr Michael Holden, Chief Executive of the National Pharmacy Association (NPA). Mr Holden gave an overview of recent developments in pharmacy within Wales.

The second speaker was Mr Mark Koziol, Chair of the Pharmacy Defence Association (PDA). Mr Koziol gave an outline on how he thought pharmacy should be shaped in the future. He said that currently NHS staff are working hard but not clever. There are 'log jams' in GP surgeries, unnecessary hospital admissions and as he put it 'silo' working within primary care all of which was leading to the patient's journey being a difficult and disjointed one. His vision for the future was:

1. The development of better pharmaceutical care to help increase concordance, decrease waste and minimise the number of adverse events.
2. To agree care plans with patients and especially those with long-term medical conditions.
3. To deliver continuity of care, to the patient, across all sectors of the NHS.
4. To provide other allied healthcare professions with adequate funding to carry out these tasks.

Achieving all this would, in his opinion, make the patient journey a much smoother one and would require the adoption of some key strategic principles, namely:

1. The alignment of the interests of the patient, the NHS healthcare team, the pharmacy contractor and the pharmacist, i.e. unites everyone behind a single unified plan.
2. To pursue roles that major on the unique skills of the pharmacist.
3. Driving forward new pharmacy roles in the community, but not at the expense of the supply function.
4. Exploit quality as well as quantity to give a structured, multi-layered care framework in the community setting.

Mr Koziol held the view that pharmacists need to get away from just the traditional role of 'licking, sticking and dispensing' into a role that sees better use of their expertise.

The next presentation was by Prof. Roger Walker, Chief Pharmaceutical Advisor to the Welsh Assembly. Professor Walker outlined the challenges facing the health service, particularly with the increase in life expectancy. In the mid 19TH century 80% of the population were dying before the age of 65 and now, in the 21ST century, 80% are living beyond 65. He stated that there has never been a greater challenge to public health, particularly when one considers that about 70% of a person's health is determined outside of the NHS, such as alcohol abuse, smoking, poor diet, social depravation and lack of physical activity. The profession of pharmacy has a pivotal role in promoting healthy lifestyles.

The conference then went on to look at the newly launched, Discharge Medicine Reconciliation (DMR) service in Wales. Three speakers from across all sectors of the service outlined the development, challenges and successes of this new service since its inception in 2011.

The final two presentations looked at skill mix and training opportunities, and how to grow a successful business.

Mr Holden then summed up the conference by saying that there needed to be trust, both within the profession and across the professions.

There was then just nice time to return home (or hotel if staying overnight) for a shower and change into evening wear to be back at the venue by 7.00pm for a drinks reception and further opportunity to network before a gala evening at the Welsh Pharmacy Awards, hosted once again by the Welsh Pharmacy Review. These awards were presented both to individuals and pharmacy teams in recognition of innovative ways of working in their particular sphere of service.

All in all a very worthwhile day and I'm looking forward to the next conference, should it become an annual event.

Hazel Baker

A Brief History of Anaesthesia

Methods of managing pain have been an obsession of physicians since before prehistoric man began trepanning to let out 'badness'. The rudimentary methods of the ancient world included narcotics that were crudely administered and barely understood. It was the concomitant developments of anaesthesia and antisepsis that have allowed medical interventions to move to the level of invasiveness achieved today to manage humanity's cries of pain. Prior to these breakthroughs, speed was the only mark of a successful surgeon and patients would often rather die than have any sort of operation.

The field of anaesthesia has a fascinating history of struggle, missed opportunities, refinement and trial and error. It reflects, in microcosm, the story of the wider shift in scientific research from anecdotal to evidence based medicine and brings to relief the qualities we desire from the ideal anaesthetic agents.

An account by Aaminah Haq, Student member, Medical Womens Federation

'Pneumatic Medicine' The First Inhalational Agents

Nitrous oxide - Although using nitrous oxide alone is not the method of choice now, at one point in the history of anaesthesia it was one of the best options available. Its possible effects on health were discussed by American doctor Samuel Latham Mitchell, who wrote a treatise on contagion and the opposing effects of nitrous oxide and oxygen, with the former supposedly being harmful and the latter beneficial.

Humphrey Davy, a gifted student at the Pneumatic Institute decided to test Mitchell's theory by experimenting with nitrous oxide on himself. He noted that the gas caused a sense of euphoric destruction of physical pain and posited that it could "be used with advantage during surgical operations" but did not carry his research further.

Until a breakthrough in the 1800s, nitrous oxide was relegated to the 'laughing gas' attraction exploited by disreputable travelling showmen. The story is well known that after watching a travelling show, dentist Horace Wells immediately recognised the potential of laughing gas and experimented with it the next day, allowing his own tooth to be extracted.

