DISPENSING DOCTORS AND PRESCRIBING PHARMACISTS: A SOUTH AFRICAN PERSPECTIVE

LEAH GILBERT

Department of Sociology, University of Witwatersrand, Johannesburg, Private Bag 3, Wits 2050, South Africa

Abstract—Adopting an historical and international perspective, this article explores and analyses the relationship and controversy between pharmacists and dispensing doctors in South Africa. In order to gain a better insight into this troublesome relationship, a combination of qualitative and quantitative methods has been employed. The findings reveal a deep ongoing sense of competition, which is manifest in the form of public debate and continuous attempts to protect professional task domains. Most of the pharmacists interviewed in this study mentioned the "dispensing doctor" as the main problem facing the community pharmacist in South Africa. Meanwhile, the medical profession, as a united front, is fiercely protecting its "inherent" right to dispense medicines. Using the South African scenario, issues such as occupational task boundaries, "business" versus "professional" systems as well as the role of the state are discussed in relation to professional dominance, jurisdiction and autonomy.

Key words—dispensing doctors, community pharmacists, South Africa, professional dominance, occupational boundaries

INTRODUCTION

From the beginnings of history, pharmacy and medicine have been inextricably intertwined. They were, in all practicality, one and the same profession. It was only as scientific knowledge increased that the tasks allotted to each began to diverge, and so it became logical to separate medicine and pharmacy into two independent professions (Angorn and Thomison, 1989). It was in 19th century Britain that organised pharmacy, as we know it, evolved into a distinct profession. The rationale for the separation of the prescribing and dispensing functions was both to avoid conflict of interest on the doctor's part who had the potential to profit from the prescription and sale of drugs, and to keep a system of checks by the pharmacist. Nevertheless, despite the division, physician dispensing paralleled the practice of British apothecaries and competed directly with that of pharmacists. The pharmacists, in turn, responded to the competition from dispensing physicians and vendors of patent medicines by engaging in general merchandising (Angorn and Thomison, 1989). Eaton and Webb argue that despite their recognition "pharmacists never achieved a monopoly over the one area of work—dispensing, which could be said to be a truly pharmaceutical activity" (1979, p. 73).

Pharmacists in South Africa are faced with a similar reality, which has serious implications for the definition of their professional boundaries, their relationship with patients and other health professionals, as well as the image and future development of pharmacy. Despite the magnitude of the problem and the increasing numbers of dispensing doctors, there is very little research on this issue in South Africa. The only studies available deal with the associated clinical aspects (Truter et al., 1995). The nature of the conflict between community pharmacists and the dispensing doctors, had been identified as a topic that should be addressed in future research (Gilbert, 1995a). This is of particular importance at this time, when policy debates, followed by attempts at transformation of the health care system, are taking place in South Africa. The aim of this paper is, therefore, to explore and analyse the relationship and controversy between pharmacists and dispensing doctors against this background. Adopting an historical and international perspective, the paper will analyse issues such as occupational task boundaries, professional versus business systems and the role of technology and the state in relation to professional dominance, jurisdiction and autonomy.

METHODOLOGY

In order to gain a better insight into this troublesome relationship, a combination of qualitative and quantitative methods was employed, which included the following:*
a documentary search and content analysis of official documentation and publications as well as articles published in newspapers.*

interviews with a random sample of 45 dispensing doctors in Johannesburg;† and

interviews with a random sample of 53 community pharmacists in Johannesburg.

These interviews were based on a structured questionnaire which included “closed” as well as “open” questions.

The discussion and analysis that follow are based on the information derived from the above sources.

THE HISTORICAL PERSPECTIVE

The development of pharmacy in South Africa has been shaped by its strong historical links with Europe, particularly Britain. Apothecaries employed by the Dutch East India Company from 1653 marked the profession’s beginnings. At the end of the 18th century, “elaborately equipped apothecary shops in Cape Town were operated as dispensaries by physicians, surgeons, barber—surgeons and apothecaries—each with their own special remedies” (Ryan, 1986, p. 1). It was during the 19th century that the function of the pharmacist in South Africa was defined for the first time. Of significance are the two rulings passed by the British Governor in 1807. The first concerned the creation of a Supreme Medical Committee, which consisted of several doctors and one apothecary; this committee advised the Governor as to who qualified for a licence to practice pharmacy. The second established that dispensing of prescriptions could legally be performed only by the apothecary; physicians and surgeons were forbidden to vend or prepare medicines. However, as Ryan asserts, “despite this tacit recognition of their status and importance, pharmacists found their livelihood and position being threatened by the Medical Committee which determined who entered their profession; by doctors who dispensed their own medicines; and by shopkeepers who sold vast quantities of patent medicines and who traded in poisons—a monopoly sought by pharmacists” (Ryan, 1986, p. 9). The struggle to rectify the situation and to defend pharmacists’ interests began with the establishment of the first pharmaceutical organisations in 1885–1887.

The competition from the trading and dispensing doctor was one of the major issues for the pharmacist. In the late 19th century the Select Committee on Medical Reform examined “the problem of dispensing by doctors and counter-prescribing by pharmacists”, and concluded that: “we take it for granted that a man who is competent to prescribe for disease, is also competent to prepare the medicine he requires for the treatment of it” (Ryan, 1986, p. 27). This issue has fuelled further debates and has continued to concern pharmacists in South Africa.

DISPENSING DOCTORS; IN SOUTH AFRICA TODAY

A significant development for community pharmacists was the granting, to medical practitioners, of licences to dispense medicines. Originally, this provision was intended to address needs of communities where there were no pharmacists. It started, therefore, with a relatively small number of exceptional cases.

