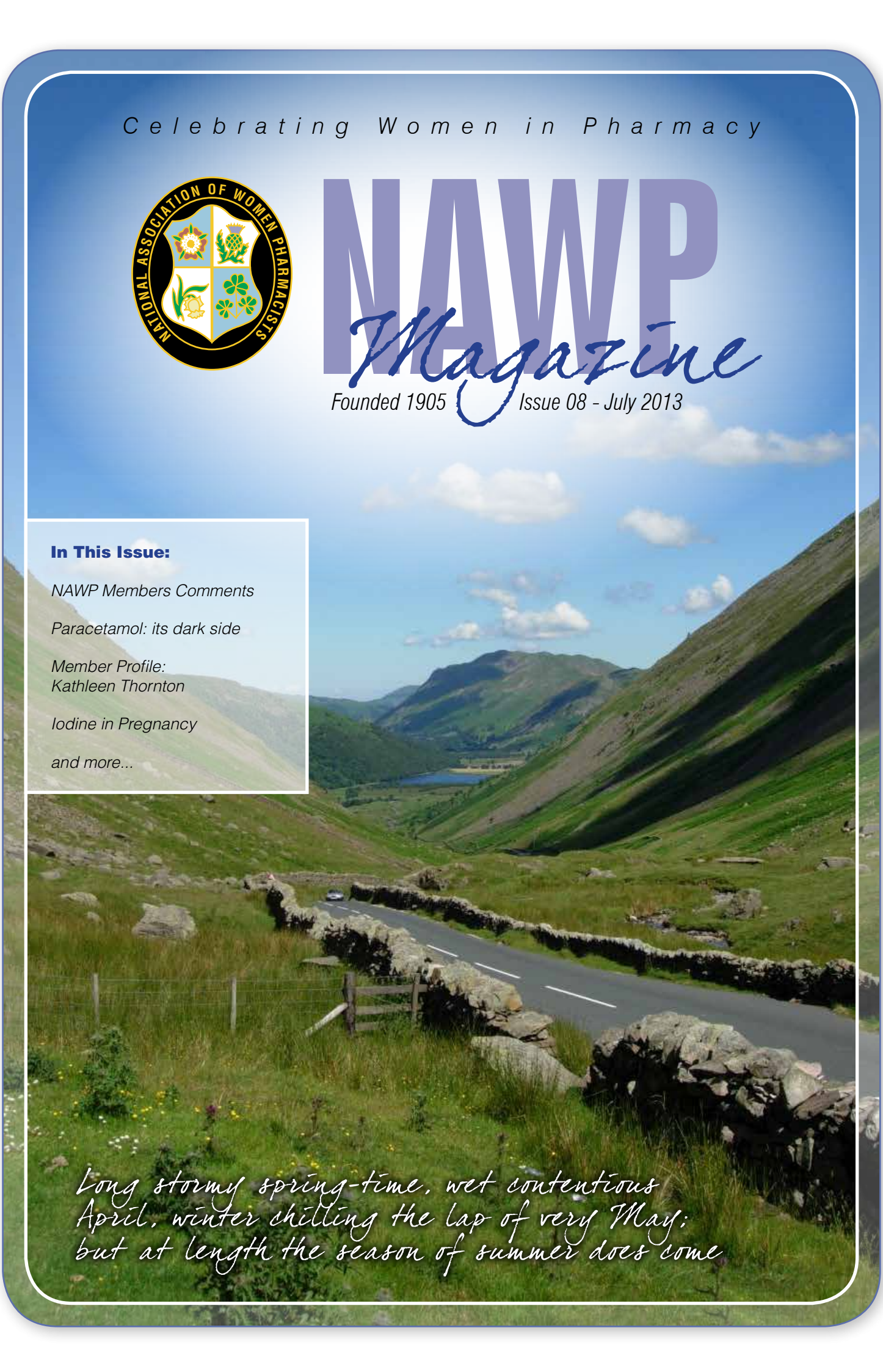
Celebrating Women in Pharmacy

NAWP Magazine

Founded 1905 Issue 08 - July 2013

In This Issue:



Long stormy spring-time, wet contentious April, winter chilling the lap of very May; but at length the season of summer does come

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Cover Quote by: Thomas Carlyle (Scottish Historian and Essayist)

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The President's Letter

Dear Colleagues,

It is with some trepidation that I begin my first report as your president. I have a hard act to follow in terms of literary competence following Virginia as I do. As you all know Virginia writes for a living, I don't, unless you call small notes on the side of prescriptions writing. I would like to take this opportunity to thank on your behalf, Virginia for all she has achieved in her 3 years as president. She has raised the profile of NAWP not only within the profession by working with the new RPS, but also with other professions particularly the Medical Women's Federation. I hope to build on these links.

We had another successful conference in April, "Healthy Mothers and Babies" held in Brighouse, Yorkshire. Thank you to all who attended and those who organised it. The speakers were, as usual, of very high standard, coming from Northern Ireland, Devon, Yorkshire and Hamburg to talk on their specialist subjects. Pregnancy should be planned and enjoyed, for those with diabetes, along with "breast is best" were the main themes to emerge from the weekend. As many of us are entering grandparenthood I think it is something we can pass on to others in both our professional and personal lives.

For the second year we ran a student competition and had two commendable presentations, this in turn attracted four more students to attend the whole conference. This is very encouraging and something we hope to build on in future years

Through the conference raffle and donations we raised £175. This money has been given to Winston's Wish a worthy charity close to Virginia's heart, her family having unfortunately needed to use its facilities in the past few years. The trip to the Bronte Museum in Haworth, with guided talk, on Sunday morning was very enjoyable.

Numbers for the conference were disappointingly low this year, for this reason we may have to seriously think about the weekend's viability and format for next year. If anyone has any ideas or comments on the subject please let myself or a member of the committee know.

The article on paracetamol on page 10 of this edition of the Magazine makes interesting reading. It appears that paracetamol may actually interfere with the antibody response of vaccinations. My advice to new Mum's has always been "don't give a dose unless the baby needs it" rather than give it just in case they need it. I recommend you all read the whole article as other interesting ideas are aired.

In October the 9th European Meeting of Women Pharmacists will be held in Munich. Several members are going to attend so if you would like to join them please see page 21 for more details. From experience it is always a very enjoyable and informative weekend and this year will come a little after the Oktoberfest, so may include some beer tasting.

As many of you know I recently celebrated my daughter's wedding. A wonderful day enjoyed by all and complimented by the weather. I now realise not only have I gained a son-in-law but I have also become a mother-in-law.

With that sobering thought I will wish you a pleasant summer and may the sun decide to shine for at least some of it.