Though Wells rushed to publicise his discovery, demonstrations of his technique were often unsuccessful because of the difficulty in adequately administering the gas. Almost simultaneously, the tide was turning in favour of ether or chloroform and ether pioneers Morton and Jackson were wrangling over who should receive credit for the discovery of anaesthesia. This competition between both scientists and chemicals led Wells to sink into depression and he, sadly, committed suicide just a few days before he would have received word that his priority in discovering and performing surgical anaesthesia had been formally acknowledged.

Ether - Ether was actually the first true anaesthetic agent to be discovered, in the 16th Century, its soporific effects were noticed but its use didn't rise to popularity until much later; indeed, ether soaked sponges were mainly discarded in the 17th and 18th centuries, possibly due to the superstitious sentiment and anti witchcraft crazes of the time. In 1842 Dr Crawford Long applied his anecdotal knowledge of ether's properties by using sulphuric ether to excise a tumour in one of his patients. Although this may very well be the first documented surgical use of ether, Long did not realise the significance of his breakthrough and so did not publish until 1849, too late to gain credit.

1846 was the year that the term anaesthesia was first coined by Oliver Wendell Holmes Snr and was also the true year of ether breakthroughs. William Morton was a medical student aware of the nitrous oxide experiments going on at around the same period. He considered that sulphuric ether would be a stronger, more effective anaesthetic and so used it in October 1846 on a patient called Gilbert Abbot to allow surgical excision of a lump in his jaw. There is some controversy surrounding this discovery, mainly either personal slurs on Morton's character and alleged avariciousness (for attempting to patent his discovery) or regarding the claim that it was Morton's teacher, Professor Charles Jackson, who deserved credit for suggesting Morton replace nitrous oxide with ether.

After this demonstration in Boston, news raced across the Atlantic and experiments were soon duplicated across Europe with tooth extractions and even leg amputations!

Chloroform - In the tangled timeline of the early history of inhalational anaesthetics, chloroform's discovery, though not its first use, came relatively late. Samuel Guthrie believed that the "sweet whiskey" he had discovered, whilst trying to make chloric ether cheaply, could be beneficial but did not realise to what extent.

Professor of Obstetrics, James Simpson was responsible for the advancing the use of chloroform. He was unsatisfied with the effectiveness of ether on his patients and so recklessly experimented on himself, sampling many gases before chloroform in 1847. Chloroform was a huge leap forward in pain relief and ease of administration – simply wave a rag soaked in chloroform from a bottle. However, this increased potency came at a price; the risk of sudden death for patients undergoing any type of operation under chloroform anaesthesia was around 1 in 2500. In the long term, for those who survived there was a risk of severe delayed onset liver damage.

The reception to chloroform use in obstetrics was mixed, although the objections were more prudish than safety conscious, with many arguing that it was immoral to transform the suffering of a mother in labour into something more pleasant. However, this dissent rapidly quieted when Queen Victoria used the drug in her own 8th and 9th pregnancies, as administered by the first physician to truly specialise in anaesthesia – John Snow.

Local anaesthesia - Local anaesthesia was the next great frontier to be breached. The great advance was cocaine, which can lay claim to many people who were vital in its development. Most significantly, William Stewart Halsted showed that by injecting cocaine locally so that it could infiltrate the nerves, anaesthesia could be produced in any chosen part of the body. Throughout the 1900s injections directly into the spine for epidural and nerve block were the inevitable progressions to this discovery, allowing surgery and childbirth to occur without the depth and risk of general anaesthetics then available.

Intravenous anaesthesia - IV anaesthesia has existed for some time but was not refined until far more recently than the inhalational agents. The first records of anaesthesia produced by injecting the agent directly into a vein are from 1656 when Christopher Wren and Robert Boyle used opium to anaesthetise a dog, but they did not progress to humans. Reigniting interest much later, Pierre-Cyprien Oré advocated the use of IV chloral hydrate as a general anaesthetic. However, the substance was unfit for purpose because of its slow recovery time and narrow therapeutic index.

Barbiturates seemed to be the next avenue for advance, allowing relatively rapid and pleasant induction and recovery. Barbital was the first used but was still found to be too slow. A suitable alternative was not found until around 30 years later with Evipal, as reported by Weese. Evipal's moment in the sun was short, being eclipsed just two years later by Pentothal, shown by John Silas Lundy to be the best agent so far in virtue of potency and absence of muscular spasms. In turn, this was replaced by other modern agents.

Anaesthesia in the 20th century - The aim in the 20th century was to discover an inhalational agent with properties closer to the ideal. Several were adopted and then rapidly discarded. For example, ethylene was demonstrated in 1923 but shown to be flammable and explosive. Cyclopropane, introduced in 1929 had a similar problem, plus a marked tendency to depress respiration but it was more popular because of quick induction and recovery period.