The current reality, however, is that 80% of practising community doctors are permitted to dispense, not only for their own patients, but also for those of their partners (Axon, 1994). As can be seen in Table 1, the number of registered dispensing medical practitioners has increased over the years owing to a host of primarily socio-economic factors, as well as to the state’s failure to provide adequate health services for all (Gilbert, 1996). Note should be taken that the gap between the total number of pharmacists and dispensing doctors has been narrowing continuously due to the growing numbers of dispensing doctor. Since 1990, the number of dispensing doctors was higher than that of retail pharmacists, who are the main dispensers of medicines in the community. In 1995, dispensing doctors outnumbered retail pharmacists by 2025. This undermines the role of community pharmacists on one hand, while on the other, any changes in legislation threaten the dispensing doctor; this creates ongoing tension between the professions, as will be demonstrated further in this paper.

Health care reform has been part of the process of political transformation taking place in South Africa. Since the establishment of the new government, various structures have investigated the matter and made a series of recommendations. As a result, the National Drug Policy (NDP) for South Africa, which was published by the Department of Health in February 1996, clearly stated that “only practitioners who are registered with the relevant Council and premises that are registered and/or licensed in terms of the Medicines and Related Substances Control Act (No 101 of 1965) may be used for the manufacture, supply and dispensing of

*The latest developments took place at the time of writing this article; thus, newspapers were a good source of information.
†At the time the study was conducted the municipal boundaries of Johannesburg were in a transitional state. In order to simplify matters, the study was limited to the old boundaries of Johannesburg.
‡Note should be taken that dispensing by doctors is regarded as a typical problem of developing countries which do not have a well controlled system of medicine distribution. The situation in South Africa is somewhat different. However, since this paper is concerned mainly with the relationship between the dispensing doctors and community pharmacists, a general analysis is beyond its scope.
Table 1. Pharmacies, pharmacists and dispensing doctors

<table>
<thead>
<tr>
<th>Year</th>
<th>Retail pharmacies</th>
<th>Retail pharmacists</th>
<th>No. of pharmacists</th>
<th>Dispensing doctors</th>
</tr>
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<tbody>
<tr>
<td>1983</td>
<td>2302</td>
<td>3142</td>
<td>6452</td>
<td>—</td>
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<td>2412</td>
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<td>2515</td>
<td>4179</td>
<td>7238</td>
<td>3594</td>
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<td>8649</td>
<td>5228</td>
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<tr>
<td>1995</td>
<td>2922</td>
<td>6276</td>
<td>9622</td>
<td>8301</td>
</tr>
</tbody>
</table>


 drugs. Medical practitioners and nurses will not be permitted to dispense drugs, except where separate pharmaceutical services are not available" (National Drug Policy for South Africa, 1996, p. 6).

According to a statement from the department of health, "problems with dispensing doctors were uncovered during Medicines Control Council (MCC) inspections, and were one of the reasons why the National Drug Policy (NDP) was formulated" (Medical Correspondent, 1996). The problems identified relate to inadequate storage and dispensing facilities, dispensing by untrained people, and the nature of information given to patients. Bada Pharasi, the health department's chief director of registration, regulation and procurement, maintains that "patient safety and drug prices are the main motivations for new controls", and substantiates this by claiming that "surveys have shown that a dispensing doctor gives his patients an average of 2.38 items, compared with 1.67 items for a doctor writing out prescriptions for a pharmacist to fill", and "dispensing doctors account for 74 percent of total medical aid drug costs" (Leger, 1996).

The proposed regulations based on this policy were published for comment in the Government Gazette of 12 July 1996. The notice stated that "the minister intends to make the changes to the Medicines Control Act in three months' time—on October 12—and invites interested parties to submit comments by August 20" (Simon, 1996).

In September, after two days of public hearing, the parliament's health committee "proposed the establishment of a working group of public and private practitioners, pharmacists and patients to consider the proposal to stop doctors from dispensing drugs" (Bulger, 1996). All this would be in order "to consult fully with all stakeholders and report back to the committee" (Bulger, 1996).

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The latest developments have raised concerns on the part of dispensing doctors, who have renewed their fight to maintain the status quo, since it seems that their attempts in the past have yielded positive results. Ryan, in his portrayal of the "question of the trading doctor", presents an advertisement for a meeting of the Society of Dispensing Family Practitioners, 1985 entitled: "The Medical Practitioners strike back", in which the "main issue being discussed is the BASIC RIGHT (sic) of the doctor to dispense medicine to his own patients" (Ryan, 1986, p. 29). This line of attack/defence has been magnified since the publication of the National Drug Policy for South Africa. The March 1996 issue of GP Bulletin has been entirely devoted to the topic of "Dispensing—the right of all doctors", and in it, the voices of most of the main stakeholders are heard.

The chairman of the National General Practitioners Group (NGPG), speaking on behalf of the organisation, emphasised that "it is in full support of doctors who dispense medicines as part of their professional service to their patients" (Botha, 1966, p. 6). Central to NGPG's presentation of the debate is the idea that "dispensing by doctors is here to stay and it, without doubt, contributes to an improved doctor—patient relationship".

A similar approach was taken by the chairman of the Health Policy Committee of the Medical Association of South Africa (MASA), when discussing the National Drug Policy in relation to the freedom to dispense: "Curtailing doctors' freedom to provide a dispensing service to their patients, seems totally unjustified. It will limit availability of one stop comprehensive services, and force patients to obtain their prescriptions elsewhere, even when it is less convenient" (McCusker, 1996, p. 19).

