doi:10.1111/j.1360-0443.2007.01790.x

Community pharmacists and tobacco in Great Britain: from selling cigarettes to smoking cessation services

Stuart Anderson

Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, UK

ABSTRACT

Aims To illustrate the ways in which community pharmacists in Great Britain have been able to benefit from a close association with tobacco and smoking from its initial importation to the present time. **Design** An analysis of relevant texts and documents, together with brief transcripts from an oral history investigation of community pharmacy in Great Britain. **Setting** Community pharmacies in Great Britain during the 20th century. **Participants** Retired and practising community pharmacists with experience of the sale of tobacco products during the period. **Measurements** Oral testimony of retired and practising community pharmacists about the use and sale of tobacco products, and quantitative analysis of commercially available products designed to help people stop smoking during the period. **Findings** Community pharmacists have been involved continuously with the tobacco habit since its first introduction into Britain. During the course of the 20th century the emphasis shifted from the sale of tobacco products to the sale of medicines intended to help people to give up smoking. Smoking cessation initiatives continue to be an important part of the business of many pharmacies. **Conclusions** The paper illustrates the continuing tension that exists between pharmacy as business and pharmacy as profession. The sale of tobacco products and, more recently, products to help people give up smoking, has been a small but significant part of the business of many community pharmacists throughout the centuries.

Keywords Cigarettes, nicotine replacement therapy, pharmacists, smoking cessation, tobacco.

Correspondence to: Stuart Anderson, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK. E-mail: stuart.anderson@lshtm.ac.uk
Submitted 7 September 2006; initial review completed 31 October 2006; final version accepted 18 December 2006

INTRODUCTION

There is now an extensive literature on the social and cultural history of tobacco, and of smoking and health [1]. This has included both monographs [2] and collected volumes [3]. More recent historical work has focused on the making of policy in this area [4]. This paper describes the historical involvement of community pharmacists with tobacco, from its first importation into Great Britain up to the present day. It illustrates, in relation to a single topic, the continuing tension that exists between pharmacy as profession and pharmacy as business. For most of the period pharmacists and their predecessors were happy to sell tobacco products, but they were equally content to sell products designed to help people give them up. In recent years pharmacists have become involved with smoking cessation initiatives, and with the supply of drugs intended as adjuncts to motivational support in nicotine-dependent patients. However, throughout its history pharmacists have been able to profit from the use of tobacco.

The medicinal uses of tobacco are perhaps rather less well known than its use for pleasure, relaxation and stress relief. Yet these uses have a long history, and predate those for pleasure. So, too, do the addictive properties of tobacco; indeed, as long ago as 1610 Sir Francis Bacon noted that trying to quit the habit was very difficult. Attempts to profit by helping the addicted to break away from their habit can be traced to that time. Over the years many groups have been involved in the promotion of tobacco, including physicians, explorers, missionaries and botanists. This paper focuses on the role of community pharmacists in the 20th century. However, in order to place this into its proper context it is necessary first to review briefly the early history of tobacco.

THE DISCOVERY OF TOBACCO

The story of tobacco use in Europe begins in 1492 when Christopher Columbus, on his first voyage to America, came across American Indians treating illnesses with leaves from a strange herb. He reported that two of his crew found many people on the island of Cuba who 'always carried a burning torch with which to kindle fire, and to perfume themselves with a certain herb' [5]. The herb was in the form of a cigar, and it was used as a disinfectant and to prevent fatigue. Amerigo Vespucci, on his voyage in 1499, noted that Indians on the island of Margarita off the coast of Venezuela 'chewed green leaves of a herb mixed with a pulverised substance [lime] to relieve thirst'. Later explorers reported the same practice being used 'to whiten teeth'. Clearly, by 1500, tobacco was being used widely on the American continent for a variety of purposes.

Over the next 50 years, European travellers to the New World carried home with them large quantities of tobacco leaves, together with a considerable body of medical knowledge about the plant. This knowledge was spread quickly, and the medicinal uses of tobacco began to be described in herbal pharmacopoeias throughout Europe. Between 1537 and 1559 some 14 books mentioning the medicinal uses of tobacco, written by explorers, historians, missionaries, botanists and physicians, were published [6]. In 1560 the French ambassador to Portugal, Jean Nicot, began to experiment with it. Nicot's experiments were performed with precision, and he kept meticulous case histories [7]. The plant was named *Nicotiana tabacum* in his honour in 1565.

