

**The Reconstruction
of Pharmacist Authority
in British Columbia: 1965-1968**

by

Stephen Dove
B.Sc (Pharm), University of British Columbia, 1974

A Thesis Submitted in Partial Fulfillment
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Abstract

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Despite extensive research on the history of medicine, little has been written on the role played by pharmacists. The diminished demand for compounding services that accompanied the explosion of manufactured pharmaceuticals after World War II left pharmacists over educated and underutilized. This study demonstrates how British Columbia pharmacists reconstructed their professional authority in the 1960s through the formation of a Pharmacy Planning Commission, a process that pre-dated and influenced other jurisdictions. Examination of the archives of the College of Pharmacists of British Columbia reveals that pharmacists overcame ethical restrictions, adopted clinically focussed education and increased accessibility to facilitate a role as consultant to the public on non-prescription medications. The addition of prescription drug counselling and an increased role as drug consultants to physicians allowed British Columbia pharmacists the authority to claim a core competency as drug information experts.

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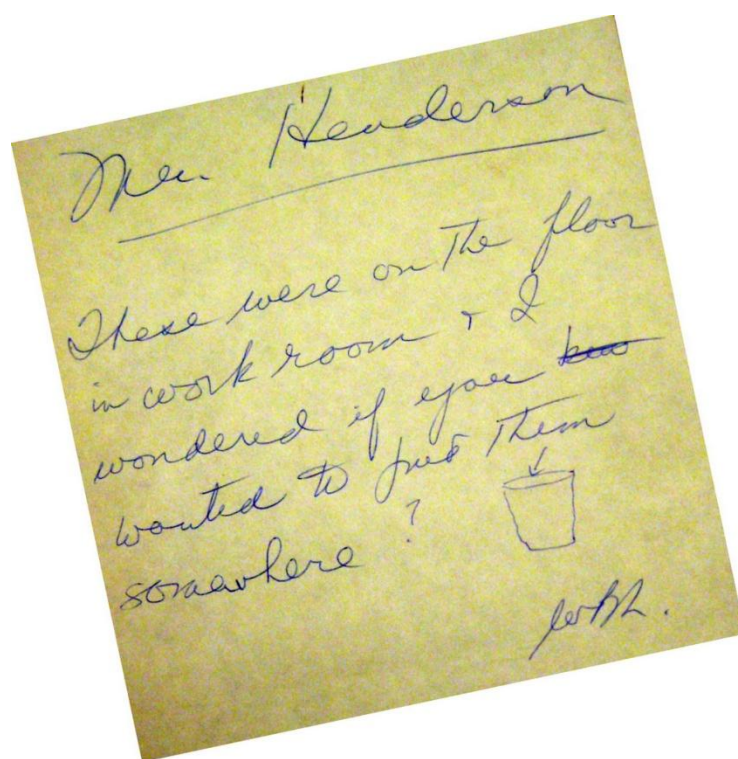
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Dedication

This thesis is dedicated to Mr. Gibb Henderson, Executive Secretary of the Pharmaceutical Association of British Columbia, who had the foresight to recognize the importance that the records of the Association would be to future pharmacists and historians. He was responsible for saving the Association records from 1891 to 1982, some by storing them in his own basement. They are now kept in the Special Collections Division of the University of British Columbia library. As you can judge by the note below, not everyone shared the vision he had about the value of these records. The note was found in one of the documents that he saved.



Introduction

*The issues at stake in the history of medicine – how societies organize health care, how individuals or states relate to sickness, how we understand our own identity and agency as sufferers or healers – are simply too important for the practice of medical history not to be persistently subjected to vigorous reflection and re-examination.*¹

Frank Huisman, Medical Historian

The community pharmacist occupies a unique position within the medical community and society. Educated in Canada with a five-year university degree, including extensive medical, biological and physical sciences, the community pharmacist's professional work setting situates them in a unique position. They usually practice their profession within the commercial retail sector, rather than within the confines of an office or hospital setting like most health practitioners. Their location in commercial areas, in combination with the large number of pharmacies in our society, has made pharmacists the most easily accessible health professional. The public takes advantage of this accessibility by often making the pharmacist their first contact with the health care system. The pharmacist may respond with simple advice, over-the-counter treatments or, if warranted, referral to another health professional. Thus, part of the pharmacist's role resembles that of a triage nurse in the hospital setting.

While accessibility has been mutually convenient and beneficial for the public and pharmacists, it has also affected the public's view of pharmacists as health professionals. For much of the twentieth century, pharmacists were unable to support themselves with income derived solely from the professional services they offered. As a result, they have

¹ Frank Huisman, "Medical Histories," in *Locating Medical History: The Stories and Their Meanings*, ed. Frank Huisman and John Harley Warner (Baltimore: The Johns Hopkins University Press, 2004), 3.

supplemented their income with a variety of non-professional commercial services and products, ranging from minimal offerings in clinic pharmacies to broad arrays of services and products in mass merchandise locations. The public expects non-professional products to be available in a pharmacy, alongside professional services. This combination of a professional and commercial role left pharmacists struggling, for much of the twentieth century, to attain recognition as a complete profession; from the public, other health professionals and even within their own profession. In this thesis, I will examine how community pharmacists in British Columbia, in the mid 1960s, reconstructed their professional foundations in an attempt to enhance their professional image. To achieve this goal, pharmacists had to break away from the ethical and legal constraints that had restricted the scope of their practice, since the 1920s.

The definition of a profession is socially constructed. Consequently, those groups recognized as professions vary in each society. At the beginning of the nineteenth century, the only recognized professions in western society were medicine, law and the clergy. These groups acquired legitimacy as professionals through a classical education which was requisite to their status as gentlemen. The classics endowed the professional with the qualities of character and culture which, in turn, conferred authority upon their expertise. This requirement ensured that the professions would be restricted to those members of society from the upper end of the economic scale since university was beyond the financial resources of the majority of the public. If they possessed these basics, professionals could develop the specific skills they needed through apprenticeships with experienced members of their profession.²

² R. Gidney and W. Millar, *Professional Gentlemen: The Professions in Nineteenth-Century Ontario* (Toronto: University of Toronto Press, 1994), 5.

Since the mid-nineteenth century, professions in Canada have gained recognition by legal statute in addition to social recognition. Typically, when the state recognizes a profession it allows them to control their membership, education and discipline through self-regulating statutory professional associations. In Canada, the Ontario College of Pharmacy was recognized in 1871 by The Pharmacy Act.³ British Columbia pharmacists received self-regulatory status with the passage of the British Columbia Pharmacy Act in 1891.⁴ While legal sanction is a prerequisite to recognition as a profession, academics have devoted considerable effort to defining the attributes that separate professions from other occupations.

Sociologist Talcott Parson defined professionals as possessing several characteristics. They are recruited and licensed, he argued, based on technical merits and use generally accepted scientific principles. Additionally, they restrict their work to their technical competences and put their client's interests first, avoiding emotional involvement in order to retain objectivity.⁵ Sociologist Eliot Freidson agrees with Parsons but points out that these characteristics could apply to other occupations as well. Freidson defines professionalism as the occupational control of work and, like most occupations, professions perform specialized functions."⁶ Unlike mechanical specialization, which includes a small number of simple, invariant, repetitive actions, professions demonstrate theoretically based discretionary specialization. These tasks are so varied that the professional must exercise considerable discretion in adapting their

³ R. J. Clark, "Professional Aspirations and the Limits of Occupational Autonomy: The Case of Pharmacy in Nineteenth-Century Ontario." *Canadian Bulletin of Medical History* Vol. 8 (1991): 44.

⁴ Arnold Raison, *A Brief History of Pharmacy in Canada* (Canadian Pharmaceutical Association, 1967), 46.

⁵ Talcott Parsons, *The Social System* (London: Tavistock Publications Limited, 1952), 434-5.

⁶ Eliot Freidson, "Theory of Professionalism: Method and Substance," *International Review of Social and Behavioural Sciences* Vol. 9 No. 1 (1999):118.

knowledge and skills to each circumstance encountered.⁷ Professional authority derives from specialized knowledge as well as legal statute.⁸ What Freidson adds to Parson is the recognition that complex judgment brings the dimension of risk, either success or failure, to the professional.⁹

When a profession is privileged with occupational control they are afforded certain monopolies. Freidson argues that these monopolies imply that the problems that professions deal with are too complex for the public to make choices that are in their own best interest. This restriction creates the possibility of exploitation and consequently professions are held to have a fiduciary role in protecting the interests of the public. Professions instil a aura of trust in the public through the adoption of Codes of Ethics and the formation of intra-professional disciplinary committees. In addition, professions make a claim to independence from either political or client control. This manifests itself, Freidson argues, in allegiance to a transcendent value of truth, beauty, enlightenment, justice, salvation, health or prosperity and enforces the professions claim to special status.¹⁰ In short, professionals are expected to value the interests of the public over their own self interest.

It is important to keep in mind, when looking at the characteristics of a profession that professions cannot be established and maintained without powers they do not possess. Freidson has pointed out that knowledge and skill might give professions human

⁷ Freidson, "Theory of Professionalism," 119.

⁸ Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York: Atherton Press Inc, 1970): 108.

⁹ Ibid., 97.

¹⁰ Freidson, "Theory of Professionalism," 127.

and cultural capital but not economic or political capital. Only the state has the power to establish and maintain professionalism.¹¹

Other academics have examined the development of professions as well.

Economist Deborah Anne Savage defines a profession as “a network of strategic alliances across ownership boundaries among practitioners who share a core competence.”¹² This definition lacks many of the accepted elements that define a profession but is useful because it introduces the concept of core competencies which reflect a professions knowledge and skill. For Freidson these competencies constitute a knowledge mandate that “represents the capacity of a profession to exercise influence by virtue of its body of knowledge and skill.”¹³ In pharmacist’s struggle to gain and maintain their professional status, core competencies, representing their knowledge mandate, would play a vital role.

Savage and Freidson’s work can provide a valuable framework for evaluating pharmacists’ professional progress. Savage defines competencies as the collective learning of an organization and distinctive competencies are those that an organization can perform better than anyone else. Core competencies are those that are crucial to an organization’s survival and play an important role in defining professions as knowledge-reliant production organizations. Capabilities are activities that an organization can perform with a set of competencies. Dynamic capability is defined as the organization’s “ability to integrate, build, and reconfigure internal and external competencies to address rapidly changing environments.” Dynamic capabilities and competencies can explain how a profession develops, and adapts itself, in response to changes in its external and

¹¹ Freidson, “Theory of Professionalism,” 123.

¹² Deborah Anne Savage, “The Professions in Theory and History: The Case of Pharmacy,” *Business and Economic History* Vol. 23 No. 2 (Winter 1994): 131.

¹³ Freidson, “Theory of Professionalism,” 127.

internal competitive environment. For Freidson, the strength of a professions capacity is measured by its knowledge and skill – the depth of its scientific foundation - , its sphere of authority – its technical, moral and cultural authority, and its institutional spheres – the legal environment where it practices.¹⁴

In Canada, pharmacists have been legally designated as professionals since the nineteenth century. Their struggles have been with the additional aspects of professionalism outlined in the preceding discussion. What makes pharmacy an important profession to examine is that they significantly adjusted their core competencies, the expression of their knowledge and skill, over the course of the twentieth century. Additionally, as their core competencies shifted, their sphere of authority, technically, morally and culturally, also adjusted.

The application of power and authority is integral to any discussion about professions. Paul Starr argues, in *The Social Transformation of American Medicine*, that the authority of medical practitioners incorporates two effective forms of control, legitimacy and dependence.¹⁵ Practitioners, he says, are able to exercise legitimacy through social acceptance of their specialized knowledge and competence. Dependence results from the expected negative consequences that might befall a patient if they choose not to accept the practitioner's authority. Backing up authority is an implied threat of coercion provided by either force or persuasion. Some authorities, such as police and the armed forces, routinely use force to back up society's collective authority. Medical practitioners generally back up their authority with persuasion although society has delegated physicians the authority to use force in certain situations. Physicians are able

¹⁴ Freidson, "Theory of Professionalism," 127.

¹⁵ Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books Inc, 1982), 9-29.

to order involuntary confinement of mentally ill patients who are a threat to themselves or society for 48 hours.¹⁶ More commonly, a health practitioner's authority derives from the patient's dependence on their specialized knowledge along with their statutory powers. In order to protect the public from potential abuse of authority, professions develop codes of ethics.

Ethical codes are put in place when a profession acquires sufficient specialized training and knowledge to justify society delegating to them the authority to make informed decisions. Along with this authority comes the responsibility and accountability to use their expert knowledge for the benefit of their client. These ethical codes ensure that the power and authority vested in the profession are used in society's best interest. Ethical codes can be developed in a number of ways. They can represent an ethical consensus among the members of the profession while not necessarily taking society's needs into consideration. A second route creates codes that outline the profession's judicial position. This type of code is useful for disputes that end up in the courts but doesn't address the "grey" issues that arise just outside of legislation. Third, codes can serve as statements of role-specific rules that are unique to the profession but differ from those that govern society as a whole.¹⁷

A fourth method is similar to the third, with the exception that codes are created by adapting ethical principles that apply to society in general, to activities that are specific for the profession. Philosopher Eike-Henner Kluge argues that since the process that a profession uses to select its members is constructed by society, it follows logically that its members should be held to the same ethical principles as that society. On that

¹⁶ British Columbia Mental Health Act, 1996, Part 3 Section 22.

¹⁷ Eike-Henner W. Kluge, *Biomedical Ethics: In a Canadian Context* (Scarborough: Prentice-Hall Inc, 1992), 46-53.

basis, the last method of constructing codes of ethics would most appropriately provide guidance to the profession on their responsibilities to society.¹⁸ Codes of ethics created using the fourth method reflect the ethical principles of the society in which it was created, as well as the profession that created them.

Codes of ethics can be created accessing several different models. The model that a profession chooses defines the type of relationship that it wishes to have with the society they serve. One alternative, the paternalistic or priestly model, allows the professional to make decisions on behalf of their client. When this model is used in medicine, the patient has very little input into their diagnosis and treatment. It follows that they need to be given very little information about their diagnosis or treatment because they are not part of the decision making process. This model is familiar in medicine and leaves the patient with the role of obeying “doctor’s orders” or “following the instructions on your prescription.”

A second alternative is the “agency” model which embodies the opposite characteristics to the paternalistic model. In this model the client is in complete control and the professional is used only for technical consultation. Unlike the paternalistic model, this patient needs as much information as possible, preferably as much as the health professional, because they are ultimately responsible for determining their own diagnosis and treatment. With complete control reverting to the patient, the health practitioner is obligated to provide a treatment, even if its effectiveness is doubtful or contrary to his or her better judgment.

One last possibility is the fiduciary model, which implies that a relationship of trust exists between the professional and the client, even though their knowledge is not on

¹⁸ Ibid., 46-53.

an equal footing. In this model, the ethical values of the health practitioner would be balanced by the values expressed by the patient. A patient in this model would have to receive enough information about the diagnosis and treatment to allow them to make an informed decision on the risks versus the benefits of the treatment. Variations of these three models have been employed at different times by health practitioners at different times in history, in different societies.

Ethical codes have played an important role in pharmacists' development. They have been used effectively to control the professional activities of pharmacists, in times when pharmacists needed to consolidate their core competencies. Conversely, they have acted as a brake on professional progress in times when pharmacists needed to expand their core competencies. Their examination will play a significant role in my study.

Frank Huisman has reminded us that an important role for medical historians is to persistently subject society's health care organizations to vigorous reflection and re-examination. The relative levels of medical authority assigned to health practitioners are constructed by society. Those levels are not static or inevitable and affect the relationships that develop between health practitioners and the public. Little has been written about pharmacists' access to authority or their relationships with physicians and patients. Although operating legally as a self-governing profession since the nineteenth century, pharmacists' access to authority in society has ebbed and waned since that time.

My thesis provides a case study of British Columbia pharmacists in the mid 1960s, a time when pharmacists in North America were pessimistic about the future of their profession. Their core competency as experts in compounding prescriptions had been disappearing in the decades after World War II with the increasing availability of

pre-fabricated pharmaceuticals. Pharmacists were trapped by an ethical code, adopted in 1923, that restricted the scope of their practice while at the same time the core competency that formed their professional identity had diminished. For much of the twentieth century, pharmacists were prohibited, by their ethical code, from disclosing the composition of the medications they dispensed to their patients or discussing patient's treatment. In the 1960s, pharmacists sought to expand their core competencies to include recognition as drug information experts and British Columbia pharmacists provide an important case study since they were one of the first jurisdictions that attempted to expand their scope of practice. Their formation of the Pharmacy Planning Commission in 1966 was pivotal for professional development of pharmacists in British Columbia. It is of particular significance, in a broader context, as it pre-dated similar commissions by the Canadian Pharmaceutical Association (CPhA) and the Millis Study Commission in the United States. Their reports were released in 1971 and 1975 respectively.

Until now, neither historians nor pharmacists have focused significant resources on the history of pharmacy, a fact noted by the few authors who have made contributions. Even fewer have focused on the Canadian scene. Despite this vacuum, there is a body of literature that will be useful in carrying out this study. Elenbaas and Worthen in their recently published article "The Transformation of a Profession: An Overview of the 20th Century" cover similar topics to those in this thesis, in an American context. While the two countries differed significantly in their health care systems, pharmacists in both countries faced similar professional struggles. Their article gives a good description of the Millis Study Commission on Pharmacy.¹⁹

¹⁹ Robert M. Elenbaas and Dennis B. Worthen, "The Transformation of a Profession: An Overview of the 20th Century," *Pharmacy in History* Vol. 51 No. 4 (2009): 151-182.

The only extensive overview of pharmacy history in the English language is *Kremers and Urdang's History of Pharmacy*.²⁰ This book provides a good survey of pharmacy from the Babylonians through to nineteenth century Europe. The authors then turn to pharmacy in the United States, which they follow from pre-revolutionary colonial days into the twentieth century. The extent of its coverage defines its strengths and its weaknesses. Nowhere else is so much information specific to pharmacy available. This makes it an essential reference to anyone writing pharmacy history. On the other hand, like all survey works, it is unable to provide depth to any one subject. For purposes of this study, it fails to provide any information on the development of pharmacy in Canada. Therefore, its usefulness is limited to providing a contextual background for Canadian pharmacy, in comparison to developments throughout the world, and specifically the United States. Another limitation to this work is that it was originally written in 1940, although updated in 1976 by pharmacy historian Glenn Sonnedecker. It cannot, therefore, provide insight into pharmacy developments in the last third of the century.

Daniel Malleck has published several articles which are useful when examining the shift in pharmacist/physician authority allocations at the turn of the twentieth century. “Professionalism and the Boundaries of Control: Pharmacists, Physicians and Dangerous Substances in Canada, 1840-1908” is important because it argues that, despite the contentious issues that separated them, pharmacists and physicians had entered into an uneasy alliance by the beginning of the twentieth century.²¹ Malleck also details Canada’s quest to control addictive substances through two articles, “Pure Drugs and

²⁰ Glenn Sonnedecker, *Kremers and Urdang's History of Pharmacy* (Madison: American Institute of the History of Pharmacy, 1976). (1986 Paperback edition)

²¹ Daniel J Malleck, “Professionalism and the Boundaries of Control: Pharmacists, Physicians and Dangerous Substances in Canada, 1840-1908,” *Medical History* Vol. 48, (2004): 175-198.

Professional Druggists: Food and Drug Laws in Canada, 1870s-1908” and “Its Baneful Influences are too Well Known: Debates over Drug Use in Canada, 1967-1908.”²²

Another article of importance is Robert Buerki's “The Historical Development of an Ethic for American Pharmacy” which follows the evolution of pharmacy ethics in the United States, noting of particular interest the 1922 clause that prohibited the discussion of therapeutic effect of a physician's prescription with the patient.²³ Buerki has also published *Foundations of Ethical Pharmacy Practice* along with Louis Vottero.²⁴ While this book is intended to provide pharmacy students with a basic grounding in current pharmaceutical ethical issues, it provides a historical overview of ethical codes put in place by the American Pharmaceutical Association from 1852 to 1994.

This study is aided by the contributions of scholars outside the discipline of history. *The Social Transformation of American Medicine*, by sociologist Paul Starr, is an excellent study of physicians, and the medical system, as it developed in the nineteenth and twentieth centuries.²⁵ Starr describes how physicians survived the competitive climate of the nineteenth century to emerge, in the twentieth century, with unprecedented professional authority, what he terms “cultural authority.” John Harley Warner compliments Starr on avoiding the temptation to account for this rise by citing increased efficacy of the new scientific medicine but says he was much more successful at describing the change than explaining it. Warner finds fault in three areas,

²² Daniel Malleck, “Pure Drugs and Professional Druggists: Food and Drug Laws in Canada, 1870s-1908,” *Pharmacy in History* Vol 48 No 3 (2006): 103-110 and Daniel Malleck, “Its Baneful Influences are too Well Known: Debates over Drug Use in Canada, 1967-1908,” *Canadian Bulletin of Medical History* Vol 14 (1997): 236-288.

²³ Robert Buerki, “The Historical Development of an Ethic for American Pharmacy,” *Pharmacy in History* Vol. 39 No. 2 (1997): 54-72.

²⁴ R. Buerki and L. Vottero, *Foundations of Ethical Pharmacy Practice* (Madison: American Institute of the History of Pharmacy, 2008).

²⁵ Starr, *Social Transformation*, 9-29.

undervalued alternative medicine in early twentieth century, the lack of recognition of “the language of science” as a source of cultural authority and the lack of patients’ voices. Despite these objections, and those of other historians, Warner maintains that “no other synthetic narrative has appeared to supplant Starr’s work.”²⁶ Warner notes that Starr’s concept of the renewal of legitimate complexity is critical to the understanding of cultural authority. Starr’s work provides a good theoretical discussion on the nature of authority and status as it applies to physicians in particular, and professions in general.