Anita White

President of the National Association of Women Pharmacists

NAWP Annual Report 2012

2012 saw a departure from the norm for the Annual Conference. Firstly it was the first time we had hosted a joint conference with our European colleagues. Secondly we ran an abstract competition whereby 4th year students from Manchester School of Pharmacy were invited to submit abstracts with the best submissions being asked to present at the Conference. Building on the success of this competition this year it was opened up to students from 3 Universities in the area namely, Manchester, Huddersfield and Bradford.

The Executive Committee (EC) has been concerned for sometime about the fall in membership and the lack of new members. To this end an in depth discussion took place at the July meeting of the EC, followed by a brainstorming session in September. The areas covered in these sessions included subjects like 'what makes NAWP distinctive?' 'what sort of organisation are we?' 'what do we currently do?' 'what do we want to do more of in the future?' 'how can we build on past success?' The EC is currently working alongside Jennifer Archer and her daughter, Sarah, to produce a range of promotional material and to update the present information leaflets.

Elsewhere during the year members of the EC have represented NAWP at a number of forums including the PDA conference, the English summit on Chronic Pain, Modernising Pharmacy Careers, the Future of Pharmacy and Public Health, a CPPE organised face-to-face workshop about return to practice and the Medical Women's Federation autumn Meeting

Articles about the work of NAWP have appeared in print in both the Welsh and English Pharmacy Review as well as being quoted in the Daily Mail newspaper.

As an RPS partner, NAWP continues to receive a weekly list of consultation documents and the EC, along with individual NAWP members, have responded to issues relevant to the organisation.

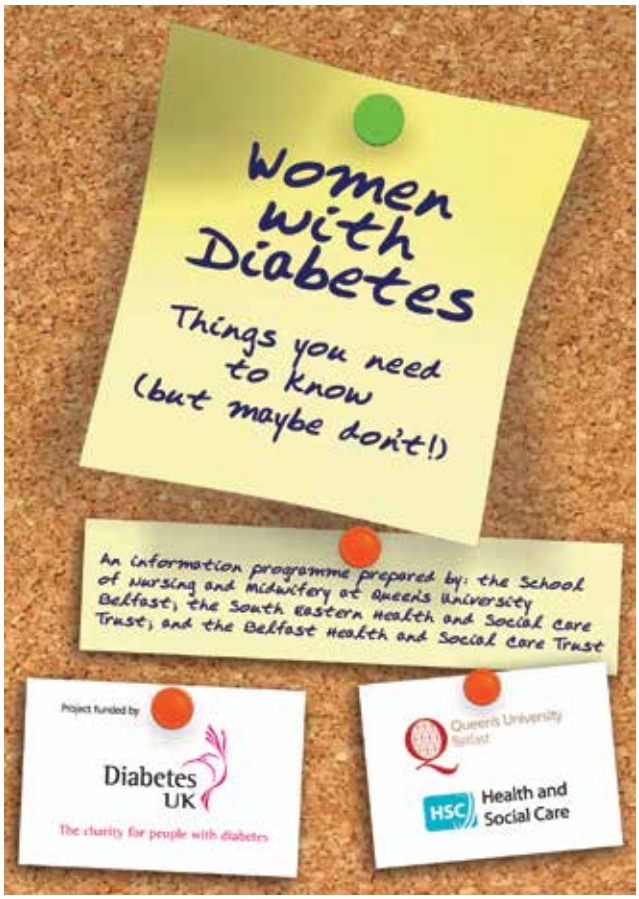
NAWP maintains its links with our European colleagues and Virginia Watson was invited to address the 10th Anniversary 'Festsymposium' of the dpv, in Berlin. Virginia took as her title 'Continuity within change'.

The EC is pleased to report that one of our members, Mrs Jenny Cobden, has agreed to represent NAWP on the 'Medicines Optimisation Advisory Group'. Most recently, our President, Virginia Watson spent a day at the PDA and was able to discuss many of the concerns raised by NAWP members.

NAWP continues to acknowledge the input of PHOENIX in producing and mailing the Newsletter.

Hazel Baker
Secretary

Preconception counselling for women with diabetes: the first step in preparing for pregnancy



Pre-pregnancy care is associated with a reduction in the risk of adverse pregnancy outcome for women with diabetes, yet many women continue to receive suboptimal pre-pregnancy care. Lack of awareness of the risks associated with pregnancy and diabetes, and of the importance of planning pregnancy, impacts on engagement with pre-pregnancy care.

Preconception counselling is a discussion about future pregnancy plans, the importance of safe, effective contraception to avoid an unplanned pregnancy and an explanation of the risks associated with diabetes and how these can be reduced by pre-pregnancy care. Preconception counselling is essential for all women with diabetes of childbearing potential, not just those actively planning a pregnancy. "Women with Diabetes: Things you need to know (but maybe don't!)" is an innovative preconception counselling resource which healthcare professionals, such as community pharmacists, can use to help raise awareness of the importance of planning a pregnancy. The resource originates from a preconception counselling DVD funded by Diabetes UK, evaluated as highly acceptable to women and which significantly increased knowledge and improved attitudes of women to pre-pregnancy care.[1] Featuring eight women with diabetes sharing their views and experiences, alongside an evidence-based commentary, the website covers issues such as 'contraception', 'risk', 'why plan?' and features a 'pre-pregnancy checklist'.
http://go.qub.ac.uk/womenwithdiabetes

Dr Valerie Holmes
Queen's University Belfast

1. Holmes VA, Spence M, McCance DR, Patterson CC, Harper R, Alderdice FA. Evaluation of a DVD for Women with Diabetes: Impact on knowledge and attitudes to preconception care. Diabetic Medicine 2012; 29: 950-6.

RPS Workforce Summit February 2013

We probably all know the old joke about the traveller who had lost his way to his destination. When asking for directions, he was told - 'well I wouldn't start from here'.

Unfortunately like the traveller, pharmacy is where it is; RPS can be congratulated for holding this summit on the future direction of the pharmacy workforce planning. Regrettably, the outcome suggested there is still no clarity on how career patterns of pharmacists already registered will develop over the medium term. Quite simply, there are too many variables involved and not all pressures are acting in the same directions.

The meeting was held at the headquarters of the BMA, now that RPS has no suitable meeting hall. It was attended primarily by representatives from: schools of pharmacy, the NHS, the Department of Health, RPS, a few big employers, and organisations such as the PDA, and NAWP. It was designed to hear opinions and collect ideas. In this sense it was successful and by highlighting a range of views, it identified key issues. For example, a contribution from Prof Robert Dewdney from Cardiff School of Pharmacy provided a perspective on pharmacy education rarely heard in pharmacy circles. This was supplemented by comment on the opportunities that schools of pharmacy have to train students from overseas, with a view to providing pharmacy services in home countries where they are currently inadequate. A presentation from Nazim Khan of the Centre of Workforce Intelligence, comprised an updated analysis of the pharmacy workforce, submitted as a report to the Department of Health in August 2012[1]. This was thorough and non-controversial.

