The Ghana Pharmaceutical Journal

Official Organ of the
Pharmaceutical Society of Ghana

- The 43rd Confab and 60th Anniversary of the Society
- New Pharmacy Council Inaugurated
- Kumasi - Venue for 1996 AGM
- IPSF Holds 41st Congress in Accra

Vol. 17 No. 3

M & G PHARMACEUTICALS LTD.

P.O. Box 1681, Accra, Ghana.
Tel: 666613 Fax: 669085

Location : D446/1 Bannerman Road. Next to DEVAG Ltd., James Town, Accra

Manufacturers of Pharmaceutical Products

Our Product Range include:

TABLETS

- Aluminium Hydroxide
- Acetylsalicylic acid (Aspirin)
- Chloroquine Phosphate
- Co-Trimoxazole
- Metronidazole
- Paracetamol
- Penicillin V
- Phthalylsulphathiazole
- Vitamin B-Complex
- Vitamin C

CAPSULES

- Amoxycillin
- Ampicillin
- Chloramphenicol
- Indomethacin
- Tetracycline
- Cloxacillin

SYRUPS/MIXTURES

- Chloroquine
- Dr. Lynn's Diarrhoea & Dyspepsia Mixture
- Haemoglobin with Vitamin B_{12}
- Multivitamin
- My Baby Cough Mixture
- No. 200 Cough Mixture
- Nutramin (Multivite Drops)
- Paracetamol Elixir
- Vitamin B Complex
- Wormex

POWDERS

- Glucose - D

Making Quality Drugs for Millions!!!

The Ghana Pharmaceutical Journal

National Headquarters of the Pharmaceutical Society of Ghana
Social Advance Institute Building
P.O. Box 2133, Accra
Tel: 228341

Vol. 17 No. 3 May, 1996

EDITOR

Merlin Mensah Ph.D., MPSGH

EDITORIAL COMMITTEE

Oscar Bruce B.Pharm., Dip. Journ., MPSGH
Merlin Mensah Ph.D., MPSGH
Eric N. Aheto B.Pharm., MPSGH, FPCPharm.
Joyce Addo-Atuah B.Pharm. M.Sc.(Clin. Pharm.), MPSGH, FPCPharm.
S.Y. Bediako-Donkor B.Pharm., M.Sc., MPSGH
Louis Nortey B.Pharm., MPSGH
Elizabeth Bruce B.Pharm., M.Sc., MPSGH

EDITORIAL CONSULTANTS

J. Atta-Nyamekye B.Pharm., MPSGH (Pharmaceutical Industry)
T.C. Corquaye B.Pharm., MPSGH, FPCPharm. (Forensic Pharmacy)
Rebecca Nordor B.Pharm., MPSGH (Hospital Pharmacy)
K. Ohene-Manu B.Pharm., MPSGH, FPCPharm. (Pharmacy Management)
Esther Osei B.Pharm. M.Sc.(Clin. Pharm.), MPSGH, FPCPharm. (Clinical Pharmacy)
K. Boakye-Yiadom Ph.D., FPSGH, FPCPharm. (Pharmaceutical Microbiology)
A.C. Sackeyfio Ph.D., FPSGH, FPCPharm. (Pharmacology)
K. Sarpong Ph.D., FPSGH, FPCPharm. (Pharmacognosy)
J.S.K. Ayim Ph.D., MPSGH, FPCPharm. (Pharmaceutical Chemistry)
Y. Dwomo-Fokuo, Ph.D., MPSGH, FPCPharm. (Pharmaceutics)

CONTENTS

EDITORIAL

We Have Come Thus Far 3

SOCIETY NEWS

Important Notice From the President 4
From the Secretary's Desk 4
The 43rd Confab and 60th Anniversary of the Society 5
1995-1997 Council Members Sworn-in 6
New Pharmacy Council Inaugurated 7
Important Decisions Taken at the 1995 Confab 8
Welfare Review Committee Submits Report 8
Kumasi Selected for AGM '96 10
Lady Pharmacists Hold 1995 Confab 10
IPSF Holds 41st Congress in Accra 11
Bell Sons & Co Donate to Faculty of Pharmacy 11
56th International Congress of FIP Provisional Prog 13

CURRENT AFFAIRS

Study Raises Doubts Over Calcium Channel Antagonists - Large Scale Trial Awaited 18
EuroPharm Forum Wins FIP 1996 Pharmaceutical Practitioner\of the Year Award 18
FIP Foundation Extends its Award Prog. to 115,000 Dutch Guilders per Year 19

PAPERS

Team Concept to Patient Care - The Pharmaceutical Perspective 20
Team Concept to Patient Care: Crossing Disciplines and International Boundaries 25
Group Dynamics and Team Building in Management 31
Report on the Activities of the Pharmacy Division of the Ministry of Health for the Year 1995 35
Pharmacy Education in Ghana - Is it Preparing the Pharmacist for his/her Role in the Healthcare Team? 37

PEOPLE 39

The Ghana Pharmaceutical Journal is published three times a year by the Pharmaceutical Society of Ghana in Accra. Correspondence concerning editorial contents and advertisements should be addressed to: **The Editor, Ghana Pharmaceutical Journal, P.O. Box 2133, Accra, Ghana.** All materials intended for publication should be submitted typewritten, in double spacing on one side of the paper and in duplicate. Materials accepted for publication may be subjected to editorial revision and, in the case of original papers, once they are published in this journal, they cannot be published elsewhere except by agreement. Authors should conform with current style in the presentation of papers, indicating where tables and figures should be inserted. Views expressed by contributors do not necessarily reflect the opinion of the editor. Partial or total reproduction of the contents of this issue in any manner or form is prohibited.

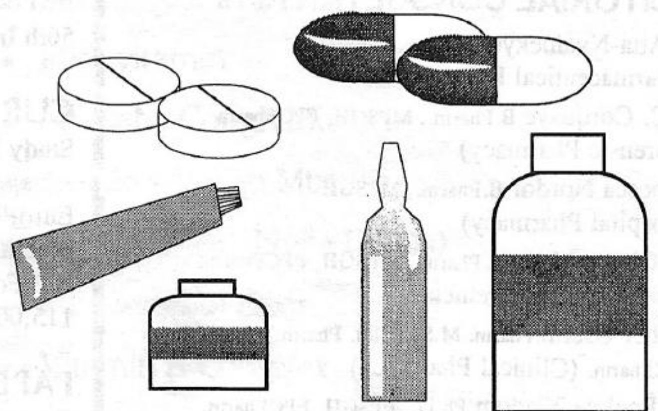
DEREK CLARKE (CHEMISTS) MIDDLESEX, U.K.

range of Quality Generics in Ghana

backed by over 40 years of reliable service in Pharmaceuticals

Includes

* **Antibiotics**
* **Antibacterials**
* **Antiinfectives**
* **Antiinflamatory**
* **Multi vitamins**



For all your requirements contact our local office

DEREK CLARKE LTD

opp. Anitex Ltd, Dadeban Loop,
Industial Area, Accra-North.
P.O. Box 6581 Accra-North.

Tel: 220817/230160
Fax: 223472

EDITORIAL

We Have Come Thus Far.....

An historic event has taken place in the annals of the Pharmaceutical Society of Ghana without much fanfare. However, to members of this august body (the majority of who attended this ceremony) the 43rd Conference was a successful event.

The choice of venue, the Accra International Conference Centre, the daily schedule of the activities, the choice of theme and speakers, the presentations and other innovative activities like the "Home Hospitality", all endeared the conference to the hearts of participants (of course this is not to say all was smooth sailing), there were lapses and we hope these would be taken into consideration in planning subsequent events. To the outgoing Council, the conference planning committee we say 'kudos', 'Ayekoo' for a job well done.

Turning now to the resolutions made at the Conference and captured in the communiqué, we are delighted to note the self-giving spirit evoked in the pledges to endow the Faculty of Pharmacy, our Alma mater, with the sum of Two Hundred and Fifty million cedis (¢250,000,000.00) and to give the Pharmaceutical Society itself a financial base for building an office facility.

We laud the spirit of co-operation and adventure stirred up among the membership to gear up for study, training and participation in team work for the delivery of effective services to our clients - the people of Ghana. Again, we laud the spirit of co-operation between the old and young members of the profession which permeated the conference and allowed deliberations, though heated at times, to come to conclusions. Criticisms have been made about some actions and personalities, challenges have been thrown up, but we have remained solidly united as one body, bound by the common aspiration of serving all men.

A chapter that began with the formation of the Pharmaceutical Society of the Gold Coast sixty (60) years ago on 19th December, 1935 and led by the late Mr. William Hansen, has turned a new page. We have come thus far by the grace of the Almighty God. In the words of J.W. Hansen "let us march forward till victory is won".

To the newly elected Standing Executive and others on the Council we wish a successful term.

We are pleased to report of the inauguration of the Pharmacy Council at last. To members of the Council we also wish a successful term.❑

Important Notice From the President

It has come to the notice of the Pharmaceutical Society of Ghana that some Pharmacists are misinforming the membership of the Society that under the new Pharmacy Act, 1994 (Act 489), Pharmacists are not required to pay their Annual Retention Fees to the Pharmaceutical Society of Ghana.

The President of the Society wishes to remind all Pharmacists that under the Professional Bodies Registration Decree NRCD 143, it is an offence for a person to practice a profession whose professional body is registered under the law in Ghana unless that person has been issued with a Certificate of Good Standing by the said Professional body. Since the Pharmaceutical Society of Ghana is the only Recognised Professional Body registered under the Law of Pharmacists, every Pharmacist in Ghana in enjoined to obtain a Certificate of Good Standing from it. A pre-requisite for obtaining such a Certificate of Good Standing is the payment of Annual Retention Fees. All Pharmacists are therefore urged to fulfil their obligation. The Pharmacy Council is being requested to inspect the Certificate of Good Standing of each Superintendent Pharmacist before renewing his or her Premises' Licence.❑

From the Secretary's Desk

The Pharmaceutical Society of Ghana must be a strong society. By this, I mean firstly, its members must be professionally very competent, secondly, it must strongly command public respect, and thirdly, it should be in a position to influence decision making not only within the health sector but also within other sectors of public life.

For this to happen, the Society needs to have a strong leadership. And by strong leadership I mean one made up of individuals who are knowledgeable (in pharmacy and in other areas), hardworking (both intellectually and physically), dedicated and upright.

In my opinion, we cannot have this kind of leadership if Standing Executive and Council positions are not made glamorous enough to attract the best material from amongst us.

I feel it is naive to think that, generally, a person would want to serve the Society in any meaningful position and way purely for the sake of it, that is, without expecting any form of reward, especially in a harsh socio-economic environment such as the one we are presently in.

Sometime during the last conference, I overheard a former Council member complain, while displaying the ¢2,000 given to him as sitting allowance, that "after all these look at what I get". And I felt disheartened when at a Standing Executive Committee meeting it was decided that the Society could not sponsor any of its executive members to the West African Pharmaceutical Federation (WAPF) Scientific Congress in Banjul because of lack of funds.

Leadership positions within the Society are voluntary and therefore cannot attract salaries but I believe that office holders must enjoy a good level of incentives which must be made known to all members of the Society. This will not only encourage incumbent office holders to give of their best but it will also serve to whet the appetite of members of the Society for leadership positions.

I must add here that a strong leadership with the qualities I have already described will be capable of coming up with ways and means of generating enough funds for the Society to provide the needed incentives. I am very certain that the Pharmaceutical Society is not at all the kind that should be in need of funds.

This message would not be complete if I fail to speculate on what we should expect if we continue in the direction suggested by what occurred last year where at the close of filing of nominations as stipulated by the constitution only two nominations for two different positions (out of eight) had reached the Secretariat.

In my opinion such a situation provides fertile grounds for a few self-made kingmakers to come together to select who should fill what position. What invariably happens is that they select their favourites and not necessarily those with leadership qualities.

In conclusion, I would restate that there is the urgent need for all of us to work to make the Society a very strong one. This we can do by making sure that the Society attracts the best material from among its membership to serve it and this can be made possible if leadership positions are made as attractive as possible employing the system of incentives. Failure to do this will result in our having a Society that always feels sidelined, perpetually meeting to discuss its image enhancement and forever complaining of lack of funds.❑

The 43rd Confab and 60th Anniversary of the Society

The Pharmaceutical Society of Ghana has held its 43rd Conference in Accra from September 20 to 23, 1995 under the theme *"Team Concept to Patient Care-The Pharmaceutical Perspective"*.

The conference coincided with the 60th anniversary of the founding of the Society.

The Hon. J.H. Owusu-Acheampong who is the Minister responsible for Parliamentary Affairs opened the conference.

He noted that healthcare was multi-complex and could only be effectively delivered through a multidisciplinary approach. He called on all health workers to cultivate the culture of team work.

Mr. Owusu-Acheampong told the conference that government would continue to extend health facilities to the rural areas and urged pharmacists, especially those in the private sector, to supplement government's efforts by spreading their activities to the rural areas.

Mr. David Anim-Addo, President of the Society, in his welcome address, advised that the nation would benefit immensely if more pharmacists were sponsored to undertake appropriate post-graduate studies so that they could take positions at various departments in all teaching, regional and district hospitals as well as the Ministry's headquarters.

Prof. G.W. Brobby, Dean of the School of Medical Sciences (SMS) at the University of Science and Technology, Kumasi, read the keynote address. His address has been reproduced elsewhere in this edition.

Other important personalities that were present at the opening of the conference include Dr. (Mrs.) Mary Grant, member of the Council of State; Mr. Addae-Gyambrah, a pharmacist and Deputy Minister of Mines and Energy; and Mr. Stuart Anderson, Research Fellow, London School of Hygiene and Tropical Medicine.

After exhaustive deliberation, the conference observed that:

1. Problems affecting the well-being of persons are multifactorial and require a multidisciplinary approach for solution.
2. Team approach to therapy is the best form of patient care.
3. Team concept makes economic sense since it offers safe and cost effective therapy.
4. Although the nation has among its numerous health care personnel the expertise for mobilisation for team work, this practise is lacking **within the health sector.**

Some of the occupants of the platform include(l to r) Mr. Stuart Anderson, Prof. G.W. Brobby, Mr. David Anim-Addo, Mr. Owusu-Acheampong and Dr. (Mrs.) Mary Grant.

And resolved therefore:

1. That members of the PSGH donate voluntarily to a fund to enable the only institution for the training of pharmacists, that is, the Faculty of Pharmacy, UST, procure equipment and materials to facilitate the training of students. And that university authorities create establishments for staff in the new areas of pharmacy practice, including clinical pharmacy;
2. That professional training opportunities be expanded to cover hospitals and community pharmacies during vacations for students;
3. That joint training opportunities be made available for the training of students of the various health care professions in the course of their studies;
4. That postgraduate training opportunities be expanded and sought for the pharmacist in such areas as health economics, management, and public health, among others;
5. That pharmacists in private practice take seriously opportunities in continuing education such as seminars, workshops, etc. to up-grade their knowledge and skills in modern healthcare methods;
6. **That pharmacists in public institu**tions be encouraged and supported to undertake further training and that the position of Assistant Pharmacist in the Ministry of Health be abolished;
7. That pharmacists take practice research seriously so as to enhance data collection and information on the Ghanaian situation for the benefit of the profession and other team members within the health sector; and
8. To institute a common forum for healthcare team members beginning with members of the Medical Association as soon as possible.❑

1995 - 1997 Council Members Sworn-in

Council members for the period 1995 to 1997 have been sworn-in on December 2, 1995 by Mr. E. Osei-Tutu, a Fellow of the Pharmaceutical Society of Ghana and past Chief Pharmacist of the Ministry of Health.

The ceremony took place during the inaugural meeting of the council held at the Pharmacy Council premises.

In his inaugural address, the President of the Society, Mr. David Anim-Addo who is also Chairman of the Council, said he expected the challenges ahead of the Council to be tough and hoped members would work selflessly together to achieve the objective set for the 1995 - 1997 period.

He noted that his singular contact over the period 1993-1995 was yielding positive results, for the school of pharmacy at the University of London had adopted the Faculty of Pharmacy and the Dean of the former school had promised to look for funding for post-graduate studies for some members of the Society.

Smithkline Beecham had also promised to provide a modern computerised Pharmacy Practice Laboratory in two phases.

Mr. Anim-Addo added that a corresponding pharmacy for the practice of vocational skills would be added to the laboratory.

With regard to career development the President said "recent events have exposed our inadequacies and lack of preparedness in respect of career development. Pharmacists must wake up and seek for those positions which today abound but which call for postgraduate qualifications. Pharmacists should make serious efforts to go for the gold, and I call upon each one of you to join me in an outreach programme to counsel and encourage pharmacists everywhere to search for the opportunity for post graduate study."

Talking about continuing education for practising pharmacists, he said "we require international donor funding to establish a centre as in the UK or USA to enable us make meaningful impact. My personal view is that only a professionally written Mission Statement on Pharmacy Education and Practice will do the trick, and then using the Journal to reach our members. We continue to spend money to print a Journal which sits in the office and which does not reach those for whom it is made. I seriously welcome new but achievable ideas from as many pharmacists as can make useful suggestions. In any case, as a Council, we need to provide our members with improved Continuing Education programmes.

Mr. Anim-Addo charged members of Council to make sure that by the next Annual General Meeting, every pharmacist would have paid in full, their contribution of ¢100,000 meant for the proposed Pharmacy House.

He hinted that "in view of the Pharmacy Council Law, I should like us to trim committees of Council in tandem with and as shadow committees to those of Pharmacy Council. There may also not be significant changes in membership".

Finally, he said that "having been brought thus far by the previous Council, we will take off now with a strategy towards Image Building and Enhancement of the Ghanaian Pharmacists, and his or her Profession. The Standing Executive Committee has already studied a working paper on the strategy as presented by Daniel Sekyere-Marfo the Assistant Hon. General Secretary."❑

Members of the new Council in a group photograph.

Enroll with the
West African Post-graduate College of Pharmacists
and Increase your Knowledge.

New Pharmacy Council Inaugurated

The first Pharmacy Council charged, with the responsibility of seeing to the provision of the highest quality of pharmaceutical services for Ghanaians, has been inaugurated in Accra on October 27, 1995 by the Minister of Health, Cdre (Rtd) Steve Obimpeh.

