SUMMARY.

1. Skin-colored preparations ("cuticolor preparations") should in general be preferred in dermatology over those of other colors and their use is mandatory so far as possible on surfaces of the body exposed to view.

2. Calamine should be improved by making its color more nearly that of the average Caucasian skin. This can be done by the addition of 4% yellow ferric oxide and the name "cuticolor powder" is proposed for it.

3. Calamine lotion can be improved by the use of cuticolor powder and the addition of 2.5% bentonite. The name "cuticolor lotion" is proposed for this improved preparation.

4. Bentonite is an excellent suspending medium for calamine, zinc oxide, precipitated chalk and other non-acid bodies.

5. A bentonite paste is offered as a possibly useful drying pigment for the skin.

6. Two different formulas are offered for water-soluble varnishes to be applied to the skin: one with tragacanth and the other with gelatin, as these are required for different purposes.

7. We offer formulas for three different cuticolor salves: "cuticolor ointment," "cuticolor cerate" and "cuticolor cream salve" as these may be needed for different effects.

8. A formula for cuticolor titanium dioxide as well as for brown cuticolor powder is given, the former as an improvement over the zinc oxide preparation and the latter for the purpose of matching brown skin color.

CONCLUSION.

All applications to the exposed surface of the skin should be made with the use of skin-colored preparations.

BIBLIOGRAPHY.

(1) Gathercoal, E. N., "The Prescription Ingredient Survey," AMERICAN PHARMACEUTICAL ASSOCIATION, Washington, D. C. (1933).

(2) "An Improved Calamine Lotion," *Perfumer and Essential Oil Record*, page 353 (September 1936).

HOSPITAL PHARMACY STANDARDS DEPENDENT ON ORGANIZATION.*

BY HAZEL E. LANDEEN.[1]

The Tower of Babel, the world's first skyscraper, was a failure because of hurry. The workers mistook their arrogant ambition for inspiration. They had too many builders and no architect. They thought to make up the lack of a head by a superfluity of hands. This is a characteristic of hurry. It seeks ever to make energy a substitute for a clearly defined plan—the result is ever as hopeless as trying to transform a hobby horse into a real steed by brisk riding.

---

* Presented before the Sub-Section on Hospital Pharmacy, A. PH. A., Minneapolis meeting, 1938.

[1] Pharmacist, St. Luke's Hospital, St. Paul, Minn.

By the preceding, the writer does not intend to infer that hospital pharmacists are showing themselves to be in too much of a hurry to accomplish a definite end in raising Hospital Pharmacy standards. Quite the contrary! As a group, I believe the majority of us are guilty of sitting back and letting others—that is, pharmacy educators and members of pharmacy boards carry too much of the responsibility of raising our standards to a level in keeping with the professional dignity which is our due. The initiation of this responsibility, no doubt, has been brought about only through the recent work and militant attitudes of a few scattered workers in our field. It is my belief that in the most of us the lack of and indifference to Hospital Pharmacy standards has produced only a basic emotion of resentment. The reaction to this, though authentic, is tardy and inadequate. A negative attitude is productive of *impotent* criticism and of superficial or unreasoning action. It is vindictive rather than constructive. Proper organization based on an understanding of the problems confronting the hospital pharmacist is the only means of attaining our objective.

The American College of Surgeons recognized the fact that pharmaceutical service, although extensively used, was not being given the consideration it deserves. Accordingly, it urged compliance with a minimum standard for pharmacies in hospitals, hoping thereby to insure the safety and efficiency of the pharmacy service. This standard appears in the latest manual of Hospital Standardization. In brief, it stipulates that the hospital shall have either the full-time service of a graduate registered pharmacist or shall receive pharmaceutical service from an approved nearby pharmacy; shall appoint a pharmacy committee composed of members from the several divisions of the medical staff, the pharmacist acting as secretary of the committee; shall maintain an adequate pharmaceutical reference library; shall use drugs, chemicals and pharmaceutical preparations of recognized quality; and shall delegate to the pharmacist supervision over the routine preparation of injectible medication and sterilization of all preparations he himself prepares, the routine manufacture of pharmaceuticals, the dispensing of drugs, chemicals and pharmaceutical preparations, the filling and labeling of all drug containers issued to nursing units from which medication is to be administered, a semi-monthly inspection of all pharmaceutical supplies on nursing units, the maintenance of an approved stock of antidotes, the dispensing of all narcotic drugs, chemicals and pharmaceutical preparations used in the treatment of patients, specifications for the purchase and storage of biologicals and all operations wherein a ready knowledge of weights and measures in all systems is necessary.

There are an estimated 7000 hospitals in the United States. What percentage of these meet the minimum requirement for pharmacy service as outlined by the American College of Surgeons, I do not know. As the writer understands it, the minimum requirement for Hospital Pharmacy service recommended by the American College of Surgeons constitutes a suggestion and is in no wise backed up by law. Hospitals with grade A ratings are expected to meet this standard and no doubt feel they do when they employ a pharmacist full or part time or have their pharmaceutical needs taken care of by a nearby store. But, in how many of these hospitals is there a pharmacy committee composed of members from the several divisions of the medical staff? In how many is there a definite drug policy? How many main-

tain an adequate pharmaceutical library, adequate equipment, facilities and space for rendering this most important public health service?

The pharmacy student who has completed a four-year course in Pharmacy is well equipped to manage and conduct a Hospital Pharmacy with a maximum efficiency of professional service. Where there is no hospital pharmacy committee, however, and therefore no drug policy, the pharmacist too often finds that his professional service must be adjusted to meet the requirements of a costs-minded administrator. This is by no means true in every case where there is no pharmacy committee. Many hospital administrators are keenly aware of the service rendered by the pharmacy. But for those who are not a pharmacy committee is the logical body to determine the hospital's pharmaceutical activities.

It is only comparatively recently that hospital pharmacists have become group-minded. They gradually began to wonder if others in the same work encountered the same difficulties and how their problems simulated or differed from their own and how they solved them. Little by little local groups of hospital pharmacists were organized. These have met and pooled their ideas, entered into lively discussions as to how best right our shortcomings and further gains already made. The idea has taken root until now it is most gratifying to learn that from these local organizations have emerged State Hospital Pharmacists' Associations. The Minnesota State Pharmaceutical Association during its 1936 convention moved to give the newly formed Hospital Pharmacists' group a section in its proceedings. For the past two years we have met in convention with our State Association. These few facts are given to show what can be done through concerted efforts of group organization.

If Hospital Pharmacists' Associations are able to effect changes and improvements in restricted localities, shouldn't our imaginations be stimulated to a realization of what could be accomplished by an organization national in character? Is it unreasonable to expect that such an association would be able to conduct surveys, secure data on hospital pharmacy standards, make suggestions for more uniform laws, approve certain hospitals for hospital pharmacy internships and provide other material of an educational nature? Isn't the question worthy of serious thought and consideration?

The groundwork for raising Hospital Pharmacy standards has been laid. How the work progresses depends on us. Let us not build a Tower of Babel. Let us make the Hospital Pharmacy Section of the AMERICAN PHARMACEUTICAL ASSOCIATION the architect for a structure of which we shall be proud.

BETTER HOSPITAL PHARMACY.*

MABEL C. STARR.[1]

For years individual pharmacists have worked to raise the standards of Hospital Pharmacy, by a little talking, a little writing and largely by day after day

* Presented before the Sub-Section on Hospital Pharmacy, A. PH. A., Minneapolis meeting, 1938.

[1] Pharmacist, Millard Fillmore Hospital, Buffalo, N. Y.