TOBACCO USE IN ENGLAND

Tobacco reached England in plant form only in 1570. Between 1570 and 1585 the doctrine of 'the panacea of panaceas' (the idea that there was one remedy which would cure all human diseases) gained prominence. One Jesuit author proclaimed tobacco to be 'God's remedy' [8]. There were few conditions for which it was not recommended. The list included abdominal pains, colds, fits, gout, halitosis, intestinal worms, madness, tooth decay, gangrene and ulcers. Whatever the patient suffered from, the remedy was tobacco.

The first English book on tobacco, by Anthony Chute, appeared in 1595, followed in 1597 by John Gerard's *The herball or generall historie of plantes* [9]. Gerard grew tobacco in Britain, but the home-grown product was not well received. Tobacco was used in a great many ways, including powders, decoctions, infusions and ointments for the cure of wounds. Gerard himself advocated inhaling the smoke, and claimed that tobacco would cure 'all the best known diseases'. New dosage forms continued to be recommended, including enemas, gruel, pills, plasters, chewed-tobacco poultices, snuff salve, tea and wine. Tobacco reached the height of its fame as a cure-all at the start of the 17th century.

In 1602 a book called *Work for Chimney Sweepers* was published in London. This exposed the harmful effects of tobacco, and was written under a pseudonym. 'Philaretes' declared that no one remedy could cure all maladies, and produced a long list of tobacco's harmful effects. The book stimulated publication of several further books either for or against tobacco. They included one by James I, entitled *A Counterblaste to Tobaco* and published in 1604, in which he denied that tobacco had any medical value. He considered it morally wrong to use tobacco for pleasure, adding a complaint about the amount of money spent on it. He tried to curb its use by prohibiting its cultivation in England, and by imposing a duty on its import.

THE INVOLVEMENT OF APOTHECARIES

Such a lucrative trade was bound to attract a wide range of individuals eager to share in the profits. Among these were many apothecaries. This group gave medical advice and sold medicines and related products. In 1615, Barnaby Rich reported that there were upwards of 7000 grocers, chandlers, inn-keepers and apothecaries living by the trade of selling tobacco in and around London alone [10]. Both the King's personal intervention and the imposition of duty seem to have had little effect on its use. Tobacco played an equally important part in the lives of apothecaries around the country [11]. In 1607 the inventory of Richard Beresford, an apothecary from Lincoln, included 10 ounces of tobacco, two lead tobacco pots and 11-and-a-half-dozen clay tobacco pipes [12].

In 1655 a book was published in France describing the preparation and use of snuff for medicinal purposes. The apothecaries became one of the main groups involved in the supply of snuff, and by 1726 it had eclipsed all other forms of tobacco in popularity. By 1700 tobacco was already being used more for pleasure than for medicinal purposes, although in 1747 John Wesley rekindled interest in the latter. In his *Primitive Physick* he recommended the medicinal use of snuff for a wide variety of conditions including earache, falling sickness, nervous headache and piles.

Only in the early 19th century was the active principle of tobacco discovered. In 1809 a French chemist, Louis Vauquin, discovered nicotine, naming it after the plant from which it had been obtained, *Nicotiana tabacum*. Its isolation was achieved only in 1828 by two German chemists, Wilhelm Posselt and Ludwig Reimann. The chemical formula was described by Melsens in 1843, and