In his inaugural address, the Minister reminded members of the Council of the enormity of the responsibilities placed on them which he said include:

1. Securing in the public interest the highest standards in the practice of pharmacy;
2. Ensuring that courses of study and training in Pharmacy at any institution in Ghana guarantee the necessary knowledge and skills needed for the efficient practice of Pharmacy;
3. Determining, in consultation with the appropriate educational institution, courses of instruction and practical training for Pharmacy Students;
4. Prescribing and exercising standards of professional conduct;
5. Upholding and enforcing professional standards through the disciplinary powers conferred on it;
6. Keeping a register of duly qualified and practising pharmacists; and
7. Regulating the distribution of pharmacies in the country.

He urged the Council to tackle what he called some of the spill-over constraints from the former Pharmacy Board namely:

1. Inadequate staff to enforce the laws;
2. Skewed distribution of pharmacy shops;
3. Abdication of professional responsibilities to non-professionals;
4. Practising of medicine behind the façade of pharmacy;
5. Centralisation of regulatory activities in Accra;
6. Emergence of dubious pharmaceutical businesses without any fixed addresses or locations;
7. The growing dangers of uncontrolled sale of "prescription only medicines" and easy accesss to drugs; and
8. The risks associated with the sale and dispensing of fake and substandard drugs.

The Minister was happy to note that the new Pharmacy Act 1994 (Act 489) which establishes the Pharmacy Council made provision for the putting in place offices of the Council in the regions. This, he said, implied that the care taker role played by Deputy Directors of Pharmaceutical Services in the regions for the Pharmacy Board would cease and thus enable them have more time to attend to their normal duties.

Cdre Obimpeh directed that until the Food and Drugs Board was formed and inaugurated, drug control and regulatory activities would be taken care of by the Pharmacy Council to forestall a total collapse of drug control in Ghana.

He expressed concern over the indiscriminate advertising of drugs especially herbals, in the media and reminded media houses to seek authorisation from the Pharmacy Council before such adverts are used.

In an acceptance speech, the first Chairman of the Council, Mr. K.A. Ohene-Manu expressed members' sincere gratitude to His Excellency, the President, Flt-Lt. (Rtd) J.J. Rawlings, the Council of State and the Minister for the honour done them.

The Immediate Past Hon. Minister for Health, Commodore (Rtd) Steve Obimpeh (seated centre) with members of the Pharmacy Council.

He said members of the Council were aware of the onerous responsibilities placed on them and assured the President that they would so their very best to ensure the attainment of the objectives of the Council.

The Chairman also assured the Minister that the Council would soon present to him its views on "what we all need to do to ensure the smooth establishment of the Food and Drugs Board so that the Council and the Board acting in tandem can meet the aspirations of the nation".

Finally, he appealed to his colleagues on the Council and the Council Staff to join hands with him so that together they would advance the Pharmacy Profession in Ghana and provide the Ghanaian public with the highest standards in the practice of pharmacy.

*(Culled from the **Health Courier** Vol.5 No. 4, 1995)*

Important Decisions Taken at the 1995 Conference

1. Retention Fees

Members unanimously agreed that names of members not in good standing with the Society should be published in the Dailies.

2. Uncommitted Licence

All pharmacists who are not using their licence to register a premise may be issued with a licence irrespective of their place of work when they apply to operate a pharmacy, provided such a pharmacy will operate strictly within the confines of the laws governing pharmacy practice. Proposed by Alex Adjei Registration No. 1111, and seconded by Mr. S. Adu-Ayeh Offei, Registration No. 453.

There were 157 votes in favour, 11 Against and 51 abstensions.

3. Faculty of Pharmacy Fund

The above is be to set up with a target of two hundred and fifty million cedis (¢250,000,000). All members are to contribute a minimum of (two hundred thousand cedis (¢200,000).

Trustees to the above fund will be:

i. The Dean, Faculty of Pharmacy, UST.
ii. The incumbent President
iii. Mr. E. Osei-Tutu
iv. Mrs. E.R. Gavu

4. Pharmaceutical Society of Ghana (House)

Another fund is to be set up to be used to build a Pharmacy House. Each member is to pay a seed money of One Hundred Cedis (¢100,000), minimum.

Welfare Review Committee Submits Report

At their meeting held on December 2, 1995, National Council of the Society, realising the need not only to respond to the professional needs of its members but also to cater for members' social welfare, set up a committee to review the existing welfare package available for pharmacists with a view to making such a package more responsive to present day requirements.

The committee was chaired by Mr. John Arthur, the Greater Accra Regional Branch Chairman.

It was inaugurated on January 17, 1996 at the Headquarters of the Pharmaceutical Society of Ghana by the Hon. Gen. Secretary, Mr. Oscar Bruce who spelt out the terms of reference for the committee.

On Tuesday, March 11, the committee submitted its report which is published below to Mr. Oscar Bruce. Members are urged to scrutinise the report so that they can actively participate in a debate on it to take place during the business session of the next AGM and which would lead to its adoption.

The Chairman of the Welfare Review Committee presenting the report to the Hon. General Secretary of the Society, Mr. Oscar Bruce. Also in the picture are some of the members of the commiittee. Mr. Nat Akuetteh (left) and Mr. Dan Sekyere-Marfo, Assist. Hon. General Secretary.

Main Report

Terms of Reference

a. To define what constitutes welfare within the Pharmaceutical Society of Ghana.

b. To suggest guidelines for the implementation of the welfare package so defined.

c. To advise on ways and means of funding the package.

Sources of Information and Consultations

Discussions were held by members with individuals for ideas and suggestions. In addition, the welfare packages of the following groups and associations were reviewed:

a. Ghana Medical Association
b. Chartered Institute of Accountants
c. Ghana Institute of Engineers
d. Ghana Registered Nurses Association.
e. The Lions Club
f. The State Insurance Corporation
g. Ananse Computer Systems
h. Tema Sanyo Ltd.

Decisions Taken

Suggested areas of coverage of package include:

a) Bereavement.
b) Celebrations; weddings and outdoorings, etc.
c) Distressed Social Life including; Hospitalisation.
d) Employment Issues - Pharmacists; Employee/Employer Relations.
e) Group Insurance and Hire Purchase.

Suggested Package - Guidelines

Bereavement

The Society shall provide on loss of:

a) **Member:** Wreath and Flying Banner; Cash donation of ¢250,000.00 to surviving spouse and children or family (as applicable); Cash donation of ¢10,000.00 and one bottle schnapps to bereaved family.
b) **Spouse:** Cash donation of ¢200,000.00 to bereaved member.
c) **Child (2 only):** Cash donation of ¢50,000.00 at a time.
d) **Parent (2 only):** Cash donation of ¢100,000.00 at a time.

Pharmaceutical Society members are encouraged to attend funerals and to identify themselves and make individual donations when they so do. It is also suggested that Pharmacists attending funerals must provide their own drinks and other requirements to ease the burden on the bereaved family.

Celebrations

These include weddings, outdoorings, enstoolments, enskinments and ordinations.

It is suggested that the Society shall not be financially committed in these matters. This notwithstanding, members engaged in the above celebrations are encouraged to invite as many pharmacists as possible. Pharmacists are again advised to identify themselves. If the Society is officially invited, the Standing Executive Committee may decide on a formal representations on case by case basis.

Distressed Social Life

a) *Addiction, alcoholism and similar circumstances*

It was suggested that the Pharmaceutical Society should identify and put on record details of such persons for surveillance and offer counselling and recommend institutional care where necessary.

b. *Hospitalisation*

Members are encouraged to inform other members when hospitalised. Visitations and gifts are advised on individual basis. Circumstances will determine what role the Society can play, e.g. prescription filling.

c. *Employer - Employee Conflict*

It was suggested that the Society may offer counselling to the affected pharmacist at the Standing Executive Committee level. It was also suggested that the Society as a matter of urgency organise Seminars on negotiating skills for pharmacists on regular basis. Funding could be sought from NGOs like the Frederich Ebert Foundation. The Society should also sensitise the Pharmacy Council to the need for Guidelines for the employment of pharmacists in Ghana. A similar situation pertains in the USA.

d. *Aberrations with the Law*

Counselling and visitations are suggested.

e. *Group Insurance*

The State Insurance Corporation has the machinery in place to undertake premiums for members who are interested in group insurance policies such as:

i) Group insurance policy on fire for pharmacy shops or private residences.
ii) Group insurance policy for life coverage/with options on values a member thinks he is worth.

Hire Purchase

Groups of pharmacists may come together to form Consumer Co-operatives (not for drug purchase as obtains with the already established pharmaceutical co-operative) but mainly for home appliances, e.g. computers, gas cookers, cooking utensils, etc. Companies such as Sanyo Tema, Akosombo Textiles and Tema Textiles Ltd. Domod, etc. will welcome such groups.

Package Funding and Administration

As a result of the financial implications of the suggested package the following suggestions were put forward.

a) 20% retention fee to be charged in addition to the retention fee as a means of funding the welfare packages. It was suggested that a separate account be opened for the welfare fund.
b) The suggested financial awards/donations to be reviewed every 2 years.
c) A directory of pharmacists including personal data is strongly advised.

INVITATION

You are invited to attend the *56th International Congress of Pharmacy* to take place in Jerusalem, Israel from September 1-6, 1996.

Call at the Society's Secretariat for further information.
See page 13 for the provisional programme.

Kumasi Selected for AGM '96

Council of the Society has decided that the 1996 Annual General Meeting (AGM) be held in Kumasi. To this end, the President of the Society, Mr David Anim-Addo with the Hon. General Secretary, Mr Oscar Bruce paid a working visit to the Ashanti Regional Branch and met with its executive for preliminary discussions on the subject.

The President and the Hon. General Secretary also inspected the Kumasi Technical Institute (KTI), the most likely venue for the meeting.❑

The President, Mr. David Anim-Addo (second from left) and the Hon. General Secretary, Mr. Oscar Bruce (left) in a meeting with the Executive of the Ashanti Regional Branch including the Chairman (3rd from left), Mr. Rudolf Mensah.

Lady Pharmacists Hold 1995 Confab

The Lady Pharmacists Association of Ghana (LAPAG) last November held its 1995 Annual Conference at the Golden Tulip Hotel under the theme *"Women's Health, the Key to National Growth and Development."*

Speaking on behalf of Mrs. Nana Konadu Agyemang-Rawlings, First Lady of the Republic of Ghana and President of the 31st December Women's Movement, Mrs. Susan Alhassan, a Member of the Council of State, noted that the unique position of women in the family unit and the community at large made their health status an important issue to society as a whole.

The Chairperson of LAPAG, Mrs. Eniton R. Gavu, hoped that the association would intensify its efforts in educating the youth and women, in particular, and the nation as whole on sexually transmitted diseases, HIV/AIDS, the misuse and abuse of drugs and implications of teenage pregnancy.

The Chairman for the occasion was Brig. H.K. Anyidoho who is also a patron of LAPAG.❑

A section of the audience at the Annual Conference

IPSF Holds 41st Congress in Accra

The Ghana Pharmaceutical Students Association (GPSA) chalked a first in her history when she played host to the first ever International Pharmaceutical Students Federation (IPSF) Congress in Ghana held in August 13-22, 1995. The 41st Congress under the theme "Quality of Drugs Moving in International Commerce" came off in Accra.

The opening ceremony held at Accra International Conference Centre in the morning of Monday, 14th August was performed by the Minister for Health, Commodore (Rtd) Steve Obimpeh under the Chairmanship of Mr. David Anim-Addo, President of the Pharmaceutical Society of Ghana. Other dignitaries present included: the Dean of Faculty of Pharmacy, Prof. Kwame Sarpong; the Dean of the Univ. of Ghana Medical School, Prof. S.K. Owusu; the Registrar of the Pharmacy Board, Mr T.C. Corquaye; and some members of the Pharmaceutical Society of Ghana. The ceremony was heralded by a troupe of cultural artists who provided traditional music and dance.

The ceremony begun promptly as scheduled with a prayer after which the chairman of the Reception Committee, Mr. Eustace Orleans-Lindsay gave a brief welcome address. After the introduction of the Chairman and Special Guests, the President of the IPSF, Mr Riku Ruhanen gave a short address. He highlighted on the aims of the IPSF and the activities planned for the congress which included for the first time an interaction with UNESCO on higher pharmaceutical education. He hoped that through their imaginative effort they would face the challenges facing today's society.

Mr. T.C. Corquaye who stood in for the International Pharmaceutical Federation (FIP) Secretary General also in an address congratulated the IPSF and noted that the theme of the 41st Congress was not only relevant in the midst of fake drugs circulating in commerce but also reflects on the theme of the FIP's 55th World Congress in Stockholm (Sweden). During that congress, the FIP would hold an FIP/IPSF students day. "The idea for such a day is to introduce students to current trends in international pharmacy and make for interaction between pharmacists and pharmacy students".

The Minister for Health who gave the keynote address welcomed participants to the congress and expressed his gratitude to the Assembly for choosing Ghana to host the 41st Congress. He highlighted in his speech the responsibility of pharmacists to provide safe, quality and efficacious drugs which the professional, through knowledge, experience and regulation must ensure. He also spoke on drugs and their use in the treatment and prevention of diseases, improving physiological function and as diagnostic agents. He lauded the theme for its relevance especially for developing countries like Ghana. He moaned the negative impact aggressive advertising has had on high pricing of drugs which tends to encourage fake, cheap and spurious drug circulation. He also spoke exhortingly on the need for pharmacists to become involved in the healthcare system as a whole by undertaking relevant studies beyond the traditional pharmaceutical education. Some areas he mentioned included epidemiology, health economics, health planning and management.

In conclusion, he quoted Dr. Mehler, former Director-General of the World Health Organisation to show that we must not allow the technologies to overcome our professional competence and appealed to participants to the congress to deliberate on the theme and related matters to bring out recommendations to enable advancement in drug management.

The opening ceremony which took one hour ended well with the Chairman exhorting delegates to have a vision to head the profession in future. He highlighted the major points raised in the addresses such as: maintaining good pharmacy practice, recognition of the profession as a member of the health team and the need for pursuing relevant education beyond traditional pharmaceutical subjects. He also called for the formation of a Young Pharmacy Group to act as a pressure group in the profession.

To commemorate the congress, a congress cake was cut by the Hon. Gen. Secretary of the Pharmaceutical Society of Ghana, Mrs. Czarina Ribeiro after a group photograph of participants.❑

Bell Sons & Co. Ltd. Donates to Faculty of Pharmacy

In a brief but impressive ceremony held in the conference room of the Faculty of Pharmacy on Tuesday, October 17, 1995, a well known British Pharmaceutical Company - Bells Sons and Company Ltd., presented a computer and accessories and in addition books worth ¢0.5m (Five hundred thousand cedis) and a promise to donate the same amount of books each year for an indefinite period.

Making the presentation on behalf of the company, Mr Charles Owusu Darkwah, a pharmacist with Meacham Pharmaceutical Company Ltd, a principal agent of Bells Sons and Co. Ltd stated that the slogan for the donors is 'Health care for the family' and as pharmacists are in the front-line of contact in health care delivery, it was essential that their training be enhanced; hence the donation.

Receiving the gift, the Vice-Chancellor, of the University of Science and Technology, Kumasi, Prof. E.H. Amonoo-Neizer expressed gratitude to the donors. He also reiterated the policy he had pursued since assuming office. He stated that since it had become obvious the development of the University could no longer be supported by government subvention alone, he had instituted a committee to

(Continued on page 13.)

LETAP PHARMACEUTICALS LIMITED.

P. O. BOX 3346 ACCRA - GHANA
TEL: 224613 FAX: 233-21- 224693 TLX: 2588 LETAP GH.

TABLETS

CAPSULES

SYRUPS

INJECTABLES

SUSPENSIONS

MAKING MEDICINES FOR YOUR HEALTH

(Continued from page 11)
strategise cohesive and sustainable funding for the faculties and institutes to a 50% level within a 10 year period.

Earlier in a welcome address, the Dean of the Faculty of Pharmacy, Prof. Kwame Sarpong had additionally given the story behind the donation. He stated that in his attempts to forge links with donors to ensure availability of logistics particularly for training in the new areas of pharmacy such as Clinical and Social Pharmacy as well as Pharmacy Practice, he had visited the Managing Director of Meacham Pharmaceuticals Co. Ltd., Mr. Isaac Acheampong in his office to appeal for support. There fortunately he met Mr. Brian Lunt the commercial manager of Bells Sons and Co. Ltd. Discussions were held which had led to the donation.

The ceremony was witnessed by the staff of the Faculty and the University at large including Prof. K. Boakye-Yiadom, Dr. G.H. Konning, Mr. K.O. Opoku, Deputy Finance Officer and Mr. Mark Owiredu who is a consultant pharmacist also with Meacham Pharmaceuticals Co. Ltd.❑

56th International Congress of FIP

Provisional Programme

Sunday, 1 September

08.00-17.00 Registration
09.00-17.00 Council meeting

Symposia

Symposia classified as "P-symposia" are organised by the Board of Pharmaceutical Practice whilst Symposia classified as "S-symposia" are organised by the Board of Pharmaceutical Sciences.

