Case No. 2. Child (Female). Age 12 years.

SPECIMEN "A" (HOMOGENIZED).

Palatability: Excellent.
Regurgitation: None.
Miscibility: All traces of emulsion removed from the mouth by drinking water.

SPECIMEN "B" AND "D" (MORTAR AND MIX-MASTER).

Palatability: Claimed taste of oil and nausea. Refused further administration.

Case No. 3. Child (Male). Age 9 years.

SPECIMEN "A" (HOMOGENIZED).

Palatability: Excellent.
Regurgitation: None.
Miscibility: All traces of emulsion removed from the mouth by drinking water.

SPECIMEN "B" AND "D" (MORTAR AND MIX-MASTER).

Palatability: Claimed taste of oil and nausea. Refused further administration.

SUMMARY.

In comparing the time of manufacture and the stability of the finished product the Homogenizer produced the best emulsion, requiring only eight (8) minutes. The Mix-Master required but eight (8) minutes for manufacture, producing a satisfactory emulsion for immediate use, but showed stratification in one (1) week. The Mortar emulsion required sixteen (16) minutes for manufacture and produced a satisfactory product for immediate use, but showed stratification after one (1) week storage. The Milk-Shake Mixer proved unsatisfactory in that no emulsion was formed after sixteen (16) minutes of agitation.

CONCLUSION.

The practice of using the ever-ready and handy Milk-Shake Mixer for the manufacture of extemporaneous emulsions is emphatically condemned.

For the manufacture of a satisfactory emulsion the following methods are recommended in the order based upon their palatability and stability. (1) Homogenized. (2) Mix-Master Mixed. (3) Mortar and Pestle.

Further study is needed in order to establish the full value of the Homogenizer to the modern practice of Pharmacy.

PHYSICIANS, PATIENTS AND PRESCRIPTIONS.*

BY CHESTER I. ULMER,[1] M.D.

For several years I worked in the L. L. Walton Pharmacy, Williamsport, Penna. I give you this rather drab bit out of my autobiography, not that it particularly interests you nor to give any unsolicited publicity to the Walton Pharmacy, but rather because it may serve as a protective buffer for some of the remarks I shall now make. Any criticisms I may make of either profession are purely constructive ones and are made with no belligerent spirit, I assure you.

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[1] Physician, Gibbstown, N. J.

Yes, I have worked behind the drug counter. I've had customers hand me their prescriptions and now, years later, I write prescriptions—some of them the very same ones. It was always interesting and sometimes amusing for me to observe the attitude of some people when they brought their prescriptions to our store. Some would triumphantly surrender the prescriptions, revealing in every gesture the fullest confidence in their doctor. Others, apparently somewhat doubtful about its value and probably lacking full confidence in the physician, would slowly come up to the counter, make furtive glances around the store and then would say, "What's in this prescription?" Or, "What's this prescription good for anyway?" Now that's a tough question for any druggist, how should he know when even the doctor himself doesn't know sometimes. Not getting much satisfaction from the first two questions the customer leans confidentially over the counter and says, "What do you think of this doctor anyway—is he really any good?" Well, the druggist doesn't know what to say to that one, and if he does, thank heavens, he just doesn't say it.

Yes, patients study and analyze their prescriptions and it is surprisingly true that many are able to read them. The quantity symbols often perplex them, however. It is a very common practice and most druggists know it—for patients to come into the store, pull out a prescription and often ask for it by name, particularly if it is a one-item prescription. Physicians should always avoid writing prescriptions for an individual item when it can be prevented. I have often seen people come into drug stores with the individual item cut from the prescription and ask the price of it. Why, even certain medical proprietaries of the air capitalize on the importance of having several items on the prescription. What did I hear over the radio the other night, "When your doctor writes a prescription he does not write for just one item, he writes for several!"

Let us discuss briefly the physician and his prescriptions. I am not in accord with that cynic who said that a physician is a man who writes prescriptions till the patient either dies or is cured by nature. For quite a long time it has been observed that many physicians have become indifferent about prescription writing and have developed a tendency to prescribe certain pharmaceutical and proprietary products in preference to official preparations. There are probably two reasons for this negligent prescription attitude of many physicians: *First,* the curricula of many medical schools give students only two per cent of pharmacology and prescription writing, yet the responsibility of that item of medicine to the laity is about twenty per cent. Therefore, a vacuum of eighteen per cent exists and it is within this eighteen per cent that clever systems of advertising prey upon the public, exploiting medicine or pharmacy with little or no consideration of either. After all the physician's *greatest* and most *effective* weapon against disease is a broad knowledge of therapeutics. The second reason, probably, for the growing tendency of physicians to prescribe certain pharmaceutical and proprietary products is because of an indifferent attitude. Many of us have become somewhat indolent and have found it easier to write for a single proprietary item than to look into our Formulary. A physician is often criticized by his more intelligent patient for using a single proprietary item instead of devising an individualized treatment.

There is no doubt that many physicians have gradually allowed their offices to become annexed to the advertising offices of many pharmaceutical manufacturers.

