Consumer stories about labelling

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A consumer panel was established to contribute to two large research projects funded by the National Health and Medical Research Council, on medication safety and chronic illness in seniors (aged 65+ years) undertaken at the University of Western Australia. These two stories are from members of the panel.

Packaging

A man had been taking two medicines (see photo) and was not aware they were the same medicine. It was not until he sought advice from his pharmacist about his unexplained adverse effects that he was told his usual medicine had been substituted for a generic medicine. The substitution had not been discussed or explained by either the doctor or the pharmacist. The panel felt the confusion was caused by several factors: the use of different names, the entirely different packaging, the apparent change in dose, and a lack of explanation about generic substitution. For most of the panel members the price of a generic substitute was insufficient to change their preference for a specific brand.

Non-specific dosing instructions on prescription medicines

A 90-year-old woman who lives on her own has several chronic conditions and takes up to 13 medicines a day. She explained she was a private person and did not want to have her medicines list on the fridge for the cleaner or anyone else to see. Her concern was that some medicines did not have proper dosing instructions when dispensed and only had instructions such as 'Take as directed by the Dr' or 'No directions specified check with Dr if unsure'. She was also worried that if she had to go to an emergency department the staff may not know the correct dosage of her medicines.

The woman has since started using blister packs, even though she could not really afford the extra cost. Now she says she 'doesn't have to worry or even think about it any more'.

Other examples

Other members of the panel cited examples of medicines that were dispensed with instructions that included Latin abbreviations, and one member regularly received medicine without any dispensing labels because he had been taking the same medicines for over a decade.

The panel felt this unsafe practice could potentially be contributing to the adverse medicines events in seniors.