09.00-17.00 P1 Medication Errors: Preventing and Reporting
Chairs: *T. Thielke, USA*, Hospital Pharmacists' Section, and *L.Stone, UK*, Community Pharmacists' Section
09.00-09.15 Introduction — *T. Thielke, USA*
09.15-09.30 a. WHO perspective — *A. Wehrli, Switzerland*
09.30-10.15 b. USA and international reporting Systems US national conference on drug misadventures — *M. Cohen, USA*
10.15-10.45 c. Using data to prevent or reduce medication errors — *F. Fritzsen, Sweden*
10.45-11.00 Break
11.00-11.30 d. Cost impact of medication errors *P. Schneider, USA*
11.30-12.00 e. Adverse drug reaction reporting system —*G.H.P de Koning, The Netherlands*
12.00-12.30 Panel discussion
12.30-13.00 Lunch
13.30-15.00 f. Case studies of prevention and reporting Systems; success stories — *D. Cousins, UK* and *M. Nakano, Japan, N. Eisenberg, Israel* and *M.H.M. Ling, Hong Kong*
15.00-15.15 Break
16.15 g. Community Pharmacy prevention and reporting systems *G.M. Hawksworth, UK* and *A. O'Shea, Ireland*
16.15-16.45 h. Regulatory agencies/boards of pharmacy - roles in error reporting and prevention — *J. Smith, Australia*
16.45-17.15 i. Use of automation to prevent medication errors — *T. Thielke, USA*

Monday, 2 September

08.00-17.00 Registration
10.00-12.00 Opening Ceremony
14.00-17.00 Pharmacy in Israel

Tuesday, 3 September

09.00-12.00 S1 Is Drug Metabolism Predictable?
Chair: *G. Tucker, UK*
09.00-09.30 a. Isoform profiling — *L. Benet, USA*
09.30-10.00 b. Molecular modelling — *N. Vermeulen, The Netherlands*
10.00-10.30 Break
10.30-11.00 c. Reaction mechanisms — *Z. Ben-Zvi, Israel*
11.00-11.30 d. In vitro - in vivo scaling — *G. Tucker, UK*
11.30-12.00 Discussion
09.00-12.00 P2 Use of Herbals/Natural Products in Health Care
Chairs: *K.W. Johnson, USA*, Section for Pharmacy Information, and *J. Bernath, Hungary*, Medicinal and Aromatic Plants Section
09.00-09.30 a. The role of herbals/natural products in health care: The South African experience — *N. Gericke, South Africa*
09.30-10.00 b. Rationale for acceptance of use of herbals/natural products — *K.W. Johnson, USA.*
10.00-10.30 Break
10.30-11.00 c. WHO records of adverse drug reactions to herbal preparations — *I.R. Edwards, Sweden*
11.00-1130 d. The need of adequate prescriber-oriented and patient-oriented information to reduce the health risks of plant-derived medicines — *P. de Smet, The Netherlands*
11.30-12.00 Discussion
14.00-17.00 S2 Is Oral Drug Delivery Delivering?
Chair: M. Donbrow, Israel
14.00-14.30 a. Is oral drug delivery delivering? —*J.R. Robinson, USA*
14.30-15.00 b. OTC analgesics: The contribution of drug delivery to time or onset and intensity of analgesic effect — *K. Brune, Germany*
15.00-15.30 Break
15.30-16.00 c. Drug delivery to the oral cavity — *A. Soskolne, Israel*
16.00-16.30 d. Potency, specificity and variability in choice of oral medications and pharmaco-econbmic implications — *J. Urquhart, USA*
16.30-17.00 Discussion
14.00-17.00 P3 The Need for Professional Re-engineering
Chairs: *C. Claesson, Sweden*, Administrative Pharmacists' Section, and *J. de Gier, The Netherlands*, Section for Pharmacy Information

14.00-14.30 a. Refocusing the profession's core and integrated functions — *M.A Tomechko, USA*

14.30-15.00 b. Technology fore-sight — *B.G Felkey, USA*

15.00-15.30 Break

15.30-16.00 c. Restructuring the pharmaceutical workforce — *P. Oakley, UK.*

16.00-16.30 d. Re-orientating pharmacy education and training — *I. Batse, UK*

16.30-17.00 Discussion

Wednesday, 4th September

09.00-12.00 S3 Terminally ill Treatment
Chair: *P. Spencer, UK*

09.00-09.30 a. Pharmaceutical care in pain relief — *A. Lipman, USA*

09.30-10.00 b. Control of drug adverse effects in the terminally ill patient — *T. Hall, UK*

10.00-10.30 Break

10.30-11.00 c. Relationships between patients and family members during terminal illness — *O. Gilbar, Israel*

11.00-11.30 d. Total parenteral nutrition in terminal illness — *M. Barnett, UK.*

11.30-12.00 Discussion

09.00-12.00 P4 Pharmacy Practice Research
Chairs: *C. Hitchings, UK*, Hospital Pharmacists; Section, and *H.G.M Leufkens*, The Netherlands, Academic Section

09.00-09.30 a. Academiea and practice - the way forward — *C. Benimoj, Australia*

09.30-10.00 b. Pharmacy practice research - the influence on health care — *C. Cairns, UK*

10.00-10.30 Break

10.30-11.00 c. Better practice - better patients — *D. Tromp, The Netherlands*

11.00-11.30 d. Using patient input to improve pharmacy practice — *B. Svarstad, USA*

11.30-12.00 Discussion

09.00-12.00 P6 Symposium on Pharmacology — Sponsored by an educational grant from Procter & Gamble Healthcare.

14.00-17.00 S4 New Initiatives in Regulatory Sciences
Chairs: *K.K Midha, Bermudas* and *H Moller, Germany*

14.00-14.30 a. Advance in drug delivery regulations FDA perspective — *R. Williams, USA*

14 .30-15.00 b. New initiatives in regulations for bio-tech products FDA perspective — *M. Beatrice, USA*

15.00-15.30 Break

15.30-16.00 c. New initiatives in European regulations — *F. Sauer, UK*

16.00-16.30 d. Industrial points of view — *M. Zhan, Germany*

16.30-17.00 Discussion

14.00-17.00 P5 The Development of Automation and Robotic and the Impact on Pharmacy
Chairs: *J. Merrills, UK*, Administrative Pharmacists' Section, and *R. Osterhaus*, USA, Community Pharmacists' Section

14.00-14.30 a Mail order. The use of automation in mail order pharmacy — Speaker to be announced

14.30-15.00 b. Robotics. The (positive) implications for the community pharmacist — *D. Glover, USA*

15.00-15.30 Break

15.30-16.00 c. The use of automated dose dispensing in Pharmaceutical Care — *A. Nilsson, Sweden*

16.00-16.30 d. Will technology replace pharmacists? — *P. Noyce, UK*

16.30-17.00 Discussion

Thursday, 5 September

09.00-12.00 P7 Status of Pharmaceutical Care
Chairs: *P. Kielgast, Denmark*, and *M. Buchmann, Switzerland*, Community Pharmacists' Section

09.00-09.30 a. Danish TOM-project on asthma — *H. Herborg, Denmark*

09.30-10.00 b. Pharmaceutical Care in the elderly — *J.C. McElnay, UK*

10.00-1 0.30 Break

10.30-11.00 c. Pharmaceutical Care in Zimbabwe — *A. Vaughan, Zimbabwe*

11.00-11.30 d. The Minnesota model — *M.A Tomechko, USA*

11.30-12.00 Discussion

09.00-12. P8 Trends in International Harmonisation: Process Development and Scale-Up of Drug Products- Pre-Approval Variations.-
Chairs: *I. McGilveray, Canada* OLMCS, and *H. Rahm, Switzerland*, Industrial Pharmacists' Section

09.00-09.30 a. Process development and critical process parameters — *R. Heasley, USA*

09.30-10.00 b. The role of the scaling-up factors in process development (is the 1/10 rule a good model for scale-up?)

10.00-10.30 Break

10.30-11.00 c. EU regulatory perspective — *D.M. Barends, The Netherlands*

11.00.11.30 d. US regulatory perspective — *R. L. Williams, USA*

11.30-12.00 Discussion

Section Meetings

Hospital Pharmacists' Section

Wednesday, 4 September

14.00-17.00 Hospital pharmacy visits

Evening Section dinner

Thursday, 5 September

09.00-12.30 Hospital Pharmacy -Future Threats and Opportunities — Chair: *J.C Kutsch Lojenga, The Netherlands*

09.00-09.10 Chairman's introduction

09.10-0950 The European perspective — *K. Sabra, Ireland*

09.50-10.30 The North American experience — *B. Woodward, USA.*

10.30-10.50 Break

10.50-11.30 The Oriental challenges — *R. Ohishi, Japan*

11.30-12-10 Australasian prospects — *H. Matthews, Australia*

12.10-12.30 Discussion

12.30-13.15 Lunch

13.15-14.00 Business meeting

14.00-17.00 High Technology - Its Influence On Patience Care.
Joint Symposium between the Industrial Pharmacists' Section, the Hospital Pharmacists' Section and Special Interest Group on Pharmaceutical Biotechnology.
Chairs: *T Nabeshima, Japan* and *D.J.A. Crommelin, The Netherlands*

The Symposium was made possible by an educational grant of Amgen-Roche.

14.00-14.10 Chairman's introduction
14.10-14.50 Biotechnology and genetic engineering- industrial perspectives — *D. Hoderlein, Germany*
14.50-15-30 The influence of bio-technology products on hospital care — *G. Smith, USA.*
15.30-16.10 The economics of future hospital therapy — *M.A.C.D. van de Poll, The Netherlands.*
16.10-16.30 Quality issues relevant for the user — *R. Shane, USA*
16.30-17.00 Discussion and chair's summary
All day Poster session

Friday, 6 September
09.00-12.30 Therapeutic Problems in the Hospital Environment — Chair: *H. Matthews, Australia.*
09.00-09.10 Chairman's introduction
09.10-09.50 Antibiotics and viruses — *O. Skold, Sweden*
09.50-10.30 Renal dialysis —*R. V. Leusem, The Netherlands*
10.30-10.50 Break
10.50-11.30 Tuberculosis — *T. Hardin, USA*
11.30-12.10 Anti-cancer drugs — *J.H. Beijnen, The Netherlands*
12.10-12.30 Discussion
12.30-14.00 Lunch
14.00-17.00 Oral communication — Chair: *T. Thielke, USA*
All day Poster session

Military and Emergency Pharmacists' Section

Wednesday, 4th September
Evening Section dinner

Thursday, 5th September
09.00-12.00 Information on the Medical Corps of the Israeli Defence Forces and on the national organisation for military and civilian emergency medical service
14.00-17.00 Study tour to military units and/or to civilian emergency service establishments

Friday, 6 September
09.00-12.00 Pharmaceutical Service in Connection with National and International Emergency Relief Operations
14.00-17.00 Short communications and posters

Medicinal and Aromatic Plants Section

Thursday, 5 September
14.00-17.00 Introduction and Production of Mediterranean Medicinal and Aromatic Plants
Chair: *J. Bernath, Hungary*
14.00-14.30 The use of native plants in the folkloric medicine of Israel — *D. Palevitch, Israel*
14.30-15.00 Leaves for the healing of the nations- towards the new millennium — *P. Houghton, UK*
15.00-15.30 Break
15.30-16.00 Medicinal and aromatic plants wealth of Eastern Mediterranean - with special reference to Turkey — *H.C. Baser, Turkey.*
16.00-16.30 Cultivation and utilisation of Mediterranean medical and aromatic plants in temperate zone of Europe — *E. Nemeth, Hungary*
16.30-17.00 Business meeting

Friday, 6th September
09.00-17.00 One day Section excursion with luncheon

Thursday, 5th September
14.00-17.00 Teaching Consumers/Patients about Medicines Programme for children; Programme for adults

Friday, 6 September
09.00-12.00 Teaching Health Professionals about Drug Information — Physicians; Pharmacists
12.15-14.30 Luncheon for members and invited guests
14.30-17.00 Oral communications

Community Pharmacists' Section

Wednesday, 4th September
14.00-16.30 Oral communications — Chair: *M. Shannon, Ireland*
16.30-17.00 General meeting
Evening Section dinner

Thursday, 5th September
Continuing Education Programme

Separate Registration
14.00-17.00 Integrating Pharmaceutical Care into Community Practice
Chair: *C.D Hepler, USA* and *M. Mesnil, Switzerland*

General objective

This programme will teach pharmacists how to adapt their existing management knowledge to effectively plan, organise, control and market the practice of pharmaceutical care in a community pharmacy.

Specific objectives

After successfully completing this programme, the pharmacist will be able to:

1. Discuss the main theoretical points of developing and maintaining new professional relationships with patients and physicians, e.g. the objectives of professional relationships, major social and psychological factors;
2. Discuss the ethics of teamwork in professional practice, in particular the balancing of conflicting duties to patient and colleague;
3. Describe a process for structuring and resolving ethical problems as in #2;
4. Describe ways to 'market' pharmaceutical care to patients, physicians, and others. (The ward 'market' in this objective means to describe the nature of the practice and the contributions that pharmacists can make to improve drug therapy outcomes);
5. Describe effective management of a pharmaceutical care practice in community pharmacy. Given a practice model and a documentation system on how to organise, direct and evaluate a practice, with particular attention to continuous improvement approaches.

Planning Committee

D.C Hepler(Chair), H. Herborg, R. Holland, M. Mesni, P. Noyce, M. Schulz and F. van Mil.

14.00-14.15 Chairman's introduction
14.15-14.45 (How) can pharmacists change the drugs use process?— Speaker to be announced
14.45-15.15 Ethics of teamwork — Speaker to be announced
15.15-15.30 Break
15.30--17.00 Workshop: Ethics of teamwork
All day Poster session.

Friday, 6th September

09.00-17.00 Continuing Education Programme continued
09.00-45 Marketing Pharmaceutical Care — Speaker to be announced
09.45-10.15 Break
10.15-12.00 Workshop: Marketing Pharmaceutical Care
12.00-14.00 Lunch
14.00-14.45 Meeting our responsibilities: Quality improvement and Pharmaceutical Care —Speaker to be announced
14.45-15.00 Break
15.00-16.30 Workshop: How to evaluate practice
16.30-17.00 Is there a life after Pharmaceutical Care? An optimistic view of community pharmacy in the next ten years — Speaker to be announced.
All day Poster session.

Industrial Pharmacist's Section

Wednesday, 4th September

Evening Section dinner

Thursday, 5 September

14.00-17.00 Trends in International Harmonisation:Product Scale-UP for Drug Products - Post-Approval Variations
Chairs: *H. Moller, Germany* and *B. Scherz, Switzerland*
14.00-14.30 Classification of types of variations in the light of specifications — *H. Moller, Germany*
14.30-15.00 Impact of process variation on the quality of marketed drug products — *H. Blume, Germany.*
15.0-15.30 Break
15.30-16.00 EU regulatory perspective — *D.M Barends, The Netherlands*
16.00-16.30 US regulatory perspective — *R.L. Williams, USA*
16.30-17.00 Discussion

Academic Section

Monday, 2 September

18.00 Informal reception

Wednesday, 4 September

14.00-16.00 Visit to the Faculty of Pharmacy
16.00-17.00 Business meeting at the Faculty of Pharmacy
Evening Section dinner

Thursday, 5 September

13.00-14.00 Poster discussion
14.00-17-00 Teaching Industrial Pharmacists
Chairs: *H. Moller, Germany* and *J.M. Aiache, France*
14.00-14.30 What to teach? The industrial point of view: What do pharmaceutical industries expect from universities — *M. Siewert, Germany*
14.30-15.00 The academic point of view: New areas at the university or by experience? — *J.M Aiache, France*
15.00-15.30 Break
15.30-16.00 The academic point of view: How to teach — *P.H. Kristensen, Denmark*
16.00-16.30 The industrial point of view: Training internships in pharmaceutical industries — Speaker to be announced
16.30-17.00 Discussion

Friday, 6 September

10.00-12.00 Academic management and leadership workshop:Creating what we want, using principles of visioning and creating.

Clinical Biology Section

Wednesday, 4 September

Evening Section dinner

Thursday, 5 September

09.00-12.00 Visit to hospital laboratories
14.00-15.00 Education in clinical biology in Israel. Practice of the profession — *G. Golomb, Israel*
15.00-16.00 Mutation research in diagnosis of rectocolic cancers — *A. Revol, France.*
16.00-17.00 From quality control to quality assurance laboratory accreditation — *J. Charret, France*

Friday, 6 September

09.00-12.00 Visit to the 'Research Institut Weizmann'
14.00-17.00 Oral Communications

Section for Official Laboratories and Medicines Control Services (OLMCS)

Wednesday, 4 September

Evening Section dinner

Thursday, 5th September

14.00-17.00 Trends in International Harmonisation: Production Scale-Up for Drug Products Post-Approval Variations
Chairs: *H. Rahm, Switzerland* and *B. Scherz, Switzerland*
14.00-14.30 Classification of types of variations in the light of specifications — *H. Moller, Germany*
14.30-15.00 Impact of process variation on the quality of marketed drug products — *H. Blume, Germany.*
15.00-15.30 Break
15.30-16.00 EU regulatory perspective — *D.M. Barends, The Netherlands*
16.00-16.30 US regulatory perspective — *R.L Williams, USA*
16.30-17.00 Discussion

Friday, 6th September

09.00-11.00 Oral communications
11.00-12.00 Business meeting

Administrative Pharmacists' Section

Thursday, 5 September

14.00-17.00 Ethics and Economics
Chairs and speakers to be announced

Friday, 6th September

09.00-12.00 OTC-Switches; Implications for the General Public and for Pharmacy — Chairs and speakers to be announced
14.00-17.00 Oral communications

DIAGELLATES

Plant Medicine

Composition: Basic Components per 100ml: *Psidium guayava* Ext. Tanninoids 750mg, Flavonoids, Resin, Reducing sugars, Chemical Additives.

Indication: Intestinal flagellates infestation Giardial Lamblia intestinalis. In diagnosed Peptic Ulcer (Gastric and duodenal). Amoebic dysentery and Gastritis of non-specific origin. In poisoning due to heavy metals and alkaloids. Controls stomach cramps in alcoholic poisoning.

Action: The resin expels flatus and has antiseptic properties on the gastro intestinal tract. The astringent and styptic effect of the tannins enable *Diagellates* to mobilise the cells in the broken mucosa to form coagulum that promotes healing of the ulcer. In poisoning due to heavy metals and alkaloids, *Diagellates* may be of value as an antidote but is by no means a substitute for lavage and other forms of therapy since the precipitated tannates may re-dissolve and the poison absorbed. *Diagellates* immobilises intestinal flagellates and expels them from the gut. The reducing sugars may play a role in the mechanism underlying the control of stomach cramps in alcoholic poisoning. If *Diagellates* is administered in the recommended dose, in the absence of diarrhoea, no constipation results. Onset of action is 15 to 20 minutes.

Posology: 5ml = 1 teaspoonful

Babies and children under 1 year — 2.5ml	Children 1 to 5 years — 5ml
Children 5 to 12 years — 7.5ml	Adults over 12 years —10ml

To be taken four times daily before meals for 5 days. In Peptic Ulcer the same dose to be taken for two weeks and the course may be repeated if necessary. In duodenal ulcer, dysentery and poisoning, double the above dose.

Pack: 75ml, 125ml, 230ml.

Overdosage: There are instances where a single dose of 50ml as a full course has yielded the desired effect. But there is the need to follow this with smaller doses to ensure total elimination of the flagellates. Never exceed 80ml as a single dose as this contravenes B.P. specifications for tannins.