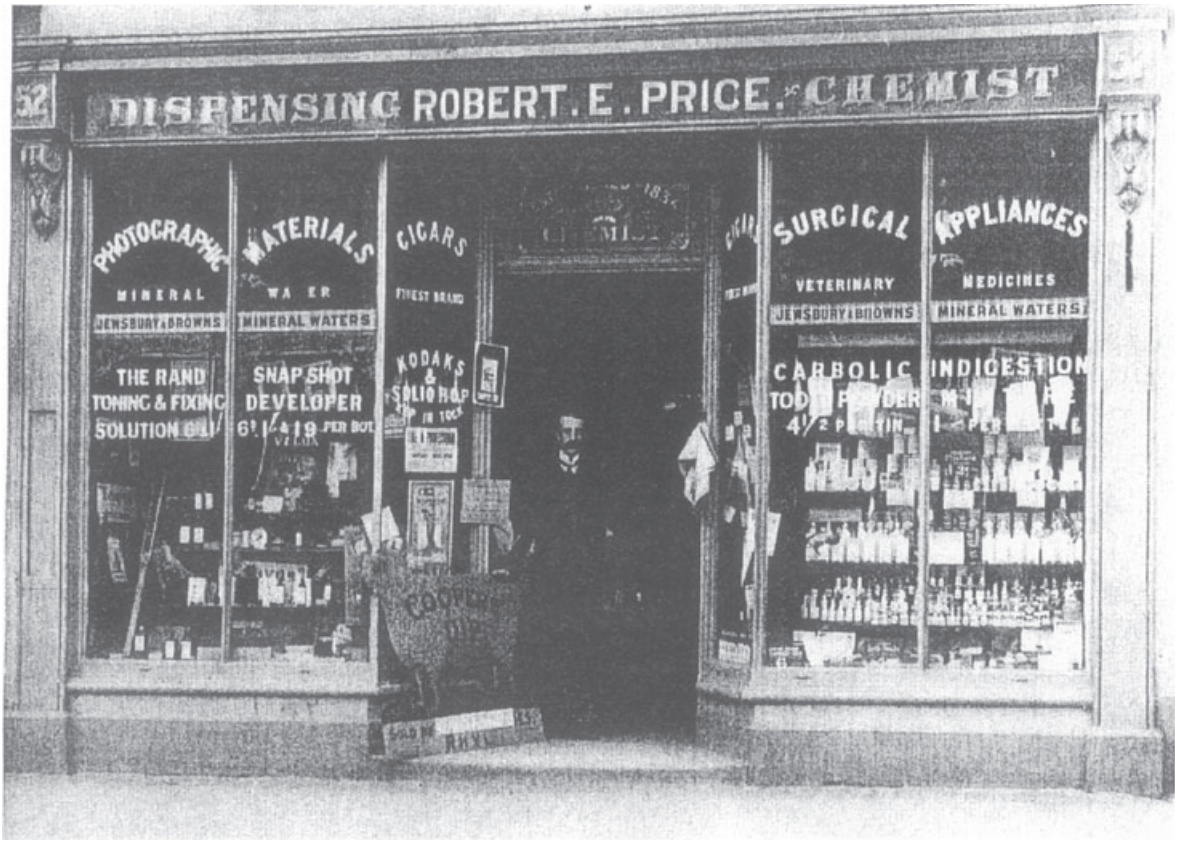

Figure 1 Price's Chemists, Rhyl, North Wales, 1909, advertising 'finest brand cigars'

it was synthesized eventually by Pictet and Crepieux in 1893.

COMMUNITY PHARMACISTS AND TOBACCO IN THE 19TH CENTURY

It was only at the end of the 18th century that tobacco finally disappeared from medical practice. Tobacco products ceased to be included in the *London Pharmacopoeia*, and did not appear in the first *British Pharmacopoeia* in 1864. There were renewed attacks against tobacco between 1830 and 1860, the opposition ranging from temperate advice to passionate denunciation. One physician blamed tobacco for causing delirium tremens, perverted sexuality, impotence, insanity and cancer; but by the end of the 19th century tobacco was essentially a leisure drug. Changes in society and the nature of work led to increases in leisure time and disposable income, and tobacco played an important part in social interactions. It invariably accompanied other social activities such as drinking and gambling.

Tobacco was available in a variety of forms, but mainly as cigarettes, as loose tobacco for use in pipes and for rolling cigarettes, and as cigars of all sizes. Snuff was also available, and the smokers' needs were met by a wide range of retail outlets. Tobacco dealing was first licensed in the 17th century, ending only in the 1960s. Premises so licensed included public houses, tobacconists, station kiosks and pharmacies. Further restrictions were imposed with passage of the Children's Act in 1908, which prohibited the sale of tobacco to children under the age of 16 years [13].

COMMUNITY PHARMACISTS AND THE SALE OF TOBACCO IN THE 20TH CENTURY

Chemists and druggists replaced the apothecaries in the retail sale of tobacco during the 19th century, and by the early 20th century the sale of tobacco products represented a significant part of the business of many pharmacies. Figure 1 shows the shop-front of Price's dispensing chemists in Rhyl, North Wales, in 1909 [14]. The shop proudly proclaims the sale of CIGARS, FINEST BRANDS in gold letters on the entrance display windows.