The 1950s also saw the introduction of the revolutionary inhalational agent, namely the halogenated ether, halothane. This was much easier to use than its predecessors and caused less airway irritation but, as it has been shown to cause liver damage, it has since been surpassed by similar, but safer compounds such as isoflurane and sevoflurane.

Throughout the 20th century the groups of anaesthetic drugs have also been expanded and refined. The classes of muscle relaxants and their adjuvant, the reversal agents were created. The first muscle relaxant was turbocurare, a drug synthesised from a poison used by South American Indians. It was discovered to paralyse muscles without affecting circulation, allowing the anaesthetist to immobilise the patient for surgery without having a dangerously deep level of anaesthesia. In addition to this class, perioperative care was improved, with analgesia and anti-emetics available after surgery.

Now and next - It is almost impossible to discuss the current 'typical' use of anaesthesia simply because contemporary anaesthetists have such a wide variety of agents at their disposal for before, during and after operations. The drugs chosen can be tailored to the individual as well as being altered throughout the course of an operation. Present day anaesthesia is dynamic, both proactive and reactive. Despite that, there is still much room for refinement and improvement in anaesthesia, with progress and development constantly occurring.

Xenon is a rare noble gas that was first discovered in 1898 and has been experimentally used as an inhalational anaesthetic for over 50 years. The drug comes close to the properties of the ideal, providing both a useful depth of anaesthesia and some analgesic effect. It allows rapid induction and recovery

Drug	Pros	Cons
Xenon	• *Doesn't cause global warming* • *Not explosive or teratogenic* • *Low toxicity*	• *Expensive to synthesise and high MAC so will need closed rebreathe system and combination with other gases*
Suggamadex	• *Reliable action* • *No muscarinic side effects so faster recovery*	• *Side effects of nausea, vomiting and lengthened QT interval*
IV Paracetamol	• *Alternative to PR and PO* • *Plasma concentration achieved quickly, reliably with less variation*	• *Expensive* • *No effect on postoperative nausea and vomiting*

and its NMDA receptor inhibition is selective even at high concentration. It does not greatly decrease blood flow to and therefore perfusion of vital organs and along with lack of cardiorespiratory depression this means there is less danger of hypoxic damage to the vulnerable intestines, liver, brain and kidneys.

Suggamadex is touted as a replacement for the use of neostigmine as a reversal for steroidal neuromuscular blockers like rorcuronium. It works by causing a transient increase in plasma concentration of the blocker and then encapsulating it on a 1:1 basis so that concentration in the neuromuscular junction decreases, it is then excreted in this form via the kidney, which could be a problem in impairment. The drug has the possible side effect that the patient could be subjected to reparalysis if there is insufficient quantity of suggamadex to bind the free blocker after it has entered the plasma. An additional human problem: if anaesthetists begin to rely on the predictable effect of suggamadex they might be tempted to overuse the blocker initially. The complete paralysis then produced could mask deficits in analgesia or anaesthesia.

Lastly, the future will have a place for IV paracetamol in the post-operative period where oral and rectal preparations are either not available or not reliable, e.g. with reduced GI motility, diarrhoea, vomiting or blockage. The preparation is well tolerated and will result in less use of opioid analgesia. On the other hand, much of the evidence base for this drug actually uses its precursor IV propacetamol and in existing liver pathology or with errors in adjusting for bodyweight overdose causing hepatotoxicity is a risk.

Xenon, suggamadex and IV paracetamol are 3 modern agents likely to have wider use in the next few years and are a valuable addition to the anaesthetist's arsenal of drugs.