Side Effects: Ill-effects have not been reported with the recommended dosage. It has however been reported in the Extra Pharmacopoeia, 28th Edition, that gastric irritation, nausea, vomiting and kidney damage may occur after the administration of large doses of tannic acid. Therefore, it is no longer advisable to apply tannins on wide area of burns and as enema. In such circumstances large doses of tannins are likely to be absorbed.

Storage: Store cool, away from light. The mucilage arising out of occasional occurrence of gun-resin may separate on standing, so shake the extract before use.

Note: As safety in pregnancy has not been established, it is advisable to avoid taking the drug during the first trimester of pregnancy. Concurrent administration of *Diagellates* with iron and alkaloids are to be made with care as *Diagellates* impedes their absorption.

MADE IN GHANA
For further information contact:
Cis Pharmacy: P.O. Box 660, Dansoman Estates, Accra, Ghana, W/Africa
Telephone Number: 301423

Distributors of *Diagellates*

Accra: • Ghana Co-op Pharmaceuticals Ltd., • Universal Chemists Ltd., • Dove Pharmacy Ltd, • J.M. Addo & Sons Pharmacy, • Kama Health Services Ltd.

Kumasi: • Ghana Co-op Pharmaceuticals Ltd., • Kama Health Services Ltd., • Empire Pharmaceuticals Ltd., • Rightway Pharmacy Ltd.

Koforidua: • Eastern Chemists Ltd.,

Cape Coast: • Honsal Pharmacy Ltd.

Takoradi: • Sam-Bens Chemist Ltd.

Tamale: • Opac Drug House Ltd.

Also Available in all Leading Pharmacies in Ghana

Study Raises Doubts Over Calcium Channel Antagonists - Large Scale Trial Awaited

A new study from the United States has suggested that there may be an increased risk of myocardial infarction (MI) in patients taking calcium channel blockers for treating hypertension.

The case-control study compared antihypertensive drug use in patients who had suffered an MI and a control group.

A total of 623 patients with a first MI and 2,032 controls were included. All had received drug treatment for hypertension. Reporting their results in the *Journal of the American Medical Association* (1995;.**274:** 620) the researchers say that use of short-acting calcium channel blockers, especially in high doses, was associated with increased risk of MI. The risk was increased by around 60 per cent compared with users of diuretics (risk ratio 1.62) or beta-blockers (risk ratio 1.57).

The increased risk persisted after adjusting for known risk factors for MI, such as age, smoking and diabetes.

The researchers, led by Dr. Bruce Psaty (University of Washington, Seattle), say that their hypothesis in carrying out the study had been that calcium channel blockers might have an adverse effect, in view of suggestions of increased mortality in secondary prevention trials.

Risk was the same for nifedipine, diltiazem and verapamil (only short-acting formulations of these drugs were being used.) At low doses of calcium channel blockers, the association was small. "Whether long acting formulations and other specific calcium channel blockers will have beneficial or adverse effects on the incidence of cardiovascular disease remains to be seen," the researchers say. They acknowledge that there are problems with case control studies and that bias might have been introduced in selection of a patient's therapy, and also that there may have been unknown confounding factors that were not taken into account.

Dr. Ian Baird (British Heart Foundation) said that the data were interesting but that case control studies had inherent difficulties in interpretation. "We do not advise any change in prescribing practice on the basis of a single case-control study," he said. The US National Heart Lung and Blood Institute, which sponsored Dr. Psaty's study, took the same view. Dr. Baird added that it would be "a disaster" if patients were to stop their medication on the basis of reports of this study.

Culled from the Pharmaceutical Journal (Vol. 255) September 2, 1995.

EuroPharm Forum Wins FIP 1996 Pharmaceutical Practitioner of the Year Award

At its meeting on January 15, 1995, the Board of the FIP Foundation for Education and Research decided to present the *FIP Pharmaceutical Practitioner of the Year Award 1996* to **The EuroPharm Forum.**

The FIP Pharmaceutical Practitioner of the Year Award is given to an individual or group who has made an outstanding contribution to pharmaceutical practice during the previous year.

The EuroPharm Forum was founded in 1992 and is a joint group of European Pharmaceutical Associations and the European Region of the World Health Organisation (WHO). Its membership has grown year by year so that, by January 1996 the pharmaceutical associations of more than 30 of the 50 countries which make up the European Region of WHO, had joined the EuroPharm Forum.

The EuroPharm Forum, according to its statutes, has amongst its purposes, "to improve health in the WHO European Region". In order to achieve this, the EuroPharm Forum has developed three task forces to develop Europe wide education programmes. These cover the areas of 'The Role of the pharmacist in smoking cessation', 'Questions to ask about your medicines', and the 'The role of the pharmacist in diabetes care (PharmaDiaB)'. It is for the innovative and far-reaching development of these programmes that the Board of the FIP Foundation for Education and Research decided to award the 1996 FIP Pharmaceutical Practitioner of the Year Award to the EuroPharm Forum. At the 1995 Annual Meeting of the Forum, Dr. J.E. Asvall, Regional Director of the WHO Regional Office for Europe, said: "I believe (the EuroPharm Forum) to be a powerful way of developing the pharmacist's role in health promotion and ill-health prevention". The Board of the FIP Foundation for Education and Research agree with Dr. Asvall's comment.

The President of EuroPharm Forum will receive the Award during the opening ceremony of the 56th World Congress of Pharmacy of the International Pharmaceutical Federation (FIP) on September 2, 1996 in Jerusalem, Isreal. The Award was introduced in 1993 and the Europharm Forum is the third recipient.

This award is made possible by an educational grant of Hoechst Marion Roussel.

FIP Foundation Extends its Award Programme to 115,000 Dutch Guilders per Year

At the Board meeting of the FIP Foundation for Education and Research in January of this year, it was decided to extend its Awards programme, which was set up in 1993, for another three year period with 115,000 Dutch guilders a year (an increase of 15%).

The Awards programme consists of Awards in Recognition of Excellence, FIP International Travel Scholarships, and FIP Fellowships. The Board decided to extend this Awards programme with the inclusion of the Bio-technology Award, which is sponsored by Amgen Inc. USA, and Development Grants. The FIP International Travel Scholarships will be increased from four to six per year.

The objectives of the FIP Foundation for Education and Research are to promote the education of, and research by, pharmacists and pharmaceutical scientists within the general fields of design, manufacture, distribution and use of medicines for humans and/or animals.

Bio-Technology Award: A person or group of persons who made a significant contribution to patient care in the field of oncology.

FIP International Travel Scholarships: To permit the recipient to travel outside his/her home country in order to develop, or to help others to develop skills and/or know-how. Scholarships can also be awarded to contribute to travel expenses for speakers at congresses, seminars or courses.

FIP Fellowships: To permit the recipient to perform research and/or training outside his/her own home country.

FIP Development Grants: Are awarded to pharmacists in developing countries to provide help with funding for a project which will be a benefit for the recipient and his/her country.

FIP Awards in Recognition of Excellence: Every year the FIP Foundation recognises outstanding achievements in the fields of pharmaceutical sciences by making four Awards. These Awards are: FIP Pharmaceutical Practitioner of the Year Award; FIP Lifetime Achievement in the Practice of Pharmacy Award; FIP Pharmaceutical Scientist of the Year and FIP Lifetime Achievement in the Pharmaceutical Sciences Award.

For further information on one of the above mentioned Awards, or other deadlines for submitting the applications, please contact:

Mr. A.W. Davidson
Executive Director
FIP Foundation for Education and Research
Andries Bickerweg 5
2517 JP The Hague
The Netherlands
Telephone number: +31 70 363 1925
Fax number: +31 70 363 3914 or
E-mail: foundation @fip.nl

World DrugAlert on the Internet

Following closely on the successful introduction of DrugAlert in the UK, the International Pharmaceutical Federation (FIP) and PharmWeb (a pharmacy related Internet server based at School of Pharmacy, Manchester University, England) have joined forces to launch World DrugAlert.

This system will provide up to the minute information on defective products, license suspension and withdrawals, batch recalls and other issues. These will be made available on World DrugAlert at around the same time as the information is released to the news media.

Subscription to World DrugAlert is free to pharmacists and other health professionals. By using the latest Internet technology, subscribers will be able to receive the correct information before the patient hears about the problem on radio, sees it on television or reads about it in the newspaper. Individuals with access to Internet can subscribe directly by going to URL:

http://www.mcc.ac.uk/pharmweb/pharmwebdrugalert.html

Share Your Honour with your Colleagues

Have You Received an Honour in Your Job?
Write to the Editor and Share Your Joy with Us.

You May Also Advertise Vacancy Opportunities, etc., at a Nominal Fee.

PAPERS

Team Concept to Patient Care - The Pharmaceutical Perspective

By G.W. Brobbey

I am mightily delighted and particularly pleased about the theme for the celebrations - *Team Concept to Patient Care - The Pharmaceutical Perspective* - which has been carefully chosen to meet the demands, aspirations and obligations of the Healing Art profession. Team concept to patient care behoves all health workers irrespective of their training and background to forge ahead and develop a unified approach to health care delivery. It is indeed an expression of and a call for unified diversity in the practise and the realisation of the goals of the health delivery system.

This diversity also demands of us an integrated but stratified approach to our teaching and training so that students of the health delivery system would be imbibed with the appropriate tenets and ethics dedicated to the cause of saving and ensuring the healthy life of our people. Currently the medical profession is undergoing a benign process of metamorphosis in terms of a new "Weltanshaung" towards the ethics and obligations of the profession. These are the challenges facing the young pharmacists, the young doctors, students of medicine, pharmacy, nursing and other health workers of today.

The present day economic factors that have led to sauntered growth and recession; kalabuleism, and the "noveau rich" attitude of some members of our society have unfortunately set the limits to the boundaries of professional activities and the quality of health care.

Nonetheless, these constraints notwithstanding the moral fibre of students of pharmacy, medicine, laboratory technology,nursing, and midwifery has not yet succumbed to these harsh realities of life. Throughout the years these young students have organised seminars, conferences, and workshops on health education, dwelling on very important topics like, drug abuse, teenage pregnancies, AIDS, STDs, and the re-emergence of TB. Important at such conferences is the team spirit among these future health workers. They have come to the realisation that team work is a *conditio sine qua non* for a successful enterprise, particularly in the area of patient care. Without this all their efforts would have come to nothing more especially when they begin to work in the hospital setting after their training.

Prof. Dr. Dr. G.W. Brobby is the Dean of the School of Medical Sciences at the University of Science and Technology (UST) Kumasi. This paper is the Keynote Address he delivered during the 43rd Conference and 60th Anniversary of the Pharmaceutical Society of Ghana held in Accra in September, 1995.

Constitutions

I have had the privilege to study most of the constitutions of these student societies. There is a blue print which runs through all of them which touches on the "Team Concept to Patient Care". There are people who will no doubt say that the principles outlined in these constitutions, which I prefer to call the "Magna Carta", are generic and obvious. True, and it is common knowledge that all constitutions throughout the world use high sounding language and propose great goals that transcend the life of a single generation. Nevertheless, who among us here present without fear of contradiction could claim that the three great principles of the French Revolution enshrined in their present constitution "Liberte-Egalite-Fraternite" that is, Freedom, Equality and Brotherhood", are generic and empty? They threw Europe into a turmoil and shook it to the very depths of its being. We must accept that, throughout history, some slogans are no sooner uttered than they change the world forever - a good example is found in a most recent revolution known to all us - "we no go sit down".

Historical Development of the Pharmacy Profession

Let us not turn our attention briefly to the genesis of Pharmacy. The characteristics of the Profession, the ethics of medical division of labour among the respective health workers in the delivery system and the overall relationship to our theme of Team Concept.

The genesis of pharmacy dates back to ancient times. When the pre-historic man expressed a juice from a succulent leaf and applied it to a wound, he was practising this ancient art called Pharmacy. In the book of Exodus, Moses was directed by the Lord to prepare "an ointment compound after the art of the apothecary". In the Greek legend, Asclepius, the god of the art of healing, delegated to the beautiful Hygeia, the duty of compounding his remedies. She was his apothecary or pharmacist. Later they fell in love. And so it came to pass that the god of healing, Asclepius or Aesculup, whose symbol is the wise serpent still used by Doctors, married Hygeia the goddess of Hygiene and Pharmacy. So, Medicine and Pharmacy are a couple ordained by the gods - a marriage not of convenience, but full of romance, and mutual respect.

The Physician-priests of Egypt were divided into two classes, those who visited the sick and those who remained in the temple and prepared the remedies for the patients. Here was the beginning of the team concept to patient care. In ancient Greece the art of healing recognised a separation be-

Original Herbal treatments from India
now available in Ghana.

* **Kofex** Herbal Syrup
for relief in cough problems

* **BruLiv** Syrup
for complete liver care

* **UTO** Syrup Plus
or complete uterine care

* ***NEED*** Capsules
for restoring strength

For Enquiries or Bulk Supplies, please contact:

Mokat Chemists Ltd.
274 South Labadi Estates (Near La Polyclinic)
P.O. Box C269, Cantonments, Accra

Tel: 773086

... for better life

tween the duties of the physician and that of the pharmacist. The separation prevailed also among the Roman practitioners. However, during the middle ages, in Europe the separation of the two groups became less distinct. Many physicians undertook the preparation of their own medicines. The Moorish influence in Europe brought about the practice of separate duties for the pharmacist and physician again. The trend of specialisation is exemplified by a law enacted by the City Council of Drugs, Belg. in 1683, forbidding physicians to prepare their own remedies. The distinct role of the pharmacist as separate from that of the physician is evidenced by the establishment of the office of apothecary general in the army of France during the middle of the 18th Century. In America, Benjamin Franklin took an important step in keeping the two professions separated when he appointed an apothecary to the Pennsylvania Hospital.

The Formal Characteristics of a Profession

With this historical perspective we shall now attempt to define the formal characteristics of a profession. At the end of my expose you will agree with me that of all the health workers working in a team for better health only doctors (including veterinary and dental surgeons), Pharmacists and Optometrists qualify to be called professionals.

What then is the definition of a Profession? What are the essential characteristics of a Profession? One can decide to place emphasis on both sides of the meaning of the word "Profession" as a special kind of occupation and profession as an avowal or promise. The second meaning of "Profession" however is of concern to everyone. It concerns everyone who has ever consulted a Pharmacist, a Physician, engage the serves of a Lawyer, solicited the advice of a minister or sat in a college classroom. All these people can always ask whether the avowal or promise has been fulfilled. Does the profession do what it promises to do? Does it accomplish what it professes? Does the profession - especially the Healing Art Profession - contain any endemic defects, defects that can be attributed not to its practitioner, but to its organisation and structure. Does the profession not function well because of lack of Team Spirit, and multi-disciplinary approach? The self-regulatory process, for example often used as one criterion of a profession, is intended to guarantee competence of its members and to protect its clients from those who can only be described as vulgar professionals. Unlike law and the ministry which have no important connection with modern science and technology, medicine and pharmacy have developed into a complex division of labour, organising an increasingly large number of technical and service workers around its central task of diagnosing and managing the ills of mankind. The Pharmacist may indulge in a misplaced or possibly exaggerated emphasis upon therapy, the lawyer upon property, the professor upon learning, the cleric upon sanctity and the artist upon aesthetics. Thus, a certain "ethnocentrism" may arise, a tendency to view and to evaluate the community of clients in terms of a professional rather than a more universal criteria. In every profession, as Friedson wisely observes, there is an ineradicable moral element. And he doubtlessly agrees with George Bernard Shaw that "Every Profession is a Conspiracy, against the Laity." A very good example of this is demonstrated by the way doctors write prescriptions. Because it is a conspiracy only Pharmacists can decipher the ugly handwritings of the doctors.

William J. Goode concentrated on two essentially "Core characteristics" of professions. These are one, "a prolonged specialised training in a body of abstract knowledge and two, a collective service orientation." From these are derived the following which border on autonomy:

1. The profession determines its own standards of education and training;
2. Professional practice is often legally recognised by some form of licensure;
3. Licensing and admission boards are manned by members of the profession;
4. Most legislation concerned with the profession is shaped by that profession; and
5. The practitioner is relatively free of any evaluation and control.

Goode's analysis becomes for us the most critical criteria for professions in so far as they are said to be casual - preaching professional autonomy. It goes without saying from the above that only Doctors and Pharmacists qualify as professionals within the Health Care Delivery System.

The Medical Division of Labour

A division of labour around the tasks of diagnosing and treating human ills has always existed in one form or another in most human societies. As you may remember, in the 60s, one of the very popular questions at the 'A' Level Biology was, "Division of Labour starts from Hydra, Discuss". In the Hospital settings of today it is possible to distinguish between Physicians and Pharmacists, as well as other workers who provide direct and indirect supportive medical services under "order" of or supervision by physician, pharmacists and other paramedical personnel. This distinction falls under the following:

a) those who serve the patient directly - primarily nursing and ward personnel but also various "therapists" (physiotherapist, speech therapist);
b) those who provide technical services contributing to medical service - laboratory and other technicians;
c) We must also not forget to mention those service workers who care for the physical plant of the hospital and perform the other tasks connected with maintaining the plant and managing the food, laundry and other services necessary for its survival;
d) the clerical personnel who prepare, transmit and store the written communication of the institution;
e) the Administrators who co-ordinate and ensure the overall realisation of the institution's objectives;
f) the legal governing board of the institution, which is not a continuously working group; and
g) the patients or clients, who are more or less passive

and frequently transient, but are nonetheless members of the organisation.

Each of these plays a very distinct but co-ordinated role in this team effort to ensure the composite success of the health delivery system. Through this division of labour expertise and know-how are ensured and manifested for the total good of the patient. Most of the occupations mentioned above, apart from the pharmacist, doctors and the administrators fall under the term Paramedical Occupation.

What then is a paramedical? The term "paramedical" refers to occupations organised around the work of healing which are ultimately controlled by physicians and pharmacists. Physician control is manifested in a number of ways. First, much of technical knowledge learned by paramedical workers during their training and use in the work tends to be discovered or enlarged upon or at the very least approved of by physicians. Second, the tasks performed by paramedical workers tend to assist rather than replace the focal tasks of diagnosis and treatment. Third, paramedical workers tend to be subordinate, in that their work tends to be performed at the request or order of, and is often supervised by physicians. Finally, the prestige assigned to paramedical occupations by the general public tends to be less than that of physicians and pharmacists. The role of the Pharmacist in a hospital setting therefore is entirely independent of the physician. The team concept to patient care is, thus based primarily on mutual respect, collaboration, and cooperative effort.