The situation was best summarised by the chairman of the dispensing committee of the NGPG, when he said: "I find it very ironic to be discussing the future of the dispensing doctor when it is really the future of the pharmacist that is at stake" (Pepler, 1996, p. 14). However, the medical profession is united in the notion that "it is the inherent right of the doctor to dispense medicines" (Pepler, 1996, p. 16), and it is prepared to fight for its preservation: "The Society would like to re-iterate that it will not allow under any circumstances any restriction on the rights of doctors to dispense medicines to their patients" (Society of Dispensing Family Practitioners, 1996, p. 33).
Of significance here is the fact that dispensing doctors feel it necessary to organise themselves into distinct organisations which are geared towards the protection of the rights of dispensing doctors, and which together with the general medical associations act in this capacity. The Society of Dispensing Family Practitioners, dispensing committee of the National General Practitioners Group (NGPG) and the Medical Association of South Africa (MASA) have supported dispensing by doctors in the past and have continued to do so in the latest unfolding of events (Botha, 1966; McCusker, 1996; Pepler, 1996; Sarlie, 1996). This unity has been made quite clear by references in the media to items such as: “the medical fraternity believes it is united on the issue of doctors being allowed to continue dispensing medicine” (Feris, 1996), and “Medical professions have joined forces to ensure that their right to dispense medicine to their patients is maintained” (Sebolao, 1996). This has lead to an establishment of a new forum representing eight national organisations—the National Convention on Dispensing (NCD), which will “seek an urgent meeting with the Government in a bid to stop legislation that will bar doctors from dispensing medicine” (Makhado, 1996).

THE PHARMACISTS’ PERSPECTIVE

Like their counterparts in other places in the world (Axon, 1994), South African pharmacists see dispensing doctors as a threat (Van Wyk, 1993; PSSA, 1994). A survey reported in the SA Pharmaceutical Journal (Survey, 1994) noted that “dispensing doctors” was the most frequently cited issue among the respondents. Of the respondents, 348 felt it was a major issue clouding the future of pharmacy. According to the survey, respondents felt manipulated and threatened by dispensing doctors. In a later survey, Theron found that 75% of respondents have noticed an increase in dispensing by medical practitioners during the last two years, and pointed out “the necessity to create opportunities for community pharmacies to compete with dispensing medical practitioners” (Theron, 1995, p. 417).

As early as 1993, the president of the Pharmaceutical Society of South Africa urged to “stop the doctors supplying medicine” and concluded that “massive mobilisation of the profession is needed to influence the consumer to take action on the dispensing doctor situation” (Kohn, 1993, p. 487). In an open interview, he later reiterated that “the society needed to push forward the role of pharmacy in the dispensing of medicines to the people”. In light of the fact that so many doctors dispense medicines, he admitted defeat: “we have fought tooth and nail against dispensing doctors. But because of the statutes that exist, the problem seems insoluble. The doctors say they have an inalienable right to dispense” (Simpson, 1994, p. 691).

In line with the above, most of the pharmacists interviewed in this study mentioned the “dispensing doctor” as the main problem facing the community pharmacist in South Africa. If the reality was to be evaluated merely by a numerical analysis, their fears might be justified (Table 1). In the Johannesburg area, there are 274 community pharmacies and 954 medical doctors with a licence to dispense.

THE DISPENSING DOCTORS’ PERSPECTIVE

A random sample of 45 dispensing doctors in Johannesburg was interviewed in order to explore their perception of the role of the pharmacist, and to assess their motives for dispensing medications to their patients.

Sixty-two percent of the doctors interviewed have been in a possession of a licence to dispense for seven years or less, which mirrors the general growth trend in the numbers of dispensing doctors.

From their replies to a range of questions intended to ascertain how they perceive the role of the pharmacist, it is clear that they see the pharmacists mainly as performing tasks related to medicines. All respondents (100%) indicated that “advice on methods of administration of medicines, advice on storage and safe handling of medicines and advice on safe and effective use of medicines” should be carried out primarily by the pharmacist. Similarly, “dispensing according to a doctor’s prescription” was seen by all the doctors (100%) as an activity which is “very appropriate and very important” for a community pharmacist to engage in.

Concerning “counsel(ling) patients about the prescription”, 80% thought it was “very appropriate and very important” and the rest (20%) that it was “appropriate and important”.

The consensus found among the doctors with regard to the pharmacist’s role in dispensing medications was not demonstrated where other activities were concerned, clearly revealing that dealing with medicines constitutes, according to them, the “core” of the pharmacist’s role.

These findings present a contradiction when viewed in the light of the issues presented earlier. The dispensing doctors see the main role of the community pharmacist as confined to medicines, yet at the same time argue that it is a legitimate component of the role of the doctor. This raises some questions with regards to their motives in engaging in dispensing of medicines to their patients.

Only 24% of the doctors interviewed mentioned financial reasons as influencing their decision to seek a licence to dispense, while 42% mentioned reasons related to their desire to offer a convenient, comprehensive and holistic service to their patients.
Additional reasons given were that “this was the trend among doctors today” (13%) or that dispensing allowed them to “keep abreast of developments in the pharmaceutical world” (11%).

THE NATURE OF THE PUBLIC DEBATE

The ongoing conflict between pharmacists and dispensing doctors has taken the form of a public debate, and has been prominently reflected in the media. Traditionally, it has taken the form of pharmacists complaining about dispensing doctors, as well as expressing their fears. The dispensing doctors on the other hand defend their “basic right” to dispense medicine to their own patients.

Discussing “the most troublesome issues facing pharmacy today, the selling of drugs by physicians”, Penna, Associate Executive Director, American Association of Colleges of Pharmacy, insists that “the term ‘physician dispensing’ should be avoided”, since according to him, “physicians do not dispense drugs, they simply distribute them to patients”. He further emphasises that pharmacists “should not give physicians who engage in such practice the dignity of describing their activities as dispensing” (Penna, 1987, p. 2058). Of significance here, might be the fact that pharmacists in South Africa refrain from using the term “dispensing doctor” in public and refer to them in alternative ways, primarily as “trading doctors”.