In contrast, the Postgraduate Dental Dean from the London Deanery, might have had a more challenging reception from other audiences. The picture that was painted of dental practice reform was rather that it was 'done-and-dusted'; something that could certainly be queried. For example, the speaker failed to mention the position of Dental Care Professionals (DCPs; nurses, hygienists, technicians etc. registered with the General Dental Council). With four months to go, the number of DCPs who may have to leave the register at the end of July 2013 due to failure to complete their CPD, stood at over 14,000[2]. Also unreported was that dental graduates are experiencing severe problems in obtaining training places, in an analogous way to pre-reg pharmacy students[2]. Just as importantly, the talk failed to highlight the fact that both dentists and DCPs have the luxury of much more flexible work patterns than the pharmacy workforce has, and this limits comparability with our profession.

During the afternoon session, attendees discussed what they saw as the major factors that are shaping, or should shape, future pharmacy careers and the workforce to match them. It was at this point that the scale of the difficulties became apparent. Engaging with new services and the delegation of some duties is widely seen as the way forward, but a coherent plan for implementing this and the finance for doing so remain to be found. Furthermore although pharmacists who engage with these reforms are 'good pharmacists' we know there are colleagues who have refused to implement some specific new work practices because they believe them to be unsafe or inappropriate. In the brave new world, are these 'good' or 'bad' pharmacists?

By the end of the meeting, provision of a set of clear roles and career patterns for the pharmacy workforce was generally seen as essential. Nevertheless there was a perceptible difference between those who were keen to provide directions for the 'lost traveller', and those who preferred to design maps.

1. *Pharmacy workforce: Education commissioning risks summary from 2012 Centre for Workforce Intelligence, August 2012.*

2. *News, Dental Practice, February 2013, Vol 51, No.1.*

Workplace Issues

Before my visit to the PDA in January, I sent an email to some of our NAWP members (selected at random) asking for any views, personal experiences and concerns on the current pharmacy working environment as I wanted to get a feel for any concerns of the membership. Anonymity of the responder was assured.

Having shared the compiled comments with the Executive at a subsequent committee meeting, it was suggested that these were published in the Magazine. I thank the respondents for giving their permission for the following to be published.

Virginia Watson

NAWP Member Comments

Community

I feel concern about the imbalance between student numbers and pharmacy posts available and feel this may adversely affect women who take a career break as it will be difficult to obtain new employment.

After I retired from my part-time job I decided not to look for locum work as I had read in the pharmaceutical press that locum work is scarcer than before.

I was a locum for several years and I never received any offers of training even when Boots switched to a completely different computer system. I felt I was responsible for my own training and attended CPPE meetings and also did two distance learning courses from Keele University at my own expense.

I heard from a friend recently who was struggling to find good locum work. He was reluctant to work for multiples and there are few independents left in this area.

I was shocked to see a job advert in PJ 22/29th Dec quoting a rate of £16 - £17.50 depending on shift length.

A friend has retired early as a result of work related stress - he was a manager for one of the multiples.

I haven't any direct experience of the consequences of over production of pharmacists but have a lot of feedback from others including:

- No longer receiving call/texts from multiples about locum vacancies.
- Locum rates being pushed down, as low as £18 an hour - this resulting not only from too many graduates but also from thze employment of overseas pharmacists.

I have a friend who is a full-time locum who will no longer work for multiples as he feels that their demands for weekly Medicine Use Reviews (MURs) is excessive. Fortunately there are sufficient independents in the area to keep him employed.

The problem of eastern European locum pharmacists coming in to the UK and being prepared to work for ridiculously low rates seems to be more serious. We had an English chap for the summer who claimed

Romanians and Poles were working in Essex for £12 to £15 per hour.

About locums - I haven't had many extra requests in the past year and I hear rates are falling; I've not put mine up for 3 years now.

The multiple for which I work adopted a policy of not employing locums about 2 – 3 years ago, and recruited eastern European pharmacists as relief pharmacists, sending them over a wide area at a time when most had no car and had to rely on public transport.

The reduction in counter staff has made the pharmacist's life very difficult as we are expected to cover the counter as well. Whilst happy to do that because I have always tried to deliver the very best pharmaceutical care and advice to prescription and counter customers, it appears that this is not appreciated by the other staff and that the culture is only to offer a rapid (and accurate) dispensing service. I estimate that on an average day 95% of my day has no customer contact because of the requirement for checking, wrapping and filing. The SOPs for receipt of prescriptions are widely ignored by the staff, with the exception of checking if we have the stock, resulting in much of my time in handing out prescription is taken up with getting the prescriptions signed and/or
taking payment.

The appointment of a new Pharmacy Director in May 2012, after apparently not having one for five years has done nothing that I can see to improve the pharmaceutical service and standards, particularly in basic dispensing, which are in my opinion, quite sloppy! However, he did promise that no-one would telephone and harass the manager/pharmacist on a daily/ weekly basis to deliver MURs at the two a day rate. As far as I know the telephone calls do not happen, but the targets are still there for the branch to achieve and reminders roll in by email or via the manager or team manager. Added to that, there is a target for New Medicine Service numbers (NMS), again a very important source of income.

I do know of cases where pharmacist/managers and non-managers have 'moved on' due to pressure of work brought about by reductions in staffing hours. In both cases they were both women. I confess that I haven't read 'Modernising Careers in Pharmacy' but I would question whether there is, or ever has been in the last twenty years, a career in community pharmacy. There appears to be no access to the company pay structure or clear progression path for new recruits of whatever gender or age.

As a locum it was becoming more of a challenge to keep accreditation current and up to date with adding services i.e. NMS, MURs, Smoking Cessation Service, Emergency Hormonal Contraception Service, and Minor Ailments Services etc. The bureaucracy was annoying as some of these services would only apply to one PCT area and I couldn't offer them in other areas.

I found that locum co-ordinators could be disorganised and would go to a job to find another locum had been booked, so several phone calls ensued to clear this up.

When I had been locuming for a long time with a company I would get a letter asking if I would consider being a manager. Once I indicated I preferred being a locum I found I wasn't securing any bookings with that company anymore.

Being a locum in the East London area started to prove problematic in that I was being asked if I spoke any other language – generally Asian – and as I didn't the work for that shop wasn't available.