Many pharmacies also continued to supply tobacco in the form of snuff. While in the 18th century the use of snuff had largely been the preserve of the rich, by the 1930s it was readily accessible to the working man. Alan

Kendall was an apprentice in a shop in Shipley, Yorkshire, in 1935. He recalls:

> The mill-workers would call in on their way to or from work—or occasionally at lunchtime—and buy 3d [3 pence] worth of snuff [1/4 oz]. Often they didn't bother to ask for it. They would just hold up three fingers, or else come up to the counter and sniff. Some of them wanted it mixed with menthol. We would charge a penny extra for it. Tiny crystals of menthol would be ground up with the snuff [interview with Mr Alan Kendall, recorded on 5 December 1995].

Preparing the snuff was the job of the apprentice in the 1930s. Alan Kendall continues:

> We weighed out a lot of snuff, which was powdered tobacco. We got through 14 pounds [7 kilograms] at a time. It arrived packed in one pound tins. It was weighed out into quarter ounce and half ounce quantities. We wrapped it in pages from the *Chemist and Druggist*, which were cut into quarters. We made cornet-shaped holders. We put the snuff into it and folded down the top [interview with Mr Alan Kendall].

With the introduction of the National Health Service in 1948 the number of pharmacies holding tobacco licenses diminished as the dispensing of prescriptions became a much more lucrative activity, but trade in tobacco products continued. Indeed, in some parts of the country chemists' shops with integral off-licenses and tobacconists were seen as natural partners. In 1971, for example, Jennifer Andrews, as a newly qualified pharmacist, worked in such a shop owned by Barnsley Co-operative Society in Yorkshire. She recalls that 'people would come in and ask for "a bottle of Benylin for my cough, and 20 Benson and Hedges, please", without seeing any connection between the two' [interview with Ms Jennifer Andrews, recorded on 6 September 1995].

Health warnings began to appear on tobacco products in 1975. This followed evidence of a relationship between smoking and cancer, first reported in 1950 [15], and confirmed later in reports from the Royal College of Physicians in 1962 [16] and 1971 [17]. Despite this, many community pharmacies continued to sell tobacco products. It was only when the Pharmaceutical Society of Great Britain issued a statement to its members in 1987, instructing them not to sell tobacco products, that their sale from pharmacies finally stopped. The statement read; 'a pharmacist must not sell or supply tobacco products that constitute a hazard to health' [18].

Over the following years the statement was progressively revised and adapted. Concern arose over the safety of Skoal Bandits, tobacco-containing pouches that were placed between the gums and cheek to provide a smokeless dose of nicotine. Their story has been described by Raw [19]. By October 1989 the Council Statement on the sale of tobacco products read:

> The Council decided at its meeting in March 1987 that members be informed that they should not sell tobacco or tobacco products, including cigarettes containing tobacco, from registered pharmacy premises. The Council agreed that pharmacists should not sell *Skoal Bandits* and similar 'non-smoked' tobacco products, and that to do so would constitute professional misconduct [20].

The Royal Pharmaceutical Society of Great Britain undertook a review of its Code of Ethics and Standards in 2002, as a result of which a more streamlined approach was taken. The relevant statement now appears in the section on stock under the heading 'service specifications'. It reads:

> Pharmacists must not purchase for sale on registered pharmacy premises any product which may be injurious to public health or bring the profession into disrepute. This includes tobacco products other than nicotine replacement therapies, alcohol and products intended to mask signs of alcohol or drug consumption [21].

THE SALE OF PRODUCTS TO HELP PEOPLE GIVE UP SMOKING

The difficulties of giving up the tobacco habit were well known from the start, and by the 19th century there was already a large number of patent remedies on offer claiming to help people give it up. In the early years of the 20th century the British Medical Association (BMA) ran a campaign against medicinal products advertised directly to the public. Its book *More Secret Remedies*, published in 1912, listed half-a-dozen so-called treatments for the tobacco habit. One such was *Woods' Cure for the Tobacco Habit,* a series of tablets and pills supplied by E. J. Woods Limited through the post. This firm placed advertisements in newspaper and magazines offering a 3-day cure for the tobacco habit. A short extract gives the flavour of the claims made:

> I offer a genuine guaranteed remedy for tobacco snuff habit, in 72 hours. Overcomes that peculiar nervousness and craving for cigarettes, cigars, pipe, chewing tobacco, or snuff . . . it is unsafe and torturing to attempt to cure yourself of tobacco or snuff habit by merely stopping—don't do it. My free book tells all about the wonderful 3 days' method. Inexpensive, reliable [22].