According to Kohn (1993), concerned pharmacists have very successfully advertised either in their local newspapers, or in the form of pamphlets, to inform the public that it is preferable for the pharmacist to dispense their medicine. In it statements such as, “the principle is accepted worldwide that medical practitioners do not themselves supply or sell medicines to patients”, or “regulations in SA forbid the doctor to keep an open pharmacy”, and “it is important to be aware that it is your right in all cases to be able to request your doctor for a prescription to be filled at a pharmacy of your choice” (Kohn, 1993, p. 487), were meant to avert patients from obtaining medications from dispensing doctors. The advertisement went so far as to point out the “advantages of dispensing pharmacists” as opposed to the problems associated with “the other option”: among them, that “trading doctors deny the patient the opportunity to utilise services and professional knowledge of the pharmacists and the controlling functions which he provides” (Kohn, 1993, p. 487). They even defamed the doctors by clearly stating that “Inspectors of the Department of National Health have found that an unacceptable percentage of doctors who dispense, commit serious transgressions with regard to the dispensing of medicines”. The benefit to the patient was given as the justification for the advice given in the advertisement, since it “was prepared with your health in mind” (Kohn, 1993, p. 487).

The public debate revealed a scenario where an all-out war is waged between pharmacists and doctors. This is evident from the use of words such as “weapon in our armoury” (Axon, 1994), clearly indicating “war talk”. Publicly, however, an effort was made on both sides to present it as an endeavour to offer a better service to the community and to protect patients’ rights.

OCCUPATIONAL TASK BOUNDARIES

Abbott’s systemic theory of professions (Abbott, 1988), which claims that the shaping force of a profession’s history is competition among professions as well as between them for jurisdiction over work, provides a key to analyse some of the issues related to this dispute. Due to the exclusive character of the jurisdiction, it follows that the professions form an interdependent system—an ecology. Therefore, a move by one will affect the others constituting a system around a task field (Schubert, 1992). As a rule, jurisdictions are not “vacant”. It is for this reason that the claim of jurisdiction will normally lead to competition. The ongoing battle between doctors and pharmacists over exclusive rights to prescribe and dispense (Ritchey and Raney, 1981; Gilbert, 1997b) provides such an example.

Historically, the two functions of prescribing medications and the dispensing thereof have been kept separate in order to maintain a system of checks and balances that helps to ensure a high quality of care. According to Webb (1995), this separation of functions had the support of most professional organisations in both medicine and pharmacy. The main purposes of this system have been avoiding a conflict of interest on the part of the practitioner, who stood to profit from recommending and selling a prescribed medication, as well as providing a review process to help prevent errors and duplicate records. This separation is strongly advocated by pharmacy leaders in the U.S.A., as clearly pronounced by Penna: “Dispensing is too complex—and too important—to be left to medicine. Physicians don’t dispense any more than pharmacists prescribe” (Penna, 1987, p. 2058).

Theoretically, this separation is valid in South Africa as well. In reality, however, the efforts of pharmacy to extend its functions into the arena of prescribing for certain conditions (Gilbert, 1995b), coupled with the existence of large numbers of dispensing doctors, raise serious doubts with regard to the separation of functions and its maintenance by both. The results of the interviews with dispensing doctors confirm the apparent overlap.

On one hand, the lack of a clear division of labour was raised as a concern by the pharmacists, since “It seems that in this instance the roles of both professions concerning their respective rights to dispense medicines appear to overlap” (Van
Niekerk, 1994, p. 4). On the other hand, the long standing dispute between the pharmacy profession and the organised medical profession on the issue of the pharmacist’s right to diagnose and prescribe medicines has been intensified by the proposed changes to the general regulations of the Medicines and Related Substances Control Act 101 of 1965, which, if approved, will allow pharmacists to prescribe specified schedule 3, 4 and 5 medicines,* under certain defined conditions (Gilbert, 1995b; Gilbert, 1997b).

At the heart of this matter is the issue of “professional dominance”, which refers to the way in which certain professions not only control the content of their own work but can also define the limits of the work of other occupational groups (Freidson, 1970a). Linked to it is the degree of “professional autonomy” or the legitimated control that an occupation has over the content of its own work (Nettleton, 1995). This is confirmed in Kronus’s historical analysis of task boundaries between physicians and pharmacists, where she clearly delineates “the relative ability of the occupation to protect its task domain from encroachment, and/or to encroach on others, as the central measure of power” (Kronus, 1976, p. 5).

Turner (1987) argues that medical dominance is maintained by means of three modes of domination: subordination, limitation and exclusion. While subordination characterises the relationship of nursing to medicine, limitation characterises pharmacy since it is restricted to a specific therapy, as well as dentistry, where the restriction is to a specific part of the body (Jones, 1994).

Pascall and Robinson (1993) argue that boundary disputes between occupations and competition over work roles are an inevitable component of a complex health care system with an elaborate division of labour and a changing social and technological environment. Work roles are not comprehensively defined in legal terms, and overlapping responsibilities are common. For this reason, paramedical occupations have had to negotiate boundaries with each other as well as with doctors when establishing spheres of competence and responsibility (Larkin, 1983).

Eaton and Webb (1979) refer to the extended role of community pharmacy as “boundary encroachment”, claiming that it is an attempt to extend the boundaries of pharmacy practice into the territory of the medical profession, the boundary in this case being that between prescribing and dispensing.

Birenbaum maintains that “as leading experts on health care matters, large or small, physicians are both the model for professional autonomy to be emulated by other health care providers and the residing powers who must be convinced of the merit of reassigning tasks and authority if the other occupations are to acquire the same or similar degrees of control over their work in the health field” (Birenbaum, 1990, p. 10).