The Pharmaceutical Perspective

Sixty years of one's life is no mean achievement. It calls for celebration and merriment. But at the same time it also calls for reflection, for evaluation, for retrospection and introspection, and, above all, for future direction. So after 60 years what next? What is our perception of the profession and our perspective in this team concept to patient care? Let us ponder on a phenomenon; at this auspicious moment over what is called "A problem drug". What is a problem drug? Does the chemical seller know what a problem drug is? Every drug has risks. "No chemical can be devised which, whether given to a woman or man, and whether used by the oral, nasal, retinal, cutaneous, subscutaneous, rectal or vaginal route, will be totally free of all risks."

What makes a drug a problem is not so much its inherent pharmacological risks, but the way it is prescribed and used. It is impossible to talk about the safety of medicines as if it was a laboratory problem. In the wrong hands or at the wrong time, even the most carefully quality-controlled medicine becomes transformed from a life-saver to a life threatener. In some cases the consequences can stretch beyond a single patient or group of patients to encompass the globe. For this reason I humbly urge the profession which is now 60 years of age to monitor closely the activities of chemical sellers. They almost always bring the name of this great and noble profession into disrepute. They always have the propensity to maximise profit and manage to sell drugs or chemicals which are potential killers. Let us try and bring them under control.

At this juncture, I am tempted to add that this august body must also try to bring the traditional healers and herbalists under control by involving them in to the Team Concept to Patient Care.

It is interesting to observe that your 60th Anniversary falls at a time when consensus is emerging that the world is in a period of fundamental change. Some of these changes point to dramatic events: the first multiracial elections in South Africa, the collapse of the Soviet Union, the reunification of Germany, the changing role of the United Nations as nationalistic tensions flare up throughout post cold-war world. At the National level we are gradually preparing ourselves to multiparty democracy albeit not without difficulty.

It has become crystal clear that surrounding your 60th anniversary celebration is the Universal acknowledgement of the supremacy of Ghanaian football over Brazilian, German and English football. This change has been documented by the Starlets' victory of August 1995. But this wind of change must also be experienced in the health profession especially in Team Concept to Patient Care.

Do we see light at the end of the tunnel in connection with the long standing dispute or deadlock between the Pharmacy and Medical profession on one side and the Traditional Healers and Herbalists on the other side? Are we prepared to have dialogue with these traditional providers of health care for the benefit of our patients in the spirit of Team-work for better health? Why can't we bend over backwards to forge a good working relationship with them for the benefit of our joint patients?

Throughout history the concepts and principles underlying the pharmacology and pharmacokinetics in herbal/traditional medicine have been showed in a fog of misunderstanding, misconception and mystery. But is it true or false that almost all medicines available on the market one way or the other originated from herbs? To assimilate these traditional healers and herbalists into the team concept to patient care, I propose the establishment of a degree programme, backed by a post-graduate diploma programme in herbal medicine to be organised jointly by the Faculty of Pharmacy and the School of Medical Sciences at the University of Science and Technology in Kumasi. A 2-year Post-graduate Diploma in Herbal Medicine could admit candidates with B.Pharm, BSc. Human Biology, BSc. Biological Sciences, BSc. Biochemistry, etc., etc. This course if properly organised, could harness the potential of herbal preparations and thus reduce our inelastic demand on foreign medical preparations which drain our foreign exchange earnings.

Osagyefo Dr. Kwame Nkrumah, Kwame for short, quoted in his first book "Towards Colonial Freedom" the renowned Gold Coast politician, Casley Hayford who wrote and I quote "Of brain power we are assured, of mechanical skill there is no dearth. What is wanted is the directing hand which will point to the right goal". So let us encourage the possible future marriage of Pharmacy and Herbal Medicine for the benefit of our people.

Experience has shown that for collaboration to succeed

inter-sectorally and within the health system, there should be a large degree of credibility between the health workers involved in respect of their goals, tasks, systems, structures, leaders and staff. The leaders and staff of health workers must not allow personal differences and personal conflicts to interfere with opportunities for a team concept to patient care. This will lead to chronic distrust and lack of genuine collaboration. In a paper on clinical pharmaceutical aspects in acute poisoning, Kesteren and Uges, in 1992, demonstrated that a team approach by pharmacists and doctors yielded the best result in caring for patients with acute poisoning. Nearly all 48 patients they reviewed survived without any physical damage. This was achieved by teamwork between the hospital pharmacist and physician.

Secondly, it is increasingly becoming evident that multidisciplinary team work or collaboration must guide our thinking and practice within the health care systems. The changing role of the hospital pharmacist vis-à-vis clinical pharmacy is a very crucial development in the right direction. According to E. Osei, the Clinical Pharmacist in a pharmocokinetic laboratory for example can assess patient compliance for therapy and determine the next dose for a patient especially for drugs like the xanthines and the Aminoglycosides which have a narrow margin of safety. It is known that Gentamycin, Streptomycin, Neomycin and Collimycin, all Aminoglycosides, are ototoxic. In fact, at a recent meeting in London where I was privileged to be among 18 scientists from around the world, a very strong resolution was taken on the prescription of these very dangerous drugs to the organ of hearing.

Many patients in the third World have been rendered deaf or profoundly deaf as a result of these drugs, especially Gentamycin. Please refuse giving Gentamycin Ear Drops or injections to patients if they are prescribed indiscriminately by physicians who do not read their journals. Gentamycin Ear Drops if instilled in an ear which has perforated drumhead travels to the oval window membrane and enters the endolymphatic fluid per continuitatem to the inner ear and immediately destroys the hair cells in the organ of corti, resulting in a permanent total hearing loss.

Pharmacists should be encouraged to make ward rounds with other Health Care Professionals (HCP) so as to assist in giving relevant information on all matters concerning medicines, dressings, etc. The pharmacist should be encouraged to play the role of a counsellor and teacher for both professional colleagues and patients.

To be an effective contributor and counsellor on matters concerning drugs regimens, constant update of the pharmacist's knowledge should be made through continuing education programmes. If a good rapport exists between the pharmacist and physician and other Health Care Workers, a meaningful contribution and exchange of good inter-professional relationship could be achieved based on mutual respect and friendship. In a paper on the changing role of the Hospital Pharmacist, E. Osei, provides very useful tools for promoting the change. She advocates medication selection, prescription monitoring in the ward, Drug therapy monitoring for Efficacy and Toxicology; and Patient Counselling and Compliance clinics. These activities for the promotion of change will go a very long way to effect a "team concept to patient care" and thus strengthen the pharmaceutical perspective.

Conclusion

Fellows and members of the Pharmaceutical Society of Ghana, have a very big responsibility to play in the team concept of patient care. It begins with the need to rationalise the procurement, provision, prescription, sales and promotion of pharmaceutical preparations. Since the Pharmacist is the last point of call in any hospital setting, he/she must be patient to counsel patients for compliance, and if possible, in his/her new role as a clinical pharmacist try to monitor drug therapy for efficacy and toxicology.

The Clinical Pharmacist should insist on going on ward rounds with clinicians and other health care workers. It is only through such partnership that we can achieve a team concept to patient care.

The pharmacy profession should continue to take the future of the training and ethics of the profession in their own hands and avoid any direct interference from any outside body. It is only by monitoring this autonomy that the status of professionalism could be maintained.

The long existing friendship and esprite de corps among students of the healing profession must be encouraged, nursed and buttered by constant meetings and fora. As the old adage goes "Birds of the same feathers fly together". For the benefit of those whose Latin has become rusty "Paris cum paribus facellime congregatus".

William Shakespeare in one of his plays wrote and I quote, "There is pleasure sure in being mad, which none but mad men know".

Allow me to allegorise and postulate that there is pleasure sure in being a health worker which none but health workers know. They work long hours, their eyes are often tired by microscopes, titration and laboratory work, but they still enjoy their work. Let us support their partnership and team concept to patient care. Such team work, and team management to patient care can create the dynamic "Problem solving" style for better health.❑

Have you changed your address recently?
Update your records at the Society's Secretariat to enable us prepare a comprehensive and up to date directory of our members.

Team Concept in Patient Care: Crossing Disciplines and International Boundaries

By Stuart Anderson

It is my pleasure and privilege, first of all, to bring you messages of greetings and congratulations, from some of your friends in the United Kingdom, who are unfortunately, unable to be here in person on this special occasion. I bring greetings from Ann Lewis - current President of the Royal Pharmaceutical Society of Great Britain, who had the pleasure of meeting many of you in Ghana earlier this year; from Philip Green - the new Secretary of the Commonwealth Pharmaceutical Association, who replaced Raymond Dickinson, earlier this year as Deputy Secretary and Registrar of the Society, following Mr. Dickinson's retirement; and from Dr. Felicity Smith, from the School of Pharmacy at the University of London who was out here only a few weeks ago visiting colleagues at the University of Science and Technology, Kumasi.

It is particularly fitting, that the theme of this year's Conference should be "team concept in patient care", and how pharmacists might contribute to it. Around the world, the status of pharmacists has grown considerably over the past 30 years or so. Both the public and other health professionals now recognise the important contribution which pharmacists make to their health and welfare, by advising on drug treatment, and giving guidance on the treatment of minor ailments. They are truly key members of the health care team.

Across the globe, pharmacists are recognised as society's experts on drugs, and the esteem in which they are held can only improve, still further as the range of services they provide expands, their knowledge of the actions and uses of drugs increases, and their contribution to patient care develops and that will increasingly be through teamwork.

Many of you will of course already be working in teams of one sort or another - whether it be with other pharmacists, with doctors, and nurses, or with members of other non-medical disciplines. Some of you will also be working with colleagues from other countries. Those of you who are, will know only too well, that teamwork means, making the most of what you've got: effective teamwork involves making the best use of the available resources, rather than simply looking for more.

And yet, for a health profession such as pharmacy, the most important resource, for progress and teamwork is people. There is a great deal which can be done - much progress which can be made - without access to computers or other expensive equipment. When we first introduced ward pharmacy in the United Kingdom in the 1960s, we had very little in the way of resources, other than people - people with vision, people with commitment, and people with determination. People who are able to identify problems, and develop solutions to them. People who are willing to invest time and energy, in thinking about things, and changing the way things are - in making plans and implementing them.

I know you have such people here in Ghana. I have been extremely impressed with what I have heard about pharmacists in Ghana from colleagues in the UK. I have met able and knowledgeable pharmacists with ideas, with dedication and with enthusiasm. They told me about some very impressive pharmacy service involving teamwork which are clearly contributing substantially to patient care. Because, through people, we develop relations with other health professionals, like doctors and nurses. And from these relationships, we can begin to develop multi-disciplinary teams, with health professionals working together for the benefit of patients. And that is very much the theme of your conference this year.

But, you know, pharmacists are much more than just experts on drugs. They are also experts in the system of health care delivery in their own country. Pharmacists have unrivalled knowledge about patterns of drugs use: they know which drugs are being used, for what purpose; they know how they are being used, and what difficulties their own people have, in both obtaining, and administering medicines. And, of course, they know their own communities: they know the proportions of old and young people in their society; they know the numbers suffering from sexually transmitted diseases; they know the incidence and types of chronic illnesses; and of course they speak their language. These are important elements in the knowledge base of the pharmacist.

So there are important cultural and locality differences in pharmacy practice, which contribute substantially to its richness and diversity across the world. This means that whilst we can all learn a great deal from each other, the lessons learnt in one country, may not necessarily be transferable to another. Lessons learnt in Great Britain may not necessarily be appropriate for Ghana. So come and see how we do it, by all means; go and see how the Americans do it, and indeed everyone else. But then come back to Ghana, and do it the Ghanaian way!

But developments in pharmacy practice, are a feature, not only in the cultural and local circumstances of the country, in which they take place: they are also a feature of the

Mr. Stuart Anderson is a Research Fellow at the London School of Hygiene and Tropical Medicine. He presented this paper during the 43rd Conference and 60th Anniversary of the Pharmaceutical Society of Ghana.

time in which they are established. When ward pharmacy was first introduced into hospitals in the United Kingdom, in the mid 1960s, the world of pharmacy was very different from what it is today - apothecaries measures were still being used and medicines dispensed in the community, were still being labelled 'the mixture' or 'the tablets'. Labels were for the most part still being hand-written, and bench-top computers had not been invented. All that has changed. If we were going about introducing ward pharmacy into hospitals today, for the first time, we would need to go about it very differently from the way we did it in the 1960s.

And yet, for me, it was through the gradual, but steady, development of ward pharmacy services in hospitals, that I learnt about teamwork. I learnt about teamwork the hard way - by trial and error. In fact, I learnt those lessons over a period of years, at a number of different hospitals, and I would like to share them with you today. I learnt that there were certain positive requirements for effective teamwork and I call these the vital virtues. Later, I learnt that there were certain negative conditions which would prevent effective teamwork from becoming established - I call these the deadly sins. So I would therefore like to share with you today, my induction to the 5 vital virtues and the 3 deadly sins, of working in teams.

But let me begin by setting the scene. As a student, in the second half of the 1960s, I well remember working, in the hospital pharmacy of a large provincial town in England. The chief pharmacist rarely left his office. Around the walls of it, were kept all the latest reference books on drug use, together with the most recent information from manufacturers. Other pharmacy staff were not allowed near them: the chief pharmacist alone was the fountain of all knowledge, and he took great pride in being so. As a result, medical staff always asked for him personally: the rest of the pharmacy staff did not exist, as far as they were concerned. The pharmacist's place was in pharmacy: the concept of teamwork, at that time, was that everyone should know their place in the hierarchy; and in my case, it was clearly at the bottom.

So it was clear, to me, even then, that two key things had to happen: firstly, pharmacists had to begin to demonstrate that they had a useful role to play, beyond the pharmacy itself: there seemed little scope for development within the walls of the pharmacy, and secondly, pharmacists themselves would have to embrace the concept of teamwork, and to start the process of job specialisation, which resulted ultimately in the recognition of specialities within hospital pharmacy, such as quality assurance and drug information. It was also apparent to me that one of the key obstacles to progress might well be the chief pharmacists themselves. And so it turned out to be that, that particular problem was only resolved by the gradual process of retirement and re-organisations which followed. All that was needed, was an opportunity for change. That opportunity came in the form of ward pharmacy following reports of significant number of drug administration errors. As many of you will know, the first tentative steps into ward pharmacy were taken in just a small number of pioneering hospitals - the Westminster and London Hospitals, and Aberdeen Hospital in Scotland, during 1964 and 1965.

But to suppose that the recognition of the value of a ward pharmacy service was an easily won victory, would be to misread history. In Great Britain, in the mid 1960, the hospital pharmaceutical services, as a whole was in crisis - in fact, it very close to breaking point. Salaries were appallingly low, recruitment was almost impossible, and in most hospitals, the staff who were at post, struggled to provide even a basic, pharmacy supply service. Looking back, it seems quite extraordinary, that under these circumstances, the first steps should be taken towards transforming the practice of pharmacy in hospitals. And yet it happened.

The Government eventually felt obliged, to support an independent review, of the hospital pharmaceutical services, (which resulted in the Noel Hall Report of 1970). The Committee of Enquiry, were able to witness for themselves, the value of ward pharmacy; they were sufficiently impressed to advocate the introduction of ward pharmacy into hospitals throughout the country. The Noel Hall Report also resulted in significant improvements to both the remuneration and career prospects of hospital pharmacists. This provided the incentives necessary to recruit sufficient numbers of young pharmacists with the necessary qualifications, who were able and willing to take things forward. One of the young pharmacists recruited at that time was me.

As a young pharmacist in the early 1970s, one of my jobs was to introduce this new idea of ward pharmacy into a hospital where it did not previously exist. By that stage, ward pharmacy had been introduced into quite a number of hospitals around the country - particularly the teaching hospitals and those in large cities. So there was considerable experience around on which to draw. The lessons I learnt at that time, served to illustrate the essential requirements of successful teamwork, wherever and whenever it is practised.

I learnt my first lesson in teamwork - my first vital virtue - at a small hospital, in a coastal town in North Wales. That lesson was that we had to be very clear about our objectives in developing a role at ward level and to make those objectives absolutely clear to those with whom we worked. And we also had to be clear about what our objectives were not. We were not there no take over the roles and responsibilities of doctors and nurses; we were not there to take over the routine tasks of unqualified staff; and we were definitely not there to act as policemen - either with regard to prescribing or stock control of medicines on the wards.

In fact, lack of clarity about such basic things resulted in quite a number of false starts to the development of ward pharmacy in the UK. On the other hand, we were there to review prescription charts on the ward - so that there was no need for charts to be sent to the pharmacy. We were there to ensure, that when medicines were ordered, they were available on the ward at the right time and we were there to agree on appropriate ward stock with the nursing staff.

It was from these early beginnings, that the need for effective teamwork amongst pharmacy staff themselves arose. As pharmacists received increasing numbers of drug related queries on the wards, there was a need for a central drug information resource - outside the chief pharmacist's office - where they could go to look up the answer. This, indeed, was the origin of drug information centres in the UK, and drug information was recognised as a specialty within hospital pharmacy in 1970. But it was not the first to be recognised - that honour fell to quality assurance, which had been recognised as a specialty as early as 1965.

Well, the next key lessons in teamwork I learnt happened when I became the Principal Pharmacist at Alder Hey Children's Hospital in Liverpool in 1974. At this hospital, the first tentative steps into ward pharmacy had already been taken. But things were not entirely satisfactory, even though the objectives of the service had been clearly set down and agreed with all concerned.

I soon learnt that there were two other important points, I needed to take account of if ward pharmacy at that hospital was to survive and prosper. The first of these - our second vital virtue - was the need to be extremely careful in the selection of the wards which were to receive the service. This generally meant the selection, not only, of a friendly consultant - and that meant one who was sympathetic to pharmacy's aims, and appreciative of the contribution which pharmacists could make to patient care - but also one whose beds, were on a ward where the sister in charge was willing to give it a try. In the early 1970s, neither welcoming sisters nor appreciative doctors were very common - believe me - and therefore careful selection of the work situation, or environment in which a new development was to be tried out, was crucial to success.