Table 1 Anti-smoking preparations available over the counter from pharmacies in Great Britain 1965.

Brand name	*Manufacturer*	*Principal ingredient*
Ancig anti-smoking tablets	Rexall	Ferrous sulphate
Antisol anti-smoking aerosol	Aerosmoke Limited	Lobeline hydrochloride
Carter's anti-smoking tablets	Carter Bros	Lobeline sulphate
Cigenda tablets	British Chemotheutic	Lobeline hydrochloride
Finifume anti-smoking tablets	Kirby	Cocarboxylase
Lobidan tablets	Uni-Pharma	Lobeline sulphate
Lobron anti-smoking pastilles	P. and M. Warrick	Lobeline hydrochloride
Lof-U-Dine anti-smoking tablets	Loftus	Lobeline hydrochloride
Lusty's anti-smoking tablets	Lusty	Lobeline sulphate
Nicoban cachous	Macarthys	Essential oils
Nicobrevin anti-smoking capsules	Miller of Golden Square	Quinidine
Nosmo anti-smoking tablets	Ayrton Saunders	Ferrous sulphate
Peska anti-smoking mixture	Peska	Ferrous sulphate
Stanwood treatment for the tobacco habit	Stanwood Proprietaries	Ferrous sulphate
Terminex anti-smoking capsules	Richards and Appleby	Quinidine 25 mg
Triumph anti-smoking tablets	Southon	Lobelia alkaloids

Source: *Martindale's Extra Pharmacopoeia*, 25th edn. London: The Pharmaceutical Press, 1967.

The BMA's campaign against patent remedies was highly effective, and the worst excesses of the anti-smoking preparations disappeared quickly from the market. These were, however, replaced quickly by a large range of products that did not make quite such extravagant claims, and this time the preparations were sold through pharmacies rather than through the post, to give them greater credibility. Yet such was the demand for such products that these soon came to form a small but significant part of the community pharmacist's business.

This market grew steadily in the post-war period, and by 1965 there were no fewer than 16 anti-smoking preparations available over the counter from pharmacies [23]. This number was exceeded only by the number of products available for the treatment of coughs, asthma and bronchitis. Some cough preparations were aimed specifically at smokers, such as Smokies Smokers Cough Pastilles, as were certain brands of toothpaste, such as Eucryl [24]. Anti-smoking preparations available in 1965 are listed in Table 1. At that time there was a large number of small proprietary medicine manufacturers, many of which had their own version of an anti-smoking preparation. Some of these products had optimistic-sounding names such as Finifume, Lobron and Terminex anti-smoking capsules. Their common feature was a bitter unpleasant taste. How successful they were is not known, but for pharmacists their sale represented a useful little business. Figure 2 illustrates two of these products, Antisol Anti-Smoking Aerosol and Lobidan Tablets.

Figure 2 Two anti-smoking preparations available in 1965

NICOTINE REPLACEMENT THERAPY

By the 1980s only a small number of pharmacies had alcohol and tobacco licences, but any loss of revenue from smokers was to be short-lived, as pharmacists were presented with a new and even more profitable way of merchandizing nicotine. This time it was packaged not in the form of cigarettes but as nicotine replacement therapy (NRT). Table 2 illustrates the rapid development of product diversity in this area.

NRT made its first appearance in the form of chewing gum. Two strengths of Nicorette, 2 mg and 4 mg, were launched in 1988 by Pfizer. Both were classified initially as prescription only medicines (POMs), available only on a doctor's prescription. At that stage they were not prescribable under the National Health Service (NHS): they were available only on private prescription. The patient had to pay a consultation fee to see the doctor, and then the full cost of the gum itself, plus the pharmacist's dispensing fee. Only in 1991 was Nicorette chewing gum

Table 2 Nicotine replacement therapy products introduced 1988–2006.