The outcry and resistance of doctors to attempts from pharmacists to invade their turf (Adamcik et al., 1986) provide the necessary evidence to show that the medical profession exercises tight control over its task boundaries. Larson (1977) argued that the medical profession latched on to medical science in order to convince the state and the public of their superior service, which was used as a strategy to facilitate and maintain strict occupational closure. Similar strategies were used in the campaign mounted by the Medical Association of South Africa (MASA) against the proposed changes in legislation (Gilbert, 1995b).

The “right to dispense” is a point of controversy between physicians and pharmacists internationally. This is evidenced by the fact that a special FIP† working group on dispensing doctors was constituted “to aid in combating what is probably the greatest threat to the profession of pharmacy” (Axon, 1994, p. 107). The symposium which followed, entitled Dispensing Doctors and Prescribing Pharmacists—Where is the Borderline?, organised by the FIP’s Section for Administrative Pharmacists at the World Congress of Pharmacy and Pharmaceutical Sciences in Tokyo, 1993, manifests the seriousness of the issue as perceived by the pharmacists (Dispensing Doctors and Prescribing Pharmacists—Where is the Borderline?, 1993).

Evidence from countries like Japan, the U.K., the Netherlands and the U.S.A. shows that, despite some differences, “dispensing doctors” are a common phenomenon all over the world (Abood, 1989; Cowen, 1992; Axon, 1994). It is also apparent that pharmacists are united in their war against it, as expressed by Axon on behalf of the “FIP’s working group”: “We must never lose sight of the opportunity to use this (generic substitution) as another weapon in our armoury against the dispensing doctor” (Axon, 1994, p. 111).

Although presently dispensing is clearly the main function of the pharmacist, and its overtaking by the doctors is a clear invasion or boundary encroachment into another profession’s “jurisdiction”, the medical profession has been able to maintain and develop it due to its dominance. Pharmacists in SA have meanwhile been waiting since 1986 to change the regulation to enable them to diagnose and prescribe in a very limited capacity, but as it currently stands, this is unlikely to materi-
This once again illustrates the professional autonomy. They claim that "such autonomy would provide professionals with a mechanism to define, control, and monopolize services of other independent professions", and therefore, "the question then becomes at what point does society intervene?"

The latest developments in South Africa might be construed as such an intervention by the state. The proposed regulations stipulate "that doctors and dentists may only dispense medicines after being authorised by the director general of health, and passing a course in dispensing prescribed by the South African Medical and Dental Council in consultation with the SA Pharmacy Council" (Simon, 1996). According to the chairman of the SA Managed Care Coalition: "this challenges my professional right to do something I'm already trained to do" (Simon, 1996). Bada Pharasi, on behalf of the Government, however, claims that "doctors were not trained in pharmacology and dispensing doctors' premises were not inspected regularly", adding further that "we are not advocating a total ban on dispensing doctors, we just want to ensure they are properly trained to do the job properly" (Rossouw, 1996).

Birenbaum (1990) maintains that pharmacy is engaged in a campaign, which operates on a practical and ideological level, to protect the occupation from downgrading. He claims that this is not an unusual response on the part of the profession under threat, quoting "the prophetic C. Wright Mills (1951)", who wrote: they "seek to monopolise their positions by closing up their ranks; they seek to do so by law and by stringent rules of education and entrance. Wherever there is a feeling of declining opportunity, occupational groups will seek such closure" (Rossouw, 1996, p. 162).

In addition to the state's intervention to clarify professional task domains, the current situation in SA represents a potential reversal of power, where pharmacy is given an opportunity to control the boundaries of doctors' work and strongly protect its own main function, that of dispensing medications.

**“BUSINESS” VERSUS “PROFESSIONAL” SYSTEMS**

The legislation concerning the "dispensing doctor" in most cases, states that "the normal situation is that the pharmacist should dispense; and that doctor dispensing is an exception" (Axon, 1994, p. 106). Japan, where the law permits physicians to dispense medicines, is an exception in this regard (Takemasa, 1994). The rationale behind most of the legislation permitting doctors to dispense medicines to their patients is that otherwise, these medicines would not be easily available, due to the absence of a pharmaceutical outlet. For this reason, the granting of licences to dispense is limited to "special cases" and restricted to "specific circumstances" (Trytek, 1988). This is the case in Australia, where currently there are only 69 dispensing doctors who "are almost always located in remote and isolated rural communities where the nearest pharmacy might be hundreds of miles away" (Axon, 1994, p. 107). In most other countries, however, the reality differs. As pointed out by Anderson with regard to the situation in the U.S.A., "today, significant amounts of physician dispensing are not occurring in rural areas or emergency situations where access to retail pharmacy may be severely limited" (Anderson, 1994, p. 119).

In the U.K., there are dispensing doctors "within a stone's throw of several pharmacies" (Axon, 1994, p. 107). As demonstrated in this paper, a similar situation exists in South Africa.

The main distinguishing feature of the Australian legislation is that it stipulates that "the dispensing doctor should not make a profit on the medicines supplied" (Axon, 1994, p. 108), which might provide an explanation for the small numbers of dispensing doctors there. Axon, as well as others (Anderson, 1994), suggest that the reason for a doctor to dispense is an economic one, and does not pertain to quality of care. Concerns about "the growth of for-profit health providers and the role of the physician as an entrepreneur", were raised in the U.S.A., and it was suggested that physicians had "conflicts of interest" while engaging in "economic self-dealing transactions for profit" (Rodwin, 1992, p. 728). This was further reiterated by Nelson, who argued that "doctors who sell drugs to patients may succumb to financial temptation and over prescribe those drugs they have in stock, whether or not the particular drug is appropriate. The motive then becomes profit first, patient care second" (Nelson, 1987, p. 67). Kapil compared the dispensing doctors in contemporary India to the 19th century in England and on this basis claims
that “the doctor earns a living by selling medications rather than by charging a consultation fee and writing a prescription; the incentive is to medicate irrespective of the diagnosis” (Kapil, 1988).