Has American pharmacy retrograded? Many times the pharmacist has to take the barbed criticism from the public that he has allowed his drug store to degenerate into an emporium or lunch retreat. If there has been some deterioration in American pharmacy then the *doctor* must share the responsibility with the druggist for having allowed the prescription department to become subordinated into a mere side issue of a drug store.

There is no doubt that the occasional untactful attitude of some pharmacists has created a feeling of apprehension as to the merit of a prescription when it is presented by the patient. Quite often the druggist sort of shrugs his shoulders when questioned about the efficiency of a prescription when instead he could just as easily inspire confidence.

We have queer companions in both of our professions! We should look at ourselves occasionally, as others see us. There are some bizarre fellows in pharmacy, believe me, and we know it, too. Look at some of our drug stores on Main Street, cluttered up with all kinds of merchandise, counters burdened with a conglomeration of gadgets. I predict that eventually the pendulum is going to swing back, out of all this chaos, back to the more dignified pharmacy of several decades ago.

In medicine we have some weird inhabitants and we know it, too. We have springing up a new cult within our own profession—they are the therapeutic nihilists—those physicians with a smug attitude, who shrug their shoulders at all drug therapy. These iconoclasts have a limited drug armamentarium to say the least, they practice medicine with only three prescriptions, water, fresh air and sunshine. The profession has entirely too many of this type of physician who think that to cure all the ills of all people is to simply write:

℞ Aqua, cong i
Sig: Glassful every hour

(Signed) Dr. Sponge

I must say a few words about the problem of counter-prescribing by pharmacists and medicine dispensing by physicians. Both practices started innocently enough many years ago but have been accelerated during the past six or seven years because of the depressed economic status of the people. Every pharmacist has, at some time, done counter-prescribing and every physician has done some drug dispensing. I have done both.

The fact remains, however, that the physician is no more qualified to engage in intelligent dispensing than the pharmacist is in counter-prescribing. In each case there is the assumption of responsibilities for which neither is fitted. Let each one stick to his trade. Let the pharmacist practice Pharmacy and let the physician practice Medicine. By doing this, confidence and respect will be established on both sides. It will create a better spirit and teamwork between pharmacists and physicians.

To help correct the tendency of proprietary prescribing and to assist in reviving the art of prescription writing a committee from the State Medical Society of New Jersey is coöperating with a committee from the New Jersey Pharmaceutical Association striving for improvement in the writing of prescriptions along ethical lines. This joint committee is known as the Joint Committee on Professional Relations.

Our endeavor is to give to the physicians practical prescriptions which will take the place of certain proprietary preparations. We differentiate between so-called *proprietary preparations* and *ethical specialties.*

A little more than a year ago, in April 1936, we commenced the simultaneous publication in both of our Journals—the JOURNAL OF THE PHARMACEUTICAL ASSOCIATION and the *Journal of the Medical Society*—a group of six seasonable, ethical formulas. They appeared bimonthly. These prescriptions have proved very popular and practical with many of the physicians in our state and I am sure that many New Jersey pharmacists have already noted that doctors are prescribing more of these ethical formulas.

It is gratifying to note that in one of the hospitals of our State of New Jersey our prescriptions are being used as a basis for instruction at the weekly conferences with the interns and medical staff.

In addition to our prescription feature we plan to present in the JOURNAL OF THE PHARMACEUTICAL ASSOCIATION and the *Journal of the State Medical Society* a series of articles covering recent developments in the use of therapeutic agents and new drugs. In the August issue of our respective Journals appeared a timely article sponsored by our Joint Committee on Professional Relations on Sulfanilamide.

In New Jersey we are going on with our work. It has really just begun.

PHARMACY AND MEDICINE—two great allied professions. With so many common interests it is most important that we face together the inevitable problems of the future.

IS THE PHARMACIST A POOR MERCHANT BECAUSE HE LACKS TRAINING IN ACCOUNTING, ECONOMICS AND BUSINESS STUDIES?*

BY RALPH R. KREUER.[1]

I have asked a question as the title of my paper, and, while I admit that it is difficult for anyone to answer that question, I am convinced, after much study and personal observations, that the answer is, "yes." Yes, the pharmacist is a poor merchant because he lacks these necessary and vital requirements.

I have seen conditions in drug stores that were appalling. I have seen pharmacists going about their daily duties with absolutely no idea of how much business they must do in order to make a profit. They could not tell whether they were heading for bankruptcy or actually making money. They could not discuss a profit-and-loss statement or stock control. Many pharmacists haven't the least idea of what their inventory is, for the simple reason that they don't take one. I have asked many pharmacists if they were making a profit on their soda fountains. The answer is usually, "yes," or "I believe so." On further questioning as to how much money they were making, or what gross profit they realized, the answer was almost invariably "I don't know." Keen competition usually takes its toll of these poor business men, because they lack the weapons with which to fight their com-

* Presented before the Section on Practical Pharmacy and Dispensing, A. PH. A., New York meeting, 1937.

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