In addition to Starr, economist Deborah Anne Savage lays out a useful framework for examining the influence that core competencies can exert on professional authority in her article “The Professions in Theory and History: The Case of Pharmacy.”²⁷ Her study is flawed in several ways. First, her interpretation of professionalism fails to take into account the fiduciary nature of professions. Second, her case study of pharmacy confuses manufacturing with compounding, thus reducing its usefulness. However her discussion on core competencies is pertinent to the restructuring of pharmacists’ professional identity. Eliot Freidson’s “Theory of Professionalism: Method and Substance” and *Professional Dominance: The Social Structure of Medical Care* help to fill in the gaps in professional theory that Savage neglects.²⁸ Philosopher Eike-Henner Kluge provides background into the origins and uses of medical ethics in his book *Biomedical Ethics in a Canadian Context*.²⁹

²⁶ John Harley Warner, “Grand Narrative and its Discontents: Medical History and the Social Transformation of American Medicine,” *Journal of Health Politics, Policy and Law* Vol 29 No 4-5 (Aug-Oct 2004): 771.

²⁷ Savage, “Professions in Theory,” 129-160.

²⁸ Eliot Freidson, “Theory of Professionalism: Method and Substance,” *International Review of Social and Behavioural Sciences* Vol. 9 No. 1 (1999): 117-129 and Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (New York: Atherton Press Inc, 1970).

²⁹ Eike-Henner W. Kluge, *Biomedical Ethics In a Canadian Context* (Scarborough: Prentice-Hall Inc, 1992).

Primary sources will be important to this study and the main source will be the archive of the College of Pharmacists of British Columbia, held in the University of British Columbia's Special Collections Division. My thesis develops a case study around the efforts of British Columbia pharmacists to reform their profession through a broad based commission. The commission is significant because of its success and because it predates similar national commissions in both Canada and the United States. This archive includes a nearly complete record of minutes, membership records, financial records, correspondence and reference files of the Registrar of the College of Pharmacists of British Columbia, encompassing College activities from its inception in 1891 to the early 1980s. This archive includes two reports that are critical to this study, The Study Committee on Pharmacy in British Columbia, completed in 1966 and the Pharmacy Planning Commission, completed in 1967. Additionally, the archive includes a number of additional reports that are pertinent to this investigation such as the “Health Services in Canada” – a report of a working conference on implications of a health charter from 1965 and the “Royal Commission on Health Services” – Pharmacist manpower in Canada from 1966. Also included are various records from the British Columbia Professional Pharmacists Society, an organization founded in 1968 to protect the interests of pharmacists. Many of the minutes recorded by each council, at their annual general meetings and interim meetings, provide a great amount of detail. They provide in depth information about the issues that were important to pharmacists, and the public, at the time of each meeting and the different opinions expressed by pharmacists.

While the college records form the bulk of the primary sources for this study, the *Canadian Pharmaceutical Journal* provides a useful source of information. Debates on

the issues that were important to pharmacists were often carried out in this journal.

Another important source is the archives of McGill & Orme Prescriptions, a Victoria pharmacy whose records are in my possession.

My study starts, in Chapter One, with a general historical overview of Canadian medical and pharmacist authority in the late nineteenth century and the significant shift that occurred in the early decades of the twentieth century. It discusses how pharmacists adapted their core competencies to adjust to changing attitudes towards health and health practitioners. Chapter Two examines the general factors that led up to the crisis in confidence that Canadian pharmacists experienced in the mid 1960s. Chapters Three and Four provide a specific case study of pharmacy of in British Columbia from 1965 to 1968. Chapter Three examines the formation of the Pharmacy Planning Commission, in 1966, and the recommendations that came out of their report. Chapter Four examines the implementation of the Commission's report and their implications for British Columbia pharmacists. This study will provide understanding in the underlying factors that led British Columbia pharmacists to reconstruct their profession in the mid-1960s.

Chapter One

*I would urge upon you and upon every druggist in Canada to pay serious attention to the educational, professional and ethical problems ... which confront us: keeping in view not only immediate results, but the more lasting effect upon Pharmacy as a vocation.*³⁰

CPhA President W. McMullen's Address to 1923 Annual Convention

In 1930, William McGill and Cecil Orme founded McGill & Orme Prescription Chemists in Victoria, British Columbia.³¹ Their business was described by McGill as an “old apothecary shop” which would “confine itself to the filling of prescriptions.”³² They pledged to carry sick room supplies, vaccines and extracts but not the general goods usually found in contemporary pharmacies. In 1935, they wrote a letter to the physicians of Victoria announcing that they were moving their pharmacy to a new location.³³ They used the opportunity to reiterate a statement of ethics originally declared when they first opened for business. One clause in their declaration is remarkable above all others, stating that a pharmacist should have “no discussion with the patient as to symptoms or treatment, believing that such belongs in the sphere of the physician only.” Pharmacists in the twenty-first century believe that one of their most important professional roles is to discuss treatments with their patients and, in fact, they are legally and ethically obligated to do so.³⁴ In this chapter, I will analyze McGill & Orme’s statement for insight into early twentieth century medical authority, through the exploration of three areas of

³⁰ W. McMullen, “President’s Address to CPhA 1923 Convention,” *Canadian Pharmaceutical Journal* Vol LVI No. 12 (July 1923): 447.

³¹ I have used McGill & Orme not McGill and Orme because that is how the company identified itself in all documents, advertising and signage.

³² Victoria Daily Times, 7 November 1930. Appendix C shows that McGill & Orme increased from 7.64 Rx/day in March 1931 (4 months after opening) to 108 Rx/day in 1947.

³³ See Appendix A for a copy of McGill & Orme’s letter.

³⁴ College of Pharmacists of British Columbia, <http://www.bcpharmacists.org/library/D-Legislation_Standards/D-2_Provincial_Legislation/5078-HPA_Bylaws_Community.pdf> (February 2, 2010). See Appendix G for a copy of the Code of Ethics adopted in 2009.

inquiry. First, did this statement, made by one Victoria pharmacy, reflect the wider ethical values of their contemporaries? Second, what does this ethical statement reveal about medical authority and its effect on physician-pharmacist-patient relationships in the early twentieth century? Finally, I will examine the implications that this ethical code had for physicians, pharmacists and patients in a general Canadian context.

In the late nineteenth century, pharmacists had fought hard and successfully for legal professional status, in both Canada and the United States. In British Columbia pharmacists were trained as apprentices with private pharmacy schools adding some academic instruction; an educational system that continue until the middle of the twentieth century. Before being granted licensure, pharmacists were tested in six subjects; botany, chemistry, materia medica, prescriptions, pharmacy and dispensing.³⁵ These subjects were focused primarily on pharmacists' manufacturing and compounding roles. In some jurisdictions, such as Ontario and the Maritimes, pharmacists could qualify with a degree in pharmacy from a university or through apprenticeship.³⁶ Pharmacists who had qualified from jurisdictions whose "standing and requirements are equal to those of the [B.C.] association" could be licensed without examination.³⁷

Pharmacists could lay claim to a wide scope of practice composed of four core competencies: manufacturing, compounding, diagnosing and prescribing. Pharmacists were not only expert compounders of physician's prescriptions but also manufactured drugs directly from raw materials. In addition, capitalizing on the public's desire to self medicate, pharmacists engaged in the practice of "counter prescribing"; diagnosing their

³⁵ University of British Columbia Special Collections, College of Pharmacists of British Columbia Records (hereafter UBC-SM-CPBC), Box 27-8, Pharmaceutical Association of British Columbia licensing exams- 1914, 1921, 1928 (hereafter Licensing exams).

³⁶ UBC-SM-CPBC, Box 27-8, Licensing exams.

³⁷ UBC-SM-CPBC, Box 9-1, Pharmacy Act – amended to December 24, 1925 Clause 12-1.

customers' ailments and prescribing treatments as well as compounding those treatments. None of these competencies were distinct, by Deborah Savage's definition, since physicians often compounded prescriptions as well as diagnosing and prescribing. The manufacturing role of community pharmacists was diminishing, due to the emergence of large scale pharmaceutical manufacturers. Despite sharing these competencies with other groups, pharmacists were recognized and respected as legitimate practitioners of all four competencies.

In Canada, physicians fought hard to prohibit counter prescribing as they felt that pharmacists had "no knowledge whatever of diagnosis and pathology."³⁸ Attempts to curb pharmacists by guiding legislation through Ontario's legislature failed, partially because of defensive lobbying by pharmacists.³⁹ Physicians were supported neither in the courts when they tried to bring actions against pharmacists nor in the media. One newspaper editorial explained their position,

*the professional man may not be at home or cannot come immediately when called; while the chemist is always behind his counter. A still more important consideration is involved ... we shut off from the poor cheap and ready medical assistance.*⁴⁰

Pharmacists benefited from their accessibility to the public, as well as their ability to provide cheap medical assistance. Physician authority was not strong enough to overcome the public's belief that pharmacists provided diagnosis and treatment that was accessible, inexpensive and legitimate.

Counter prescribing by pharmacists was also opposed by pharmacy elites, who tried to prohibit its practice through the use of ethical codes. The American

³⁸ Clark, "Professional Aspirations," 52.

³⁹ Ibid., 52.

⁴⁰ Ibid., 52-53.

Pharmaceutical Association (APhA) had declared, in their 1852 Code of Ethics, that “the practice of pharmacy is quite distinct from the practice of medicine” and “the conduction of the business of both [medicine and pharmacy] professions by the same individual” could lead to “pecuniary temptations.”⁴¹ In April 1880, the Victoria Pharmaceutical Society developed a Code of Ethics that included the clause that pharmacists should not practice medicine or give medical advice.⁴² Some pharmacists followed those ethical directives; Victoria newspapers carried the advertisement “If you are sick see a doctor. If you get a prescription [see] C.E. Jones [at] The Peoples Popular Prescription Pharmacy.” In many other cases, pharmacists ignored that ethical stricture.

Physician’s efforts to prevent pharmacists from counter prescribing had failed to find support through legislation or through the press. Pharmacy elites had similarly failed to control it with ethical codes. Pharmacists did not accept an ethical code that prohibited counter prescribing because the public supported its practice. Although not formally constructed, pharmacists operated in an ethical environment that most closely resembled an agency model. Patients were primarily responsible for their own healthcare decisions and were free to access whichever health professional they trusted to provide them with information or treatments they required.

Much of the public’s thirst to self medicate was quenched by the increasing availability of so-called “patent” medicines, although most of these medications were not actually patented. Those medicines that were patented had their formula revealed in the details of their patent. More often, although termed patent medicines, they were not actually patented but were considered as proprietary products by their manufacturers and,

⁴¹ David Cowan, “Pharmacists and Physicians: An Uneasy Relationship,” *Pharmacy in History* Vol. 34 No. 1 (1992): 9.

⁴² The Daily Colonist, 15 April 1880, 3.

as such, their formulas were kept secret. They were advertised directly to the public as specific remedies for specific diseases, often with extravagant claims of success. Physicians felt that specifics made people “look to the medicine alone, as possessing the skill within itself – as though it had intelligence, genius, judgment, learning, all combined.”⁴³ While physicians and pharmacists both condemned patent medicines, their objections were never completely consistent with their actions. Physicians participated in their sale through endorsements and most prescribed them to their patients. In 1890, Dr. D.D. McDonald claimed in an advertisement in the *Victoria Daily Colonist* that “I have been prescribing Scott's Emulsion with good results ... especially ... in persons of consumptive tendencies.”⁴⁴ Some physicians also manufactured patent medicines as did pharmacists but, more importantly, pharmacists also sold them in their pharmacies. Druggists Cochrane and Munn advertised *Aphrodite*, the celebrated French cure, warranted to cure any nervous disease or money refunded.⁴⁵ A pharmacist in 1880, declared that patent medicines made up thirty percent of his sales, a strong indication how economically dependent pharmacists were on patent medicines and self-medication.⁴⁶

At the beginning of the twentieth century, the spectre of drug addiction from recreational drug use and patent medicines had become a concern in Canada. William Lyon Mackenzie King, federal deputy minister of labour and future Prime Minister, had observed that smoking opium resulted in “baneful influences [that] are too well known to

⁴³ Lee Anderson, *Iowa Pharmacy 1880-1905: An Experiment in Professionalism* (Iowa City: University of Iowa Press, 1989), 23.

⁴⁴ *The Daily Colonist*, 19 February 1890, 1.

⁴⁵ *The Daily Colonist*, 11 March 1891, 4.

⁴⁶ *Canadian Pharmaceutical Journal* Vol XIII No 7 (1881): 238.

require comment.”⁴⁷ Patent medicines were also coming under fire, in both Canada and the United States. Many patent medicines were, in reality, nothing more than standard, safe formulations from the British or U.S. pharmacopoeia. On the other hand, others contained addictive drugs such as cocaine, morphine, heroin, and opium as well as excessive amounts of alcohol. The fact that their formula was secret meant that neither the public nor pharmacists and physicians knew which products might be harmful.

The public’s use of addictive drugs led to the fear that the health of the nation could be harmed, as well as individuals. In 1907, the *Western Canada Medical Journal* noted that “the best asset that any nation can have ... is health.”⁴⁸ Physicians used the opportunity to criticize the practice of self-medication, “the first objection to proprietary medicines is that the prescribing of such preparations is apt to lead to self-medication by the public.”⁴⁹ Physicians were clear that “our weak-kneed friend, the druggist” had pandered to the public's desire for self-medication by selling patent medicines and thereby helping patients avoid paying the physician's fee.⁵⁰ The editor of the *Canadian Pharmaceutical Journal* accepted the criticism, but felt the blame was the result of three causes, “the carelessness on the part of physicians ... a certain class of patent medicines ... [and] the aid rendered by unscrupulous druggists.”⁵¹

The debate over the appropriate control of patent medicines elicited different solutions from physicians and pharmacists. Physicians wanted full disclosure of the formula on the label. Pharmacists banded together to form the Canadian Pharmaceutical Association (CPhA) and argued that disclosure was naïve, as it didn't recognize the

⁴⁷ Malleck, “Baneful Influences,” 264.

⁴⁸ *Ibid.*, 274.

⁴⁹ Anderson, *Iowa Pharmacy*, 132.

⁵⁰ Malleck, “Pure Drugs,” 111.

⁵¹ Malleck, “Professionalism,” 188.

manufacturer's rights to protection from competitors copying their product. They also did not believe that the public were knowledgeable enough to understand the formula.⁵²

Pharmacists wanted manufacturers to submit their formulas to an impartial government board. When the Patent and Proprietary Medicine Act was finally passed by the federal government in 1908, they chose a compromise between the two suggestions. Products that contained substances from an attached schedule would be labelled with those ingredients. If the manufacturer chose to print the entire formula on the label, they would be exempt from the act.

The passage of the Patent and Proprietary Medicine Act was of critical significance to pharmacists, physicians and the public. Manufacturers were required to register annually with the federal Inland Revenue department and submit their formulas and products for analysis.⁵³ For the first time, social authority over drugs included laboratory science and was administered by the federal government. Daniel Malleck has argued that this signalled a shift by pharmacists and physicians to use laboratory science to back up their right to protect the public from dangerous drugs. They had previously relied on moral authority and character. The act prohibited the inclusion of cocaine in the formula of any patent medicine. Henceforth, cocaine would only be available on a physician's prescription, filled by a licensed pharmacist. The 1911 Opium Act added morphine and opium to the list and, perhaps more significantly, empowered the government to add substances as was “deemed necessary in the public interest.”⁵⁴ For physicians, these two acts made them gatekeepers assigned with the authority to safeguard the public from the misuse of drugs. A self-medicating public was seen as

⁵² Malleck, “Pure Drugs,” 111.

⁵³ Ibid., 113.

⁵⁴ UBC-SM-CPBC, Box 9-1, An Act to prohibit the improper use of Opium and other Drugs, May 19, 1911.

detrimental to the health of the nation; physicians were now the public's best source of medical advice and treatment. S.E.D. Shortt has explained that the advanced knowledge of physiology and pathological conditions meant that medical knowledge was no longer accessible to the layman. Physicians “gained stature not because they could always act effectively, but because only they could name, describe and explain.”⁵⁵

For pharmacists the verdict was mixed. On one hand, they had succeeded in pushing the government to consider their views on patent medicines. They had also won the right to be the only legally sanctioned distributors for the drugs named in the act. On the other hand, views on self-medication and counter prescribing had hardened, resulting in a reduced scope of practice for pharmacists.⁵⁶

Pharmacists' traditional core competency of manufacturing was also disappearing. A pharmacist's primary skill for centuries had been manufacturing medications directly from raw materials, usually botanical but sometimes chemical. They were trained to distil and extract active medicinal ingredients from plants and prepare them in a form that allowed ingestion or application by the patient. Pharmacists also had training in chemistry that facilitated the manufacture of medications such as ether or chloroform.

R. J. Clark argues that during the last twenty years of the nineteenth century, physicians were standardizing the dosage forms they prescribed. This consolidation encouraged wide scale manufacturing and reduced the role played by pharmacists as “cottage

⁵⁵S.E.D. Shortt, “Physicians, Science, and Status: Issues in the Professionalization of Anglo-American Medicine in the Nineteenth Century,” *Medical History* Vol. 27 (1983): 63.

⁵⁶ McGill & Orme's letter in 1935 assured physicians that they would discourage the use of secret or quack nostrums. They would advise their patients to see their physician instead. The CPhA and APhA code of ethics “discouraged the use of objectionable nostrums.” It is ironic that physicians and pharmacists discouraged the use of secret remedies at the same time that they were keeping the composition of their prescriptions secret.

industry” manufacturers.⁵⁷ This development coincided with a shift from skilled tradesmen to mass production techniques. It was at this time that pharmaceutical companies such as Merck, Lilly, Frosst and Abbott were founded. Manufacturing innovations such as automatically powered compressed and coated tablet machines in 1875 and Warner's parvules (small pills) in 1879 could be produced on a large scale. New extraction processes pioneered between 1845 and 1875 and biological products, such as diphtheria anti-toxin, at the turn of the twentieth century were not suited for manufacture in community pharmacies.⁵⁸ It made more sense to purchase pre-fabricated medications from manufacturers whose economies of scale could provide pharmacists with cost savings. By the twentieth century, the manufacturing role had all but disappeared from community pharmacies. Pharmacist J. Murdoch felt that this shift had resulted in a loss of prestige and expertise, “our knowledge of dispensing is confined to washing the bottle and being careful not to spill the mixture.” This, he says, meant that “the public are beginning to question our right to make any charge for knowledge or services, in filling the prescription.”⁵⁹ Lee Anderson argues that pharmacists gambled on the strength of self medication and manufacturing traditions. The loss of both avenues of revenue left them in a vulnerable position.⁶⁰ Pharmacists had lost the legitimacy that specialized skill and competence in manufacturing had provided. When added to the loss of legitimacy created by the movement away from self-medication, the public’s overall dependence on pharmacists had also diminished. As Paul Starr has argued, a reduction in legitimacy and dependency is reflected in a corresponding reduction in authority. Loss of

⁵⁷ Clark, “Professional Aspirations,” 46.

⁵⁸ Sonnedecker, *History of Pharmacy*, 329.

⁵⁹ J. Murdoch, “A Far Cry from Swansdown to Suntan,” *Canadian Pharmaceutical Journal* Vol LXII No.22 (July 15, 1929): 777.

⁶⁰ Anderson, *Iowa Pharmacy*, 137.

authority contributed to a sense of pessimism among pharmacists by the early twentieth century. Some feared that pharmacy might disappear as a profession altogether.

The rise of scientific medicine in the late nineteenth century created the optimistic view that science might ultimately solve all health problems. Progress had been made in diagnosis, antiseptic techniques and surgery as well as preventative measures such as vaccines and public health measures. Drug therapy, however, had seen very few advances. Oscar Herzberg wrote, in Lippincott's Magazine in 1898, that “it is not unreasonable to believe that ... the drug-shop will be in less and less demand, until ... it may become entirely extinct.”⁶¹ The spectre that their profession might disappear completely weighed on the minds of pharmacists.

It was in this context that the work of educator Abraham Flexner contributed to pharmacist insecurity. In 1910, he had written a report for the Carnegie Foundation that advocated the reform of medical education in the United States and Canada.⁶² Although Flexner did not include pharmacy in that report he did examine the question, “Is Pharmacy a Profession?” in a separate study, in May 1915.⁶³ His findings were not designed to please pharmacists, and they did not. On the positive side, he found that pharmacy had a definite purpose, communicable technique and acquired essential material from science. On the negative side, Flexner claimed, pharmacy was not primarily intellectual and its responsibility was not primary or original. “The physician”, he said, “thinks, decides and orders while the pharmacist obeys, albeit with discretion,

⁶¹ Robert Buerki, “The Public Image of the American Pharmacist in the Popular Press,” *Pharmacy in History* Vol. 38 (1996): 73.

⁶² Abraham Flexner, *Medical Education in the United States and Canada* (North Stratford: Ayer Company Publishers Inc, 2003 reprint edition).

⁶³ Buerki and Vottero, *Foundations*, 5.

intelligence and skill.” Flexner concluded that pharmacy was an arm of medicine, not a profession.⁶⁴

Flexner's verdict struck directly at pharmacists' professional identity. The loss of counter prescribing and manufacturing as core competencies and the resultant reduction of authority left pharmacists demoralized and pessimistic about their future. CPhA President, W. McMullen, started his address to the 1923 convention with the declaration that “the future of Pharmacy is uncertain. It is a matter of grave concern to us what the future will be.”⁶⁵ McMullen was not alone in his fears; throughout the 1920s many others were adding their voices to the chorus. Dr. V. Henderson, Professor of Pharmacy and Pharmacology at the Faculty of Medicine, University of Toronto, said that “this continent has run wild on pharmacy as a business and not as a profession.”⁶⁶ An editorial in the *Canadian Pharmaceutical Journal* felt that the public's regard for pharmacists was “slipping down the ladder rung by rung.”⁶⁷ The problems, President McMullen said in his opening address to the convention, were educational, professional and ethical.