Pharmacists make use of this factor in their fight against dispensing doctors by displaying the now famous logo: “WARNING—DISPENSING BY DOCTORS CAN DAMAGE BOTH YOUR HEALTH AND YOUR POCKET” (Axon, 1994, p. 109). Spencer and Edwards maintain that “antagonism between the professions is perhaps best symbolised by the long standing conflict between dispensing doctors and pharmacists, who are potentially in competition for business” (Spencer and Edwards, 1992, p. 1672).

“As far as dispensing is concerned, MASA and the NGPG accept that the choice of prescribed drugs should not have an effect on the income of the doctor” (McCusker, 1996, p. 19). This is the official view in South Africa within the medical profession, as expressed by the chairman of the Health Policy Committee. However, although the official representatives of the medical profession emphasise the doctor’s intrinsic right to dispense medicines, as well as the benefit to the patient as the main factors in their support of dispensing doctors, an additional factor—“to make profit” (Pepler, 1996, p. 16)—was mentioned by the chairman of the dispensing committee of the NGPG, when explaining why doctors dispense. While listing the reasons why pharmacists want to dispense medicines, he repeated: “profit, profit, profit (it is their right as businessmen—doctors do not have business)”. This seemingly contradictory approach (or double standard) was further revealed when he stated that “the fact that pharmacists now want to become community pharmacists [neau (sic) dispensing doctors], is not because they are new generation Florence Nightingales, but because they are experiencing market pressure” (Pepler, 1996, p. 16). Evidence from the interviews with dispensing doctors in Johannesburg suggests that economic forces are, among others, responsible for the increasing numbers of doctors who turn to dispensing.

The reluctance to highlight the “business” aspect with regard to the practice of doctors does not exist where pharmacy is concerned. The director general of health is quoted as saying: “The free market principle should be adhered to—pharmacy is a business like any other” (Schickering, 1996, p. 10). It seems, however, that the same principles apply to dispensing doctors. In the medical profession’s attempts to fight the restrictions, this was indirectly alluded to in the statement that “it views any action by any party to force patients to obtain their medicines from specific pharmacies or alternative retail outlets as a contravention of the free market principle” (Botha, 1966 p. 6). Corroborating this were comments by dispensing doctors who sought the licence to dispense as means of “attracting clientele”, to “keep them coming back”, or, as succinctly put by one doctor, to “capture and keep”.

Attempts to explain this ongoing conflict between dispensing doctors and pharmacists, rely on the use of “theories of professions”*, some of which were mentioned earlier in the paper. Of particular relevance here are the seemingly contradicting philosophies of “professions” versus “business”, as identified in the literature (Kronus, 1975). It appears that the prevailing perception is that “business and professional systems are theoretically incompatible” (Hepler, 1989, p. 409). According to Hepler, this is so since “business” is expected to pursue its own interest, while the “profession’s” reason for existence is to serve the public interest. This might explain why the “profit” motive to dispense medicines features less in both the doctors’ replies as well as in the public debate, while justifications such as the “provision of a comprehensive or one stop service” and “the patients’ right to choose” received prominence.

Evidence in this direction is provided in an open debate between dispensing doctors and pharmacists in Britain, where accusations and counter-accusations are hurled (Geddes et al., 1992), such as “that doctors prescribe to line their own pockets as the pharmacists would have the uninstructed believe” (Roberts, 1992, p. 187) or that there is “considerable disquiet felt by many doctors over the increasingly ambiguous position occupied by pharmacists. Primarily business people motivated by profit, chemists sit apart from other members of primary health care teams, whose first allegiance is to the patient” (Thomas, 1992, p. 650).

Similar sentiments are echoed in the South African Medical Journal, in which a statement is made about the “immoral war being waged by a sometimes pious medical profession ‘immoral’ because neither the pharmacists nor the doctors have the patient’s best interests at heart, but are rather consumed by their own financial gain. The point is well articulated by Roos, who claims that this is clearly not a war being fought in the depths of medical ethics, but in the shallows of naked economics! The bottom line here is the reduction of “economically insecure GPs from ‘respected professionals’ to ‘squabbling medical shopkeepers’, quibbling over profit margins” (Roos, 1994, p. 168).

Although not explicit, an examination of the South African scenario reveals that the issue of economic gain is at the centre of the conflict. For the doctor, as this study reveals, it is a way of

*Note should be taken that it is not the intention of this paper to present a review and analysis of the current voluminous theoretical research literature on the professions (Brante, 1988; Macdonald and Ritzer, 1988; Brint, 1993, Macdonald, 1995), but rather use some of its concepts in the analysis of the conflict between dispensing doctors and pharmacists.
"making a living"; as articulated by the managing director of Medsolve, "the GP has thus looked to other avenues of revenue and a lot have turned to dispensing and supplemented their income with the profits made from trading commercially in medicine" (Green, 1996, p. 26). Corresponding views were expressed by the president of the Pharmaceutical Society in an open interview, in which he claimed that "It was important for pharmacists to show the new government that they were anxious to get medicines to the people. Perhaps the starting point could be primary health care...but there is no money in it. How did one go to the profession and tell them to get involved in primary health care when there was no money in it?" (Simpson, 1994, p. 689). This accentuates the fact that "the confusion about the purpose of pharmacy is more troublesome because the business and professional systems are theoretically incompatible" (Hepler, 1989, 409).

The solution, according to the PSSA president, lies in changing the scenario: "the focus had to be to bring the people from the dispensing doctors into the pharmacy, saying, 'Your one stop shop is here in the pharmacy, not at the doctors'" (Simpson, 1994, p. 689).