The second lesson I learnt at that hospital - and the third of our vital virtues - was that not all pharmacists are cut out to be effective ward pharmacists: not all of them had the knowledge, the communication skills and the diplomacy necessary to make that initial - and vitally important - positive impact. Indeed, some early attempts at ward pharmacy came to an abrupt end, because of the selection of unsuitable candidates as those first ward pharmacists. Clearly, for such a delicate mission, certain characteristics were essential - a sound knowledge of the drugs used and available, the ability to communicate well with other health professionals, and more than a modicum of tact and diplomacy. The timid and ill-informed pharmacist is as much a threat to the maintenance of effective health-care teams, as the arrogant and over-confident doctor was to their establishment in the first place.

Just a few years later - in 1978 - I had the privilege of becoming Chief Pharmacist at London's Westminster Hospital, which had been the pioneer of ward pharmacy in the UK (in 1964), under the leadership of its then Chief Pharmacist - John Baker. Ward pharmacy had thus been going on there, for nearly 14 years by the time I arrived, and the difference was very apparent. Ward pharmacy was not only established on every ward, but the bright, young pharmacists there, were already accepted as important members of the clinical team at ward level. It was there, that I learnt two further key lessons in effective pharmacy teamwork. The first - and the fourth of our vital virtues - was that it takes time for teams to be built up, for attitudes to change, and for the fruits of the efforts involved to be seen. But seen they were as junior doctors sought advice about prescribing, as consultants began requesting clinical pharmacists of their own, and as prescribing practices became more rational and effective. So patience is as important a virtue for teamwork as it is for anything else.

But there was one other factor, which set ward pharmacy at the Westminster Hospital apart from that at others - and that was the fifth and final of our vital virtues; the most important ingredient of all - leadership. Ward pharmacy started at Westminster Hospital, largely through the dynamism and vision of one man - John Baker, the then chief pharmacist, who, through the force of his personality, had won over doctors, nurses, administrators and even the porters and cleaners, to his way of thinking. As his reputation grew, he was also able to build up, around him, a talented team of the brightest and ablest young pharmacists around. That lesson stood me in good stead, when I later moved to St. George's Hospital.

And so I learnt that teamwork in hospital pharmacy practice required not only the setting of clear objectives, not only the selection of the right people to do the job, not only the identification of the right environment in which to make a start, and not only the passage of time for the team to become established and to work effectively together, but also I learnt that strong leadership is needed to start the ball rolling; that teams need clear and effective leadership to make them work efficiently. Well, all that was now some time ago in the UK, and in hospitals today, clinical pharmacy - in one form or another - is practised virtually everywhere and in hospitals, at least, the pharmacist is seen as a valuable and even essential member of the health care team. But the same cannot be said so far, of community pharmacy practice.

It was when I moved to St. George's Hospital in London in 1983 that I began to take a closer interest, in community pharmacy. There were three reasons for that interest; firstly, at that time, in the early 1980s, community pharmacy in Britain, seemed to be experiencing the kind of crisis that we had experienced in hospital pharmacy in the early 1960s. Secondly, there were problems being repeated in patient care concerned with what we now call "the interface" between hospital and community services. And thirdly, there was an opportunity to undertake with others some important research in this area.

In 1986 - as some of you will know - there was an independent inquiry into the whole of pharmacy in the UK which resulted in the Nuffield Report. This provided the stimulus, not only for greater co-operation between community pharmacists and other health professionals working in the community - particularly general medical practitioners - but also for greater research into the practice of pharmacy, in order to establish which aspects of the role of the pharmacist provided the greatest benefits to patients.

In due course the Royal Pharmaceutical Society, and the Department of Health, together produced a document, entitled 'Pharmaceutical Care', which made a number of proposals as to how community pharmacy in the UK might develop in future.

It was no accident that many of these so-called 'extended roles' were based on successful activities already undertaken by hospital pharmacists; it was also no accident that many of them involved teamwork with other health professionals, as the need for health professionals to work closely together for the benefit of patients was by then well recognised. Amongst the various roles proposed, were participation in health promotion campaigns, the selection of medicines and dosages within agreed protocols, and the provision of aids and equipment for elderly and disabled people.

And yet, progress in all these areas has been painfully slow. But there is no lack of clear objectives; no lack of suitably qualified individuals; no lack even of leadership. There must therefore be some other factors which are essential for the successful development of teamwork in the community besides the 5 vital virtues that I have already referred to. In fact, the experience of community pharmacy practice in the UK taught me there were three more factors necessary for successful teamwork in the community - and these I call the three deadly sins. They are however negative factors - where they exist, teamwork will not thrive

The first of my deadly sins is lack of time. It takes time to lay the foundations of effective teamwork, to develop relationships with key individuals, and to clarify just what the needs of patients are and I am not referring here simply to the passage of time, as I was earlier. For the community pharmacist - usually working alone, with the need to be physically on the premises, and to supervise the sale of pharmacy medicines - the time available to participate in teamwork is little indeed. Inevitably, the immediate needs of customers in the shop will outweigh the less urgent need to work with other health professionals in more formal ways for the benefit of patients.

Well, of course, time is money, and that leads me on to the second deadly sin of teamwork, and that is lack of incentive. It is probably true that in the UK today, most community pharmacists see little incentive in spending time in developing new services when they see no clear system of payment and remuneration for many of the things they are already doing. That is clearly understandable, and the issue needs to be urgently addressed.

But one of the consequences of this obstacle to the furtherance of pharmacy teamwork has been the creation of a new breed of pharmacy innovator - the pharmaceutical adviser. These people, are employed directly by the health authorities which commission health care on behalf of their local populations. Their brief is generally to work closely, not only with community pharmacists in the area, but also with other health professionals, particularly general medical practitioners. The hope is that these individuals will act as catalysts for greater teamwork between health professionals concerning the use of medicines - with community pharmacists playing a key role. They would have both the time and the motivation to develop the links required.

But this activity has served to expose the third - and final - of our deadly sins of teamwork: lack of training. It soon became clear that if community pharmacists were to become more involved in the primary health care team - so as to achieve more efficient and cost effective use of medicines by patients - they would require more training, not only in the clinical uses of drugs, but also in communication skills, and health promotion. And so it has been. With the establishment of the Centre for Postgraduate Pharmacy Education (based in Manchester) in the UK today, we now have extensive programmes of continuing education for community pharmacists mainly in topics concerned with the clinical uses of medicines, aimed at enabling the individual community pharmacist to play his or her part in the primary health care team.

In England then, team building has been crucial to the development of pharmacy services, and to ensure the optimum contribution of pharmacists to patient care. We learnt the lessons the hard way, and I hope that by sharing some of my experiences with you, you may be able to achieve effective teamwork in Ghana more quickly and less painfully. But I do want to reassure you that the effort is worthwhile. In England today, there are now closer links than ever before between pharmacists in hospitals and in general practice, between pharmacists and other health porfessionals such as doctors and nurses and between pharmacists and carers, such as social workers and occupational therapists. And as research into pharmacy practice itself has developed, so have links with other disciplines; today, we have pharmacists who are working closely with economists, with sociologists, with psychologists, and even, as in my own case at present - with historians.

But we also recognise the value of international exchange and collaboration, and of comparative international studies. For it is only by working together that we can identify the strengths and weaknesses, of each new development and hence learn from each other's mistakes. And perhaps also, we can obtain inspiration and encouragement from the achievements of our colleagues in other countries. I have no doubt that pharmacists in Africa have a lot to offer in terms of international collaboration and co-operation and I look forward to even greater links between practitioners and researchers in our two countries in the future.

So, in conclusion, the message I bring to you today is this: Teamwork is the way forward for pharmacy practice; and you already possess (in abundance) the most important resource of all needed for successful teamwork: people who are dedicated, hardworking, and enthusiastic like yourselves. There will doubtless be many hurdles to overcome, many disappointments to handle, many setbacks to deal with. But there will - I have no doubt - also be many successes, as links with other health professionals are forged and the benefits of the unique contribution which pharmacists can make to patient care are recognised.

As you move forward, build on the many strengths which you already have - your expertise in the use of

5 Dadeban Rd., North Industrial Area
P.O. Box 5258, Accra-North.
Tel: 232574, 232575
Fax: 232576

Manufacturers of High Quality Pharmaceuticals <u>you</u> can afford!

OUR PRODUCT RANGE:

Aspirin 300mg *Tabs*
Aluminium Hydroxide 500mg *Tabs*
B-Complex *(Tabs & Syrup)*
Danacin *(Asprin + Caffeine)*
Diazepam 5mg & 10mg *Tabs*
Dumocalcin *(Calcium Phosphate Dibasic 500mg+ Vit. D. 500 units) Tabs*
Dumosil Tabs *(Alu. Hydroxide 300mg + Mag. Hydroxide 280mg)*
Dumotrim *(Co-trimoxazole) Tabs & Susp.*
Elyzol *(Metronidazole 200mg) Tabs*
Ferromex 200mg *(Ferrous fumarate BP) Tabs*
Folimex 5mg *(Folic Acid) Tabs*
Griseofulvin 125mg *Tabs*
Frusemide 40mg *Tabs*
Ibunex 200mg *(Ibuprofen BP) Tabs*
Isonex 100mg *(Isoniazid BP) Tabs*
Malarex 250mg *(Chloroquine phosphate BP) Tabs*
Malarex Syrup 125mg/5ml
Mebenex *(Mebendazole BP) Tabs*
Multivitamin BPC Tabs
Paramol 500mg *(Paracetamol BP) Tabs*
Paramol Syrup 120mg/5ml
Prednisolone 5mg *Tabs*
Phenobarbitone BP 30mg & 60mg *Tabs*
Sulphadimidine 500mg *Tabs*
Thiacetazone 150mg & Isoniazid 300mg *Tabs*

Reserpine 0.25mg *Tabs*
Suldox *(Pyrimethamine 25mg+Sulfadoxine 500mg) Tabs*
Triplesulfa *(Sulphadiazine 167mg + Sulphadimidine 167mg+ Sulphamerazine 167mg) Tabs*
Danegan *(Promethazine Hydrochloride) Syrup*
Dannex Cream of Magnesia - *Mint and Non Flavours*
Dannex Gripe Mixture
Durol Tonic *(Palatable Blood Tonic)*
Koffex *(Cough Expectorant)*
Multivitaplex *Syrup*
Nematex *(Piperazine hydrate) Syrup*
Calamine *Ointment*
Dan Rub *Ointment*
Dithranol 0.1% *Ointment*
Ichthamol *Ointment*
Methylsalicylate *Ointment*
Sulphur *Ointment*
PMF *(Paraffinum Molle Flavum BP)*
Salicylic Acid 2% *Ointment*
Whitfield's *Ointment*
Zinc *Ointment*
Germ-x *(Disinfectant)*
Clorex *(Antiseptic)*
Gluco-Naf C *(Glucose)*
Gluco-Naf D *(Glucose)*
Kaolin
ORS

DISTRIBUTORS:

Accra - **DANAFCO Ltd. with branches in Kumasi, Tamale, Takoradi, Hohoe.**
ANGELS CHEMISTS.
ERNEST CHEMIST.
PHARMA CO-OP.
Kumasi - **RIGHTWAY PHARMACY.**
Tema-Ashaiman - **EKUUS PHARMACY.**
Koforidua - **KOFORIDUA CHEMIST.**
Sunyani - **SAM BENNET PHARMACY.**
Takoradi - **KENDICKS PHARMACY.**
Cape Coast- **HONSAL PHARMACY.**

Also available in all leading Pharmacies and Chemical Sellers Shops.

medicines and in the workings of the health care system of your own country. Rejoice in your individuality and your national identity, so that pharmacy in Ghana in the 21st Century, takes the best of practice from other countries and combines it with the best of what is uniquely Ghanaian.

But, in all you do, never lose sight of the reason why all of us pharmacists are here - to see that the best possible use is made of available medicines to ensure optimum patient care. In that way, we will make a real contribution - through teamwork - to the health and happiness of the people we serve, and in that way we will secure the best possible chance of our own prosperity.

I wish you all success with teamwork; as you move forward, remember my 5 vital virtues and my 3 deadly sins. I also wish you all a productive, stimulating and enjoyable Conference.❑

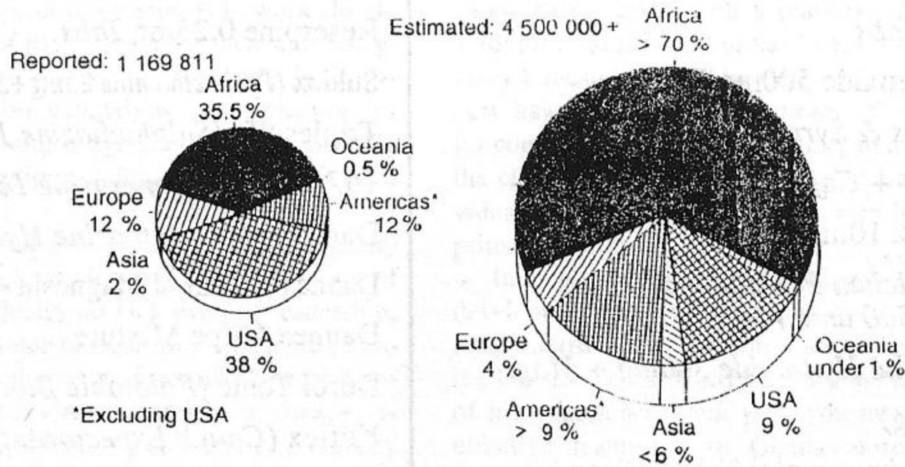


FIG. 1. *Cumulative AIDS cases in adults and children, mid 1995*

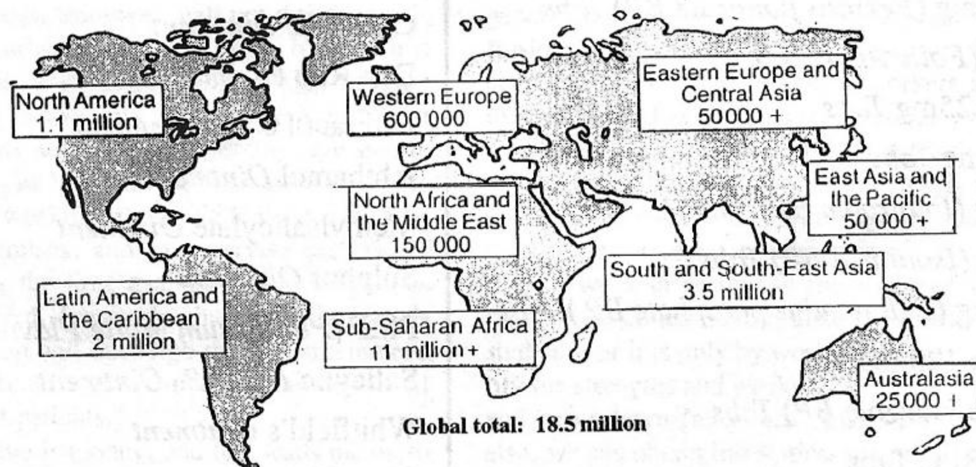


FIG. 2. *Estimated distribution of cumulative adult HIV infections, mid 1995*

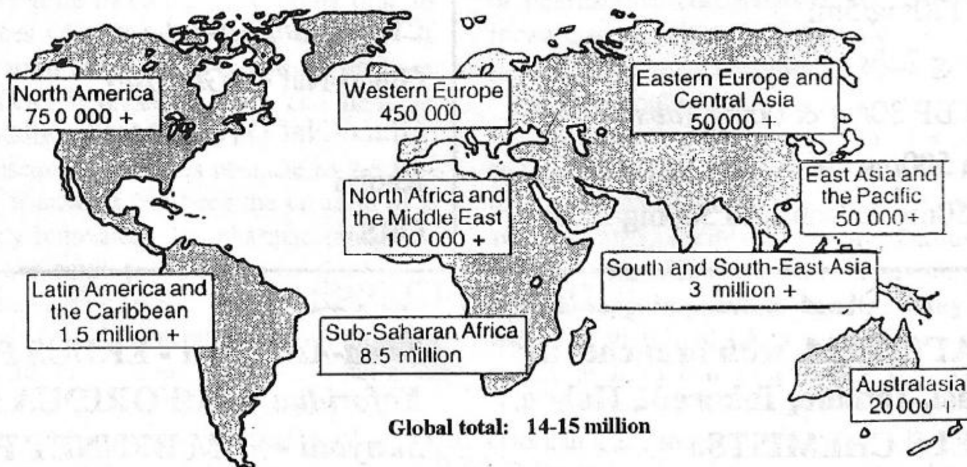


FIG. 3. *Estimated distribution of HIV prevalence in adults, mid 1995*

WORLD HEALTH ORGANIZATION GLOBAL AIDS STATISTICS. Source: AIDS CARE, VOL. 7, NO. 4, 1995

Group Dynamics and Team Building in Management

By S.A. Amoa

One of the things that has intrigued me about health care services is the fact that it is an essentially human service and labour-intensive which requires a large workforce and its service cannot be delivered by one health professional, however the various professionals have found it difficult to operate as a team. From the broad concept of Health for All through its implementation strategy of Primary Health Care to Patient Care in the wards, it is so obvious that the best means of achieving the goals in the area of health is through multi-sectoral and multi-disciplinary approach. However, despite all efforts made by WHO, health professionals have not embraced the concept of teamwork the way it should be towards performance at their work. The complexity of health organisations and the multiplicity of vital issues of life, illness and death demand that a high quality of management is needed to achieve efficient and effective health care. One of the tools for effective management is teamwork.

I hope with the presentation of the Lecture on "Teamwork in Pharmacy, Crossing Disciplines and National Boundaries" most of you might have become aware of the need for teamwork in your professional discipline, and in the management of health care.

But let me start my presentation on teamwork by referring to what one Kwame Ashaai wrote recently in the *Free Press* column "Murmurs from the Ruins" on the topic 'Real Significance of Starlets Victory. He wrote:

".....those countries which are progressing by leaps and bound - those countries which are being able to feed themselves, create jobs for the jobless, make in-roads into poverty and squalor, handle the health and sanitation problems, attract foreign investment, etc., etc. - are those in which teamwork is valued, in which there is a fair amount of harmony and peace, in which those who say "no" are seen as being as patriotic, mature, and progressive as those who say "yes" and in which the motto always is a pluribus Unum".