Pharmacists in the United States felt the same despair. In an attempt to remedy the situation, APhA president Charles LaWall, proposed a revision of their 1852 Code of Ethics. Flexner's determination that professions are “explicitly ... meant for the advancement of the common social interest” led LaWall to declare that “the soul ... of a professional organization is its code of ethics.”⁶⁸ Although LaWall received “sincere support” from the APhA, no concrete action was taken so he undertook the project

⁶⁴ Buerki, “Historical Development,” 57.

⁶⁵ W. McMullen, “President's Address to CPhA 1923 Convention,” *Canadian Pharmaceutical Journal*, Vol LVI No. 12 July 1923, 447.

⁶⁶ Editorial, *Canadian Pharmaceutical Journal*, Vol LIX No 12 (July 1926): 536.

⁶⁷ V. Henderson, “Dr. Henderson urges the Importance of Advance in Canadian Pharmaceutical Education,” *Canadian Pharmaceutical Journal* Vol LIX No 9 (April 1926): 367.

⁶⁸ Buerki and Vottero, *Foundations*, 3.

himself in the hope that it would restore pharmacists' professional prestige and reputation.⁶⁹ LaWall's new version was adopted by the APhA in August 1922.⁷⁰

The CPhA invited LaWall to their convention as keynote speaker, in July 1923, to discuss pharmaceutical ethics. At the convention, the CPhA adopted the APhA Code of Ethics as a basis for their own, with only a few minor modifications. LaWall divided his code of ethics into three sections, each one detailing a pharmacist's duty to a different constituency.⁷¹ Significantly, LaWall included physicians, along with the public and fellow pharmacists, highlighting his belief that pharmacists had a special relationship with physicians, worthy of special ethical conditions. The code enumerated a series of role-specific rules that were unique to the profession of pharmacy, spanning issues from the conduct of wholesalers to patient confidentiality to financial arrangements with physicians. The following clauses (numbered for clarity) were included as duties to the Physician.

Clause 1

The Pharmacist even when urgently requested so to do should always refuse to prescribe or attempt diagnosis. He should, under such circumstances, refer applicants for medical aid to a reputable legally qualified Physician.

Clause 2

*He should never discuss the therapeutic effect of a Physician's prescription with a patron nor disclose details of composition which the Physician has withheld, suggesting to the patient that such details can be properly discussed with the prescriber only.*⁷²

McGill & Orme's ethical statement can be recognized as an economically worded rephrasing of the above two clauses. Based on its genealogy, it appears that McGill &

⁶⁹ Ibid., 3.

⁷⁰ Ibid., 3.

⁷¹ See Appendix G for a copy of the APhA Code of Ethics.

⁷² "Principles of Pharmaceutical Ethics," *Canadian Pharmaceutical Journal*, Vol LVII No. 3 (October 1923): 18 & 24.

Orme's ethical view did reflect the wider view of their contemporaries, both in Canada and the United States.

I will analyze both of these ethical statements by connecting McGill & Orme's concise version to the more comprehensive clauses adopted by the CPhA and APhA. McGill & Orme's promise to refrain from discussion of symptoms encapsulates the heart of the first clause. Symptoms, whether observed or measured, are the basis upon which diagnosis is determined. McGill & Orme's prohibition on discussing treatment with patients also summarizes the first clause, as well as the second. Treatment is the end result of prescribing but also can be used to "back engineer" information about the diagnosis. Any discussion of treatment or symptoms could migrate to an evaluation of the appropriateness of either the diagnosis or the prescribed treatment, both designated, by the code, as within the professional boundaries of the physician. Charles LaWall emphasized this point, in his revised Code of Ethics, by including it within the pharmacist's duties to the public, as well as to physicians. Pharmacists, he said, "should make no attempt to prescribe or treat diseases."⁷³ By including this prohibition on diagnosis and prescribing as a duty to the public, LaWall acknowledges that pharmacists who engaged in this practice were potentially jeopardizing the safety of the public. A prohibition was necessary to follow Flexner's view that professions must advance the common self-interest. This meant putting the public's interests ahead of those of pharmacists.

The promise not to discuss treatment summarizes the second clause; encompassing both therapeutics and composition. This clause would be unacceptable to twenty-first century pharmacists because therapeutics forms the basis of their profession.

⁷³ Ibid., 18.

To resolve the dichotomy created between professional views from both eras requires an examination of the term “therapeutics”, as well as medical and pharmacy education. In the twenty-first century, therapeutics is closely associated with pharmacology. Standard pharmaceutical reference books, such as Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, emphasize the interaction of the two subjects.⁷⁴ These reference books, as well as detailing the indications (uses) of drugs, also explain the post-administration reactions that occur when drugs interact with complicated physiological processes in the human body. Included in that discussion are drug-drug interactions and drug side-effects. Modern therapeutics is largely concerned with what happens after the drug enters the body and twentieth-first century pharmacists are extensively trained in therapeutics and pharmacology. When McGill & Orme made their ethical statement, therapeutics had a narrower meaning and pharmacists had different training. The Merriam-Webster dictionary traces the term therapeutics back to 1671 and cites its definition as “the application of remedies to diseases.”⁷⁵ That definition is restricted to the indications aspect of therapeutics with no mention of post-administration effects.

Medical science, in the 1920s and 1930s, did have some knowledge of post-administration effects of drugs and that knowledge was taught to physicians through courses in pharmacology. Pharmacists, however, did not receive any training, nor were they examined, in pharmacology or any other related studies such as toxicology. The reference books used by pharmacists, such as the British or U.S. Pharmacopoeia, give the indications of drugs but virtually no information on post-administration implications.

⁷⁴ Goodman and Gilman's *The Pharmacological Basis of Therapeutics* was first published in 1941 and is currently in its 11th edition.

⁷⁵ Merriam-Webster Dictionary, <<http://www.merriam-webster.com/dictionary/therapeutics>> (February 2, 2010).

The narrower definition of therapeutics at the time put therapeutics outside the practice boundaries of pharmacists. Further, and even more significantly, pharmacists were not trained in pharmacology and were therefore not qualified to discuss therapeutics, in the modern sense, with competence.

McGill & Orme's 1935 promise not to discuss treatments with patients would have assured physicians of their agreement not to disclose composition. The Pharmacy Act of 1925 states that disclosing the composition of a prescription was not required if it originated from a physician's order.⁷⁶ In this circumstance, pharmacists were neither legally required nor prohibited from labelling prescriptions with its composition. On the other hand, with the exception of cocaine, morphine and heroin, pharmacists were allowed to compound and dispense any drug without a physician's prescription but, in that case, they were required to record the composition on the label.⁷⁷ Additionally, the Pharmacy Act specifically stated that any person could request a copy of their prescription, provided the pharmacist kept the original on file.⁷⁸ The decision to disclose composition, therefore, was legally within the jurisdiction of the pharmacist and the patient. Conversely, the ability to keep the composition secret was out of the physician's legal control. In practice, however, pharmacy ethics promised to voluntarily revert that control back to physicians. In this case, pharmacy ethics increased physician authority beyond what was assigned to them by law. For pharmacists, this allowed them to strengthen their link to physician authority, as well as ensuring that the public would continue to be dependent upon physicians and pharmacists to provide treatments for their ailments.

⁷⁶ UBC-SM-CPBC, Box 9-1, Pharmacy Act – amended to December 24, 1925 Clause 28.

⁷⁷ Ibid., Clause 26 & 27.

⁷⁸ Ibid., Clause 23.

Did pharmacists, in practice, withhold composition? In addition to the Code of Ethics declaration, and McGill & Orme's letter, there are two additional pieces of information that indicate that they did. Appendix D shows labels from the 1930s to the 1960s that were generated without composition information. Additional evidence comes from two books of prescriptions, filled at McGill & Orme in 1931 and 1947 (Appendix C). In practice, when a physician wanted a pharmacist to disclose composition he would add the notation "label" to his prescription. In these cases, the pharmacist would label the prescription with its composition. In the survey, I found that only one prescription included the notation "label" in each sample.⁷⁹ McGill & Orme's records can be reasonably taken to represent pharmacists' practices at that time and they indicate that, at least in this pharmacy, physicians rarely asked pharmacists to reveal composition. Considering all these factors it is unlikely that pharmacists revealed the composition of a physician's prescription, except in rare occasions, and only on the request of the prescribing physician.

Why would physicians want to withhold the composition of a prescription? In most cases, in the 1920s and 1930s, patients would have to pay to consult a physician. From a physician's point of view, the treatment they prescribed represented the tangible result of the patient's consultation with the physician. Included in the cost of consultation was the intangible art and skill of the physician's diagnosis and choice of treatment. Disclosing composition and discussing diagnosis would reveal the secrets of the physician's art and skill. The potential implications of these revelations can be seen through an examination of the 1931 McGill & Orme prescription survey. Here we see that only 58 out of 978 prescriptions were for heroin, morphine and cocaine. These were

⁷⁹ See copies of prescriptions in Appendix C.

the only drugs that the Pharmacy Act restricted solely to a physicians' prescription. Conversely, 920 prescriptions could have been dispensed on the direct request of a patient, without a physician's prescription.⁸⁰ These included phenobarbital, digitalis, phenazopyridine, quinidine and quinine, all of which were eventually made prescription only. If the composition of their treatments was revealed, patients could use that information at a later date to self-medicate, either for their own conditions or those of their family or friends. This would be facilitated further, if the patient's diagnosis was discussed by the pharmacist. Therefore, prohibition on the discussion of diagnosis was important to physicians for proprietary reasons, not just to prevent second guessing.

A second reason that physicians might not wish to reveal composition was the number of manufactured products, many of them patent medicines. The sample examined from the records of McGill & Orme show that 390 out of 978 or 40% of prescriptions dispensed were manufactured products.⁸¹ This ratio of manufactured products to total prescriptions fits roughly with other surveys of this time period. In the United States, manufactured products were found to make up 25% of the prescriptions surveyed.⁸² The sample includes patent medicines such as Musterole, Lavioris, Calamine Lotion and Ichthyol antiseptic vaginal cones. Most of these products, like many other prescribed remedies, could be purchased without a physician's prescription, at a pharmacy, department store or grocery.

Access to prescription information may have tempted patients to economize by self-medicating their conditions with non-prescription or patent medicines rather than

⁸⁰ In 2010, the situation is reversed. The vast majority of prescriptions are written for drugs that can only be obtained through a physician's prescription. Therefore, secrecy is not important to safeguard the physician's art and skill. Even when the patient knows what was prescribed they are unable to get more in the future without a prescription from the physician.

⁸¹ See Appendix C.

⁸² Sonnedecker, *History of Pharmacy*, 315.

consulting a physician. For pharmacists, revealing the composition of a prescription might encourage patients to purchase patent medicines in non-pharmacy locations. The increase in drug regulations was an important part of the transference of medical authority to physicians, in the early years of the twentieth century. Having lost the authority to be advisors to the public in their efforts to self medicate, pharmacists saw that their best interests lay in supporting physicians in their efforts to control information about their patient's health.

President McMullen had warned that pharmacists faced educational, as well as ethical and professional problems. Pharmacists still retained an educational curriculum designed for manufacturing, despite the fact that its usefulness was becoming limited. Pharmacists were not required to have any knowledge of anatomy, physiology, bacteriology, toxicology, or pharmacology. By the twentieth century, these were the subjects that formed the basis of modern medicine.

By the 1920s, pharmacists were coming under fire from within the profession as well as from the medical profession because their education had not kept up with the times. Dr. V Henderson, told pharmacists that “we are talking a different language” because pharmacy education had not kept pace with new developments.⁸³ This lack hurt pharmacists because, as Eliot Freidson argues, “without a common language, cooperative endeavours are impossible.”⁸⁴ Dalhousie Pharmacy Dean, George Burbidge, believed that education should be “acquired only in a college of pharmacy ... in close contact with the science and medical facilities of a university.”⁸⁵ Burbidge, like many pharmacists,

⁸³ Henderson, “Canadian Pharmaceutical Education,” 536.

⁸⁴ Freidson, “*Theory of Professionalism*,” 117.

⁸⁵ G. Burbidge, “Are Apprentices being properly Educated?,” *Canadian Pharmaceutical Journal* Vol LIX No 8 (March 1926): 313.

worried whether the profession would survive and believed that education needed to be improved, before pharmacists could advance.

These commentators indicated that educational improvement could be achieved in three areas. First, pharmacy needed to be taught in universities where it would have access to medical and scientific faculties. Private pharmacy schools were no longer adequate to educate pharmacists. Second, pharmacists needed to re-evaluate certain areas of study, specifically botany and materia medica, which were rooted in their manufacturing past. Third, pharmacists needed to learn to speak the modern language of medicine. Burbidge believed that pharmacy needed to update the field of materia medica to courses in pharmacology.⁸⁶ Progress in education was uneven across Canada. Some provinces, such as Ontario and Nova Scotia, were already educating pharmacists at universities in the 1920s. British Columbia would be the last to convert; at the 1925 Annual General Meeting of the Pharmaceutical Association of British Columbia (The Association), Councillor Crowder told the meeting that the association was seeking affiliation with the University of British Columbia. Curriculum, he said, should be adjusted to include biology and toxicology with reduced emphasis on botany but, due to competition for facilities at the new university, no progress should be expected for three or four years.⁸⁷ In reality, Crowder was optimistic; pharmacy education would not move to the university until 1948. The state of pharmacy education in the 1920s was such that pharmacists were unqualified to do more than compound prescriptions. They had no educational legitimacy to diagnose or prescribe and had lost the economic viability as medicinal manufacturers.

⁸⁶ Burbidge, "Apprentices," 313.

⁸⁷ UBC-SM-CPBC, Box 23-33, Minutes of Annual General Meeting, Pharmaceutical Association of British Columbia, June 10, 1925.

Pharmacists were at a professional crossroads. They had lost their manufacturing function as well as their role in self-medication. Their education over emphasized a manufacturing role that had all but disappeared and was deficient in the subject areas that defined modern medicine. Pharmacist's insecurities about the future of their profession were encouraged by plans to classify pharmacy as a trade by the British Columbia legislature. This plan was thwarted by a delegation led by CPhA delegate, John Cochrane.⁸⁸ A Canadian Pharmaceutical Journal editorial advocated in 1925 that pharmacists return to their ancient role as the physician's cook, focusing their fortunes on the remaining core competency of compounding physician's prescriptions. Forming what LaWall termed an "entente cordiale" would allow pharmacists to attach their professional fortunes to the medical authority of physicians.⁸⁹ A key feature to any arrangement with physicians would be a prohibition on diagnosis and prescribing by pharmacists, a goal that had proven unachievable in the past.

Pharmacy elites were aided in their goal by increasingly stringent regulations and enforcement. The Act Respecting the Practice of Medicine and Surgery had specified, since 1911, that only those who were licensed as members of the College of Physicians and Surgeons could practice medicine in British Columbia.⁹⁰ In Ontario, pharmacists were warned that they would be prosecuted if they counter prescribed in contravention of their medical legislation.⁹¹ The files of the Association contain numerous letters citing

⁸⁸ Raison, *Brief History of Pharmacy*, 35.

⁸⁹ Buerki, "Historical Development," 68.

⁹⁰ UBC-SM-CPBC, Box 9-1, An Act respecting the Practice of Medicine and Surgery, 1924.

⁹¹ *Canadian Pharmaceutical Journal*, Vol LIX No. 6 (Jan 1926).

pharmacists for infractions against the by-laws.⁹² Regulation and enforcement was now sufficiently strong to ensure that those who did not comply would be disciplined.

The Code of Ethics adopted by the CPhA went beyond legally defined limits, however. The prohibition on counter prescribing, the discussion of treatment and the disclosure of composition were only partially backed by legal statute. Pharmacy elites had endorsed a similar prohibition for decades but lacked the authority to enforce its adoption throughout the pharmacy profession. Pharmacist's professional practices were now dictated, in detailed form, by the pharmacy elite. Local pharmacies, such as McGill & Orme Prescriptions, provided consensus for the 1923 code because they believed that confining their professional pattern of practice to the filling of physician's prescriptions was their best hope for professional survival. Pharmacists were able to replace authority lost by the reduction of their core competencies with authority gained by forging professional alliances with physicians. Pharmacists' success in attaching themselves to the authority of physicians meant that the public would remain dependent on pharmacists for drug distribution and physician's for drug information for nearly fifty years. Pharmacists may have lost some of the authority they had enjoyed in the nineteenth century but were able to forestall the fears of their demise by attaching themselves to physician authority and concentrating on their one remaining competency, compounding.

⁹² UBC-SM-CPBC, Boxes 2-5, 2-6, 2-7, 2-25, Letters and Inspections, 1891-1917.

Chapter Two

Today, the public overlooks the real mission and social value of our profession. We forget to put in the limelight the importance and real dignity of our work and of our social role ... We are losing our prestige.

Emile Coderre August 14, 1957⁹³

In the 1920s, pharmacists identified their core competency as the compounding of physician's prescriptions. Using the Code of Ethics, pharmacy elites were able to ensure that pharmacists stayed primarily within the capabilities dictated by this core competency. As long as compounding skills were required to fill the majority of prescriptions, this remained a viable capability. In this chapter, I will examine how the dynamics of pharmacy in North America changed significantly after World War II, in two very important ways.

Firstly, the number of prescriptions increased rapidly. In the United States, prescriptions rose from 400 million per year in 1950 to 1 billion per year in 1965 while prescriptions usage rose from 2.4 to 5 prescriptions per person per year from 1950 to 1965.⁹⁴ The increase came mainly from increased prescription usage, not increased population. Canada experienced a similar trend; the number of prescriptions filled increased from 35 million in 1956 to 60 million in 1965.⁹⁵

The second change that occurred was the mix of prescriptions filled by pharmacists. More and more, prescriptions were being filled with manufactured pre-fabricated products, primarily tablets and capsules, while pharmacists were being called

⁹³ UBC-SM-CPBC, Box 9-18, Emile Coderre, introductory remarks to the paper "An outline of the History of Pharmacy in the Province of Quebec from 1617-1930." presented to the Canadian Academy of the History of Pharmacy, Montreal August 14, 1957.

⁹⁴ Stephen Schondelmeyer, "Recent Economic Trends in American Pharmacy," *Pharmacy in History* Vol. 51 No 3 (2009): 104-5.

⁹⁵ UBC-SM-CPBC, Box 12A-10, Report of the Pharmacy Planning Commission, May 1967 (hereafter PPC Report), 11.

on to compound fewer prescriptions. We can see this trend in the analysis of McGill & Orme's prescription registers, the percentage of compounded prescriptions dropped from sixty percent in 1931 to twenty-five percent in 1947.⁹⁶ In the United States, statistics were similar, compounding dropped from seventy-five percent in 1930 to twenty-six percent in 1950 and to three-four percent in 1962.⁹⁷

Elenbaas and Worthen have examined the twentieth century transformation of United States pharmacy and conclude that "pharmacy was at the crossroads" in the 1960s and 1970s. Their verdict was that pharmacists were viewed by the public as the "most overeducated and underutilized healthcare profession" who achieved little more than "counting pills from big-bottles into little bottles."⁹⁸ Pharmacists reached this unenviable position, they say, because of the decline in compounding and the increase in pre-fabricated medications.

From a business perspective, this shift in prescription dynamics was a boon to community pharmacists. Although the loss of compounding represented a corresponding loss of revenue this was more than made up by the increase of prescription volume. Pharmaceutical companies constantly developed new medications and many, such as penicillin, tetracycline and other antibiotics, were dramatically effective. Manufacturers were also successful in simultaneously promoting new medications and the conditions they treated. Although advertising was restricted in the United States by the enforced inclusion of risks as well as benefits, pharmaceutical companies were able to infiltrate popular media to create demand.⁹⁹ Pharmaceutical companies formed the Medical and

⁹⁶ See Appendix C.

⁹⁷ Sonnedecker, *History of Pharmacy*, 315.

⁹⁸ Elenbaas and Worthen, "Transformation of a Profession," 156-7.

⁹⁹ David Herzberg, "Will Wonder Drugs Never Cease!," *Pharmacy in History* Vol. 51 No 2 (2009): 50.

Pharmaceutical Information Bureau (MPIB) which distributed drug information, complete with brand names, to the media. Articles such as "Aureomycin: It fights germs penicillin won't" read like news articles and promised availability "right now on your doctor's prescription."¹⁰⁰ Miltown (meprobamate) was touted in *Cosmopolitan* magazine by MPIB writer, Donald Cooley, as bringing "perfect peace" and helping "frigid women who abhorred marital relations" and juvenile delinquents to become "calm ... quiet, cooperative, better-behaved children."¹⁰¹ This trend helped expand the market for medications. Other health breakthroughs such as polio vaccines increased the public's confidence in medical science. Prescription revenue increased in the United States from \$1.25 billion in 1955 to \$2.75 billion in 1965.¹⁰² In Canada, prescription revenues increased from \$87 million in 1956 to \$200 million in 1965.¹⁰³ Since pharmacists priced prescriptions with a mark-up on the cost of the drug these revenue increases resulted in a gross margin increase of over 100% over the ten year period. Pharmacies benefited from this increased revenue and dispensaries started to contribute more to the overall financial health of the drugstore. In the United States, twenty-five percent of drugstores in 1962 received at least half of their revenues from the pharmacy department, up from only one percent in 1931.¹⁰⁴ Economic benefits came from more than just increased prescription volume. The reduced filling time required to fill pre-fabricated prescriptions increased pharmacist productivity and thus improved the profitability of dispensaries. Some pharmacies used that increased productivity to promote their businesses. In August 1955, a drive-in pharmacy boasted that "an average prescription is compounded and delivered

¹⁰⁰ Ibid., 51.

¹⁰¹ Ibid., 51.

¹⁰² Sonnedecker, *History of Pharmacy*, 313.

¹⁰³ UBC-SM-CPBC, Box 12A-10, PPC Report, 11.