The attempts to affect legislation and extend the pharmacist's legal boundaries are evidence to that effect—their purpose is to give the pharmacists more meaningful roles, while at the same time providing an alternative/competitive venue to seek medical care from, thus "luring" patients away from the dispensing doctor. The growing development of pharmacies as "primary health care centres" by incorporating nurses within their practices might be another example for the above (Gilbert, 1997a), under the pretense of the need to provide a comprehensive service for the patient's benefit. It would appear that the state is adopting a similar line, by distancing itself from the "business" aspects in the debate. As stated by Pharasí: "The most qualified profession must do the task. We move from the premise that medicines and health care are not ordinary commodities of trade" (Medical Correspondent, 1996).

This analysis draws on Ladinsky, who maintains that "professions are simply monopoly occupations, ones that succeeded in using the symbols of professionalism to gain exclusive power and control of their work. To many of those who hold to this power model of professions, the task of analysis is to demystify the professions, to break through the cloak and expose self-serving motivations" (Ladinsky, 1981, pp. 5–6).

THE ROLE OF TECHNOLOGY

Progress in medical technology and in the medical sciences during the 19th and early 20th centuries provided the doctor with vastly improved skills for diagnosing disease, while the pharmaceutical revolution of the past 50 years has transformed medical practice and the doctor's ability to cure disease (Kapil, 1988).

In the early 20th century, the pharmacist's role evolved into that of an expert in drug formulation, while physicians concentrated upon the effects of the drug on the patient (Trytek, 1988). However, the big business of drug manufacturing overtook the pharmacist's role of drug formulation and by the mid-20th century, the dispensing of the pharmaceutical manufacturer's premade prescription drugs remained the main function of the pharmacist (Mrtek and Catizone, 1989). Concentrating on the dispensing of drugs, pharmacists developed the expertise to doublecheck doctors' prescriptions, thus saving many a patient from the mistakes of doctors. Roberts claims that "this role is rapidly being supplanted by computer technology in doctors' surgeries and dispensaries. Modern software includes essential cross-checks to improve the safety of dispensing, including a complete pharmacopoeia together with side-effects and interactions cross-referenced with the doctors' repeat prescription list and with a patient–disease register" (Roberts, 1988, p. 563). This, according to Roberts, makes the dispensing of drugs by the doctor much safer, and thus the backup role of the pharmacists is disappearing. This idea is further supported by the chairman of the Nuffield Foundation Committee of Inquiry (1986), who is quoted as saying: "the dispensing role of the community pharmacist is in unstoppable decline" (Roberts, 1988, p. 563).

Ironically, pharmacy's success in its attempts to extend its role relies on use of and access to the same technology. Since the patient–disease register is confidential, the information can only be held by the doctor, and the pharmacist can never have full access to it. Mrtek maintains that the lack of access to patients' medical records in a community pharmacy is one of the main barriers to the role extension of the pharmacist (Mrtek and Catizone, 1989).

The proponents of this role extension, therefore, recommend the facilitation of improved record-keeping mechanisms (Britten, 1994). At the same time, the availability of this latest technology, together with the patients convenience and reduced costs, are used by dispensing doctors as the main factors in defence of the superiority of their service delivery. All this can be interpreted as yet another strategy used by the medical profession in order to maintain its occupational dominance by taking over the dispensing function from the pharmacists, since the new technology provides them with the means to do so.
THE ROLE OF THE STATE

Positioning this debate in the context of "professional hegemony" as presented by Johnson (1972), and further discussed by (Freidson, 1970a,b), which denotes the dominance of power of the medical profession in its relationship with other health professions, provides a possible explanation to the South African scenario. Johnson suggests that the state has had a crucial effect in weakening the control of the medical profession by acting as the mediator between profession and client. According to Eaton and Webb (1979), Armstrong and Alaszewski have concurred with this perspective and advanced the argument further, by pointing to the crucial role of the reorganisation of the National Health Service (NHS) in the decline of medical dominance and increased autonomy and independence of the others in the U.K. Starr, in his analysis of the social transformation of American medicine, argues that "while the power of physicians to call the shots in health care is not as great as it once was, they have successfully resisted being dominated, as other artisans and craftsmen were, by the corporation of the state" (Starr, 1982, p. 25).

In the National Drug Policy for South Africa to be implemented in 1996-1997, the Department of Health clearly indicates who and what premises may be used for the manufacture, supply and dispensing of drugs. In order to leave no doubt and to avoid confusion, it states that "medical practitioners and nurses will not be permitted to dispense drugs, except where separate pharmaceutical services are not available" (National Drug Policy for South Africa, 1996, p. 6). If this document is to be implemented as proposed, it has the potential to play a crucial role in the decline of the medical profession's hegemony in South Africa as well. This sentiment was echoed by the NGPG, when its chairman declared that "pharmacists are businessmen and did such a phenomenal lobbying that it appears that the Government intend making them the dispensing doctors of the future" (Pepler, 1996, p. 14).

However, Eaton and Webb assert that "those who argue that there has been a decline in medical hegemony have paid insufficient attention to the reaction of the medical profession to the activities of professionalising paramedical groups" (Eaton and Webb, 1979, p. 70). The organised attempts by the medical profession to delay and block the amendments to Act 101, which would have meant extending the pharmacists' discretionary powers, as discussed by Gilbert (1995b), indicate that at this stage the decline of its hegemony is only a theoretical possibility. Furthermore, the latest campaign by the mobilised and united medical organisations to stop the Minister from implementing the changes provides additional support to the above. Organised medicine demonstrated its influence by its ability to mobilise wide support for its cause. "Trade unions, medical, dental and consumer organisations united for the first time...to voice their objections to the planned changes at a meeting with the health department" mainly on grounds that "the proposed regulations...contradicted the objective of making affordable health care more accessible" (Simon, 1996). Following this, the implementation was further delayed by the recommendation to establish a working group to deal with the matter.