Indeed the observation made is true for the health sector as it is for any organisation. James L. Hayee has also written that: "But in an organisational setting, no one person can be completely responsible for any result .... Implicitly, and of necessity, all efforts is team effort, all results is team result".

From the two quotations, it is very clear that the human being is a gregarious or social animal and lives in groups than exist alone and that any organised effort involves people working together in teams or groups.

S.A. Amoa is the Director of Human Resource Development Division at GIMPA. He delivered this paper at the 43rd Conference and 60th Anniversary of the Pharmaceutical Society of Ghana held in Accra in September, 1995.

People interact as they form and work in groups and this also affects their work performance. In the field of management, it is an accepted fact that not much can be achieved without working through a concerted effort. From the way an organisation is designed or structured, we realise that no individual occupying any position in an organisational structure can operate effectively without others. As a manager or an employee you find yourself working in different groups all the time. At a point in time you are in a command group, at another time you may function in a task group, an interest group or friendship group. Production processes or service deliveries also are equally interactive making it near impossible for any one single process to stand out by itself. So, there is no way an enterprise can effectively be managed without the collective efforts of groups or individuals. This explains the need for group formation in all social situations.

Why Group Formations?

The reasons for group formation are of diverse nature. However reasons which could be cited are:

1. The tendency to seek out and congregate with other humans.
2. As a means of survival, e.g., babies, poor people, etc.
3. People have learned to become interdependent and to benefit out of division of labour.
4. Affiliation needs, e.g. friendship, support, love.
5. As a means of establishing and testing reality, e.g., consensus for making things real, validate perception and feelings best by checking them with others, etc.
6. As a means of developing, enhancing or confirming a sense of identity, and maintaining self esteem and gain in status.
7. As a means of increasing security and a sense of power in coping with a common or powerful enemy or threat.
8. As a means of concerted effort to do something or serve as a source of co-operation and encouragement.

Group dynamics is, therefore, the interactions of people in a group setting and involves four basic elements.

Four Basic Elements

The four basic elements of Group Dynamics are:

Conformity - compliance with existing rules or customs; obedience to norms or standards of groups; acceptance of sanctions. However the degree of conformity depends on the type of organisation, the persons level in the organisation and the task being performed.

2) **Aggression** - offensive action expressed by physical or non-physical acts to protect, for example, territory or power. A number of factors cause aggression and amongst which are frustration, annoyance and attack.

3) **Competition** - a struggle between two people or more to obtain the same object, e.g. food, share of markets, power, money, etc. Competition exist because of limited resources. Healthy competition, however, is vital for superior performance.

4) **Co-operation** - joint effort not motivated by purely selfish interest to achieve a common goal. Co-operation is essential for organisation's survival and goes hand in hand with competition.

The interactions of people involve the basic elements of conformity, aggression, competition and co-operation because in any group situation three distinct behaviour patterns operate which managers should be aware of and utilise for team building. These behaviour patterns are:

a) Task-oriented Behaviour Patterns - activities or behaviours that motivate productivity and achievement of group goals, e.g., initiating, opinion seeking, opinion giving, information seeking and giving, clarifying, consensus testing and summarising roles.

b) Maintenance-oriented Behaviours - activities or behaviours that increase group cohesiveness and team spirit, e.g., standard setting, standard testing, harmonising, gate-keeping, compromising, encouraging and diagnosing roles.

c) Highly Personal Role Behaviours - activities or behaviours that are to address personal, selfish needs and could be described as anti-group behaviours, e.g. aggression, domination, withdrawal syndromes.

As individuals in groups may adopt any of these behaviour patterns depending on the situation and their needs, a lot of forces are thrown up and operate in groups. It is these forces operating in groups and which influence behaviours of the group members positively or negatively which are referred to as Group Dynamics.

It is against this background that numerous studies of group dynamics have concluded that to achieve total effectiveness, the manager and his subordinates must pay particular attention to organisational or group dynamics.

As pharmacists operating in the health sector or other situations, you may find yourselves interacting with other pharmacists, doctors, nurses, laboratory technicians, administrators, patients, your business partners, customers and others. Your interaction and the behavioural patterns you and the others put up may be determined by basic elements of group dynamics. Even if you are operating a private pharmacy, the atmosphere in your enterprise will be determined by the interaction among your staff and of your staff and your customers. But since interaction could produce negative, or unhealthy competition and relationships, the fundamental responsibility of creating effective team in management rests upon those who manage or lead the organised effort. This brings us then to look at team building.

What is a Team?

Dave Francis and Don Young in their book 'Improving Work Groups' define a team as "An energetic group of people who are committed to achieving common objectives, who work well together and enjoy doing so, and who produce high quality results". According to the definition, a team consists of individuals each possessing a given set of skills, working together harmoniously to reach specific goals and achievements or individuals who relate directly together to get things done.

Characteristics of an Effective Team

As pharmacists, you work with a team of colleagues or subordinates. As a team member or leader, you have a responsibility to ensure that your team functions effectively. Before we talk about methods for improving team functioning, I will like to discuss the characteristics of an effective team.

According to Francis and Young, a team that is mature and effective has been painstakingly built. In such a team problems have been worked through, relationships deepened and roles clarified. Such teams are able to achieve results because they have the following characteristics:

1 Shared Objectives

The team has a purpose that is understood, shared and felt to be worthwhile by its members. This purpose can be described as the team's "mission". It sets targets of performance (objectives) that are felt to be stretching but achievable. Energy is mainly devoted to the achievement of results, and team performance is reviewed frequently to see where improvements can be made.

2 Commitment to the Team

Team members feel a sense of individual commitment to the aims and purposes of the team. They are willing to devote personal energy to building the team and supporting other team members.

When working outside the team boundaries the members feel a sense of belonging to and representing the team.

3 Constructive Climate

The team has distinctive spirit. This team spirit makes people feel relaxed and able to be direct and open. Such a team develops an atmosphere within which confidence can be shared, personal difficulties worked through and risks undertaken.

4 Effective Work Methods

The team has developed lively, systematic and effective ways to solve problems together.

5 Critique Without Rancour

In an effective team, group and individual errors and weaknesses are examined, without personal attack, to enable the group to learn from its experience.

6 Creative Strength

An effective team has the capacity to create new ideas through the interactions of its members. Innovative risk taking is rewarded, and the team supports new ideas from individual members or from outside. Good ideas are followed through into action.

7 Mutual Support and Trust

Mutual support and trust for effective team develops trust amongst its members and through that creativity encouraged and influence is shared.

Symptoms of Lack of Teamwork

Where the above characteristics are absent in a group the following characteristics which are symptoms of lack of team spirit show up. These are:

— bitter fights which are based on misunderstanding
— political battles between units and individuals
— violation and disregard for established policies and procedures
— duplication of efforts
— poor employee morale
— lack of recognition of individual skills
— unconducive climate characterised by intense jealousies and fear
— destructive criticisms
— unhealthy competition
— low productivity

What is Team-building?

Teams do not automatically acquire attributes identified as characterising effective teams. Learning is generally thought of as an individual pursuit, but this is not wholly true. Teams also learn and their skills and experiences become the property of the group as a whole. The process of deliberately creating an effective team is called team building. This definition suggests that effective teams have to be constructed and that the construction goes through several stages and take time to complete.

In the effort to develop an effective team, group members will have to address themselves to certain issues. These issues generally are:

What are we here to do?

How shall we organise ourselves?

Who is in charge?

How do we work through problems?

How do we fit in with other people?

These questions are not answered in a step-by-step process. In practice, issues are worked through as they become significant blockages to progress. If a blockage is worked through successfully, then the team becomes stronger. If the blockage is not cleared, then the team regresses.

Team building involves the deliberate working through of all blockages to progress until a working group becomes an effective team. The term "working through" is emphasised because time and focused effort is required to resolve blockages.

Maximising Teamwork Effectiveness

Teamwork has to be productive if it has to pay the efforts of organising it. But this cannot be achieved unless conditions are made conducive for effective group performance. In order to enhance group work effectiveness, some useful measures such as the following need to be taken:

a) The right size of group depending on the type of task assigned, time frame allocated and the degree of confidentiality required, should be established.

b) Members with the right frame of mind, exposure and knowledge and ability to conform with the group need to be selected.

c) The right chairperson has to be appointed, elected, nominated or legally designated.

d) Clear definition of instructions concerning groups purpose, authority, deadline for work, resources required, chairperson or co-ordinator role, oral or written report and recipient of final report, should be provided.

e) Clear definition of operating procedures like place, length of time to be taken, voting procedures, eligibility of attendance, etc.

f) Provision for required information and assistance.

Results of Team Building Efforts

When the manager makes an effort to build a team for his/her work, the team building effort helps create a team that:

a) is well-prepared with regard to clearly understood task, healthy member relationship, efficient client - oriented workplan and smoothly tackled assignments.

b) is well-integrated through close working relationship with administrative resources and support people in order to ensure a continuity and smoothness.

c) has a responsive field strategy - equipped and prepared to respond with confidence and competence to new developments and factors that emerge in the course of its operation.

d) has improved morale and performance where members know what is expected of them and their colleagues, establish comfortable norms of team behaviour, performance and decision-making and so interpersonal difficulties which could be obstacles to team performance are reduced.

e) enhance better team result through delivery of responsive results in the way the business is required to be done.

f) facilitates improved feedback and learning with regard to performance and recruitment and indicating weaknesses and strengths of individuals and organisations for corrective actions.

Conclusion

In this presentation, I have discussed the importance of group dynamics and its relevance for Team Building. I have reviewed the basic elements of group dynamics, and the reasons for group formation and forces operating in groups. My presentation has further touched on what is a team, the characteristics of a team, the process of building a team and how to maximise team effectiveness.

From the presentation made so far, I am sure that most of you will agree with me that it is not everyone who has the ability to utilise the knowledge of group dynamics to build an effective team out of the workforce for managerial effectiveness. On the other hand, it is a skill that all managers must have, in the sense that the manager must possess the right leadership and the leadership skills to get the best work out of those for whose work he/she is responsible and accountable. A team leader therefore must possess the following qualities for effective team building. The team leader must be able to lead the team, encourage full participation of all members and utilise to the maximum the potential of all the strengths of the members of the team. The team leader must be confident, self-assured and assertive so that he/she can create a co-operative climate. The team leader must be able to challenge his/her team to hard work. The team leader must be capable of identifying tasks and goals to be achieved and those who can be assigned to do the jobs.

The success of a team leader will depend on his/her ability to consult; ability to delegate as much as possible to his/her team members; ability to be aware of his/her own strengths and weaknesses; ability to communicate objectives of tasks; ability to define results that are expected and the ability to listen.

In a number of management situations, people in leadership positions have assumed that it is only through their own efforts that results are achieved. They do not consider the importance of the contribution of others towards the achievement of goals and objectives. Where this has happened, one realises that not much is achieved and the level of performance also goes down. Where emphasis has been put on teamwork, results have been impressive.

It is from this point of view, that managers or all those in responsible positions should be concerned with and interested in creating effective teamwork in their organisations. For it is only through team work that managerial effectiveness and high levels of productivity can be achieved.❑

Do not forget to send to the Secretariat of the Society, your proposal for amendment of the Constitution

Your Article is needed for inclusion in the next edition of the

Ghana Pharmaceutical Journal.

Share your views on topical issues with your colleagues.

Send your articles and letters to the Editor now.

The Report on the Activities of the Pharmacy Division of the Ministry of Health for the Year 1995

By E. Fofie

Provision of good quality essential drugs is vital for anefficient health care delivery system. The Ministry of Health therefore requires efficient pharmaceutical services to be able to provide better health care to the people. To achieve this, there is the need to update the knowledge and skills of the pharmacy staff and provide the necessary logistics and supplies.

The objective of the Pharmacy Division of the Ministry of Health for the year under review are as follows:

i. To ensure that good quality essential drugs are always at government health institutions;
ii. To ensure rational use of drugs at government health institutions; and
iii. To update the knowledge and skills of Pharmacy Staff through seminars, workshops, in-service training and post-graduate training.

Achievements

Capacity Building

It has been observed that for the division to perform better, there is the need to strengthen its capacity at headquarters. To this end, a third office has been acquired to add to the two offices of the division. This office has recently been renovated and is presently being equipped. Some of the functions assigned to this office are:

i. Development and maintenance of efficient drug management information system.
ii. Monitoring the drug supply system and the revolving drug fund, i.e. the Cash and Carry to ensure its efficient operation.
iii. Research into drug utilisation to ensure rational use of drugs at health institutions.
iv. Monitoring the quality of drugs within the Ministry of Health.
v. Ensuring accurate estimation of drugs at the institutions and collating these to form the national requirements.

Under the division are quality assurance and national Cash and Carry monitoring teams.

Cash and Carry

The National Cash and Carry monitoring team has visited three regions so far within the year. The regions are Western, Central and Greater Accra. It is scheduled to visit the Northern, Upper East and Upper West regions in October/November this year.

The monitoring exercise has been useful as it has made the pharmacy staff not only alive to their responsibilities but also helped to put some corrective measures in place. It has also improved drugs supply to the regions through the reports submitted to headquarters and subsequent reactions which followed.

I am glad to inform the gathering that pharmacists have now been made mandatory signatories to the drugs accounts to help check the misapplication of drugs fund and ensure that monies are always available for purchases of drugs.

A remarkable achievement has been made in the availability of essential drugs at health institutions. Presently, not less than 80% of essential drugs are always available at most of our health institutions.

In-service/Post Graduate Training/Seminars

Acquisition of knowledge and skills are vital for improvement in any organisation. It has therefore been the aim of the division to encourage pharmacy staff to undergo further training.

This year, three pharmacists have undergone further training/ one in logistics and supplies management and the remaining tow on drugs supply management and rational drugs use. Each of the courses covered a period of nine (9) weeks and were taken at the Robert Gordon University in Aberdeen, UK.

Through the assistance of the Commonwealth Pharmaceutical Association (CPA), a long distance course in drug management and rational drug use is being organised for twenty nine (29) Pharmacists in the Government Sector.

Interview for Masters Degree Course in Public Health has also been conducted for selection of candidates for both public and private sectors. It is our hope that some Pharmacists from the public sector would be considered for the course.

Two Pharmacists are through with the processing of their papers and will soon be leaving the country to undertake their Masters Degree Courses, one in Clinical Pharmacy and the other in Pharmaceutical Services and Medicines Control.

Upon nomination by the division, one pharmacist has gained admission to do a Master of Arts (MA) Degree Course in population studies at the University of Ghana.

Two more pharmacists have obtained scholarships to do Masters Degree (MSc) Courses, one in Population Nutri-

Mr. E. Fofie is the Chief Pharmacist of the Ministry of Health.

tion and Health and the other in Biopharmacy, all in Universities in the United Kingdom.

One other Pharmacist from Korle Bu Teaching Hospital is also about to leave for Japan on Japanese Government scholarship to do nine (9) weeks course in hospital pharmacy.

A total of four (4) pharmacists have also benefited from seminars/workshops on Clinical Pharmacy and Quality Assurance organised by the West African Pharmaceutical Federation (WAPF) in Lagos and in Accra.

A lady pharmacist was sponsored by the Ministry to attend an FIP Conference in Stockholm, Sweden, where she mounted an exhibition on Government's role in Women's Health and Grass Roots organisations to promote women's health.

Lastly, I attended a seminar on Control of Narcotic drugs and Psychotropic substances in Tunis from 6th March to 11th March, 1995. I also attended a meeting on Drug Advisory Council of West African Health Community (WAHC) in Lagos from 1st to 2nd August, 1995.

Rational Drug Use

Rational drug use at government institutions is one of the priority areas the division is focusing its attention on. copies of the Ministry of Health Essential Drugs List and National Formulary have been printed and the division has taken the responsibility for their distribution to the regions and health organisations. In addition, a Standard Treatment Protocol is being prepared for the various levels of the health delivery system to help promote rational drug use.

Quality Assurance

The Pharmacy Division is aware of fake and substandard drugs which are now flooding the market. The quality control unit of the division in collaboration with the Pharmacy Board Laboratory, the Ghana Standards Board and Faculty of Pharmacy is ensuring that drugs being supplied to government health institutions are of good quality. The regions have also been asked to report to the division about any drug found to be of doubtful potency and substandard. In addition, regular inspection is carried out by pharmacists at the Central Medical Stores to ensure that imported drugs arriving at the Stores satisfy WHO specifications and records of good quality.

Divisional Meetings

The division has now instituted monthly meetings of pharmacists working at the headquarters including those at the Central Medical Stores. The purpose of these meetings is to constantly review our performances and plan new strategies to be adopted to solve problems which may be confronting the division as a whole.

Half yearly meetings of Deputy Directors of Pharmaceutical Services has also been put in place. This serves as a forum for discussing matters of professional interest and finding solutions to problems identified in the regions. The first meeting was held on 21st July, 1995. It was well attended and very useful deliberations were made for the improvement of the Pharmaceutical sector of the Ministry.

Promotions

Recommendations have been submitted and soon the following groups of pharmacists will be invited for interview for promotion to the next grades:

i) 78 Assistant Pharmacists to Pharmacists
ii) 26 Pharmacists to the grades of Senior Pharmacists
ii) 4 Senior Pharmacists to the grades of Principal Pharmacists.

I must say that unfortunately, the appraisal reports of some have still not been received. The Public Services Commission will now not wait any longer to receive all before starting the promotions.

I therefore wish to appeal to those who are yet to submit their appraisal reports to send them immediately after this conference.

Problems and Constraints

There are three major problems facing the division. These are:-

i) Lack of living accommodation for the staff;
ii) Inadequate funding of planned activities - even though the division has the largest vote under the institutional care, we are unable to carry out some of our activities because of the limited amount available; and
iii) Delays and sometimes non-submission of the necessary information, reports and returns required at the headquarters from some of the regions.

Conclusion

In conclusion, I wish to say that even though some achievements have been made, there is still more to be done. We should therefore work harder and show commitment to duty so that more would be achieved to help raise the image of our profession.❑

Omission

It has been brought to our notice that a portion of the article "The Uncommitted Licence" written by Mr. Alexander Adjei of the Pharmacy Council is omitted.