¹⁰⁴ Sonnedecker, *History of Pharmacy*, 311.

in less than two minutes ... all prescriptions are filled in full view of customers.” The pharmacist, Tony Lauglin, explained that “since drug houses put up many standard prescriptions in tablets today, the pharmacist can count these in a matter of seconds.”¹⁰⁵

While the efficiency that Lauglin prized may have been good for short term economics, the public were now viewing pharmacists in a different light. Rather than expert compounders, the public saw pharmacists primarily as “pourers and counters.”¹⁰⁶ Despite increases in prescription volume, dispensing pre-fabricated products allowed pharmacists to spend more time in the non-professional areas of the store. While this increased their visibility to the public, that visibility was primarily in a non-professional capacity. Pharmacists were seen as commercial retailers, with a technical role in dispensing physician’s prescriptions. Pharmacists’ core competency of compounding no longer occupied the center of their professional practice. Bound by a Code of Ethics that restricted the scope of their practice, pharmacists struggled to develop new competencies.

Running parallel to a loss of public prestige, pharmacists also faced increasing public criticism regarding the cost of prescriptions. A poll in 1953, found that 63.1 per cent of people thought prescriptions were “higher than they should be.” Manufacturer Sharp and Dohme's survey found that 38 per cent of their sample believed that “prescription prices have gone up faster in the past five years than have other prices.”¹⁰⁷ Prescription pricing was also a sensitive issue in Canada, prompting the federal government to form the Special Committee on Drug Costs and Prices in July 1966.¹⁰⁸ To counter negative public reaction publicity campaigns were instigated by provincial

¹⁰⁵ Robert Buerki, “The Public Image of the American Pharmacist in the Popular Press,” *Pharmacy in History* Vol. 38 (1996): 75.

¹⁰⁶ Elenbaas and Worthen, “Transformation of a Profession,” 156.

¹⁰⁷ Buerki, “Public Image,” 69.

¹⁰⁸ *Canadian Pharmaceutical Journal* Vol 99 No 7 (July 1966): 28.

associations and private pharmacies. The Pharmaceutical Association of British Columbia issued a pamphlet that attempted to show that prescription prices had remained steady at the same time that other medical costs had risen steeply.¹⁰⁹ Private community pharmacies such as Jay's Pharmacy in Vancouver produced their own pamphlets that showed the costs incurred to dispense a prescription.¹¹⁰ This public focus on prices would have an impact on pharmacist's attempts to professionalize prescription pricing.

Although licensed as professionals, pharmacists operated under the economic framework of a commercial enterprise. They had traditionally priced prescriptions by adding a percentage to the drug cost to reach a retail price, a method used in most commercial retail settings. It was hard for pharmacists to promote their professionalism when they priced their professional services in the same way as Kleenex, paint or tobacco. As early as 1957, Professor H.J. Fuller, Professor of Pharmacy at the University of Toronto, advocated shifting the pricing of prescriptions to a system of cost plus professional fee. The professional fee would cover all of the overhead costs incurred in the dispensary and would bear no relation to the cost of the drug. This became known as the Fuller Method. This method of pricing was not adopted quickly, by 1963 only ten percent of pharmacies in Canada used this system.¹¹¹ This reluctance can be attributed to several reasons. Firstly, most pharmacies did not keep separate account records for their dispensaries and thus would be unable to determine the overhead costs for the dispensary alone. Secondly, pharmacists worried that, although this system would decrease the cost to consumers for some prescriptions, others prescriptions would increase in price. Lastly,

¹⁰⁹ UBC-SM-CPBC, Box 1-27, The Low Cost of Drugs, July 1967.

¹¹⁰ UBC-SM-CPBC, Box 1-24, The Facts about Prescription Prices, 1967.

¹¹¹ David Thompson, "More Pharmacists to Price a la Fuller?," The Financial Post Vol 57 No. 14 (April 6, 1963): 11.

the public view that pharmacists were “pourers and counters” made it difficult to justify a professional fee for what appeared to be a purely technical function.

Technical aspects had always been part of the pharmacist role but with the decline in compounding, that technical role had simplified considerably. Pharmacists had received university training in British Columbia since 1948 but their ethical code prohibited them from fully accessing much of that knowledge. As a result, pharmacists were seen by the public as overeducated and underutilized. This was not a new issue. An editorial in the *Pacific Drug Review* in February 1950 had noted that a pharmacist “finds himself in a sort of no man’s land, charged with professional responsibility but denied the right to exercise individual professional judgment.”¹¹² By the 1960s, pharmacists started to worry that filling prescriptions could become a strictly technical function not requiring the services of a pharmacist. In Kentucky, hospital administrators opposed a bill proposed by pharmacists that would prevent non-pharmacists from dispensing medications in hospitals.¹¹³ In Canada, the pharmaceutical manufacturer’s policy of selling drugs to hospitals for less than community pharmacies was seen as a threat by pharmacists. They feared that low prices could encourage provincial governments to dispense government-paid welfare prescriptions through hospital outpatient departments.¹¹⁴ Potentially this could be accomplished by technicians rather than pharmacists. In British Columbia, many hospitals did not have a pharmacist on staff in the 1960s. Eliot Freidson argues that when professionals are seen as merely technical specialists, they will be given little autonomy

¹¹² Buerki, “Historical Development,” 70.

¹¹³ Ronald Akers, “The Professional Association and the Legal Regulation of Practice,” *Law and Society Review* Vol. 2 No. 3 (May, 1968): 475.

¹¹⁴ John Bachynsky, “Pharmacy in a New Age – A Milestone Study,” in *Canadian Pharmacists Association 1907-2007 -100 Years of Leadership in Pharmacy* (Ottawa: Canadian Pharmacists Association, 2007), 26.

or authority beyond their technical speciality.¹¹⁵ Pharmacists worried that they might be downgraded from professionals to technicians.

The academic world still saw pharmacy as an incomplete profession, just as Abraham Flexner had in 1915. In an article titled, “Incomplete Professionalization: The Case of Pharmacy”, Denzin and Mettlin use Carr-Saunders and Wilson's definition of a profession as an “occupation which is based upon specialized intellectual study and training, the purpose of which is to supply skilled service or advice to others for a definite fee or salary.” They further specify that professions organize themselves into

*professional groupings, develop special codes of ethics, engage in formalized recruitment patterns, establish formal institutions to transmit the knowledge of the occupation, develop social organizations to insure the perpetuation of the profession through time and finally, take on the characteristics of self-governing, autonomous institutions.*¹¹⁶

Denzin and Mettlin argued that pharmacy constituted an incomplete profession because they failed to abide by the requirement of a profession that “you do not advertise” and failed to recruit “truly committed persons who would ... commit their lives to the altruistic goals and values of the profession.” They claimed that pharmacists also failed to control the object of their profession, the drug, or create a “systematic body of scientific knowledge which can only be learned by socialization in their own institutions.”¹¹⁷ The authors quote pharmacists as saying their “the professional profile is hazy and soft.”¹¹⁸ Hospital pharmacists referred to retail pharmacists as “garden hose

¹¹⁵ Freidson, “*Theory of Professionalism*,” 126.

¹¹⁶ A.M. Carr-Saunders and P.A. Wilson, *The Professions*, (Oxford: Clarendon Press, 1933) quoted in Norman K. Denzin and Curtis J. Mettlin, “Incomplete Professionalization: The Case of Pharmacy,” *Social Forces* Vol 46 No 3 (March 1968), 375.

¹¹⁷ *Ibid.*, 376-7.

¹¹⁸ *Ibid.*, 376.

druggists”, highlighting the non-professional nature of products sold in drugstores.¹¹⁹

Denzin and Mettlin recognized that pharmacists possessed some aspects of professionalism, codes of ethics, formal education, and specialized skills as well as segments, such as hospital pharmacy that did not advertise. To professionalize, the authors claimed, pharmacists would have to stop treating drugs as a product and start treating the dispensing of drugs as a service. In practical terms, this meant adding a uniform service fee to the cost of the drug, rather than marking the cost of the drug up by a percentage, a system paralleling the Fuller Method. Denzin and Mettlin felt that this would be difficult as the public saw pharmacists as “counters and pourers” and pharmacists lacked credibility with the medical profession in the goal to be seen as “experts on drugs.” They quoted the “American Druggist’s” statement that “the public recognizes that the pharmacist has considered himself a merchant and they think ... a prescription is a commodity, a product, so why not, they say, buy it at the discount house.”¹²⁰ While pharmacists were professionals in a statutory sense, many observers saw them as businessmen more than health professionals.

Throughout the 1950s and into 1960s, pharmacist’s professional moral continue to decline. Deborah Savage argues that the success of an organization depends on having “practiced organizational routines” that underlie the existence of their core competences and capabilities. “No matter how brilliant the plan, an organization that has the wrong set of complementary capabilities will be unable to implement it.”¹²¹ In the 1960s, pharmacists’ practiced organizational routines had become “pouring and counting” while the core competence for which they were trained remained compounding prescriptions.

¹¹⁹ Ibid., 376.

¹²⁰ Ibid., 378.

¹²¹ Savage, “Professions in Theory,” 133.

These “pour and count” activities, performed on a daily basis, now formed the capability of the organization but were out of sync with their core competency. The legitimacy and dependence underlining their authority in the past had been embedded in the core competency of compounding prescriptions. This competency had been recognized as specialized knowledge only acquired by pharmacists, qualifying it as a distinct competency. No other group could compound prescriptions as well as they could. The declining usefulness of this specialized knowledge diminished their claim to legitimacy. Likewise, the public dependence on pharmacist’s compounding skills diminished. Neither legitimacy nor dependence could be replaced by pharmacists whose skills appeared to be nothing more than “pouring and counting.” The result was a diminished reputation; therefore the pharmacist’s fear that they had lost prestige was an accurate assessment. To turn this loss of authority around pharmacists’ dynamic capabilities would be tested. Could they reconfigure their competencies to address the changes that had occurred in their professional environment? The next two chapters explore attempts by pharmacists in British Columbia, in the mid 1960s, to alter the dynamics of their profession. Like pharmacists throughout North America, they were expressing concerns about their profession’s future.

British Columbia pharmacist, Ben Gant, echoed Emile Coderre (as quoted to start this chapter), and in fact, went much further with his address titled “Pharmacy: A Dying Profession.” While Coderre worried that pharmacists were “losing ... prestige”, Gant worried whether the profession would survive at all. Gant recognized that “the professional function of the Pharmacist [had changed] from a manual art in which the ability to compound mixtures and pills etc. established his professional identity, to one of

knowledge in the complete use of drugs and their inherent dangers.” He believed that pharmacists had “become vulnerable to those outside the profession who ... sought to immortalize the count and pour philosophy as the sole professional responsibility of the Pharmacist.” Gant knew that in order to survive, pharmacists had to change; “the continued existence of society and any organization within it is dependent upon their capability to adapt to any changes which may influence their environment.” The changes he envisioned would come with the acceptance that pharmacy “is no longer a manual art” and its refocus on two areas where pharmacists should be responsible for drug interactions, the dispensary for prescriptions and the front store for over-the-counter drugs. Gant rejected the notion that “possible interactions and other therapeutic misadventures ... [were] the physician’s responsibility.” Pharmacists would be able to “live up to our professional responsibility” only when they were allowed to utilize “this knowledge to the benefit of those people in our community.”¹²²

The opening statement in the submission by the Study Committee on Pharmacy in British Columbia to the Pharmacy Planning Commission (both reports to be examined in detail in chapters three and four), contained the words that struck a familiar tone, “Pharmacy is in trouble.” The authors argued that all pharmacists would agree that the public image of pharmacy had been “slipping for decades.” Its professional status had been chipped away as the profession remained “caught between the dichotomy of commercialism and professionalism.” Everyone, they declared, “is of one voice that something must be done, and right now, if the profession is to survive.” These pharmacists were also concerned about another aspect of survival, recruitment of new

¹²² UBC-SM-CPBC, Box 13-21, Ben Gant Address, “Pharmacy: A Dying Profession.”

members of the profession. Recruitment to the pharmacy program at the University of British Columbia had fallen below the “level necessary to sustain the service which the public has a right to require of Pharmacy” and this was because pharmacy had “lost its lustre for the young.” Although all pharmacists agreed that something needed to be done, the committee believed that “there is no unanimity ... as the methods to be employed ... as the instrument ... for furthering the interests of Pharmacists.”¹²³ The next two chapters will provide a case study that examines how pharmacists in British Columbia attempted to reconstruct their profession.

¹²³ UBC-SM-CPBC, Box 12A-12, Submission of the Study Committee on Pharmacy in British Columbia to the Pharmacy Planning Commission January 1967, 1.

Chapter Three

It is important that the pharmacist should recognize that he has become a Pharmaceutical Chemist with powers and rights in the province of British Columbia and is a responsible professional person. Nobody need hire him; no one undertakes to give him a position, but the Association and the University have given him a Certificate that he may carry with him wherever he may go, subject to the laws of the land wherever he may travel.

Earl MacPhee¹²⁴

The Pharmaceutical Association of the Province of British Columbia (the Association) was established as a corporate body, by the British Columbia legislature, with the passage of The Pharmacy Act on April 20, 1891.¹²⁵ The overall mandate of the Association is to oversee the practice of pharmacy in British Columbia. Pharmacists must be licensed with the Association before they are entitled to practice pharmacy in the province. In 1966, when British Columbia pharmacists created the planning commission that forms the basis of the case study examined in this thesis, the Association's administration included a council of six councillors elected, by the membership, from six geographical districts throughout British Columbia plus four elected from Greater Vancouver. Paid staff included a Registrar/Secretary-Treasurer, an Executive Secretary/Inspector plus four clerical staff. The councillors elected an executive committee of five members, one of whom was elected president. The president appointed three council committees, discipline, finance and legislation and the council selected six committees, drug advisory, economics, education, health services, professional relations, and public relations. Special committees were appointed as

¹²⁴ UBC-SM-CPBC, Box 12A-10, PPC Report, 139.

¹²⁵ Raison, *Brief History of Pharmacy*, 46. In 1974, the name was changed, by statute, to the College of Pharmacists of British Columbia. It still exists under that name. The British Columbia Professional Pharmacists Society then took over the title of British Columbia Pharmacy Association. The College is mandatory, the Association is voluntary.

needed for specific projects. The council appointed a Board of Trustees, four CPhA delegates and recommended a board of examiners to be officially appointed by the Lieutenant-Governor.

The federal government is responsible for approving new drugs for sale in Canada through the Food and Drugs Act and Regulations in which they designate a list of prescription-only drugs (Schedule F & G).¹²⁶ Provinces also develop prescription-only drug schedules, which must include all Schedule F & G drugs, but which may also include any other drugs, as deemed necessary by the provincial association.¹²⁷ In 1966, British Columbia's Pharmacy Act included Schedule A, part I which listed prescription-only drugs (including all Schedule F and G drugs), Schedule A, part II which listed items that could be sold without a prescription but which required a signature in a poison register, Schedule A, part III which listed over-the-counter (OTC) drugs that could only be sold in pharmacies and Schedule B which listed drugs that could be sold by any person. Drugs that were listed in the federal government's Proprietary and Patent Medicine Act could also be sold by any person.

In addition to their mandatory membership in the Association, many pharmacists belonged to voluntary local professional pharmacy organizations. These included the Lower Mainland Pharmacists Association (LMPA), Okanagan Pharmacists Association and the South Vancouver Island Pharmacists' Association (SVIPA). In September 1965, the SVIPA gave notice to the Association of a resolution which they subsequently presented to council in November. It requested that a province wide committee, made up of four practicing pharmacists from each district, be set up to provide a "thorough

¹²⁶ Department of Justice, <http://laws.justice.gc.ca/en/f-27/C.R.C.-c.870/index.html> (June 19, 2010).

¹²⁷ Thus, when a drug is removed from Schedule F or G by the federal government it does not become available without a prescription until it is removed from the provincial schedule.

analysis of the situation in pharmacy especially regarding the security of the profession and the protection of the public health.” This resolution was received positively by council and they recommended that a Pilot Committee of eight members be formed - two employers and two employees from each of the SVIPA and LMPA. The pilot committee would expand upon the areas of reference referred to in the resolution, as well as recommend whether a commission approach or a committee representative of all areas of the province should be adopted. Council appointed an outside chairman for the pilot committee and a meeting was arranged at the offices of the Association for March 9, 1966.¹²⁸

On February 28 1966, Association councillor for Victoria, Jack Johnston, informed Association Registrar Douglas Denholm that the SVIPA committee members objected to the terms set out by the Association on four grounds, the selection of an outside chairman, the terms of reference, the expectation that the pilot committee would report to the Association and the site of the meeting (the Association offices).¹²⁹ The council decided that they were willing to accede to all points with the exception that the Pilot Committee must report back to the Association. In the view of council, this was an Association funded and appointed committee and was therefore responsible to all the membership, not just themselves. Subsequent to that decision, the SVIPA and LMPA informed council that it had decided to continue meeting “at an informal level” outside the jurisdiction of the Association. All expenses would be paid out of their own pockets.¹³⁰

¹²⁸ UBC-SM-CPBC, Box 23-38, Resolution of council for the consideration of the BCPhA Annual Meeting, June 1966, 160-161.

¹²⁹ UBC-SM-CPBC, Box 12A-9, Letter to BCPhA council by Registrar Denholm, March 3, 1966.

¹³⁰ UBC-SM-CPBC, Box 23-38, Resolution of council for the consideration of the BCPhA Annual Meeting,

Renamed and reformulated as the “Study Committee on Pharmacy in British Columbia” (Study Committee), - nine additional members from around the province were added- the committee proceeded to carry on without support from the Association. In the report they produced, the Study Committee stated that they had examined all provincial legislation pertaining to professions in British Columbia and met with individuals and groups throughout the province. Their twenty page report detailed the problems that faced pharmacists which, they believed, centered on issues such as economics, negotiating and bargaining, employer-employee relations and enforcement of standards related to unethical trade practices. These were problems, the committee believed, that were beyond the scope of the legislative authority that the Pharmacy Act gave the Association. This lack of jurisdiction had created a communication gap between pharmacists and the Association. They quoted a LMPA committee report that “there exists the feeling that the association offices operate in an ivory tower atmosphere.”¹³¹

The solution proposed by the Study Committee was a second pharmacist organization (the Society) that would deal exclusively with the problem areas that they had previously discussed. This would allow the Association to concentrate on its role as “protector of the public interest” and leave the Society to protect the interests of pharmacists.¹³² The report outlined a detailed plan for the Society, including potential districts, voting procedures and committee structures. The Study Committee suggested that the Association could collect mandatory fees, in addition to the annual Association fees, that could be passed on to the Society. Thus, although the Society would be

June 1966, 161.

¹³¹ UBC-SM-CPBC, Box 10-32, Report of Study Committee on Pharmacy in British Columbia (hereafter SC Report), 4.

¹³² UBC-SM-CPBC, Box 10-32, SC Report, 10.

voluntary, the fees would be mandatory. Additionally, both organizations could share office staff and offices as well as hold joint annual meetings. Linkage, between the two organizations, had the potential to create a conflict of interest. Since the Association was mandated by the legislature to safeguard the public and the Society looked after the interests of pharmacists, their goals might not always be compatible. Finally, the new Society would set up a permanent Planning Commission to deal with problems in the long term and formulate new standards of practice and a Code of Ethics.¹³³ Ethics are an example of a potential conflict of interest. An ethical code is created to ensure that professionals act in the best interest of the public; the Society was mandated to look after the interests of pharmacists.

The interactions that surrounded the SVIPA's resolution to the Association highlight the divisions amongst British Columbia pharmacists at this time. The SVIPA was not looking to work from within the Association saying that "it was necessary to protect the council and the Association by not involving the Pharmacy Act or its custodians in any official capacity."¹³⁴ Their report shows that they believed that the Association played a central role in pharmacists' problems. For that reason they wanted the freedom to investigate these problems, free from any Association input or control. When the Study Committee's report was released it revealed that their goal was a new pharmacy organization, the Society, designed to take over the functions that they believed the Association would not or could not address. While they did envision a planning commission it would be part of, and controlled by, the Society, not the Association. They did not want to report to the Association because they felt their responsibility was to the

¹³³ UBC-SM-CPBC, Box 10-32, SC Report, 12.

¹³⁴ UBC-SM-CPBC, Box 10-32, SC Report, 1.

membership of the Association, not council. They wanted to, and did, report to the Association only when they had finalized their report and believed they had majority support from pharmacists in the province. Jack Johnston, councillor for South Vancouver Island, made it clear that some members of the SVIPA wanted their committee to retain independence from the Association, stating “right from the start there were certain members of the SVIPA who wanted to keep this entirely separate from council and they pressed that.”¹³⁵

In June 1966, the Study Committee invited council to a presentation of their findings.¹³⁶ At that meeting the Study Committee presented their report and requested that council approve their proposals in principle and to direct the Study Group to prepare a draft constitution and bylaws of a second pharmacy association. Council declined to respond citing two reasons. Firstly, they noted that, although they spent considerable time examining the report, the substantial proposals they contained required more time. Secondly, they wanted advice from their solicitor on both requests. They did promise to discuss the report further at council meetings scheduled at the end of June, after the closing of the Association’s annual meeting.¹³⁷

At the Association’s annual meeting, held immediately after the Study Committee presented their report, council tabled a four page summary of the previous seven months activities surrounding the resolution. Council expressed that they were impressed with the report but were somewhat dismissive in their praise. “It is obvious” they said, “that a great deal of thought has been directed by the pharmacists on the Study Group to many of

¹³⁵ UBC-SM-CPBC, Box 23-38, Discussion on SVIPA-LMPA Pilot Committee, BCPhA Annual Meeting, June 1966, 110.

¹³⁶ UBC-SM-CPBC, Box 12A-12, Letter from D. Denholm to C. Hoffman, June 7, 1966.