Hospital

In my hospital pharmacy days the more senior posts were usually occupied by men. There was then a trend which started in about 1996 to employ pharmacy technicians in preference to pharmacists by simplifying the jobs and thus saving money in salaries. I feel this probably did a lot of damage to the prospects of pharmacists like myself who wanted part time work and found only low grade posts were available. I have found more recently that the employment of checking technicians as pharmacy managers has now reached community pharmacy and wonder how this will affect the quality of service in the future.

I also note that most employees involved in administration of the large companies are not pharmacists and wonder if lack of knowledge of pharmacy law may result in slick business plans which are either unethical, illegal or both.

I am one of those pharmacists who has been able to combine part time work in hospital/retail with raising a family without any major problems - something I do not see happening to my younger colleagues.

I work in hospital and our current batch of pre-registration students are very worried about what happens after August, out of last year's group of four only one has obtained a permanent job, with two back with us on one year contracts to assess whether it is better to do FP10s in house, the fourth had to return to Hong Kong to obtain work.

Several women returning from maternity leave have asked to go part time - recently this has not been allowed so several have returned for the three months (effectively less than this because of accrued annual leave) to avoid having to refund their maternity pay and have then left but have not been replaced anyway.

If a pharmacist leaves they are not automatically replaced but a case for their job replacement has to be put forward to the directors - it is often successful but there is often a six month delay because recruitment takes so long. In some cases the job is downgraded to a lower salary band - even to recruiting a technician and a technician leaving would be replaced by a pharmacy assistant.

We had three pharmacist redundancies shortly before Christmas - these were senior posts and due to the merger of three trusts and suitable employment could not be found for them. There will be more redundancies amongst cancer network pharmacists soon and these are people who are experts in chemotherapy and related drugs. Others have been down-banded so after a protected period will have a salary reduction. These mergers and cutbacks are quite commonplace.

Pharmacy graduates have the double whammy of the vast increase in graduates combined with a reduced number of jobs and they are also having to compete with some excellent European pharmacists (we have pharmacists from Lithuania, Norway, Germany, Italy etc.) and mothers working full time (which was less common twenty odd years ago). We also have a few technicians who are qualified pharmacists in their own countries waiting to start the conversion courses.

Medical schools have controlled their intake fairly tightly to ensure employment so why not pharmacy schools although even if this happens immediately it will take five years to have any effect but better late than never. We had a knee jerk reaction of rapid expansion after the pharmacist shortage following the fallow year caused by the change from the three year course to the four year course. There are also five conversion courses for overseas pharmacists something which doesn't happen in the opposite direction. I feel the student places have to reduce to make up for the increased supply from elsewhere chasing fewer jobs.

Current hospital situation in Wales:

- most jobs are now temporary
- giving out 3-24 month contracts
- the hospital at which I work is not advertising band 8 posts and those in band 8 post have had to re-apply for their own jobs
- of my friends with Clinical Diplomas one has managed to get a 12 month contract and one without diploma has managed to get a 3 month contract
- they are using Band 7 staff to cover Band 8 responsibilities
- there are a decreasing number of pre-registration and clinical diploma places on offer
- some trusts are only recruiting internally

Stress

When I was working I felt there was a lot of stress involved due to the many different demands to be met (MURs PGDs etc.) although I did not feel that I was put under pressure by Lloyds in any way. If anything I felt more under stress from the PCT and of course certain patients. I felt that men and women were probably both affected by stress but individuals react in different ways according to their personality.

Despite the reduced number of staff at the hospital there are still the same or more patients and of course the work still has to be done and those of us left have to cover the work of those who have gone. I am trying to do some of the work of three people who have left/retired/been made redundant and it would be wonderful to have the assistance of one of the newly qualified pharmacists who is currently unemployed. I am finding this very stressful.

Stress was becoming an issue too – the need to achieve targets for, say, MUR's, was paramount and I had to give up a Saturday locum as the company I was employed by set targets for my Saturdays along with addition tasks of filing the whole weeks prescriptions, putting away large orders from Friday and so on. Staff on Saturdays were generally the minimum and often had a high turnover rate. I had locumed in that branch for 8 years and had been happy up until then when this type of pressure was put on me.

Miscellaneous

I am currently in receipt of a NHS pension which was built up working full time in hospital when I first qualified and part time when I had children. I hope that the present generation of female pharmacists will have the same opportunity.

I have been very impressed with everything that has flowed from the PDA and I think they are developing a strong lobby which somehow gets heard louder than the RPS. They need our support and any research into gender implications of the work they are doing would be interesting

Although I sound gloomy I am glad I became a pharmacist, it was one of the few professions that opened on Saturdays so I could keep my skills going and the children still had a parent at home with them while they were small and I was able to gradually return to full time and a senior position as they got older. Despite some problems at the moment with the volume of work, I still love what I do on a day to day basis if I could go back to 1975 would do the same thing.

Disillusionment I think was the main motivating factor for me to make the huge move to a new professional career. I have been in pharmacy many years but was starting to feel that the support frameworks were going and it all seemed to be about "procedure, protocols and form-filling", and less about the actual job of communicating with customers. It is good to offer enhanced services but make training and provision for this structured, organised, and in accessible form. Companies need to have the staff levels to cope while pharmacists and managers provide these services.

Paracetamol: its dark side

Seemingly with the intention of fostering innovation under the Liberating the NHS agenda,[1] the GPhC has indicated its intention to allow the self-selection of P medicines where, in the professional judgment of the pharmacist, this would not compromise patient safety. Perhaps not surprisingly, the Pharmacists' Defence Association is seeking to resist this change.

If / when this change happens, a planogram update from Head Office could well place 200ml bottles of Paracetamol Oral Suspension next to the 100ml bottles on the open shelves, and boxes of 32 Paracetamol Tablets next to the boxes of 16.

We would hope that such a change in the planogram will have received the blessing of the Superintendent Pharmacist. But that would not be enough. It would surely be down to the Responsible Pharmacist on the day to decide whether or not any particular P medicine would be suitable for self-selection. And that decision would itself be coloured by the level of training and competence of the medicines counter and general sales staff.

In a perfect world, with properly implemented standard operating procedures (SOPs) against which support staff have been properly trained by an accredited and named trainer, one could envisage the safe supply of some P medicines by self-selection from open shelves. But would paracetamol products fall into this category?

We all know why over-the-counter pack sizes for paracetamol tablets were limited to 32 in pharmacies and to 16 elsewhere. Whether or not this pack size limitation was responsible for the reduction in suicide rates that followed is not clear.[2,3] However, in terms of morbidity associated with paracetamol use, hepatotoxicity on overdose may be just a minor issue: paracetamol has a far more sinister dark side that is now revealing itself. And when the potential enormity of the emerging issues is contemplated, pharmacists should find themselves wondering whether the time has not now come to move all paracetamol preparations behind the counter, including GSL packs, and even to begin pressing for a recall of all GSL packs of paracetamol products from non-pharmacy outlets.
The following explains why:

A. Prophylactic paracetamol administration at the time of vaccination may interfere with the antibody response to, and hence compromise the effectiveness of the vaccine.