We do apologise for this error and wish to state that the last sentence of paragraph 13 on page 24 should read *"The pharmacist may do so alone or engage part time pharmacists to assist."*

Pharmacy Education in Ghana - Is it Preparing the Pharmacist for his/her Role in the Health Care Team

By Prof. Kwame Sarpong

Introduction

In recent times all over the world, emphasis on the practice of pharmacy is being shifted from a drug/product oriented approach to patient oriented one. The situation is not different in Ghana. The above statement does not mean that the basic pharmacy syllabus has changed from the traditional sciences to the clinical sciences. Any attempt to assess or evaluate the current pharmacy education must take this fact seriously into consideration. This presentation will cover the pharmacy course structure - past, present and future, the role of the pharmacist, and how relevant the present day education is to the pharmacy practitioner in particular, in his role as a member of the health team in patient care.

Since the inception of the Faculty and until recently, the academic programme has been based on the traditional courses namely: Pharmaceutical Chemistry, Pharmaceutics, Pharmacognosy and Pharmacology. Graduates of these programmes have sustained the pharmaceutical sector over the years and provided effectively the pharmaceutical needs of the nation.

In the early sixties, pharmacy took a new turn. In addition to preparing, manufacturing, storing, distributing and dispensing drugs, patient care with emphasis on therapy monitoring and counselling became an essential part of the pharmacist's role in health delivery thus making him/her a more effective member of the health care team. This development called for a review of the pharmacy curriculum. New areas were included especially in the areas of biological and clinical sciences to improve upon the pharmacist's knowledge and skills and together with other health care team members provide the most effective care for the patient. Some of the traditional core subjects had to be trimmed down or deleted. It took the Faculty of Pharmacy in the University of Science and Technology and indeed the country at least two decades for this wind to blow onto us. It is worth noting at this point that for us in Ghana, clinical pharmacy was not an entirely new concept as such. A good number of courses considered the preserve of clinical pharmacy were already part of our existing curriculum. The difference was in placement of emphasis and the non-active interaction of pharmacy practitioners in the health care team with the patient.

Prof. Kwame Sarpong is the Dean of the Faculty of Pharmacy at the University of Science and Technology (UST), Kumasi.

The Organisation of the Course Structure

In 1989, the Faculty became fully aware of the need for re-orientation and re-organisation of its bachelor of Pharmacy degree structure in line with current trends in pharmacy practice. Topics in the traditional core subjects now regarded as part of clinical pharmacy were taken out and put together to form the nucleus of the syllabus for clinical pharmacy course. Although the Faculty did not have any of the teaching staff member with higher qualification in clinical pharmacy, the Faculty mounted the course using its own senior members and assisted by two specialists in clinical pharmacy on part-time basis. Since then the Pharmacy Curriculum has been extensively revised.

Role of the Pharmacist

The pharmacist's traditional role in health delivery include the preparation (compounding or manufacturing) of drugs, procurement, storage, distribution and dispensing of drug products for the treatment and prevention of disease. These functions are very essential for any effective health delivery system. In recent times however, the pharmacy profession has seen many rapid and tremendous changes. Pharmacists have therefore been compelled to take on additional and rather challenging roles in the practice of their profession. In addition to their traditional roles, pharmacists are now expected to assure the quality of the drug products that they market or dispense and also to provide drug products with clinical services. These clinical services include:

i) Communicating effectively with medical practitioners, nurses, other health workers, as well as patients on proper drug usage.
ii) recognising the signs and symptoms of diseases of common occurrence.
iii) detecting drug-drug and drug-food interactions and how they can be managed or prevented.
iv) appreciating the pharmacokinetic profile of drugs for effective therapy.
v) keeping patients medication records.
vi) maintaining and providing an information data-base.

Present Course Structure

These novel roles as mentioned above, certainly require the injection of new courses into the pharmacy programme to facilitate the upgrading of the skills and knowledge of the practitioner.

The present day pharmacy graduate from the Faculty of Pharmacy is very well equipped to face and take on these challenges.

The reason is very simple. The course structure and the curriculum have been reorganised to accommodate the newer relevant topics.

The Pharmacy degree programme now include traditional medicine, anatomy, clinical pathology, pharmacokinetics, psychology, social pharmacy including behavioural sciences, management, computer skills, communication skills, bio-statistics, pharmacy and drug laws and ethics.

These courses and topics are taught by lecturers who are highly qualified in these areas.

Very positive efforts have therefore been made to ensure that at least during their course of study, pharmacy undergraduates are trained to be effective members of the health-care team.

Problems and Prospects

Admittedly, the training of pharmacists in the Faculty is not without problems. Facilities are inadequate. The long vacation practical attachment programmes are no longer being undertaken for two reasons. Funding for vacation training has become a problem. Secondly, Universities in Ghana have not had long vacations for years due to frequent disruptions of the academic calendar.

The provision for a year's pre-registration internship could assist the fresh pharmacy graduate in putting the knowledge they have acquired at the Universities into practice. Unfortunately, however, many of the pharmacists who are supposed to supervise them and offer practical training are not in tune with current developments and new trends in pharmacy practice.

Indeed some of us are hopelessly out of date.

It is important that serious efforts should be made to provide intensive training programmes for most practising pharmacists so that they can offer the right kind of leadership and training to the young pharmacists.

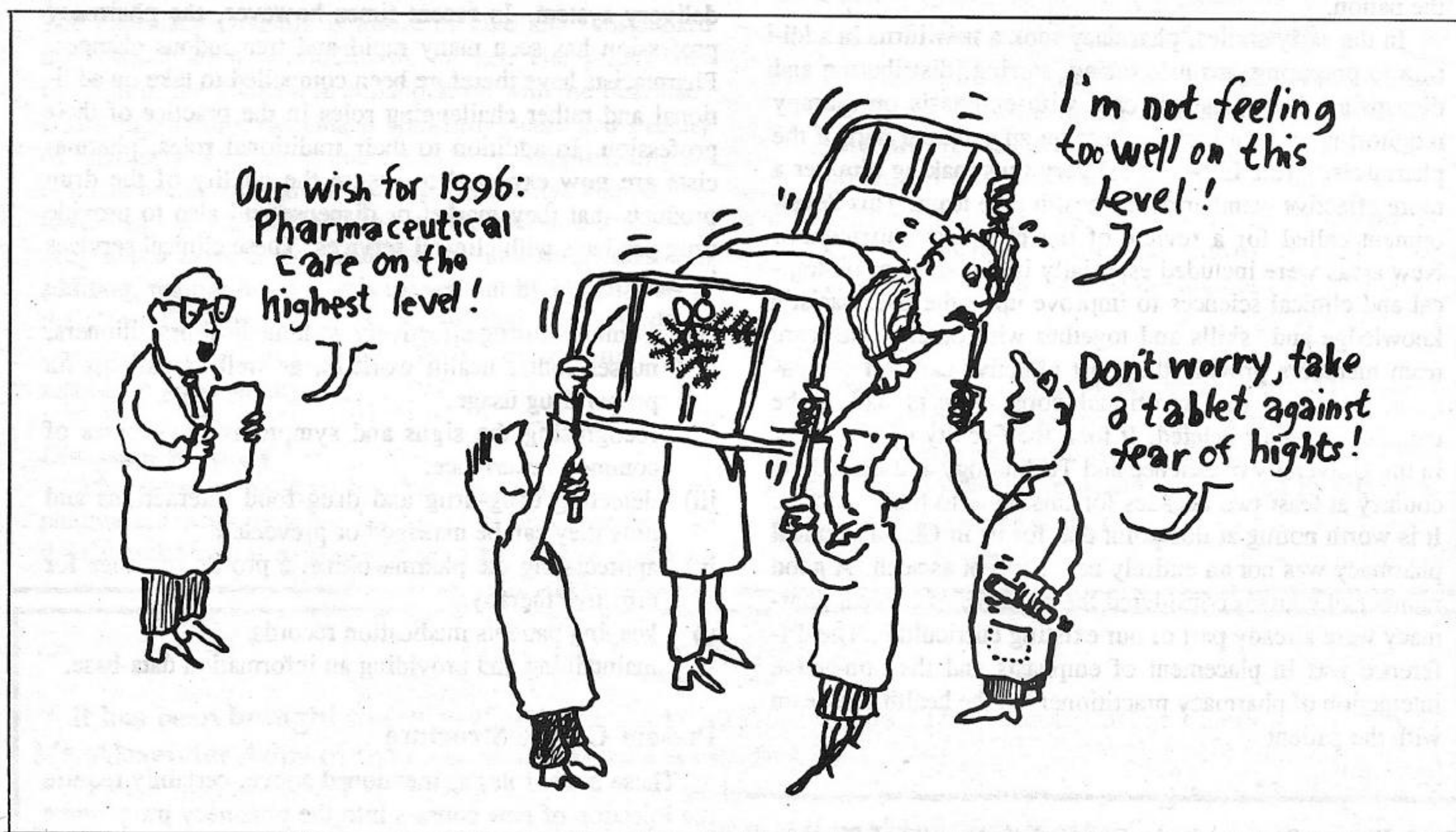
Conclusion

Pharmacy is a dynamic profession and therefore its practice will continue to experience changes with time. It is for this reason that the Faculty of Pharmacy periodically revises and updates its curriculum to offer the prequisite pharmacy education which would enable the pharmacist cope with the challenges of modern pharmacy practices, in particular, his effective role in the health care team.

The Faculty is considering setting up a Pharmacy Practice Unit with assistance of the School of Pharmacy, University of London. This will further enhance the training that we offer our students.

We are however, handicapped by lack of full complement of equipment and other facilities to ensure the maximisation of our operational capabilities.

We will continue to appeal to you for assistance and I know that you will also continue to support the Faculty.❑



Credit: International Pharmaceutical Journal; Vol. 9 No. 6 1995

PEOPLE

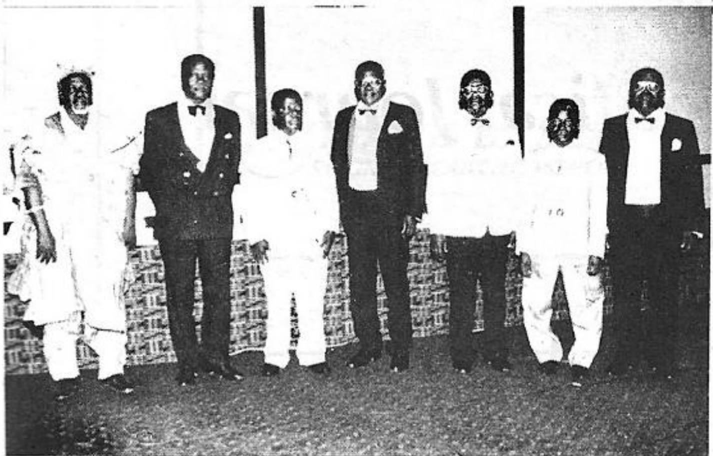
At the 43rd Conference of the Society which took place in September, 1995, **Mr. David Anim-Addo** was re-elected President to serve a second term in office. Also re-elected were **Mr. Dela Ashiabor**, the Vice-President, and **Dr. Merlin Mensah**, the Editor.

Mr. Oscar Bruce, the Editor and Publisher of the *Health Courier* Magazine was elected Hon. General Secretary. **Mr. Daniel Sekyere-Marfo**, who is the resident pharmacist at the Bank of Ghana Clinic in Accra, is the new Assistant Hon. General Secretary.

Mrs. Joyce Addo-Atuah of the Ghana Police Hospital was elected Hon Treasurer whilst **Ms Nancy Owusu** and **Ms. Marigold Korri** all of the Military Hospital are the other elected members of the new Standing Executive Committee which would serve the Society until September of 1997.

Standing Executive Committee (SEC) members (l to r): Ms. Nancy Owusu, Messrs. Dan Sekyere-Marfo, Oscar Bruce, David Anim-Addo, Mrs. Joyce Addo-Atuah and Ms. Marigold Korri.

The 43rd Conference of the Society has confered fellowship of the Society on seven members during a dinner to round off the conference in Accra. They include (from left to right in the picture below): **Messrs. Ayeh-Offei, Sam Bentum, M.K. Aboagye, S.A. Botchway, Amoah-Ampah, E. Fofie** and **F.K. Bruce.**



Mr. John Arthur of Midland Chemists Ltd. in Accra was in January this year named Chairman of an ad hoc committee set up to review the current welfare package available to members of the society, with a view to making it more attractive. Other members of the committee include: **Mr. Dan Sekyere-Marfo** of the Bank of Ghana Clinic, **Mr. Nat Akuetteh** of Dove Pharmacy, **Mrs. Joyce Addo-Atuah** of the Ghana Police Hospital and **Ms. Nancy Owusu** of the Military Hospital.

Mr. John Arthur

The Management Board of Korle Bu Teaching Hospital has, in recognition of her meritorious services to the hospital during the year 1994, presented an award to **Ms Paulina Amoh,**

Ms. Paulina Amoh is the Pharmacist-in-Charge of the Pharmacy Unit, Child Health Department of Korle Bu Teaching Hospital. The award was in the form of a present and the event took place during a durbar and awards ceremony held at the premises of the hospital early part of last year.

Ms. Paulina Amoh

At its meeting on January 15, 1996, the Board of the FIP Foundation for Education and Research decided to present the *FIP Lifetime Achievement in the Pharmaceutical Sciences Award 1996* to Professor Toshio Nambara(Japan).

Professor Nambara has received this Award in recognition for his research achievement which for many years have made a great contribution to the advancement in not only fundamental analytical chemistry, but also in bioanalytical studies of metabolism, pharmacokinetics, bioavailability and bioequivalence.

Professor Nambara obtained his B. S. in Pharmacy in 1951 from the Pharmaceutical Institute, Tokyo University, Japan, and his Ph.D. in 1957 from the Tokyo University of Japan. Professor Nambara has served not only as President of scientific organisations, but also as a member in many advisory committees for the Japanese. He is now Chairman of the Central Pharmaceutical Affairs Council of Japan, the highest position in pharmaceutical science and the pharmaceutical profession.

In addition, he is both a leader in pharmaceutical education in Japan, and the President of the Hoshi University, Tokyo, Japan.

Professor Nambara is really an international outstanding scientist in the field of bioanalytical chemistry. He has published over 470 research papers and 10 books. He has developed a variety of micro-analytical methods, which are useful to determine biological body components with a very high accuracy. He has not only received the highest recognition in pharmaceutical and bioanalytical fields in Japan, but received also many awards like the Japanese Analytical Chemistry Society's Award; the Japanese Pharmaceutical Society's Award; and the Medal with Purple Ribbon of Japan (in the presence of the Emperor of Japan).

He is also very active with FIP activities. He was one of the organisers, a symposium speaker and co-chair of the FIP Tokyo Congress 1993, and co-chair of the workshop at the BIO-International 94 which took place in Munich. In the forthcoming BIO-International 96, which will be held in Tokyo in April, the analytical workshop is planned to honour the great and lifetime contribution to bioanalysis by Prof. Nambara.

Professor Nambara will receive his Award during the opening ceremony of the 56th World Congress of Pharmacy of the International Pharmaceutical Federation (FIP) on September 2, 1996 in Jerusalem, Israel. The Award was introduced in 1993 and Professor Nambara is the third recipient.

The award is made possible by an educational grant of Pharmacia & Upjohn Inc.

At its meeting on January 15, 1996, the Board of the FIP foundation for Education and Research decided to present the *FIP Pharmaceutical Scientist of the Year Award 1996* to **Professor Patrick Couvreur**(France).

Professor Couvreur was awarded the FIP Pharmaceutical Scientist of the Year Award 1996 because of his outstanding achievements in international sciences, especially in the field of targeted drug delivery. He was among the initiators of the developments in this field.

In 1972, Professor Couvreur became a pharmacist and in 1974 an industrial pharmacist at the Catholic University of Louvain (Belgium). He obtained his Ph.D. in pharmaceutical sciences in 1975.

Professor Couvreur was a researcher at the Institute for Scientific Research in Industry and Agriculture (Belgium) from 1972-1975, Assistant at the Catholic University of Louvain from 1976-1977, and Senior Researcher at the Belgian National Funds for Scientific Research from 1977-1979 and became an Associate Professor at the Catholic University of Louvain in 1979. In 1984 he was appointed Full Professor at the University of Paris-Sud (CNRS Unit 1218, Centre d'Etudes Pharmaceutiques of Chatenay-Malabry). Since 1995, he has been Head of the Doctoral Formation 'Pharmacotechnie and Biopharmacie' in France. He held many administrative positions in France and academic positions at foreign universities.

Professor Couvreur was President and Founder of the GTRV (Group Thématique de Recherche sur les Vecteurs) and member of the Board of Governors of the Controlled Release Society (1989-1993). Since 1992, he is a member of the Board of APGI (Association de Pharmacie Galenique Industrielle) and a member of the Board of Pharmaceutical Sciences (BPS) of FIP since 1994.

He is editor and co-editor of four books, author or co-author of more than 190 research publications, and member of the Editorial Board of various scientific journals. Professor Couvreur organised many national and international congresses and symposia, and received many scientific awards.

Professor Couvreur will receive his Award during the opening ceremony of the 56th World Congress of Pharmacy of the Intentional Pharmaceutical Federation (FIP) on September 2, 1996 in Jerusalem, Israel. The Award was introduced in 1993 and Professor Couvreur is the third recipient.❑

Advertise

in the

Ghana Pharmaceutical Journal

for

Better Results

GOKALS LIMITED (PHARMACY)

D 822/3 Club Road
Opp. S.D. Karam & Sons
P.O. Box 623
Accra-Ghana

Tel: (233-21) 667906 • 668266
Fax: (233-21) 668094 • 665979
Cables: GOKALS

DISTRIBUTORS FOR:

Glaxo

rPr MAY & BAKER
RHONE - POULENC RORER

Upjohn

Service in Medicine

DANAFCO LIMITED

**6 Ring Road West, P.O. Box 5260, Accra North, GHANA Cables: Danafco, Accra.
Tel: 021-228221, 228278. Tlx: 2129 Danco GH. Fax: 021-228241**

Branches: Kumasi, P.O. Box 1703, Asumfo Road, Tel: 22823; Takoradi, P.O. Box 12, Liberation Road, Tel: 23732; Koforidua, P.O. Box 294, Tel: 22762; Tamale, P.O. Box 900, Tel: 22678; Hohoe, P.O. Box 135, Tel: 093520-88