¹³⁷ UBC-SM-CPBC, Box 23-38, Resolution of council for the consideration of the BCPhA Annual Meeting, June 1966, 162.

the problems facing our profession, *many of which are currently under study by Council or Committees of the Association*” (emphasis added). Council stated their belief that the solution proposed by the Study Committee, namely a new pharmacy organization, was “based on inconclusive evidence and is premature.” They did not believe that a new organization could solve pharmacists’ problems more easily than they could. Rather than accept the findings of the Study Committee, council submitted their own resolution for a Planning Commission to the annual meeting. Citing “now evident widespread interest”, council entered a motion that “immediate steps be taken to appoint a Planning Commission” designed to “produce the answers required to ensure the profession’s future, if not its very existence.”¹³⁸

The language in their report reveals council’s attempts to take back control from the Study Committee. Although nominally praising their report, they diminished its importance by stating that the problems that they were studying were already being handled by the Association. The Study Committee’s report was presented to council as a final report. They believed that their province wide committee had done a thorough job and had presented the solution to pharmacists’ problems. The solution would be the formation of a second pharmacy organization and implementation should proceed as soon as possible. The Association disagreed; the solution proposed was unsatisfactory and premature. A Pharmacy Planning Commission (the Commission), under their control, was the only method that would produce a satisfactory answer. It appears that the disagreement was not whether action of some sort was needed, but the form that action should take. The lines of battle were drawn and as the annual meeting progressed, the

¹³⁸ UBC-SM-CPBC, Box 23-38, Resolution of council for the consideration of the BCPhA Annual Meeting, June 1966, 162-3.

membership would be called on to decide the mechanics of the actions that would be undertaken.

Members of the Association provided their input at annual meetings through Syndicate Discussions; a procedure that had been in use since 1963. Members of the Association participated in an appraisal of various areas of pharmaceutical practice “with a view to providing guidance and leadership to the Association.”¹³⁹ In 1966, council’s resolution was assigned to Syndicate Two, under the title “Pharmacy Organizations in B.C.” Four meetings were held over three days, with 35-45 pharmacists at each meeting. The two main topics of discussion were council’s resolution and the Study Committee’s recommendation of a second pharmacy organization. The syndicate voted to support council’s resolution with four dissenting votes, three of which came from members of the Study Committee.¹⁴⁰ It was noted that “urgent study was required.” Discussion about a second pharmacy organization brought “lively discussion.” The majority wanted continued study, to supplement that done by the Study Committee, jointly with the Association but some wanted the Study Committee to continue separately and only liaise with the Association. Some were opposed to the immediate formation of the new organization until it had been carefully studied in consultation with legal counsel.

It was generally agreed that “urgency, extreme urgency” was required in the follow-up of the Study Committee report and that council and the syndicate saw pharmacists’ problems in the same light. The solution was not unanimous with some feeling that the “formation of a separate organization for the welfare of Pharmacy could have severe repercussions and public criticism.” In the final meeting of the syndicate, it

¹³⁹ UBC-SM-CPBC, Box 13-4, Syndicate Discussions, BCPhA Annual Meeting, June 1964.

¹⁴⁰ UBC-SM-CPBC, Box 23-38, Syndicate Discussion #2, BCPhA Annual Meeting, June 1966, 186.

was moved and carried that the Commission should include the report of the Study Committee in its deliberations. The last speaker in the meetings was John Turnbull, executive director of the CPhA, who asked the delegates “to bear in mind that the rest of Canada was watching us very carefully.”¹⁴¹

When the time came to address the council’s resolution amongst the full Association membership, discussion was lengthy. Five members of the Study Committee brought proxies with them, giving them twenty four votes of the eighty that would be cast. Syndicate Two’s amendment that the Commission should consider the report of the Study Committee was passed, after some discussion. Much more discussion centered on the amendment proposed by Stan Fyfe, a member of the Study Committee. His amendment put significant time restrictions on the completion of the Commission. It stipulated that the Commission be formed by October 1966 and report their findings to council and all interested pharmacists by March 1967. Further, the amendment stipulated that the members of the commission and its terms of reference “be acceptable to practicing pharmacists through district meetings.” This amendment prompted considerable discussion. Many argued the time restrictions would hamper the effectiveness of the committee. As one member noted “you would certainly be tying council’s hands by providing time limitations.” Many pharmacists were concerned about the practicality of canvassing the pharmacists in such a large province, within the prescribed time period.¹⁴²

Objections to time restrictions and the ratification of the commission members and terms of reference were all made by members of council. Gant’s determination that

¹⁴¹ Ibid., 186-7.

¹⁴² Ibid., 190-2.

these restrictions showed a lack of confidence in council was probably quite accurate.

Those who spoke in favour of the motion were all members of the Study Committee.

Charlie Burr summed up the general feeling of that faction:

*I think time has gone on for years where we have sat in on committees. We have had results of surveys, and we have a lot of basic facts to go on and I think we are putting pressure on ourselves as well as Council and it is absolutely essential with some of the main problems that Pharmacy is going to be faced with that we come up with definite plans for the future. ... Our grass roots are hollering for it.*¹⁴³

The amendment, and thus the resolution, was finally passed with a margin of fifty-six votes to twenty-four. Clearly, the membership was divided on the issue of time and ratification restrictions, not on the concept of a planning commission or the inclusion of input by the Study Committee. The majority agreed, however, that the issues were urgent and that the commission should have grass roots support and input. The SVIPA and the Study Committee had challenged the authority of the Association. Although they had not been successful in achieving immediate implementation of their preferred solution, the Society, they were able to ensure that all aspects of the Commission would receive grassroots input, in a timely fashion.

On the last day of the Association's 1966 annual meeting, council convened all afternoon to resolve the Commission's logistics including the selection of a chairman and commission members as well as the drafting of terms of reference.¹⁴⁴ The choice of chairman presented the least difficulties since the resolution had put that fully in the hands of council. After considerable discussion on the size and make-up of a search committee it was decided that the Executive Committee should conduct the search and

¹⁴³ Ibid., 191-3.

¹⁴⁴ See Appendix E for final wording of the Pharmacy Planning Commission resolution.

submit their candidate to council in September for approval.¹⁴⁵ The more complicated and contentious issue was developing terms of reference for the commission. The tension in this discussion was between councillors who wished to dictate the direction of the Commission and those who feared that the membership would not accept their authority. In the end, the compromise suggestion adopted was that the Executive Committee would draw up specific terms of reference using the Registrar's reports, committee reports and recommendations from Association members and study groups. A draft of their terms of reference would be edited and approved by a workshop of ten non-council pharmacists from all districts, prior to final ratification by council in September. The workshop did take place on August 28 with nine non-council pharmacists taking part and producing the fourth draft of the terms of reference.¹⁴⁶

The final decision was the make-up of the Commission members. Consensus was reached that an ideal commission would include an employee, employer, government and hospital pharmacist plus an educator belonging to the Association and one person representing the other health professions.¹⁴⁷ A motion was passed that the Commission should be made up of no less than four or more than six persons, to be selected by the Executive committee and ratified by council.¹⁴⁸ This went directly against the resolution passed at the annual meeting which specified that "this Planning Commission and the terms of reference be acceptable to all practicing pharmacists through district meetings."¹⁴⁹ In an information letter, on the progress of the Pharmacy Planning Commission, sent to all members of the Association on August 15, 1966, the membership

¹⁴⁵ UBC-SM-CPBC, Box 12A-10, Notes from BCPhA Council meeting, June 26, 1966, 60.

¹⁴⁶ UBC-SM-CPBC, Box 13-23, Notes from BCPhA Council meeting, August 28, 1966.

¹⁴⁷ UBC-SM-CPBC, Box 12A-10, Notes from BCPhA Council meeting, June 26, 1966, 61.

¹⁴⁸ Ibid., 69.

¹⁴⁹ See Appendix E for copy of resolution.

was told that the “suggestions for the membership of the Commission will be prepared by the Executive for presentation to the District Meetings.”¹⁵⁰ It appears that council had relented and did allow some input from the districts on the makeup of the Commission’s membership.

District meetings were organized for the membership between September 1st and 8th, 1966. This was to discuss the terms of reference and potential members of the commission. On September 11, council held a special meeting to finalize the chairman, membership and terms of reference of the commission. The Executive Committee gave a full account of their search for a chairman and council ratified their candidate, Dean E.D. MacPhee. Input from the district meetings were incorporated into the draft produced by the August pharmacist workshop and a finalized version of the Terms of Reference was passed by council. Twelve candidates for membership on the committee were discussed, with the consensus being that the most important criteria would be “the ability to understand and interpret the problems of pharmacy.” Since Dean MacPhee had requested that the commission have only three members, their original decision to have between four and six members was abandoned. Council voted by secret ballot and the new commissioners were Murray Dykeman,¹⁵¹ John Dyck, and Trevor Watson. The Pharmacy Planning Commission was now established, one month ahead of the schedule imposed by the annual meeting’s resolution.¹⁵² Although council had been irritated by the constricting and untrusting nature of the resolution passed at the annual meeting, it did abide by the basic intent of the resolution in the selection of the Commission’s

¹⁵⁰ UBC-SM-CPBC, Box 13-23, Letter from BCPhA to membership, August 15, 1966.

¹⁵¹ Murray Dykeman had been Council candidate for chairmanship of the Pilot Committee that never happened.

¹⁵² UBC-SM-CPBC, Box 1-23, BCPhA Council Meeting Minutes, September 11, 1966.

membership and terms of reference, acknowledging the importance of grass roots involvement.

Earl MacPhee, chairman of the Commission, had been Dean of Commerce and Business Administration and Dean of Financial and Administrative Affairs at U.B.C and also taught in the Faculty of Commerce. MacPhee previously had a career in business as Managing Director for various British companies from 1929 to 1950; he had no previous experience with pharmacy but all three commissioners were pharmacists. The Commission travelled around the province meeting with pharmacists in each of the seven Association districts. Twenty eight meetings were held in eighteen locations with a total attendance of 443 pharmacists or thirty-seven percent of the 1210 registered pharmacists in British Columbia. Attempts were made to schedule meetings that maximized attendance; taking into consideration store hours and geography. Attendance was evenly distributed between urban and rural areas while employers (sixty-five percent) were over-represented compared to employees (twenty-five percent).¹⁵³ The striking difference in attendance between employers and employees may have had several sources. Employers were likely in the prime of their career and certainly had a greater financial interest in the outcome. Also, many stores were two pharmacist operations; it would have been more likely that the employee would have been left to run the store while the employer attended the meeting. Nonetheless, it is clear that pharmacists in British Columbia supported the Commission and, therefore, did feel there was an urgent need to address the problems facing the profession.

¹⁵³ UBC-SM-CPBC, Box 12A-10, PPC Report, p.iii. Note: Ironically, District One, South Vancouver Island, had the second lowest attendance (32%), despite being the driving force behind formation of the Commission.

In addition to the pharmacist meetings, the Commission received input from many other sources. Written submissions were received from thirty-one individuals, many of them pharmacists as well as the Hospital Pharmacists, the Faculty of Pharmacy and the Study Committee. Additionally, they consulted with forty-eight individuals, including Association council members and staff, health administrators, academics, provincial and federal government officials, and the wholesale drug industry. They met with physicians, veterinarians, nurses, teachers and consulted with various pharmacy organizations. The Commission also examined thirteen reports and surveys prepared in British Columbia since 1961 including submissions by the Association to the Royal Commission on Health Services (Royal Commission) in 1962 and reports on Continuing Education (1965), Dispensing Costs (1965), the Commercial-Professional Balance (1965), student enrolments (1966) and the Welfare Drug Program (1966).¹⁵⁴

The Commission polled the opinions of a wide cross section of pharmacists and the wider health care community. Their report shows that they listened closely to the views of pharmacists. The authors noted a “growing feeling of discontent and unhappiness amongst Pharmacists ... in such proportions that could not escape our attention.”¹⁵⁵ The opinions of many different aspects of pharmacy were considered. For example, students were noted as primarily being concerned with their professional image.¹⁵⁶ In terms of influence, however, two groups seem to predominate. The Commission noted that the “opinions expressed were primarily those of the ownership group” because, as we have seen, the majority of those attending were employers.¹⁵⁷

¹⁵⁴ Ibid., iv-vii.

¹⁵⁵ Ibid., 13.

¹⁵⁶ Ibid., 15.

¹⁵⁷ Ibid., 35.

Their concerns dominated the commission's five recommendations that involved commercial considerations. The second group who were able to exert considerable influence was the representatives of the Faculty of Pharmacy. Many of the seven recommendations on educational reform came through input by the Dean and other faculty members.

The Commission report notes that the thirteen reports and surveys examined had "not had time to fructify in any major way."¹⁵⁸ They also note that investigations had been carried out by other Canadian pharmaceutical organizations. Association president, Bernie Brown, had made the Association's position clear that they did not want a report that merely summarized all previous reports. Rather, they wanted to achieve a "searching look at our own profession."¹⁵⁹ The commissioners were aware of the hopes that British Columbia pharmacists had for practical solutions to their problems. They hoped that the Association would "debate, commend or, if necessary, condemn such findings" because they were "the problems of the next ten or even twenty years" more the "the issues of today." Everybody involved in this Commission seemed to be on the same page, this was a call to action, not an opportunity to create another study to be left to collect dust on a shelf.¹⁶⁰

The report produced by the Commission was organized into thirteen chapters. Chapter One presents the thirty-five recommendations of the Commission, categorized by chapter.¹⁶¹ Recommendations fall generally into three categories, those that increase the scope of practice for pharmacists, those that increase the professional image of

¹⁵⁸ Ibid., v.

¹⁵⁹ UBC-SM-CPBC, Box 12A-10, Notes from BCPhA Council meeting, June 26, 1966, 65.

¹⁶⁰ UBC-SM-CPBC, Box 12A-10, PPC Report, v-vi.

¹⁶¹ See Appendix F for copy of recommendations.

pharmacists and those concerned with economics. Many of the recommendations can be viewed within more than one of these general categories, education was critical to both increasing their scope of practice and their professional image. Pharmacists' attempt to increase their scope of practice was also a key factor in their quest to improve their professional image.

Chapter Two gives a broad history of pharmacy from Babylonian times to British Columbia in the twentieth century, then proceeds to recent statistics relating to pharmacy; new students admitted to pharmacy in each province, statistical relationships between pharmacists, pharmacies and the general population in each province and the number, total value and individual cost of prescriptions filled in Canada, as well as the number of pharmacist licenses issued in British Columbia over the previous ten years. The next section of this chapter looks at pharmacists' image from various points of view, the University of British Columbia, pharmacists, students and private enterprise. The last section looks at the relationship between the Faculty of Pharmacy and the Association.¹⁶²

Each of the last eleven chapters covered a different area of concern to pharmacists. The topics covered were as follows:

Chapter Three	The Role of the Pharmacist
Chapter Four	Professional and Commercial Services
Chapter Five	Pharmacist Utilization and Remuneration
Chapter Six	Education
Chapter Seven	Pharmacy Organization
Chapter Eight	Communications
Chapter Nine	Economic Considerations
Chapter Ten	Relationship to Other Health Professions and Health Care Plans
Chapter Eleven	Relationships with Government
Chapter Twelve	Relationships with Suppliers
Chapter Thirteen	Legislation and By-Laws ¹⁶³

¹⁶² UBC-SM-CPBC, Box 12A-10, PPC Report, 1-16.

¹⁶³ Ibid., a-c.

Each of these chapters was divided up into sub-categories within the broader topic.

The Commission noted that the loss of compounding and the concurrent rise of prefabricated medications had “affected our function.” Along with this loss was a “lessening of our own respect for the art which was the basis of pharmacy practice for the last three decades. The application of merchandising techniques to the pricing ... of medications has affected both our identity and function.”¹⁶⁴ The Commission sought to replace the loss of that compounding function, which had previously constituted pharmacists’ core competency, by expanding their scope of practice as medication consultants.

The Commission had noted that physicians were being overwhelmed by the volume of drug information sent to them by manufacturers regarding the adverse effects of drugs, but they were also told “that the physicians were not really expecting the pharmacist to be his consultant on drugs.”¹⁶⁵ It would take time to increase their scope of practice by positioning themselves as drug consultants to physicians. It would not be possible until pharmacists could demonstrate to physicians that they possessed legitimacy through specialized knowledge. The ethical prohibition on labelling prescriptions with composition was still in effect and this would make it difficult to extend their consultation role to prescription medications.¹⁶⁶ This prohibition involved a tacit agreement between pharmacists and physicians; an agreement that pharmacists did not want to unilaterally alter. Robert Buerki has argued that pharmacists are more self-conscious about their public image than other health professionals: a claim that, he says,

¹⁶⁴ Ibid., 49.

¹⁶⁵ Ibid., 39.

¹⁶⁶ Pharmacists would not routinely label prescriptions with their composition, without physician permission, until 1972. They only started to do so after receiving the support of physicians.

sociologists have put down to a “massive inferiority complex borne of a functional subservience to medicine.”¹⁶⁷ That lack of confidence may have inhibited their will, despite the fact that, as an independent licensed professional, the agreement was not binding.

The Commission stated that “although not in a position to diagnose or prescribe, the pharmacist often learns early of health problems and situations, and is well equipped to advise the patient pertaining to the particular way in which medicine should be used or recommend that self-treatment be discontinued and medical advice sought.”¹⁶⁸ The members consulted felt that “pharmacists should become consultants to the public about the use of drugs in their health needs.”¹⁶⁹ Pharmacists would be able, because of their training, “to evaluate and advise, to create proper thinking about self-medication.”¹⁷⁰ The Commission therefore developed recommendations that focused on increased pharmacist involvement in counselling customers, now termed patients, in selecting appropriate over-the-counter (OTC) medications and the education needed to facilitate that counselling.

One of the obstacles that pharmacists faced, as consultants on OTC drugs, was the physical layout of most drugstores. The general feeling amongst pharmacists was that “there was no professional reason to promote the use of such items, as they are not just merchandise, but are potent drug forms, required by law to be sold only under the supervision of a pharmacist.” The Commission found that these products were sold, in most cases, in self-service areas of the stores and were promoted in a similar manner to

¹⁶⁷ Buerki, “Public Image,” 72.

¹⁶⁸ UBC-SM-CPBC, Box 12A-10, PPC Report, 22.

¹⁶⁹ Ibid., 39.

¹⁷⁰ Ibid., 22.

other non-professional drugstore products.¹⁷¹ Dean Matthew, from the Faculty of Pharmacy, pointed out that “it is difficult to distinguish the interior of the average pharmacy from a super market. All of those items which come with the legal definition of drugs might easily been segregated in a clearly marked area.”¹⁷² The Commission recommended that OTC items that were restricted to sale in a pharmacy (Schedule A part III) be “removed from public access and placed within an area under the personal supervision of a licensed pharmacist.”¹⁷³ Their idea was to create a professional area inside the pharmacy. Customers would leave the non-professional area of the drugstore and enter a separate professional “office” that housed the dispensary and OTC drugs.

The Commission noted that “idealists have told us that pharmacy must divest itself of its commercial involvement if it wishes to survive as a recognized profession.” This solution was not realistic; “the drugstore is here to stay.” The practical solution lay in the “separation and identification of the professional aspects.”¹⁷⁴ In focusing on the physical aspects of the distribution of drugs, the Commission says, the pharmacist has “lost sight of his responsibility to protect and advise the public on the use of drugs.”¹⁷⁵ Provincial legislation gave pharmacists the exclusive right to sell these medications (Schedule A Part III) and along with this monopoly came the responsibility and opportunity for pharmacists to use their training. If pharmacists failed to provide professional consultation to the public when they purchased OTC medications, there could be no justification for the retention of their monopoly. Expanding their drug consulting role in this manner did not impact directly on the pharmacist-physician

¹⁷¹ UBC-SM-CPBC, Box 12A-10, PPC Report, 35.

¹⁷² *Ibid.*, 26.

¹⁷³ Recommendation One, Appendix F.

¹⁷⁴ UBC-SM-CPBC, Box 12A-10, PPC Report, 49.

¹⁷⁵ *Ibid.*, 50.

relationship and was one that pharmacists believed was necessary and desired by the public. It had the added advantage of being provided free of charge to the public.

The Commission made a number of other recommendations that would complement the removal of pharmacy-only OTC medications from public access. They recommended that if a pharmacy locked the professional area of the store, the pharmacy should still be able to sell non-professional products, without a pharmacist being on duty. This would allow one pharmacist stores in isolated areas to comply with the recommendation while still serving the public with non-professional products and services.¹⁷⁶ A second corollary recommendation was the restriction on the advertising of pharmacy-only OTC products. Since advertising was best handled at a national level, because of the countrywide nature of many company's advertising campaigns, it was recommended that the Association request that the CPhA lobby the Food and Drug Directorate to tighten advertising controls on these medications. The Commission felt that OTC drugs should not be advertised in the same way as patent medicines, sold by non-pharmacies.¹⁷⁷

The Commission recommended that inspections by the Association be improved.¹⁷⁸ In some areas of the province, the Commission was told, non-pharmacies were openly selling pharmacy-only OTC's. This practice was a direct challenge to the monopoly granted to pharmacists. Since the Association was responsible for enforcing all provisions of the Pharmacy Act, "our inattention to proper enforcement could well result in a loss of authority in this area."¹⁷⁹ If the Commission's recommendation to restricted

¹⁷⁶ Ibid., 46.

¹⁷⁷ Ibid., 42.

¹⁷⁸ Recommendation Nineteen, Appendix F.

¹⁷⁹ UBC-SM-CPBC, Box 12A-10, PPC Report, 36.

access of pharmacy-only OTC's was enacted, while at the same time they were readily available in non-pharmacies, the public could reasonably question the necessity of the restriction.