It is not unusual to see prescriptions written by GPs for paracetamol or ibuprofen for post-immunisation pyrexia in accordance with BNF guidelines. Indeed, it is probable that small bottles of paracetamol or ibuprofen oral suspension are bought for this purpose by self-selection from both larger pharmacy stores and from non-pharmacy outlets. BNF guidelines advise that a dose of paracetamol or ibuprofen may be given IF pyrexia develops after childhood immunisation AND the infant seems distressed, and that a second dose can be given but only if necessary. The common experience of many pharmacists will be that parents / carers of children administer antipyretics for fever (even when there is minimal or no fever) because they are concerned that the child must maintain a "normal" temperature. Moreover, there is a common misconception amongst parents / carers that antipyretic use prevents febrile convulsions.[4]

In a study funded by a major vaccine producer (GlaxoSmithKline Biologicals) and published in 2009,[5] the authors concluded that prophylactic administration of antipyretic drugs at the time of vaccination should not be routinely recommended since antibody responses to several vaccine antigens were seen to be reduced. Whilst the study involved only paracetamol, it is probably safe to assume, until proved otherwise, that ibuprofen would similarly reduce the effectiveness of the vaccination. It would be interesting to know how many cases in recent epidemics of whooping cough and measles have occurred in vaccinated individuals and whether inappropriate use of paracetamol (and/or ibuprofen) at the time of vaccination has been a contributory factor.

B. Whilst the incidence of Reye's syndrome has decreased, an epidemic of asthma and eczema[6] seems to have emerged following upon a switch in the mid 1980s from aspirin to paracetamol for treating childhood fever.[7]

In a questionnaire study[8] (published in 2005) involving a population of 13,492 subjects in the US with an average age of 45 years, paracetamol use was found to be associated with an increased risk of asthma and COPD. From a subsequent study in Mexico[9] (published in 2006) involving 3,493 children aged between 6 & 7 years, it was concluded that frequent paracetamol exposure was associated with a significantly increased risk of wheezing and rhinitis and probably eczema. Essentially identical findings have been reported from two Spanish studies (published in 2010 & 2012), the first[10] involving 13,908 children aged 6–7, the second[11] involving more than 20,000 children and adolescents.

In an Australian prospective study (published in 2010)[12] of a birth cohort of 620 children at high risk of developing atopic conditions, who were followed from birth to 2 years of age, and then to age 7 years, it was concluded that in children with a family history of allergic diseases, there was no association between early paracetamol use and risk of subsequent allergic disease after adjustment for respiratory infections or when paracetamol use was restricted to non-respiratory tract infections. It should be noted that 30% of this cohort of children had asthma at age 7 years, and that a weak association was found between the frequency of paracetamol use and increased risk of childhood asthma.

In a study carried out by the New Zealand Asthma and Allergy Cohort Study Group (published in 2011), which involved 914 individuals followed in a birth cohort study to age 6, the findings led the authors to suggest that paracetamol has a role in the development of atopy and in the maintenance of asthma symptoms.[13]

The association between paracetamol consumption and asthma was investigated in Phase Three of the International Study of Asthma and Allergies in Childhood (ISAAC) programme.[14] This involved 205,487 children aged 6–7 years from 73 centres in 31 countries.

This study (published in 2008) found that:

- use of paracetamol for fever in the first year of life was associated with an increased risk of asthma symptoms when aged 6–7 years;

- current use of paracetamol was associated with a dose-dependent increased risk of asthma symptoms;
- use of paracetamol was associated with the risk of severe asthma symptoms; and that
- paracetamol use, both in the first year of life and in children aged 6–7 years, was also associated with an increased risk of symptoms of rhinoconjunctivitis and eczema.

In response to the findings of the ISAAC Phase Three Study Group, the MHRA issued the advice[15] that:

The results of this new study do not necessitate any change to the current guidance for use in children. Paracetamol remains a safe and appropriate choice of analgesic in children. There is insufficient evidence from this research to change guidance regarding the use of antipyretics in children.

Notwithstanding the conclusions from all of these studies, a direct causal link between paracetamol exposure and the development of asthma and eczema has not been properly established. Indeed, it would be unethical to carry out a definitive study capable of demonstrating such a link.

Perhaps most importantly, none of these studies appears to have controlled for pre-natal (in utero) exposure of the child to paracetamol in pregnant women. So, a worrying finding is that in a study of 345 women,[16] it was found that use of paracetamol in middle to late (but not early pregnancy) seems to predispose the child to respiratory symptoms in its first year of life. The authors of this study identify two other publications, one published in 2005,[17] the other in 2002[18] describing essentially the same phenomenon. These observations are worrying because a mother-to-be who regularly self-medicates with paracetamol during pregnancy may well become a mother who regularly medicates her child with paracetamol (and/or ibuprofen).[19]

C. And did the switch from aspirin to paracetamol also trigger an epidemic of autism?

A thought-provoking article[20] published in 2009 provides a rather compelling suggestion that the autism epidemic, which mirrors the epidemic of asthma and eczema in terms of its onset in the 1980s, may actually be linked to the use of paracetamol to treat fever and pain following vaccination.

D. And does paracetamol exposure in utero, lead to "reduced masculinisation" or even "feminisation of males"?

In the wider world outside pharmacy, there is an ongoing discussion as to the causes of the observed demasculinisation and/or feminisation of males, not only of humans but also of other animals. A number of environmental / xenobiotic endocrine disruptors have been identified, including the herbicide atrazine, bisphenol A and various phthalates used in the manufacture of plastics, phyto-oestrogens, certain pesticides, etc,[21] but human evidence linking these substances to developmental disorders is scarce.[22] Nevertheless, these endocrine disruptors have been implicated not only in the obesity epidemic, metabolic syndrome, and in interference with thyroid function but also as causes of cryptorchidism and hypospadia, or in more general terms, testicular dysgenesis syndrome.[23] In human terms, the latter represents a spectrum of altered developmental states ranging from effeminate but otherwise normal males with poor semen quality to "intersex" conditions (i.e. individuals with genital ambiguity), and in its widest sense encompasses genetic disorders[24] as well as developmental disorders brought about by putative xenobiotic exposure.