Timeline of some key dates in anaesthesia	
Ancient Greece	*Asphyxiation, hellebore, dittany, hashish, opium and wine of mandragora in use*
1540	*Valerius Cordus describes "sweet vitriol" synthesised from alcohol and acid*
	Paracelsus notes that "sweet vitriol" produces sleep in chickens
	Ether soaked sponges are widely used until the witchcraft crazes of the 17th and 18th centuries
1656	*Christopher Wren and Robert Boyle anaesthetise a dog with IV opium*
1730	*August Frobenius renames "sweet oil of vitriol" to "ether" from the Greek eithr meaning 'the upper and purer air'*
1774	*Joseph Priestly isolates nitrous oxide from air*
1779	*Franz Anton Mesmer publishes a book on the healing power of magnetism and hypnosis, while discredited in 1784 he may have popularised the idea of painless surgery with the public*
1784	*Scottish surgeon James Moore advocates nerve compression as a method of pain relief*
1798	*Thomas Beddoes founds Pneumatic Institute in Bristol*
1800	*Humphrey Davy publishes his work on nitrous oxide*
1832	*Samuel Guthrie synthesises "sweet whiskey" aka. Chloroform whilst trying to cheaply synthesis chloric ether*
	Credit is shared with Soubeiran in France and Leibig in Germany, who independently made the discovery at the same time
1842	*Crawford Long uses ether to remove a tumour from the neck of James Venable*
1844	*10th December – Horace Wells watches a travelling show*
	11th December – Horace Wells allows his own tooth to be extracted under nitrous oxide anaesthesia
1845	*Wells' demonstration of nitrous oxide at Massachusetts General Hospital is a failure*
1846	*16th October – William Morton demonstrates use of sulphuric ether to excise a lump*
	21st November – Oliver Wendell Holmes Snr writes a letter to Morton, suggesting the term "anaesthesia" from the Greek an + aiesthesis meaning 'without feeling'
	19th December – Tooth removed under ether by James Robinson in London
	19th December – Leg amputated under ether in Dumfries
	21st December – First surgical use of ether anaesthesia in England by Robert Liston
1847	*January – James Simpson begins by using ether in labour, later in the year he tries chloroform on himself.*
	November – James Simpson administers chloroform to Wilhelmina Carstairs
1848	*First widely reported fatality from chloroform*
1853	*John Snow administers chloroform to Queen Victoria for the birth of Prince Leopold*
1873	*First documented death from nitrous oxide inhalation*
1874	*Pierre-Cyprien Ore administers chloral hydrate as an IV general anaesthetic*
1884	*Carl Koller's report of cocaine solution as a local anaesthetic is reported to the Congress of Ophthalmology*
1897	*Dr August Bier administers the first spinal anaesthetic*
1902	*IV barbital use introduced by Emil Fischer*
1904	*Novocaine introduced*
1923	*Ethylene introduced*
1929	*Cyclopropane introduced*
1932	*Evipal use reported by Weese*
1935	*Pentothal trialled by John Silas Lundy*
1942	*Curare first synthesised by Griffith and Johnson*
1946	*Curare first used clinically by Professor Grey*
1950s	*Halothane in used*
MODERN DAY	*A huge variety, including halogenated ethers, neuromuscular blockers, antiemetics, analgesics, propofol etc.*
The Future?	*IV paracetamol? Suggamadex? Xenon?*

2012 Annual Subscriptions

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Associate Membership is open to individual healthcare professionals (including pharmacists in other countries and technicians) who support the objectives and activities of the Association. Associate members may attend and speak, but not vote at the Annual General Meeting of the Association.

Cheques should be made payable to NAWP.
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The Editor would like to thank everyone who has contributed to this issue of the Magazine and PHOENIX for their continued Sponsorship.

If you would like to contribute to the next issue, please contact the Editor or any member of the Executive Committee.

Tribute to Edith Spivack

1911-2012

It was with great sadness that we learnt of the death on 15th January only days before she would have celebrated her 101st birthday (Pharm J. 2012; 288: p123 and p396).

Virginia Watson writes, Edith qualified as a pharmacist in 1936, after undertaking a pre-graduate apprenticeship (1930 -1933) at a pharmacy in Marlyebone, London before studying at Chelsea Polytechnic. She then worked in a number of pharmacies in the London area before opening her own pharmacy in 1951 in Kingsbury, London. Her personal touch won her many customers and she was often referred to as 'Dr Edith'. She also encouraged young people who worked for her after school or during the holidays to take up science or pharmacy.

She sold her pharmacy in 1975. Inevitably, during her 45 years in practice Edith saw many changes in pharmacy practice, including having to change to the metric system towards the end of her professional working life and the decline in extemporaneous dispensing and chemist nostrums. During World War II she worked through the 'Blitz' and when proprietary household products were no longer available she found herself making hand creams and cosmetics.

When Edith qualified, pharmacy was still a male dominated profession and there were occasions when she encountered prejudice, but she went on to become the first woman to chair the Hendon and Edgeware Local Branch. She was a member of NAWP and a member profile of Edith was published in our June issue last year. In 2005 to celebrate NAWP's centenary, at the age of 95 and as our oldest member, Edith shared many memories of her life in pharmacy with us on a DVD which featured her talking about her experiences as a pharmacist. Edith celebrated her own centenary in January 2011.

Edith retained her interest in pharmacy throughout her retirement and was very proud to be a pharmacist.

We extend our sympathies to her family.

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22 – 23 September 2012

at Best Western Premier, Hotel Steglitz International, Berlin

Celebrating Women in Pharmacy

NAWP Magazine

Founded 1905

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