The Commission recognized that increasing the amount of time that pharmacists spent counselling the public on their OTC selections could have an impact on their other professional duties. For that reason, the Commission recommended that a category of Non-Professional Assistants (NPA) be created to handle clerical duties in the pharmacy. This could have multiple benefits for the pharmacists since his "time will be more productive and more rewarding if used to advise the public on the use of medicines than if used to type labels and make entries in registers and reports."¹⁸⁰ To achieve maximum professional efficiency, pharmacists "must start to utilize lay help to assist ... in providing this professional service."¹⁸¹ Creating a category of Non-Professional Assistants would allow pharmacists to control the professional functions that were restricted to pharmacists as well as those duties that could be done by non-professionals. It was hoped that by decreasing the non-professional duties performed by the pharmacist their professional image would increase as well as make pharmacy more attractive to potential recruits.

In order to be better qualified to provide increased counselling services to the public, pharmacists needed to update the education they received. The Commission recommended that the Faculty of Pharmacy become more aware of the "needs of community and hospital practice and re-orient themselves to the importance of these

¹⁸⁰ Ibid., 41.

¹⁸¹ Ibid., 45.

aspects of the practice of Pharmacy.”¹⁸² Specifically, it was recommended that the physical sciences be reduced and a greater emphasis be placed on biological sciences. This would enable the student to be better prepared for changing patterns of patient care. The study of Pharmacognosy should be drastically reduced and the student should be exposed to clinical practice while an undergraduate.¹⁸³ The clinical practice should be practical and involve members of the profession in community practice.¹⁸⁴ The Faculty of Pharmacy presented a brief to the Commission in which they expressed the concern that there had been a “lack of active study within the profession to define its role in society and to clarify the present and future occupational roles of the pharmacist.”¹⁸⁵ It was noted that pharmacy was the only health profession that did not have a clinical component in its education. “If the pharmacist is to be a participating member of the health team, he must have clinical exposure and experience.”¹⁸⁶ While it may be difficult for pharmacists to quickly gain the trust of physician’s, this clinical training could have immediate effects on their interactions with the public, through counselling on OTC medications.

It was recognized that education through the Faculty was primarily focused on future pharmacists and that this did not address educational deficiencies of practicing pharmacists. Additionally, it was recognized that pharmacy was a constantly changing profession. For these two reasons, it was recommended that the existing continuing education program, deemed to be inadequate, should be improved.¹⁸⁷

¹⁸² Recommendation Eleven, Appendix F.

¹⁸³ Recommendation Twelve, Appendix F.

¹⁸⁴ Recommendation Thirteen, Appendix F.

¹⁸⁵ UBC-SM-CPBC, Box 12A-10, PPC Report, 77.

¹⁸⁶ Ibid., 84.

¹⁸⁷ Recommendation Sixteen, Appendix F.

If implemented, all of these recommendations would help expand pharmacists' scope of practice and legitimize a new core competency as medication consultants. This would eventually require that pharmacists counsel patients on OTC drugs and prescriptions as well as acting as a drug consultant for physicians. In the short term, OTC drug counselling would provide the first step along the path to this goal. The second two goals could only be achieved after their educational goals were completed and their ethical code was updated. A core competency as medication consultation experts was an essential ingredient in pharmacists' goal to improve their professional image.

The Commission also recommended some measures that could directly enhance the professional image of pharmacists. Improvements in public relations with the public, more pharmacist control of the Association and ensuring that every hospital in the province could access pharmacy services would all help pharmacists' image. A concerted effort to recruit quality candidates to the Faculty of Pharmacy would pay future dividends; up until this time the dropout rate had been very poor and this had been blamed on failure to recruit quality candidates. New district organizations were encouraged but more importantly, the Commission recommended the formation of a Society that "would concern itself with the promotion of Pharmacy in the interests of pharmacists." The Commission also endorsed the Fuller Method of prescription pricing; cost plus professional fee. To aid this method of pricing, they recommended accounting systems that would allow a pharmacy to isolate the costs incurred by the dispensary from the costs of the entire drugstore.

The Society would also be instrumental in advancing the economic issues recommended by the Commission. Mechanisms to increase administrative awareness,

carry out negotiations between pharmacists and manufacturers, wholesalers and government would fall under their jurisdiction. Also permanent employer-employee committees that would deal with employment issues and salary would be their responsibility. This would leave the Association responsible only for the provisions of the Pharmacy Act.

All of the effort expended by the Commission and its participants would be wasted if pharmacists failed to act upon their recommendations. Chairman MacPhee had a clear message for pharmacists; they had been given rights and powers by legislation but the direction of their professional growth was in their hands. They should not expect to be granted authority they had not earned. It was in their hands to take the recommendations of the Commission and either accept, modify, or reject their findings and create the profession they wanted.

Chapter Four

We pharmacists sometimes feel that we are alone in facing the increasing complexities and demands of a society whose attitudes and complexion have undergone such marked change in the past decade. There is good reason to believe that the fault is our own by not keeping pace with society in its rapidly increasing degree of sophistication.

BCPhA Registrar Douglas Denholm, June 1967¹⁸⁸

The Pharmacy Planning Commission submitted their report to the Association's annual meeting in June 1967, having completed their investigations within the time frame stipulated the previous year.¹⁸⁹ MacPhee summarized their main findings and finished by saying, "some of our findings will be acceptable; some of the arguments which have been advanced will cause some debates over the year ahead."¹⁹⁰ Pharmacists were assigned the task of evaluating the recommendations, through the use of syndicate discussions. They took their role seriously, with meetings held over two days. Although some objections were raised, the pharmacists attending the syndicates were in favour of the majority of the thirty-five recommendations. The two recommendations that placed highest in priority were the removal of OTC's from public access and the formation of new pharmacy organization, the Society. These two recommendations signalled pharmacist's intentions to use the Commission to increase their scope of practice by developing a new core competency as well as increase their professional status. Many other recommendations would help with both those goals.

A special council committee was struck, in July 1967, to investigate removing OTCs from public access. The committee was asked to define the terms "public access"

¹⁸⁸ UBC-SM-CPBC, Box 23-38, Registrar Report, D. A. Denholm, BCPhA Annual Meeting, June 1967, 84.

¹⁸⁹ This timeframe seems to have come to as surprise to Chairman MacPhee who noted in his report that "I had not realized that your intent was to complete this study in a period of eight months."

¹⁹⁰ UBC-SM-CPBC, Box 23-38, Report of Dean MacPhee, BCPhA Annual Meeting, June 1967, 135.

and “personal supervision” as well as prepare a list of the drugs that would be affected.

A motion to amend By-law 44(3) was tabled at the March 1968 council meeting as follows:

All drugs and preparations ... restricted to sale by licensed pharmaceutical chemists shall be ... offered for sale in an area of the pharmacy which is under the personal supervision of a licensed pharmacist and not open to public access.¹⁹¹

The key phrase was “not open to public access” as it was interpreted to mean that a physical barrier would prevent the public from access to these drugs. The professional area would occupy a separate room; a professional office within the pharmacy. When patients entered this “office” they would be aware that they were now accessing health professionals. All non-professional activities would take place outside of this office. There was some opposition to this amendment for a number of reasons. Firstly, the renovations necessary would entail considerable expense for most pharmacies, as well as increased staffing and a potential loss of sales (estimated at 25%). Secondly, the public might object “on the basis that it reduced competition.” Thirdly, there was concern over an adequate phasing in period. Councillor Dyck reminded council that this recommendation had been placed in the *Immediate Action* category in July 1967 but, in view of the objections, it was included as a Syndicate discussion at the 1968 annual meeting.¹⁹²

The Syndicate was in favour of the amendment but advised council that they should “proceed with caution realizing more research, public relations, and inter and intra-professional relations are needed at this time.”¹⁹³ The committee agreed that

¹⁹¹ UBC-SM-CPBC, Box 27-1, BCPhA Council meeting, March, 1968, 39.

¹⁹² Ibid., 38-42.

¹⁹³ UBC-SM-CPBC, Box 10-33, Syndicate Two Report, BCPhA Annual Meeting, June 1968.

research needed to be done to “establish the fact that the proposal was essential to the public interest and not inimical to the pharmacist’s interest.”¹⁹⁴ The research would be done by a literature search for adverse reactions from OTC drugs and inquiries with the B.C. Medical Association, who had done a similar study. The result of their research was released to the membership at the June 1969 annual meeting. No evidence could be found of adverse reactions that had resulted from the indiscriminate use of OTC drugs. Although they believed that adverse reactions did exist, but were not documented, they were forced to recommend that council not proceed with legislative removal of OTCs from public access. Pharmacists did not have the authority to restrict access to OTC drugs because they could not demonstrate that it would advance the public’s interest.

The committee recommended that efforts be continued to educate pharmacists on the professional distribution of OTC drugs. Consciousness had been raised concerning the need to fulfill a professional responsibility by providing professional input in the sale of OTC drugs. Alternate means of distinguishing the professional area of a pharmacy from non-professional areas were discussed. The Professional Relations Committee suggested, at the 1971 annual meeting, that the OTC area be marked with signs that created a separate area with the drugstore.¹⁹⁵ This method was eventually adopted and required unique signs that distinctly delineated the professional area. All OTC drugs had to be kept within this area, which could extend no further than twenty-four feet from the dispensary, in order that they could be under the direct supervision of a pharmacist.

Despite being unable to remove OTC drugs from public access, pharmacists continued to act on other recommendations that could further their efforts to claim

¹⁹⁴ UBC-SM-CPBC, Box 27-1, BCPhA Council meeting, October, 1968, 10.

¹⁹⁵ UBC-SM-CPBC, Box 23-39, Professional Relations Committee Report, BCPhA Annual Meeting, June 1971, 27.

legitimacy as drug information consultants. A committee investigating Non-professional Assistants (NPA) was appointed by council, in March 1968, and syndicate discussions were organized at that year's annual meeting. By October 1968, the committee produced a comprehensive manual, which detailed those duties which must be performed by the pharmacist and those which could be performed by Non-professional Assistants. The committee noted that although the use of NPA's would improve the utilization of pharmacist manpower by freeing them from technical activities, it would also provide them more time for public and interprofessional consultation. This would have the added benefit of "enhancing his status with the public and other health professions."¹⁹⁶ When patients entered the professional area of a pharmacy they would encounter pharmacists who performed professional duties and Non-Professional Assistants for technical duties. This would mimic the physician's office where the physician was assisted by a non-professional who made appointments and managed files. The manual that was produced by this committee was of interest to the CPhA who noted that "the B.C. manual [would] be used as a basis for study of the subject by the CPhA and constituent bodies."¹⁹⁷

In order for pharmacists to be fully recognized as drug information consultants, the Commission had recommended that their educational requirements be updated, both at the University and through continuing education. The Faculty had presented a brief to the Commission that showed their willingness to re-evaluate the curriculum provided by UBC. The Commission noted that "the Faculty recognizes that the present organization of the curriculum leaves much to be desired and are presently in the process of ... [a]

¹⁹⁶ UBC-SM-CPBC, Box 27-1, BCPhA Special Committee on Non-Professional Assistants, October 1968..

¹⁹⁷ UBC-SM-CPBC, Box 1-13, CPhA Delegates Report, August 1969, 9.

revision of the course of studies."¹⁹⁸ The Pharmacy Act gave the Association responsibility for education; prior to the founding of the Faculty of Pharmacy at UBC, the Association was directly involved in the education and examination of pharmacists.¹⁹⁹ The Association proposed to the Dean that a Joint Advisory Committee be formed with representatives from practicing pharmacists, as well as the Faculty. This proposal was agreed to by both sides and the Joint Advisory Committee on Curriculum was appointed, in January 1968. The Faculty made changes to the curriculum to incorporate a clinical program for fourth year students, to be implemented in September 1968. The Faculty also decreased, by fifty percent, instructional time devoted to pharmacognosy.²⁰⁰ It was replaced by a one hundred percent increase in pharmacology, as well as the addition of anatomy and pathology. The curriculum now included basic science in first year, basic medical science in second year, pharmaceutical science in third year and clinical pharmacy in fourth year. The Dean believed that new graduates would have sophisticated knowledge in biology, chemistry, biochemistry, microbiology, physiology, anatomy, pathology and pharmacology to the "point where he is oriented to the patient in the diseased state." This, he stated, will allow pharmacists to "play its part effectively in two areas – drug distribution and in drug information both to the patient and to the physician."²⁰¹

Continuing Education was transferred from the Association to the Faculty. After the adoption of the Commission's report, in-depth continuing education courses were offered in hospital pharmacy, medicinal chemistry, general pharmacy and pharmacology;

¹⁹⁸ UBC-SM-CPBC, Box 12A-10, PPC Report, 81.

¹⁹⁹ UBC-SM-CPBC, Box 2-5, British Columbia Pharmacy Act 1925, 5(1) (a), 3.

²⁰⁰ Pharmacognosy is the study of medicines derived from natural sources.

²⁰¹ UBC-SM-CPBC, Box 27-1, BCPhA Council Minutes, October 1968, 48-53. The Dean also noted that the increase in emphasis on medical and pharmaceutical science necessitated a reduction in students receiving a broader education, a result that he regretted.

each being two or three day courses. Future plans included education in clinically oriented subjects such as unit dose systems and family record plans.²⁰² Pharmacists in British Columbia had made the first steps needed to create a new professional core competency as drug information experts. Pharmacists had accepted the necessity to separate professional areas from non-professional areas within the pharmacy. This was an essential precursor to making themselves available to the public; facilitating effective and consistent counselling of OTC medications. The use of Non-Professional Assistants would reduce technical tasks and increase available time for professional services. Cooperation between the Association and the Faculty had resulted in rapid changes to the university curriculum and these changes would allow pharmacists to be more clinically educated and integrated with other health practitioners. Acting as drug consultants for physicians would require credibility and that would take time. Nonetheless, pharmacists had taken the first steps that were necessary. Counselling patients on prescription medications would also take time, as several obstacles still stood in their way.

Pharmacists' professional activities had been restricted by the ethical prohibition on disclosing or discussing therapeutic and composition information since the 1920s. British Columbia pharmacists realized that this prohibition could no longer be supported, if the profession was to advance. In June 1967, the Professional Relations Committee issued a "strong recommendation" at the Association's annual meeting that their committee or a special committee be instructed to draw up a new, modern code of ethics.²⁰³ The Professional Relations Committee reported, to the 1968 annual meeting, that the Society was also working on a Code of Ethics. Subsequently, a Joint

²⁰² See sample in Appendix D.

²⁰³ UBC-SM-CPBC, Box 23-38, Report of Professional Relations Committee, Pharmaceutical Association of the Province of British Columbia Annual Meeting and Convention June 1967, 39-40.

Association-Society Committee was appointed to prepare a study and evolve a single Code of Ethics for the two organizations. The Joint Committee presented a draft Code of Ethics to council in October 1968 and recommended that it be distributed to all members for acceptance. They suggested that 75% approval would indicate acceptance by the membership.²⁰⁴ John Moran reported to council, in March 1969, that 600 replies had been received of which the vast majority expressed approval (see Appendix G).²⁰⁵ This code had been achieved by a democratic consensus amongst its membership.

Whereas the Code of Ethics adopted in 1923 was detailed, in the code adopted in 1969 specifics were conspicuously absent. The new code made no mention of therapeutics, symptoms or composition. Instead, those clauses were replaced by the pledge to “provide the highest level of patient care possible by the use of my skill, and judgment and by co-operation with other members of the health sciences.”²⁰⁶ This opened the door for pharmacists to access their knowledge to counsel patients, if they believed it would provide benefits for the patient. Whereas, the 1923 code would only allow pharmacists to disclose as much information as allowed by the physician, this code put the judgment in the hands of the pharmacist. In 1923, the power had been in the hands of the physician and in 1969, the decision rested with the pharmacist, thus both codes were paternalistic. Patients were still not in control of information concerning their treatments. Pharmacists pledged co-operation with fellow health practitioners, however, so before they could start providing information to prescription patients, they would have to come to an agreement with physicians.

²⁰⁴ UBC-SM-CPBC, Box 27-1, Report the Joint Association-Society Code of Ethics Committee, BCPhA council meeting October 1968, 39-40.

²⁰⁵ UBC-SM-CPBC, Box 27-2, Joint Association-Society Code of Ethics Committee, BCPhA Council Meetings March 1969, 64.

²⁰⁶ See Appendix G..

In 1971, British Columbia pharmacists amended their by-laws to allow pharmacists the right to provide therapeutic information to patients, but not therapeutic or medical advice. The committee argued that the use of Family Record Cards and “an increasing number of questions from the public” meant that pharmacists “must give therapeutic information.”²⁰⁷ At the same time pharmacists were invited to attend the pharmacy committee of the British Columbia Medical Association (BCMA) to discuss the labelling of prescriptions with its composition. The BCMA declined to agree to changes at that time, therefore labelling remained at the discretion of the prescriber, for the time being. By July 1972, after several discussions and acknowledgment of “pros and cons in both directions”, the pharmacy committee reversed themselves. Consequently, the BCMA supported legislation that would require pharmacists to label all prescriptions unless specifically requested not to do so by the physician.²⁰⁸ The path was now clear for pharmacists to provide drug information to patients about their prescriptions; all legal and ethical obstacles had been removed. Pharmacists could now claim to be drug information experts for both OTC and prescription drugs.

The second area of priority for pharmacists was the formation of a new pharmacy organization, with a mandate to protect the interests of pharmacists. Pharmacists Bedford Bates and Donald Hoffman were charged with overseeing the inauguration of the British Columbia Professional Pharmacists Society (BCPPS).²⁰⁹ As recommended by the Commission financing would be voluntary, not mandatory as suggested by the Study Committee. The Society was given jurisdiction over recommendations that concerned

²⁰⁷ UBC-SM-CPBC, Box 23-39, Professional Relations Committee Report, BCPhA Annual Meeting, June 1971, 28. See Appendix D for an example of a Family Record Card.

²⁰⁸ UBC-SM-CPBC, Box 13-4, BCMA New-Views-Reports July 1972.

²⁰⁹ Bedford Bates was co-owner of McGill & Orme Prescriptions along with Ron Stocks. Ron Stocks had purchased his shares from William McGill in 1955. Stocks was one of the original members of the SVIPA who had pushed the BCPhA to form the Pharmacy Planning Commission.

mainly economic matters such as separate accounting for dispensaries, improved administration instruction, salary and working conditions and negotiations with government and suppliers. The Commission had also recommended that the Association restrict its activities to the requirements of the Pharmacy Act, when the Society was functional.²¹⁰ At the time of the inaugural meeting of the Society, on June 12, 1968, over fifty percent of British Columbia pharmacists had joined the new organization.²¹¹ An Association-Society liaison committee was formed to ensure effective communication between the two groups. Special committees were formed immediately to develop a Code of Ethics and to negotiate with the government on welfare prescriptions.²¹² Payments for welfare prescriptions were hotly contested in 1968. The Association's failure to find a satisfactory resolution was an important factor in the Study Committee's call for a second pharmacy organization.

Pharmacists had been in a running battle with the provincial government over the reimbursement of Welfare prescriptions. The Association had been unable to update the pricing agreement with the province that had been in effect since 1954. One of the issues was that the province would not accept a pricing policy that included fee for service. Even more worrying was the two tiered pricing method employed by manufacturers; prices to community pharmacies was substantially higher than those to government funded organizations such as hospitals. The provincial government had been directing physicians to send expensive prescriptions to the Provincial Dispensaries. Pharmacists were concerned that this trend would increase and jeopardize their ability to make their living filling prescriptions. In June 1967, the council tabled a proposal at the annual

²¹⁰ Recommendations Five, Eight, Nine, Ten, Twenty, Twenty-five, Thirty-Two and Thirty-Four, Appendix F.

²¹¹ UBC-SM-CPBC, Box 27-1, Registrar Report, D. Denholm, BCPhA Annual Meeting, June 1968, 38.

²¹² UBC-SM-CPBC, Box 27-1, Association-Society Liaison, BCPhA Annual Meeting, June 1968, 74-75.

meeting to call the provincial government's bluff and threaten to discontinue prescription service to Welfare patients. When this was put to a vote, it was defeated seventeen to fifteen. Pharmacists feared that this might backfire and encourage the government to increase the use of Provincial Dispensaries. Additionally, some felt that refusing service to a specific group would not be good for pharmacists' public reputation. As one pharmacist stated, "we have had enough trouble in the past with our relationship with the public." As an alternative, Stan Fyfe from the Study Committee moved that the matter be referred to the inaugural committee of the Society and in the mean time council should continue negotiations. This motion passed by a majority of nineteen to zero.²¹³ Turning this issue over to the Society, even before it was officially formed, showed the confidence the members had in the new organization and also the type of issues they wanted it to handle.²¹⁴

The Welfare prescription issue also highlights an important reason why the Pharmacy Planning Commission had successfully instigated so many substantive changes, while other attempts had failed. Credit should be given to the individuals that participated in the Commission and its implementation. There were clearly many strong willed characters who promoted changes throughout these years. But strong individuals cannot account for the extent of the changes seen at this time. The pharmacists involved were not new to the profession; they had been involved in British Columbia pharmacy for many years. The Welfare prescription issue defined the fears of pharmacists that their profession might disappear or be reduced to a technical function. Registrar Denholm had

²¹³ UBC-SM-CPBC, Box 23-38, Annual Meeting Minutes, BCPhA Annual Meeting, June 1967, 194-5.

²¹⁴ Ironically, the issue of Welfare prescriptions was the first major challenge that the Society dealt with when it formed. Their solution was to level a \$1.00 surcharge on all welfare prescriptions. They were sued by the federal government for price fixing since they had advocated that all pharmacies participate. They fought the lawsuit unsuccessfully and were levied a \$10,000 fine, a substantial amount in the late 1960s.

put the blame on the profession by suggesting that pharmacists had not kept “pace with society in its rapidly increasing degree of sophistication.”²¹⁵ Dean MacPhee put the onus on pharmacists to take charge of their profession. Fear is a great motivator and pharmacists were worried enough about their future to overcome any disagreement over tactics to find effective ways to recreate their profession. While the accomplishment was driven by the force of a few key individuals, the degree of success was only possible with the collective acceptance of change by the majority of the profession. Achieving public acceptance as drug information experts could only be possible if practicing pharmacists actively made themselves available to the public for consultation on OTC drugs. The result was an increase in their scope of practice through the addition of a core competency as drug information experts. The long term effect was increased professional respect, with the public and other health professionals.