Question marks have been raised over whether the levels of bisphenol A that people are routinely exposed to are high enough to cause the diseases that have been linked to this chemical.[25] Similar questions might also be raised for other putative xenobiotic endocrine disruptors. But the same cannot be said for exposure to paracetamol, which in an adult can amount to 1 gram taken up to four times a day, possibly for several days at a time. This is why we should be concerned to read that maternal intake of acetaminophen for more than 4 weeks during pregnancy, especially during the first and second trimesters, may moderately increase the occurrence of cryptorchidism;[26] or that intrauterine exposure

to mild analgesics is a risk factor for development of male reproductive disorders in human and rat;[27] or that paracetamol (acetaminophen), aspirin (acetylsalicylic acid) and indomethacin are antiandrogenic in the rat foetal testis;[28] or the conclusion reached in the Generation R study[29] that intrauterine exposure to mild analgesics, primarily paracetamol, during the period in pregnancy when male sexual differentiation takes place, increases the risk of cryptorchidism.

Concluding remarks

The picture that is emerging is that paracetamol is not safe to use in pregnancy (except perhaps only as very occasional single doses) and should perhaps be categorised as a potential teratogen. Nor is it as safe as has hitherto been believed for use in children. New guidelines[30] are urgently required.

Readers are invited to add the topic "Paracetamol: its dark side" to their CPD portfolios. Paracetamol needs to be more widely recognised as the [likely] cause of significant but avoidable morbidity. The associated cost to the NHS of this morbidity is also a matter that should concern us all. The tide will not turn whilst paracetamol products remain accessible on self-selection as GSL medicines.

Richard J. Schmidt
Locum community pharmacist

For ease of access references have been provided as weblinks, a full reference list is available on request

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Member Profile – Kathleen Thornton

Well, here goes.....

I was asked if I would share some of my experiences in my journey to Return to Practice, and which I am delighted to do.

After obtaining my degree from Leicester School of Pharmacy in 1982, I completed my pre-registration year at Boots the Chemist in New Street, Birmingham. After qualifying, I went to work for a smaller company, Bannister and Thatcher, working as a second pharmacist, relief manager and then later manager. Later on I returned to Boots, preferring to be a vocational pharmacist, rather than a manager.

I married a chemical engineer called Kevin in 1990. When I found out that we were expecting our first child, I intended to return to work on a part-time basis. I had not taken into account that I may feel differently after my son was born. How could I leave him, even to go to work? So I became a stay-at-home mom and this was to be my life for the next eighteen years.

It was early in 2011, after my husband had been out of work for a year that I began to think seriously about work again but I had "retired" from the register some years before. We had six children, plus a dog and two rabbits, so I was pretty busy. I had Sunday school teaching and a toddler group which I helped run, to fill in any spare time, along with serving on the local parent council.

I found that I could join the RPSGB as a "retired" member, which gave me access to much support, resources etc. The GPhC had taken over the regulatory role and I had to have my application form signed by a practising pharmacist of good standing. But who to ask? We had moved to the North of Scotland and I did not know any pharmacists. Then I realised that I had to compile a portfolio, to satisfy the GPhC that I was competent and fit to practise. The challenge was on!

I studiously worked through many distance learning courses, which I obtained through NES, the Scottish equivalent of CPPE. NES were fantastic and a lovely lady called Valerie answered many queries. They let me order courses using my RPSGB number as I was not yet registered with the GPhC.

I read up on everything I could. I then contacted Boots and shadowed pharmacists in three branches. I also went to the Return to Practice course at Strathclyde University, which was excellent. There were also some evening courses, the first one I went to being on Palliative Care. I was so nervous, but people were very nice and made me welcome.

The portfolio was sent off to the GPhC at the end of February 2012. I heard on 10th April that I had been successful and registered on April 15th 2012. I was so delighted.

But now, what should I do? I still felt quite nervous about actually going out and "being a pharmacist" again. It was a veterinary friend who said last summer, "you have a degree, this shows you can find information," which gave me the confidence to apply to pharmacies.

I now work as a part-time locum for some local independents and I LOVE IT!

A brief panic again when my CPD record was called for review this year, but I have been recording this on the official site, as I have done it, since being back on the register. I was unsure

if I had recorded enough examples of how I have put each piece of learning into practice, but sent in the required number, plus three extra. The relief when I had actually clicked the tab to send it. The even greater relief when I received confirmation that all was fine - 100% of the assessable criteria met. Phew!! I feel so blessed to have had all those years at home, but able to work as a pharmacist once again.

I would just like to say a huge thank you to all those who encouraged me, especially the team at NES, the tutors at Strathclyde, NAWP of course and the three pharmacists I shadowed. Especially also to my long-suffering husband who had to put up with my saying that I would never do it and who has cooked, cleaned, looked after the home and supported me so that I could study and now work again.

Kathleen Thornton

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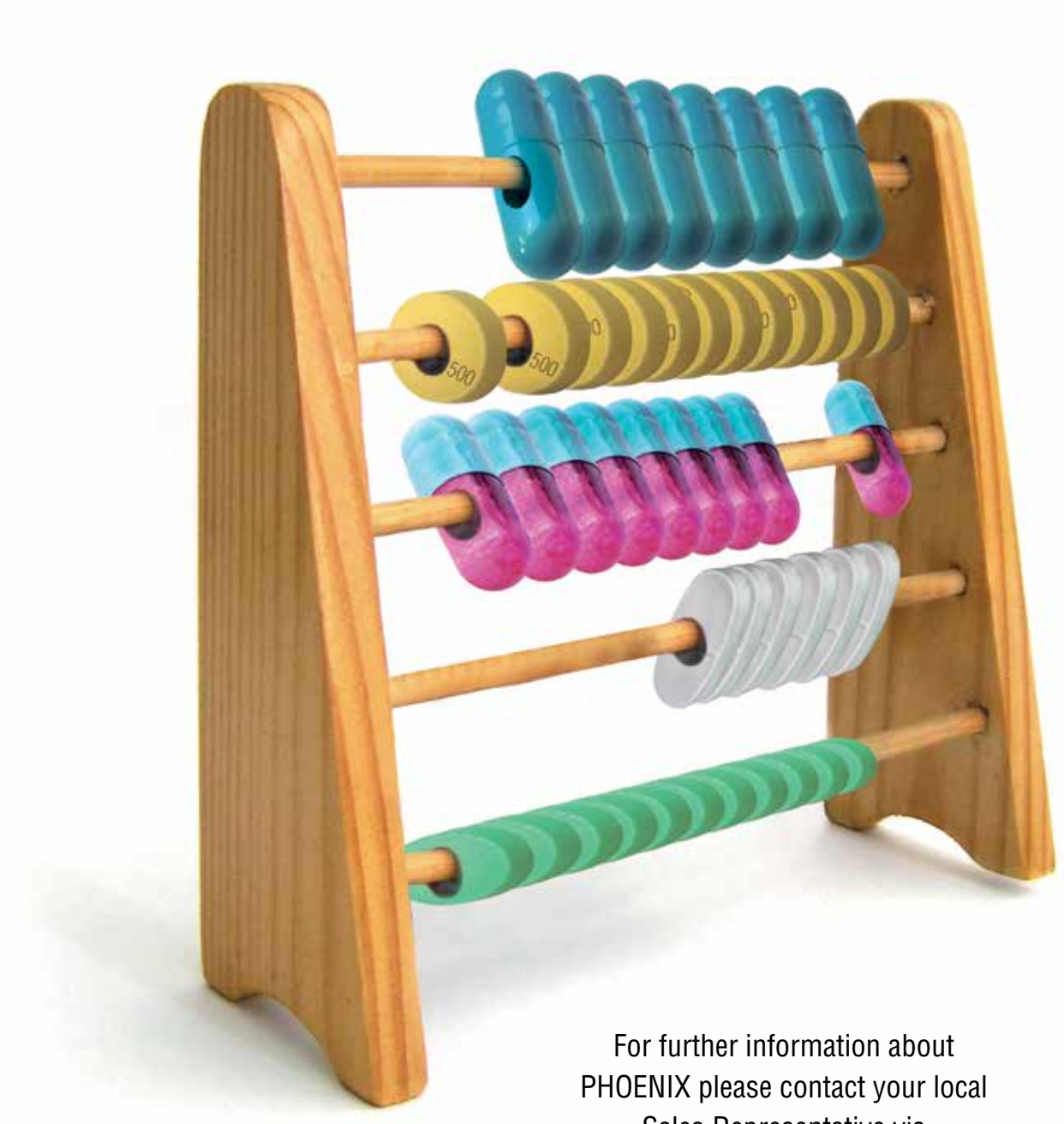