In the latest unfolding of events, the government's plans to regulate the medical profession have been met by opposition from the Interim National Medical and Dental Council (INMDC) who told Parliament's health committee that they "opposed to clauses in the legislation relating to the licensing of medical practitioners...to dispense medicines." They said that "it was unacceptable that, in accordance with the (proposed) bill, the director-general of health...would regulate the dispensing of medicines by doctors while the council would only oversee other aspects of professional practice". Clearly indicating that the INMDC wanted "to maintain the regulation of the medical profession and the licensing of dispensing doctors". It even went further than that, and "objected to proposals that the Pharmacy Council should have an incisive role in training of health professionals falling within the jurisdiction of the council" (Ranato, 1997).

All the above is once again casting doubts on pharmacy's ability to control medicine's tasks domains even through the intervention of the state.

CONCLUSION

A proclamation by the Governor in 1807 which established that dispensing of prescriptions can legally be performed only by the apothecary (Ryan, 1986), has not succeeded in preventing doctors in South Africa from doing it since then. The establishment of the first Pharmaceutical Organisations in 1885-1887 was the beginning of the struggle to protect the pharmacist's interests. However, despite the existence of powerful professional organisations, pharmacists in South Africa have not been able to maintain a monopoly over the one function, about which there is no dispute, that constitutes the core of the pharmacist's role.

According to Freidson, "most of medicine's control has not been exercised directly in negotiation with clients or employers, but rather indirectly, through licensing, registering and certifying legislation that establishes constraining limits"; thus, "legislation is a more effective method of controlling the circumstances of work". Since, "through their influence on regulatory agencies, the organised professions are often responsible for writing the job description for their members..." (Freidson, 1981, p. 18).
The medical profession in South Africa has demonstrated an ability to curb pharmacy's attempts to prescribe, and to continue dispensing medications, thus providing additional confirmation of its power and professional dominance: it has managed to successfully protect its task domain from encroachment on one hand, while nevertheless encroaching on pharmacy's main function, on the other.

This paper confirms Birenbaum's assertion that "the quest to remake the division of labour in health care is set against the social background of professional domination by medicine" (Birenbaum, 1990, p. 11). He refers not only to its ability to control scarce resources, but also to the widely shared belief that medicine should and can deal with matters of health and illness. This is corroborated by the outspoken support given by the entire medical profession for the dispensing doctor. It would appear that they are claiming to be holding full responsibility for as well as protecting the interests of "their" patients, thus excluding other health professionals from the equation.

According to Birenbaum, "there is a structure of expectations, constituting society's approval, that the medical profession is expert in matters of health and illness" (p. 11). However, the shifts that have occurred in society in relation to health and the subsequent development of the socio-environmental model of health and disease (Gilbert et al., 1996) have attenuated this notion. The growth of the "New Public Health" movement and the emphasis on Primary Health Care have brought to the fore the idea that "health care starts with people", and that the people themselves play "a major role in solving multi-faceted health problems" (Gilbert, 1995c, p. 118).

The current scenario, as presented in this paper, deals with a bid by pharmacy in South Africa to emulate what has been, historically and universally, successfully done by medicine: namely, gaining control over what they consider to be their professional jurisdiction.

Against the above general trends and due to a combination of factors, pharmacy in South Africa has managed to bring the state to intervene by drafting the NDP, and by proceeding in its implementation. The elements which have facilitated this can be summarised as follows:

- a society in transition where institutions are compelled to change structures and mind-sets;
- a health care sector in the process of restructuring itself with a bias towards PHC, which aims to dispose of the traditional domination of physicians and bring health care to the people;
- circumstances in which, due to the deficiency of the past health care services, large numbers of doctors were forced to dispense medicines to their patients in less than ideal circumstances. This was exploited by drug companies, which encouraged its development in areas where the services were not really needed by facilitating financial gains for doctors. All the above gave pharmacists the ammunition to claim doctors' inadequacy as dispensers on one hand, and as "profit seekers" on the other; and
- pharmacy's unresolved status and role in the health care system and the strength of its professional organisation.

Despite the existence of the above components, which have assisted Pharmacy in achieving its current desirable outcome, it seems unlikely that, in the long term, pharmacy will be successful in its manoeuvre. Nevertheless, there is no doubt that the current state of affairs and the final outcomes provide an interesting case study in the ongoing saga of the battle between medicine and pharmacy.

During this transitional period of fluid policies, the predictions tend to be that a "negotiated settlement" (Eaton and Webb, 1979, p. 85) will be reached. In other words, pharmacists will ease up on their attempts to trespass on "sacred" clinical activities such as diagnosing and prescribing, in return for doctors' agreement not to trespass on "core" pharmaceutical activities such as dispensing. The fact that the structure of health care delivery in South Africa is most likely to develop toward more "group practice" and "managed care" is bound to aid this process, since in such a system, the advantages of separating prescribing and dispensing may be less relevant. As put by Webb: "To increase the consistency of care provided and to improve the availability of primary care, prescribing must be transformed into a collaborative process of pharmaceutical care delivered by a multidisciplinary team" (Webb, 1995, p. 1695).

Finally, it would seem that the emphasis on Primary Health Care and the multidisciplinarity it implies, as well as other countervailing forces presented in this paper, have the potential to act as a force towards the erosion of rigid boundaries of professional jurisdictions (Soothill et al., 1995; Webb, 1995; Johnson et al., 1995). However, this requires further research, which lies well beyond the scope of this paper.

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