²¹⁵ UBC-SM-CPBC, Box 23-38, Registrar Report, D. Denholm, BCPhA Annual Meeting, June 1967, 84.

Conclusion

The profession of pharmacy has reconstructed their professional role within the Canadian health care system since achieving statutory professional status in the nineteenth century. While health care throughout North America has evolved over that time period, pharmacists have been forced to realign their practices in order to maintain their position as experts on medications. Pharmacists have been able to adapt to changing situations by redefining and expanding their core competencies.

In the late nineteenth century, community pharmacists displayed four competencies; compounding, manufacturing, diagnosing and prescribing. None of these competencies could be considered distinct as each was performed by at least one other group. Pharmacists were recognized in the nineteenth century as legitimate practitioners of all four practices, as shown by the public who accessed their services. Not all competencies were recognized by physicians, who argued that pharmacists did not have the necessary specialized training to diagnose or prescribe (counter prescribing). Pharmacy elites tried to control counter prescribing unsuccessfully, using pharmacy ethics. The public, however, was dependent upon counter prescribing pharmacists for economic and accessibility reasons. Pharmacists were also aided by the public's acceptance of self-medication as a valid treatment option. The public afforded the legitimacy and exhibited the dependency that gave pharmacists the authority to resist opposition. Resistance was important to pharmacists because counter prescribing enhanced their financial stability. Although manufacturing had diminished since the middle of the century, pharmacists were extensively trained to isolate drugs from natural

or chemical sources and that skill remained an important role in their profession.

Compounding physicians' prescriptions made up a financially small but professionally important competency.

These four competencies were crucial to pharmacists' survival in the late nineteenth century and thus formed their core competencies. In combination, they created a capability that extended from manufacturing raw materials to the preparation and distribution of drugs. Pharmacists were able to interact with society through direct relationships with a self-medicating public as well as indirectly through physicians' prescriptions. Health practitioners, in the nineteenth century, operated independently in a rough and tumble era with few regulations on practitioners or their practices. Similarly, each member of the public would choose their health practitioner based on the reputation of the individual. They may choose a physician to treat their medical conditions but might alternatively choose a pharmacist, homeopath or naturopath. Their choice would often be based on the individual reputation of the health practitioner, rather than their medical specialty.

In the early twentieth century, societal attitudes towards medicine shifted and the pharmaceutical manufacturing industry strengthened. Manufacturing at the community pharmacy level faded into insignificance with its resultant loss as a core competency. The backlash against patent medicines and self-medication shifted medical authority toward physicians. Governments were now increasingly regulating medications; opium became the first of many drugs that could only be obtained after consulting a physician and receiving a prescription. As physician authority increased, pharmacist authority waned. Pharmacists had capitalized on the public's self-medication habits but had lost its

legitimacy to diagnose and prescribe when society turned away from self-medication and towards the authority of physicians. Physicians were now increasingly seen as the only legitimate profession that could diagnose and prescribe and the public's dependence on them grew. Pharmacists' loss of three core competencies along with the spectre that modern scientific medicine might eliminate the need for drugs, left pharmacists worried that their profession might not survive. Abraham Flexner's verdict that they were a branch of medicine, not a profession left pharmacists struggling to revitalize their professional with an education that was thirty years out of date and an ethical code that had been ignored for decades. Pharmacists' dynamic capability, its ability to reconfigure to rapidly changing environments, was tested.

Pharmacists used a revised Code of Ethics, adopted from the APhA in the 1920s, to configure pharmacist's professional focus. This code included detailed instructions that covered many activities that pharmacists carried out daily. Pharmacists should refrain from discussing treatments or symptoms with patients and only disclose the composition of a prescription upon the request of the prescribing physician. This ruled out counter prescribing and, along with the loss of manufacturing, left pharmacists with only one remaining core competency, compounding. What remained of a pharmacist's authority was now deeply imbedded in the authority of physicians. The revamping of medical education, early in the century, had resulted in fewer, better educated physicians and this improved their economic opportunities. Although some prescriptions were still being compounded in the physician's office, especially in rural areas, most were now filled by pharmacists. Although reduced to one core competency, that competency could now be considered distinct to the pharmacy profession. As a profession they accepted

ethical restrictions on divulging drug information; acting together to protect their core competency, compounding. Pharmacists' dynamic capability had successfully adapted their competencies to meet changing circumstances.

Like manufacturing previously, compounding disappeared as a core competency after World War II. Pharmacists were now seen by the public as “pourers and counters” and, as noted by Elenbaas and Worthen, overeducated and underutilized. They were now in danger of losing the right to claim any core competencies that could qualify them as professionals. Pharmacists still retained a drug distribution role but that role now seemed more technical than professional and they were saddled with an ethical code that prohibited them from any involvement beyond drug distribution. By the 1960s, some pharmacists were ignoring their ethical code by providing prescription counselling but these were isolated cases. While pharmacists all over North America faced the same challenges, British Columbia pharmacists undertook to remake their profession, in the mid 1960s. The Pharmacy Planning Commission, sparked by pressure from a local pharmacy organization, started the process that allowed pharmacists in British Columbia to incorporate a new core competency as drug information experts.

When the Pharmacy Planning Commission (the Commission) was formed in 1966, pharmacist's authority was at low ebb. Their previous experience with reformulating their profession had required them to adapt to the loss of core competencies. They now sought to add a core competency. This would not be as simple as unilaterally declaring themselves drug information experts; they did not have sufficient authority. Pharmacists saw that there were three avenues they could explore to disseminated drug information. Firstly, they could act as drug consultants to physicians.

The Commission found, however, that physicians did not believe that pharmacists could exercise legitimacy as drug consultants, primarily because of deficiencies in their education. Secondly, pharmacists could counsel their patients about their prescription medications. Unfortunately, pharmacy ethics still prohibited pharmacists from discussing prescriptions with their patients and only allowed them to divulge the name of the drug with the physician's consent.²¹⁶ Pharmacists had a tacit agreement with physicians concerning prescription information and they did not want to unilaterally alter that agreement. Acting as drug experts in both areas was beyond pharmacists' authority in 1966.

Offering OTC drug consultations to the public was the only avenue that pharmacists could access immediately. The Commission believed that the public was looking for help when making OTC medication choices and would welcome a pharmacist's expert opinion, if pharmacists were accessible. This was an opportunity for pharmacists to regain a role in assisting the public to self-medicate that they had lost decades earlier. Society was dependent upon pharmacists through legislation as many OTC medications could only be purchased in a pharmacy. Legislative dependence was in jeopardy, however, because pharmacies were routinely selling these medications with no involvement by pharmacists. By creating a professional area within the pharmacy, pharmacists could add professional dependence to legislative dependence. The alternative might be a severe blow to their professional status; if they failed to retain their monopoly. To protect their monopoly and its legally assigned authority, the Commission specifically recommended that a full time inspector be hired to ensure that non-

²¹⁶ This practice was not changed until 1972.

pharmacies did not sell restricted OTC drugs. Maintaining their monopoly would ensure that OTC drug consultation was a distinct competency. Shifting their education to include clinical programs with direct involvement with patients along with continuing education efforts would add to the legitimacy of their specialized training. Increasing both legitimacy and dependency would allow pharmacists the authority to claim, at least in one area, a core competency as drug information experts.

The limitations of authority can be seen in pharmacists' failure to create the professional area in pharmacies envisioned by the Commission. Pharmacists did not have the authority to arbitrarily remove a freedom enjoyed by the public, in this case access to OTC drugs, unless they could prove that it was in the public's interest. This is one of the key features of professionalism, as noted by Parsons and others; professionals put the public's interests ahead of their own. Even though pharmacists believed that there was potential harm to the public from the misuse of OTC drugs, they could not find specific cases in the literature that showed the public being harmed by them. With evidence lacking, a move to restrict the public's access would be seen as in pharmacists' interest, not the public. Without that authority, pharmacists were forced to back down from their plan. Despite being unable to restrict public access pharmacists did raise awareness, amongst the profession, about the importance of engaging with the public during the sale of OTC medications. Those medications were subsequently concentrated close to the dispensary to facilitate consultation. That shift allowed pharmacists to be seen, by the public, as drug information experts.

The Commission was a groundbreaking event for British Columbia pharmacists and was important to pharmacy for several reasons. Firstly, they tackled issues that were

critical to pharmacists; core competency, education and organizational structure. Secondly, pharmacists in British Columbia were able to effectively act upon the recommendations to make substantive changes to their profession. This stands in contrast to studies, in Canada and the United States, that had failed to trigger the changes that pharmacists required. Thirdly, the Commission allowed British Columbia to set professional standards that other jurisdictions sought to emulate. Executive director of the CPhA John Turnbull foreshadowed the Commission's importance, at the Association's annual meeting in 1966, when he told delegates that they should "bear in mind that the rest of Canada was watching us very carefully."²¹⁷

British Columbia's Commission pre-dated commissions that followed similar patterns in the United States and Canada. John S. Millis was chancellor emeritus of Case Western Reserve University with a background in physics and mathematics; he had no pharmacy experience. He led the Millis Commission on Pharmacy in the United States whose mandate was to "determine the scope of pharmacy services in health care and project the educational processes necessary to insure that these services are obtained."²¹⁸ Their report, released in December 1975, found that pharmacy education should include contact with other healthcare professionals, at the bedside of the patient, not isolated behind the prescription counter. This would integrate pharmacists into the healthcare team, and allow them to use their knowledge to ensure appropriate medication use by patients; clinical pharmacy would be the primary focus.²¹⁹ Elenbaas and Worthen argue that clinical pharmacy went through a period of implementation and evaluation in the 1980s and 1990s, culminating in the emergence of pharmaceutical care, "a covenantal

²¹⁷ UBC-SM-CPBC, Box 23-38, Syndicate Discussion #2, BCPhA Annual Meeting, June 1966, 186-7.

²¹⁸ Sonnedecker, *History of Pharmacy*, 254.

²¹⁹ Elenbaas and Worthen, "Transformation of a Profession," 156-7.

relationship between a patient and a pharmacist in which the pharmacist performs drug use control functions (with appropriate knowledge and skill) ... to the patient's interest.”²²⁰

In Canada, the CPhA embarked on a study similar to the Millis Commission with the formation of the Commission on Pharmaceutical Services, in 1967. Their mandate was broadly similar to the Millis Commission and British Columbia's Commission. They were asked to explore the occupational, organizational and economic aspects of pharmacy as well as recruitment and educational requirements. The chairman was Dr John B. MacDonald, Professor in the Faculty of Dentistry and Past President of U.B.C., along with prominent pharmacists from across Canada. The CPhA was aware of British Columbia's Commission, and its significance, having remarked that it was a “first” for B.C. pharmacists in their journal the previous year.²²¹ As noted earlier, CPhA Executive director John Turnbull had told pharmacists when the Commission was formed that all Canada was watching them. Their report was released in June 1971, with ninety-seven recommendations that were as broad as their terms of reference. A major section of their report dealt with the occupational role of the pharmacist. The use of non-professional assistants was recommended; the CPhA would provide individual provinces with training and occupational guidelines. The importance of patient contact and the monitoring of medications through the use of patient medication records were emphasized. Many of their suggestions were later imbedded in the concept of pharmaceutical care.²²²

Examination of British Columbia's current Code of Ethics shows the shift in focus

²²⁰ Elenbaas and Worthen, “Transformation of a Profession,” 165.

²²¹ *Canadian Pharmaceutical Journal* Vol 99 No 8 (August 1966), 285.

²²² Bachynsky, “Pharmacy in a New Age,” 29.

toward patients.²²³ It is significant that British Columbia's Commission was able to achieve similar results in advance of both national efforts.

It is possible to identify a number of innovations emanating from the Commission that influenced pharmacy in the rest of Canada. The SVIPA original goal of a second pharmacy organization (the Society) came at a time when pharmacist advocate organizations did not exist in Canada. Previously, each province had one licensing body to enforce their Pharmacy Act and to handle issues that affected the interests of pharmacists, such as economics. This created an obvious conflict of interest and the development in British Columbia of one organization to look after the interests of the public and another to look after the interests of pharmacists was critical. Ontario was also developing an organization, the Ontario Pharmacists Association, at the same time while other provinces followed suit over the succeeding decades. In August 1969, the Society's employment code was directed by the CPhA to pharmacy organizations across Canada for their study. Following the Commission's recommendation that Non-Professional Assistants (NPA) be used to allow pharmacists to restrict their efforts to professional duties, British Columbia developed a comprehensive manual detailing the duties that a pharmacist must perform and those that a NPA could perform. In August 1969, this manual was recommended by the CPhA for use as a basis for study by the provinces and the CPhA. At the same time, the Code of Ethics developed in the aftermath of the Commission, was recommended by the CPhA for adoption by the provinces. Pharmacists were now able to break away from the constraining ethical code that prevented them from seeking legitimacy as drug information experts. Although still

²²³ See Appendix G for British Columbia's 2009 Code of Ethics.

paternalistic, it set the stage for a truly fiduciary code to follow in the 1990s; one that put patients at the front rather than health professionals. On the development of practical university based clinical training and continuing education for practicing pharmacists, it was noted that “B.C. stands well in the forefront of developments in both fields.”²²⁴

Progress in the adoption of Fee for Service pricing, the Fuller Method, was aided by the endorsement of the committee. The number of pharmacies using the method increased from 69.5% in September 1967 to 85% in January 1968.²²⁵ This answered a key question that had hampered pharmacists’ claim as full professionals: charging for a service rather than selling a product.

Pharmacists in British Columbia have recognized the importance to the work that was done by the individuals involved in the Pharmacy Planning Commission and its aftermath. Commission members John Dyck and Trevor Watson were made honorary members for life of the British Columbia Professional Pharmacists Society as were Donald Hoffman, entrusted by the Commission to implement the Society and Peter Bell, the Society’s first executive director. They make up four of the sixteen pharmacists with this honour. The Society has honoured the final member of the Commission by creating the Murray Dykeman Mentorship Award. They have also created the Ben Gant Innovative Practice Award to honour the Association councillor who was active in the creation and implementation of the Commission.

The Pharmacy Planning Commission produced practical recommendations that British Columbia pharmacists implemented resulting in improved profession status. The Commission used the same format that would be followed later at the national level in

²²⁴ UBC-SM-CPBC, Box 1-31, CPhA Delegate Report, August 1969, 9 & 13.

²²⁵ UBC-SM-CPBC, Box 27-1, Economic Committee Report, Pharmaceutical Association of the Province of British Columbia Annual Meeting and Convention June 1968, 13.

both Canada and the United States. All three commissions used a non-pharmacist academic as their chairman with practicing pharmacists as members and all consulted pharmacists, government, academics and the public in their deliberations. British Columbia accomplished their commission in 1967; the CPhA would not release their report until 1971 and the Millis Commission in 1975. This put British Columbia at the forefront in taking effective action that would allow their profession to advance over the following decades. The actions they proposed started pharmacists on the path to a new core competency, as drug information experts, in the only area they could control at the time, OTC drugs. As the recommended educational curriculum improved to include clinical programs, pharmacists were able to integrate themselves fully into the health care team. This allowed them the legitimacy to increase their influence to counselling on patient prescriptions. Pharmacists who had once been ethically prohibited from counselling on prescriptions eventually became legally required to counsel on all prescriptions. By the 1990s, pharmaceutical care had become mainstream professional practice. As physicians became more comfortable with the specialized knowledge offered by pharmacists, they were able to accept them as viable drug consultants for their practices. Pharmacists now had the clinical education, integrated with patients and other health professionals, which could command physicians' respect. For most of the twentieth century, pharmacists were unable to divulge drug information to the public. The Pharmacy Planning Commission helped British Columbia pharmacists reconstruct their profession to allow the addition of drug information expert as one of their core competencies and enhance its professional image. This thesis has followed the path that

transformed pharmacy from a profession with legal status but lacking other professional characteristics to recognition as a full profession.

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McGill & Orme Prescription Records, currently held by Steve Dove at 861 Richmond Avenue, Victoria, B.C. These contain business records, newspaper clippings, photographs, prescription files from 1931, 1941 and 1947, and historical notes prepared by William McGill.

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Appendix A²²⁶

TELEPHONE
GARDEN 1196

McGill & Orme
LIMITED
PRESCRIPTION CHEMISTS

FORT ST. AT BROAD
VICTORIA, Canada

Seventh - September - 1935.

We beg to announce that we are now ON THE CORNER--NEXT DOOR to our former location. We cordially invite you to visit us and inspect the new shop.

For your convenience we have set apart a room for physicians use only. There you will find on file the recent literature on all pharmaceutical specialties as well as a reference library and telephone. It is our desire that you will find this a real convenience and that you make free use of this room at all times.

May we tender our sincere thanks to you for your encouragement and support during the past 5 years. This has made possible the measure of success that has been ours.

To have become established as indicated by this expansion suggests that we have built on a sound basis - that our standard of professional principles works to the mutual advantage of both patient and physician.

We should like to remind you of our original statement of ethics as first propounded five years ago. They still apply:

1. No other consideration than excellence in pharmaceuticals used.
2. No discussion with the patient as to symptoms or treatment, believing that such belongs in the sphere of the physician only.
3. The discouraging of the use of secret or quack nostrums. Advising patients who enquire about such to consult their physician.
4. To keep informed on current advance and change in things pharmaceutical.

May we emphasize the fact that we will continue to limit our institution to the dispensing of physicians prescriptions and associated supplies.

Yours very truly,

CHEMICALS.....
SURGICAL INSTRUMENTS

McGILL & ORME, LTD.

²²⁶ McGill & Orme Archives, Letters.

Appendix B²²⁷

These labels (with the exception 1933 and 1948) were saved because they had humorous errors in their directions not because they were missing composition details. Note that in most cases there was not enough room on the label to add drug names. Patient's last

names have been removed for privacy reasons.



²²⁷ McGill & Orme Archives, Labels.

Appendix C²²⁸

Prescription Survey

In February 2010, I examined two files of prescription filled at McGill & Orme Prescriptions in Victoria. One set included 978 prescriptions filled between March 23 and July 28, 1931 and the second included 975 prescriptions filled between February 26 and March 6, 1947. These prescription files are from my private collection. My survey sorted and counted the prescriptions in the following categories;

	<u>1931</u>	<u>1947</u>
1. Total prescriptions surveyed	978	975
2. Total Compounded Prescriptions	588	250
3. Prescriptions filled with commercially manufactured products. -	390	725
4. Prescriptions containing morphine -	49	12
5. Prescriptions containing opium -	14	10
6. Prescriptions containing heroin -	1	6
7. Prescriptions containing cocaine -	8	2
8. Prescriptions with ingredients that required a physician's order	72	340
9. Prescriptions filled per day	7.64	108

Discussion

Category Two

Category two contains prescriptions compounded with one to nine ingredients. Prescriptions with one ingredient included items such as Tincture of Opium, which may have been purchased from a manufacturer or compounded locally. Since McGill & Orme were still locally compounding products that were available commercially in the 1970s, I believe that most of these products would have been compounded locally.

Category Three

Category three contains prescriptions for commercially manufactured products. In 1931 they were mainly either manufactured tablets, capsules or hypodermic tablets (Luminal tablets) or patent medicines (Lavoris). McGill & Orme compounded tablets and capsules in 1931 but they were counted in this category if the manufacturer was recorded on the prescription or if it was a standard manufactured dose. Compounded tablets and capsules with two or more ingredients were included in category one. In 1947, manufactured products came in more dosage forms including tablets, capsules, topical creams, ophthalmic ointments, vaginal creams, injectables and nasal mists.

Category Eight

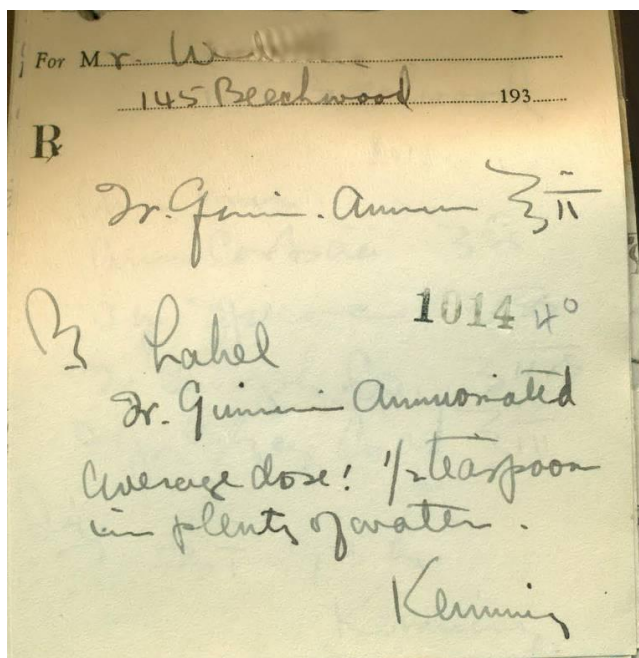
Category eight includes prescriptions that could only be dispensed on a physician's order. In 1931, that only included prescriptions for morphine, heroin, opium and cocaine. In 1947, that list included morphine, heroin, opium, cocaine plus aminopyrine, amphetamine, aureomycin, barbituric acid, cinchophen, neochinchophen,

²²⁸ McGill & Orme Archives, 1931 and 1947 prescription files.

desoxyephedrine, methedrine, ortho-dinitrophenol, penicillin, pervertin, phenytoin, streptomycin, sulphonamides, tetraethylthiuram, thiouracil, thyroid, thyroxin and urethane.