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Return to the register – building a portfolio

Pharmacy professionals who apply to return to the GPhC register after an absence of more than 12 months are now required to submit a portfolio of evidence to demonstrate current professional competence within their intended scope of practice. The CPPE are offering help in the form of a new event, Return to the register-Building a portfolio, available as a workshop or webinar. See CPPE website for the next available event.

http://www.cppe.ac.uk/

Misoprostol in childbirth: can it save lives?

Misoprostol, a synthetic prostaglandin, is licensed in the UK for the treatment of benign gastric and duodenal ulceration and for the prophylaxis of NSAID-induced gastric and duodenal ulcers. The BNF also mentions the unlicensed use of misoprostol (orally or vaginally) to induce labour, in postpartum haemorrhage and in medical and surgical abortions.

Post-partum haemorrhage (PPH) is a leading cause of maternal death. It is reported that this affects more than eight million women each year and accounts for one in four of all maternal deaths . (Pre-eclampsia and eclampsia are the second most common cause of maternal death). Deaths from PPH in the UK are fortunately rare; five deaths were reported in the UK for 2006-2008 . However, the situation is very different in the developing countries especially the countries of sub-Saharan Africa and South Asia which between them account for 90% of all maternal deaths. In these two regions more than half of the women do not have access to even skilled birth attendants let alone emergency obstetric services.

One of the United Nations Millennium Development Goals is to reduce maternal mortality by 75% by 2015. A significant reduction in deaths from PPH would make a major contribution to this goal.

Oxytocin is the drug of choice for the prevention and treatment of PPH. It may be given alone or in conjunction with ergometrine. However, one of the drawbacks with oxytocin in the developing countries is that at high temperatures its shelf life is considerably reduced: it is stable for 5 years at 2-8°C, but at room temperatures up to 30 °C it must be discarded after 3 months. Thus the practicalities of distribution and storage are a problem for many local facilities in these countries. Misoprostol, which like oxytocin is an uterotonic, has the advantage that it is available as an oral formulation, does not require cold chain transport and storage, and can be stored for 3 years at temperatures up to 30 °C.

Therefore, misoprostol has a place in the treatment and prophylaxis of PPH in those women who have limited access to modern and well-equipped obstetric facilities.

The WHO makes a number of recommendations for the treatment and prevention of PPH . In brief, for the prevention of PPH it recommends that women should be offered i.m. or i.v. oxytocin 10 IU during the third stage of labour. In settings where oxytocin is unavailable, patients should be offered injectable ergometrine/ methyl ergometrine, fixed dose oxytocin ergometrine combinations, or a single oral dose of misoprostol 600 µg. For women without access to skilled birth attendants the WHO recommends that if oxytocin is not available health care workers may administer oral misoprostol 600 µg.

Similar recommendations are made for treatment of PPH with i.v. oxytocin being the preferred option. Misoprostol 800 µg may be administered if oxytocin is unavailable, but only if it has not been given prophylactically.

Supplies of suitable medication to developing countries may be intermittent, of unknown or variable quality, licensed or unlicensed. Distribution to birthing centres and to remote communities may be difficult. There is also a paucity of good quality research into the efficacy and safety of misoprostol in prevention and treatment of PPH in birthing centres and remote communities.

Although not recommended by the WHO, consideration is being given to implementing a project in sub-Saharan Africa in which pregnant women without access to adequate healthcare support during labour would be provided with a single dose of misoprostol for self-administration during labour. However, one of the major concerns is to be able to control the supply chain of misoprostol to ensure that it does not become available for unsafe or inappropriate use.

There are several organisations, charities and ministries of health already developing programmes for using misoprostol in this way, but there are many challenges ahead for people working in this field.

Virginia Watson

Acknowledgement: I would like to thank Trudi Hilton of International Health Partners (www.ihpuk.org) for drawing NAWP's attention to the situation in sub-Saharan Africa and for reviewing this article.

1 *Working paper prepared for the United Nations Commission on Life Saving Commodities for Women and Children 2012*

2 *D. Fleming, R. Gangopadhyay, M. Karoshi and S. Arulkumaran. Maternal Deaths from Major Obstetric*

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5 *WHO Recommendations for the Prevention and Treatment of Postpartum Haemorrhage 2012*

Blue Pill, Pink Pill: another update

Dr Jane Flint, Chair of the BCS Joint working Group Recommendations for Women's Heart Health recently advised us that 'evidence of increasing cardiovascular risks in women in the <55 age group (smoking, gestational diabetes and STEMI) continues to emerge'.

Myocardial infarction (STEMI) is increasing in women aged over 55 years and a MINAP (Myocardial Ischaemia National Audit Project) audit has shown smoking to be increasing in this patient group. A study in the Journal of the American Medical Association (JAMA) in 2012 found that the highest mortality rate from myocardial infarction was in women over 55 years with more atypical symptoms.

Following up on whether there had been any progress on our request for more pre- and post-marketing safety analyses by gender I have learned that due to changes in pharmacovigilance legislation last year, the MHRA have had to focus on the implementation of the new procedures. The former Pharmacovigilance Working Party has been replaced by a Pharmacovigilance Risk Assessment Committee with increased powers to request and review safety data. Currently there are two significant safety referrals relating to women's health products on-going within Europe: these are for combined hormonal contraceptives.

Virginia Watson

Medicines Optimisation

'Helping patients to make the most of medicines', the good practice guidance for healthcare professionals in England has been endorsed by NHS England, RCGP, RCN, AoMRCs and ABPI, and was published on May 2nd. A copy of the Guidance and further information is available on http://www.rpharms.com/medicines-safety/medicines-optimisation.asp

The Self-selection of P medicines

Discussions between the GPhC and various organisations, including the RPS and PDA, earlier this year have not resulted in any change in their decision to go ahead with the proposed ruling that will permit the self-selection of P medicines.

The PDA have recently held a series of meetings across the country to discuss the proposal with members and to collect their views as a prelude to further action.

We also understand that the RPS is planning to consult with its members on this issue.

What are your views? Don't let this issue pass you by without having your say.

The Women's Library

We reported last year that The Women's Library was under threat of closure unless it could find a new home. Fortunately the LSE has come to the rescue and has been running the Women's Library since January this year when from January until 23rd of March the Reading Room and Exhibition areas were open, albeit for reduced hours.

The Library is now closed until 1st August to allow staff to prepare the collections for removal and relocation to the new premises. It will then operate from the LSE archives Reading Room until work on a new Reading Room (which will house the open access printed material) and Exhibition area has been completed. During this transition period archive and museum collections will be available from August and books, periodicals, pamphlets and other printed materials from September.

Virginia Watson

Iodine in Pregnancy

Iodine tablets are given routinely to pregnant women in Germany stated Antonie Marqwardt during her presentation on 'Health Promotion for Mothers and Babies' at our Brighouse Conference. This came as a surprise to many of us and led to discussion on the possible rationale for the different approaches adopted by the UK and Germany.

Therefore, it was with some interest that I watched a report on the local BBC TV news one day last week. A paper has been published in The Lancet reporting that iodine deficiency in pregnancy may have an effect on the mental development of the baby[1]. Analysing urine samples from over 1,000 women during the first trimester of pregnancy revealed that over two thirds were classified as iodine deficient, as defined by the WHO guidelines on recommended concentrations of iodine during pregnancy. Cognitive development in the women's children as assessed by IQ measurements at age 8 and the reading ability at age 9 was found to be significantly lower in those born to women who were classified as iodine deficient.

The paper concludes that even though severe iodine deficiency is not an issue in developed countries, nonetheless iodine deficiency should be treated as an important health issue to be addressed in the UK.

A number of the national papers reported on these new findings last week, but if you want to read more the full paper can be accessed on the Lancet website.

Virginia Watson

1 *Bath, SC, Steer,CD, Golding J, Emmett P, Rayner MP. Effect of inadequate iodine status in UK pregnant women on cognitive outcome in their children: results from the Avon Longitudinal Study of Parents and Children (ALSPAC). The Lancet. Early online publication 22 May 2013.*

2013 Annual Subscriptions

A reminder that your Annual Subscriptions is now due.
If you have not paid your subscription fee for this year, please do so as soon as possible.

Subscription fees for 2013 are:

Full time £30

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Students are entitled to join NAWP free of charge and to pay a reduced subscription of £10 for the first three years after registration (please state the year of graduation)

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

Cheques should be made payable to NAWP.
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Forthcoming Events

9th European Meeting of Women Pharmacists

18 – 20 October 2013

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Einzelzimmer/Single room	**€ 105.00**
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Letzte Buchungsmöglichkeit	**06.09.2013**
Registration deadline	**06.09.2013**

Sollte die Veranstaltung oder Teile von ihr aus welchen Gründen auch immer abgesagt werden müssen, werden bereits gezahlte Gebühren in voller Höhe erstattet. Weitergehende Ansprüche sind ausgeschlossen.

If the meeting or a social event is cancelled, for whatever reason, any fees for this event already paid will be refunded in full. No further claims for compensation will be accepted or made.

General Information

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9. Europäisches Pharmazeutinnen Treffen 9th European Meeting of Women Pharmacists

München
18.- 20. Oktober 2013

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Deutscher Pharmazeutinnen Verband

Kongresssprache: Deutsch/Englisch
Congress Language: German/English

Samstag/Saturday, 19.10.2013

Symposium

Vorläufiges Programm

Starke Frauen in der Pharmazie - neue Herausforderungen annehmen
Powerful Women in Pharmacy - accepting new challenges

ab 9:30 **Anmeldung/Registration**

10:00 - 10:30 *Begrüßung und Grußworte*
Welcome and Welcome addresses

10:30 – 11:15 Apothekerin im Kloster
Women pharmacist in monastery
Sr. Karin Johanna Haase, Stuttgart

11:15 – 12:00 Fortbildung neben Beruf und Familie - kann eLearning die Lösung sein?
Continuing learning, a job and a family- can eLearning be the solution?
Prof. Dr. Dorothee Dartsch, Hamburg

12:00 – 13:30 *Mittagspause/Lunch*

dscharo Dich zu einer besseren Führungsperson macht
How climbing Mt. Kilimanjaro makes you a better leader
Monique Kappert, Niederlande/Netherlands

15:00 – 15:45 Situation der Apothekerinnen in Island; Balance zwischen Familie und Beruf
The situation of women pharmacists in Iceland; the work-life-family balance
Thoruun Kvedja, Island/Iceland

15:45 - 16:15 *Kaffeepause/Coffeebreak*

16:15 – 17:00 Förderpreis für Studentinnen/ Award for female students
Vorstellung der Projekte/
Presentation of the projects

17:00 – 17:30 *Abschlussdiskussion und Verabschiedung*
Final discussion and farewell

20:00 **Gemeinsames Abendessen/ Joint Dinner im Hofbräukeller**

Sonntag/Sunday, 20.10.2013

10:00 – 12:00 **Stadtspaziergang: "Ohne Frauen geht nix"**
City walk: "Nothing works without women" (Deutsch/English)

Mitglieder dpv/ dpv Members	**€ 80** ___
Doktoranden/ Postgraduates	**€ 60** ___
Studenten; Praktikanten/ Students; Trainees:	**€ 10** ___
Freitagabend/Friday evening Konzert/ Concert	**€ 50** ___
Samstagabend/Saturday evening (ohne Getränke/without drinks) Abendessen; 1 Glas Sekt + 4 Gänge Joint Dinner; 1 Glas of Sekt + 4 courses	**€ 40** ___
Sonntagvormittag/Sunday morning Stadtspaziergang /City walk (Deutsch/English)	**€ 15** ___

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NAWP Magazine

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