Miscellaneous Information

1. The physician instruction "label" was found on only one prescription in 1931 (Rx1014) and one prescription in 1947 (250823). This notation instructed the pharmacist to include the composition of the physician's order on the patient's prescription label.
2. In 1931, physicians sometimes included designations in the directions that would identify the prescription without listed the ingredients. Examples include: Rx 1377 – THE TABS One tablet three times daily before meals
Rx 1126 – THE DROPS As directed
3. Physicians would occasionally add "clinical therms" to the prescription such as Rx1843 - "Keep in mouth for full two minutes." These instruct the pharmacists to pass this information on to patients. Unless requested, pharmacists were not supposed to give any additional instructions to the patient.
4. The following drugs in the 1931 prescription file would not be prescribed in 2010. Calomel (Mercurous Chloride), Strychnine, Arsenic and Cannabis. Synthetic cannabis (nabilone) is used in 2010 to treat nausea resulting from cancer chemotherapy.
5. Four homeopathy prescriptions were filled in 1947.
6. Antibiotic prescriptions accounted for 130 out of 975 prescriptions in 1947.



Appendix D²²⁹

#32 FAMILY RECORD CHART FOR PRESCRIPTIONS — MCGILL & ORME LTD.

SURNAME: [REDACTED] CHILDREN'S NAMES: Rx 614848 96gr Pot Iodide
 HUSBAND'S NAME: [REDACTED] 96gr Ammon Carb (6.24)
 WIFE'S NAME: MRS. A. 320gr Pt, Bicarb + 16 gr
 ADDRESS: 2063 Westbrook Dr (Sidney V. 4K8) Agree 9 S. + 80 ml.
 TELEPHONE: 656-5110 PHYSICIAN: E. R. HIGGS 592-2451
 chg P 27013 H. P. Marshall
 CHARGE INSTRUCTIONS: MUST HAVE TYLENOL #3 Rx 5 7526.5

DATE	NUMBER	PRICE	FOR	DR.	REP.	Ph.C.	R
Jan 5.81	152506		Mrs	ERH	X		Adeflor prenatal tabs 100 i dd
"	2404784		Mrs	ERH	X		Deltasone 5mg 1100 utd
13/1/81	2750	703	569 Mrs	ERH			Entair 1x Caps 100x i prn.
"	3159419	672	Mrs	ERH			Saline Soln 2000 mls utd.
2-2-81	2750703	569	Mrs	ERH			Entair M; 100 S: i prn
"	4098085	141	"	"			Erythromid 250mg M: 30 S: i qid
"	2519218	1806	"	"			Alupent Sol M: 45 S: 5m used in bird respiratory prn
"	4972940	38	Mr	HPM			Eltroxin 50mcg M: 30
6-2-81	5095152	3 09*	Mrs.	ERH			Fiorinal Tablets M: 50
"	2404784	1 04*	"	"			Deltasone 5mg M: 100 S: utd.
"	5098085	8 81*	"	"			Cotazyl capsules M: 100 S: i tid ac.
2-3-81	2519218	2031	Mrs	ERH			Alupent Sol M: 45 S: 5m used in bird resp.
"	2750703	569	"	"			Entair Cap M: 100 S: i prn
March 2.81	4934424		Miss L. HJL	X			Erythromycin 4% Zinc Acetate 1.2% wsb
Mar 16.81	3159419		Mrs	ERH	X		Saline sol 2000(abb) utd
"	4098083		"	"	"		Erythromid 250mg i qid 30
"	2519218		Mrs	ERH	X		Alupent sol 45liq 5 gtts in bird resp. prn
"	2750703		"	"	"		Entair caps i prn 100
"	4098085		Mrs	"	"		Cotazym caps i tid ac 100

FAMILY RECORD CHART FOR PRESCRIPTIONS — MCGILL & ORME LTD.

SURNAME: [REDACTED] CHILDREN'S NAMES: WATCH!! 2 men living here - father & son
 HUSBAND'S NAME: [REDACTED] R.W. Davidson 00 father
 WIFE'S NAME: [REDACTED] 3020 Lansdowne 595-3111 -02 son
 ADDRESS: [REDACTED]
 TELEPHONE: 592-3571 PHYSICIAN: [REDACTED] R.W. DAVIDSON
 CHARGE INSTRUCTIONS: Pharm. 41553946900 ALLERGIES, ETC. (If Any)

DATE	NUMBER	PRICE	FOR	DR.	REP.	Ph.C.	R
Apr 7.81	4988111		MR	RWD	X		Norpace 100mg i q6hrs 200
30-4-81	5218014	2 02*	Mr.	GWM			Lanoxin 0.25mg M: 100 S: i die.
"	5218018	7 40*	"	"			Diazide tablets M: 100 S: i die.
May 27.81	4988111		"	RWD	X		Norpace 100mg i q6hrs x 200

Appendix E

Pharmacy Planning Commission – Resolution of the 1966 BCPhA Annual Meeting

That: the 1966 Annual Meeting of the Pharmaceutical Association of the Province of British Columbia recommends to council that immediate steps be taken to appoint a Planning Commission by the time of the October 1966 council Meeting. This Commission is to receive briefs from interested individual pharmacists, groups of pharmacists, associations, etc. Such Commission is to consist of all facets of our profession with consultants and advisors. The chairman to be appointed at the discretion of council. Also, that this Planning Commission and the terms of reference be acceptable to all practicing pharmacists through district meetings. Further, that this Commission be instructed to report their findings to a meeting of the council and all interested pharmacists at the time of the March 1967 meeting of council and, further, to include in its deliberations the Report of the Study Group on Pharmacy in British Columbia under the auspices of the South Vancouver Island Pharmacists' Association and the Lower Mainland Pharmacists' Association as submitted to council on Sunday, June 19th, 1966.²³⁰

Pharmacy Planning Commission – Terms of Reference

General

The Commission shall inquire into and report upon all aspects of the practice of pharmacy, the provision of pharmaceutical services to the public and the organizational structure of the profession within the province of British Columbia, making such recommendations as it sees fit respecting the service provided to the public, the status of the pharmacist and the profession's organizational structure.

Specific

Without limiting the generality of the foregoing, the Commission shall inquire into and report upon:

²³⁰ UBC-SM-CPBC, Box 12A-10, PPC Report, i.

- a) The organizational structure of the Association and its functions, both statutory and representative, including a consideration of the need and/or advisability of extending them or establishing other organizations to separate the functions.
- b) The relationship between the “profession” of pharmacy and the “business” of pharmacy (i.e., the professional-commercial balance), including an assessment of the utilization of the pharmacist’s professional services and education.
- c) The economics of providing professional pharmacy services (without reference to the cost of the drug itself).
- d) The relationships between employer and employee pharmacists, including a consideration of remuneration to, and other conditions of employment of, employed pharmacists and registered students.
- e) Manpower sources and requirements, including the recruitment, enrollment and training of pharmacy students and the registration of pharmacists from outside the province.
- f) Communications and relationships between the Council of the Association and pharmacists and pharmacy students.
- g) Communications and relationships between pharmacists and themselves.
- h) The relationships between pharmacists and physicians and other health professionals at the practising, organizational and educational levels.
- i) The relationships between pharmacists, as represented by the Association, and departments of government.
- j) The relationships, current and potential, between pharmacists, as represented by the Association, and insuring agencies providing drugs and pharmaceutical services as benefits in health care plans.

- k) The relationships between pharmacists individually and collectively (the Association) and the pharmaceutical manufacturing and wholesaling industries.²³¹

²³¹ UBC-SM-CPBC, Box 12A-10, PPC Report, ii.

Appendix F

Pharmacy Planning Commission Recommendations

Chapter 4 – Professional and Commercial Services

1. The Commission recommends that all medicinal products that are restricted to sale in a pharmacy be removed from public access and placed with an area under the personal supervision of a licensed pharmacist.
2. If a physical barrier were installed sufficient to prevent all access to a dispensary and restricted OTC area, we recommend that pharmacists be allowed to lock the pharmacy department and leave the balance of the operation open, without the supervision of a pharmacist.
3. We recommend that our Association, through CPhA, urge the Food and Drug Directorate to create effective legislation regarding advertising of drug products.
4. On the question of proliferation in pharmacies, we have concluded that there can be no form of control of the professional-commercial balance by regulatory action.
5. We recommend that all pharmacies institute a separate accounting procedure for the professional department.

Chapter 5 – Pharmacist Utilization and Remuneration

6. We do not find that there is a shortage of pharmacists in the province at the present time, but we recognize that this situation may not continue. We recommend that recruitment activity be intensified, to attract the most capable applicants.
7. It is obvious that there is under-utilization of the competency of the pharmacist and that this is having a detrimental effect on such things as remuneration, and job satisfaction.

8. Employees must develop a full awareness of the administrative problems of an operation, so that a “professional partnership” may develop. The benefits and rewards of such a partnership should be enjoyed by both parties.
9. We have concluded that a starting salary for pharmacists of approximately \$7,200 would be fair. We recommend a salary scale which, over the first six years of practice would result in a basic salary of \$10,000 per annum for employed pharmacists.
10. We recommend the development of a permanent negotiation procedure to be concerned with remuneration and working conditions for all pharmacists.

Chapter 6 – Education

11. We recommend that the Faculty become more aware of the needs of community and hospital practice and re-orient themselves to the importance of these aspects of the practice of Pharmacy.
12. We recommend curriculum revisions in the following area:
 1. A reduction in the emphasis placed on the physical sciences and an increased emphasis toward the biological sciences, to better prepare the student for the changing patterns of patient care.
 2. Drastic changes in the emphasis placed on pharmacognosy.
 3. Development of a program of clinical exposure at the undergraduate level.
13. We recommend development of a program of practical experience for undergraduates which would involve the profession in the training of students.
14. We recommend that the Faculty establish a Department of Pharmacy Administration to better prepare the undergraduate to function in our present retail distribution system.
15. We recommend that the Faculty continue to assist in all programs of recruitment.

16. We recommend immediate attention to be given to the inadequacies of our present Continuing Education program.
17. We recommend that Pharmacy ensure the provision of pharmacy service in all hospitals and related institutions.

Chapter 7 - Pharmacy Organization

18. We recommend that the members of Council involve themselves more in interpreting Council actions to the membership through more attention to their district organizations, and that the President assume a prominent role in directing the affairs of the Association.
19. We recommend improved inspection services to ensure public safety and standards of practice.
20. We recommend that the BCPhA restrict its activities to those which are justified within the confines of the Pharmacy Act.
21. We recommend that the Council of BCPhA give consideration to providing adequate reimbursement of the expenses of the President, and increased remuneration for Councillors.
22. We recommend that there be four Council meetings annually and that they be held in January, March, June and September.
23. We recommend that District 7 be divided as follows:
 1. Burnaby-Richmond-Steveston to elect one councillor
 2. North and West Vancouver, Sechelt and Squamish to elect one councillor.
 3. The City of Vancouver to elect two councillors.
24. We recommend that the By-laws of the Association be amended to declare the Dean of the Faculty of Pharmacy as a member of the Council.

25. We recommend the formation of a Society which would concern itself with the promotion of Pharmacy in the interests of pharmacists. The financing for such an organization must be on a voluntary basis. We have recommended a procedure to assist immediate implementation of this recommendation.

Chapter 8 – Communication

26. We recommend the formation of vigorous local organizations in all areas with the initiative being provided by pharmacists in the individual districts.
27. We recommend a properly conceived and financed attack on our public relations problems.

Chapter 9 – Economic Considerations

28. We recommend that pharmacists pay particular attention to the resolution of CPhA that when dispensing a prescription by its proper name, (we) continue to consider the interests of the patient and use a drug having both high quality and reasonable price and that ... a brand name of a drug product does not necessarily confer reasonable price nor is it the sole guide of quality.
29. We recommend that pharmacy take the initiative in encouraging physicians to adopt generic nomenclature for prescriptions. This would remove a major stumbling block which has restricted pharmacy in its attempt to provide economical prescription service.
30. We recommend that cost plus professional fee be the method used for determining prescription prices.

Chapter 10 – Health Care Plans

31. We conclude that it would be unwise for Pharmacy to attempt to establish its own drug insurance program. We recommend that Pharmacy support the development by other carriers of Extended Health Benefits which include prescription

coverage, and that we maintain liason to ensure the maintenance of equitable arrangements.

Chapter 11 – Governments

32. We recommend that in negotiations with governments involving the economics of the profession there be a greater degree of consultation with and involvement of practicing pharmacists.
33. We recommend that the proposed alterations in the regulations applying to the distribution of veterinary drugs and medicated feeds be implemented, and that the provisions of the Pharmacy Act as they apply to this field be enforced

Chapter 12 – Suppliers

34. We recommend that pharmacists individually and collectively pursue solutions to the problem of the costs of merchandise as they apply at the wholesale and manufacturer's level, with particular attention to the attitudes of certain manufacturers.

Chapter 13 – Legislation and By-laws

35. We recommend certain alterations in the fee structure of the statutory organization.²³²

²³² UBC-SM-CPBC, Box 12A-10, PPC Report, ix-xiii.

Appendix G

Principles of Pharmaceutical Ethics (adopted by APhA August 17, 1922)

(Adopted by CPhA in 1923 as the basis of a Canadian Code of Ethics)

Chapter 1 The Duties of the Pharmacist in Connection with his Services to the Public

Pharmacy has for its primary object the service which it can render to the public in safeguarding the handling, sale, compounding and dispensing of medicinal substances. The practice of pharmacy demands knowledge, skill and integrity on the part of those engaged in it. Pharmacists are required to pass certain educational tests in order to qualify under the laws of our States. The States thus restrict the practice of pharmacy to those persons who by reason of special training and qualifications are able to qualify under regulatory requirements and grant to them privileges necessarily denied to others. In return the States expect the Pharmacist to recognize his responsibility to the community and to fulfill his professional obligations honourably and with due regard for the physical and moral well being of society. The Pharmacist should uphold the approved legal standards of the United States Pharmacopoeia and the National Formulary for articles which are official in either of these works, and should, as far as possible, encourage the use of these official drugs and preparations and discourage the use of objectionable nostrums. He should sell and dispense only drugs of the best quality for medicinal use and for filling prescriptions. He should neither buy, sell nor use substandard drugs for uses which are in any way connected with medicinal purposes. The Pharmacist should be properly remunerated by the public for his knowledge and skill when used in its behalf in compounding prescriptions, and his fee for such professional work should take into account the time consumed and the great responsibility involved as well as the cost of the ingredients. The Pharmacist should not sell or dispense powerful drugs and poisons to persons not properly qualified to administer or use them, and should use every proper precaution to safeguard the public from poisons and from all habit-forming medicines. The Pharmacist, being legally entrusted with the dispensing and sale of narcotic drugs and alcoholic liquors, should merit this responsibility by upholding and conforming to the laws and regulations governing the distribution of these substances. The Pharmacist should seek to enlist and merit the confidence of his patrons and when this confidence is

won it should be jealously guarded and never abused by extortion or misrepresentation or in any other manner. The Pharmacist should consider the knowledge which he gains of the ailments of his patrons and their confidences regarding these matters, as entrusted to his honour, and he should never divulge such facts unless compelled to do so by law. The Pharmacist should hold the health and safety of his patrons to be of first consideration: he should make no attempt to prescribe or treat diseases or strive to sell drugs or remedies of any kind simply for the sake of profit. He should keep his pharmacy clean, neat and sanitary in all its departments and should be well supplied with accurate measuring and weighing devices and other suitable apparatus for the proper performance of his professional duties. It is considered inimical to public welfare for the Pharmacist to have any clandestine arrangement with any Physician in which fees are divided or in which secret prescriptions are concerned. The Pharmacist should primarily be a good citizen, and should uphold and defend the laws of the State and nation. He should inform himself concerning the laws, particularly those relating to food and drug adulteration and sanitation and should always be ready to co-operate with the proper authorities having charge of the enforcement of the laws. The Pharmacist should be willing to join any constructive effort to promote the public welfare and he should regulate his public and private conduct and deeds so as to entitle him to the respect and confidence of the community in which he practices.

Chapter 2 The Duties of the Pharmacist in His Relation to the Physician

The Pharmacist even when urgently requested so to do should always refuse to prescribe or attempt diagnosis. He should, under such circumstances, refer applicants for medical aid to a reputable legally qualified Physician. In cases of extreme emergency as in accident or sudden illness on the street in which persons are brought to him pending the arrival of a Physician such prompt action should be taken to prevent suffering as is dictated by humanitarian impulses and guided by scientific knowledge and common sense. The Pharmacist should not, under any circumstances, substitute one article for another, or one make of an article for another in a prescription without the consent of the Physician who wrote it. No change should be made in a Physician's prescription except such as is essentially warranted by correct pharmaceutical procedure, nor any that will interfere with the obvious intent of the prescriber, as regards therapeutic action. He

should follow the Physician's directions explicitly in the matter refilling prescriptions, copying the formula upon the label or giving a copy of the prescription to the patient. He should not add any extra directions or caution or poison labels without due regard for the wishes of the prescriber, providing the safety of the patient is not jeopardized. Whenever there is doubt as to the interpretation of the Physician's prescription or directions, he should invariably confer with the physician in order to avoid a possible mistake or an unpleasant situation. He should never discuss the therapeutics effect of a Physician's prescription with a patron nor disclose details of composition which the Physician has withheld, suggesting to the patient that such details can be properly discussed with the prescriber only. Where an obvious error or omission in a prescription is detected by the Pharmacist, he should protect the interests of his patron and also the reputation of the Physician by conferring confidentially upon the subject, using the utmost caution and delicacy in handling such an important matter.

Chapter 3 The Duties of Pharmacists to Each Other and to the Profession at Large

The Pharmacist should strive to perfect and enlarge his professional knowledge. He should contribute his share toward the scientific progress of his profession and encourage and participate in research, investigation and study. He should associate himself with pharmaceutical organizations whose aims are compatible with this code of ethics and to whose memberships he may be eligible. He should contribute his share of time, energy and expense to carry on the work of these organizations and promote their welfare. He should keep himself informed upon professional matters by reading current pharmaceutical and medical literature. He should perform no act, nor should he be a party to any transaction which will bring discredit to himself or to his profession or in any way bring criticism upon it, nor should he unwarrantedly criticise a fellow Pharmacist or do anything to diminish the trust reposed in the practitioners of pharmacy. The Pharmacist should expose any corrupt or dishonest conduct of any member of his profession which comes to his certain knowledge, through those accredited processes provided by the civil laws or the rules and regulations of pharmaceutical organizations, and he should aid in driving the unworthy out of the calling. He should not accept agencies nor objectionable nostrums nor allow his name to be used in connection with advertisements or correspondence for furthering their sale. He should courteously aid a fellow Pharmacist

who may request advice or professional information, or who in an emergency, needs supplies. He should not aid any person to evade legal requirements regarding character, time or practical experience by carelessly or improperly endorsing or approving statements relating thereto. He should not imitate the labels of his competitors nor take any other unfair advantage of merited professional or commercial success. When a bottle or package of a medicine is brought to him to be refilled, he should remove all other labels and place his own thereon unless the patron requests otherwise. He should not fill orders which come to him by mistake, being originally intended for a competitor. He should deal fairly with manufacturers and wholesale druggist from whom he purchases his supplies; all goods received in error or excess and all undercharges should be as promptly reported as are shortages and overcharges. He should earnestly strive to follow all proper trade regulations and rules, promptly meet all obligations and closely adhere to all contracts and agreements.²³³

The Code of Ethics of Pharmacists in British Columbia

(drafted by Joint Association-Society Code of Ethics Committee: adopted March 1969)

I, Pharmacist Name

Do hereby promise to accept those responsibilities vested in me as a Pharmacist in the pursuit of fulfillment of the health needs of my community.

That I will place above all other considerations, my regard and concern to provide the highest level of patient care possible by the use of my skill, and judgment and by co-operation with other members of the health sciences.

That I will strive to attain the highest degree of personal quality, attitude and objectivity, all of which will result from constant vigilance in practicing my profession with dignity.

That I will participate in programs of continued study throughout my professional life, in order to keep abreast of new advances in pharmaceutical practice and technique and in order to maintain a high level of competence in working with other health practitioners.

²³³ "Principles of Pharmaceutical Ethics," *Canadian Pharmaceutical Journal*, Vol LVII No. 2 (Sep 1923): 18 & 24.

That I will seek to be regarded by the public, my colleagues, members of the other health professions and my business associates as a law-abiding citizen, evidenced by compliance and performance.

That I will actively support to the best of my ability, organizations engaged in the provision of high standards of pharmaceutical service and professional behaviour, thereby contributing to the advance of the public health.

Signed by Pharmacist²³⁴

Schedule A – Code of Ethics Adopted 2009

All pharmacists practicing in British Columbia are governed by a Code of Ethics. By entering the profession of pharmacy, every pharmacist commits to moral norms of conduct. We assume a professional commitment to the health and well-being of every one of our patients.

Value 1

Pharmacists respect the professional relationship with the patient and acts with honesty, integrity and compassion.

Value 2

Pharmacists honour the individual needs, values and dignity of the patient.

Value 3

Pharmacists support the right of the patient to make personal choices about pharmacy care.

Value 4

Pharmacists provide competent care to the patient and actively supports the patient's right to receive competent and ethical care.

Value 5

Pharmacists protect the patient's right of confidentiality.

Value 6

Pharmacists respect the values and abilities of colleagues and other health professionals.

²³⁴ UBC-SM-CPBC, Box 27-1, Report the Joint Association-Society Code of Ethics Committee, BCPhA council meeting October 1968, 39-40.

Value 7

Pharmacists endeavour to ensure that the practice environment contributes to safe and effective pharmacy care.

Value 8

Pharmacists ensure continuity of care in the event of job action, pharmacy closure or conflict with moral beliefs.²³⁵

²³⁵ College of Pharmacists of British Columbia, “Code of Ethics”, <http://www.bcpharmacists.org/library/D-Legislation_Standards/D-2_Provincial_Legislation/5087-HPA_Bylaws_Code_of_Ethics.pdf> (June 21, 2010).