Product form	*Brand name*	*Strength (mg of nicotine)*	*Maker*	*Year introduced*	*Initiallegal status*	*Legal status 2006*
Chewing gum	Nicorette	2 mg	Pharmacia	1988	POM	GSL
	Nicorette	4 mg	Pharmacia	1988	POM	GSL
	Nicotinell	2 mg	Novartis	1995	P	GSL
	Nicotinell	4 mg	Novartis	1999	P	GSL
	Boots own	2 mg	Boots	1998	P	GSL
	Boots own	4 mg	Boots	1998	P	GSL
	NiQuitin CQ	2 mg	GSK	2003	P	GSL
	NiQuitin CQ	4 mg	GSK	2003	P	GSL
Patches	Nicotinell TTS	7 mg	Novartis	1992	P	GSL
	Nicotinell TTS	14 mg	Novartis	1992	P	GSL
	Nicotinell TTS	21 mg	Novartis	1992	P	GSL
	Nicobate	7 mg	Merrell	1993	P	Discontinued 1994
	Nicobate	14 mg	Merrell	1993	P	Discontinued 1994
	Nicobate	21 mg	Merrell	1993	P	Discontinued 1994
	Nicorette	5 mg	Pharmacia	1993	P	GSL
	Nicorette	10 mg	Pharmacia	1993	P	GSL
	Nicorette	15 mg	Pharmacia	1993	P	GSL
	Niconil	11 mg	Elan	1994	P	Discontinued 1999
	Niconil	22 mg	Elan	1994	P	Discontinued 1999
	Boots own	5 mg	Boots	1998	P	GSL
	Boots own	10 mg	Boots	1998	P	GSL
	Boots own	15 mg	Boots	1998	P	GSL
	NiQuitin CQ	7 mg	GSK	1999	P	GSL
	NiQuitin CQ	14 mg	GSK	1999	P	GSL
	NiQuitin CQ	21 mg	GSK	1999	P	GSL
Nasal spray	Nicorette	0.5 mg	Pharmacia	1995	POM (until 2000)	P
Inhalator	Nicorette	10 mg	Pharmacia	1998	P	P
Microtabs (sublingual)	Nicorette	2 mg	Pharmacia	1999	P	P
Lozenges	Nicotinell	1 mg	Novartis	2000	GSL	GSL
	Nicotinell	2 mg	Novartis	2004	GSL	GSL
	NiQuitin CQ	2 mg	GSK	2002	GSL	GSL
	NiQuitin CQ	4 mg	GSK	2002	GSL	GSL

Source: *British National Formulary*. London: BMJ Publishing and RPS Publishing; 1987–2006.

2 mg (but not 4 mg) reclassified as a pharmacy medicine (P), which meant that it was available for sale from pharmacies: the patient now only paid for the product. The 4 mg gum remained a POM until 2000.

The second form of NRT to appear was skin patches; the first to be launched (by Novartis in 1992) was Nicotinell TTS patches, in three strengths: 7 mg, 14 mg and 21 mg of available nicotine. Other brands followed quickly. In 1993 Merrell introduced Nicabate patches in three strengths, 7 mg, 14 mg and 21 mg, although these were withdrawn from the market in 1994. A year later chewing gum containing no more than 2 mg of nicotine was reclassified as a general sales list (GSL) medicine, which meant that Nicorette chewing gum 2 mg and the others could now be sold directly to the public from any outlet, although their advertising was restricted.

A third presentation of NRT appeared in 1995. Nicorette nasal spray was introduced by Pharmacia as a POM, giving a 500 microgram dose of nicotine. In 2000 its control was relaxed to that of a P medicine, and today no nicotine replacement therapy products remain regulated as prescription-only medicines. Also in 1995 Nicorette nasal spray and Nicotinell chewing gum became prescribable under the NHS, although they were subjected to particular scrutiny. 'Prescriptions will be sent to FHSAs [the Family Health Service Authorities which monitored the prescribing of general medical practitioners] to investigate the circumstances under which they were written' [25].

In 1998 came a relaxation in the control of direct advertising of NRT products to the public. NRT products classified as Ps and GSL medicines could be advertised, including on television. Within a short time other players entered the market. Boots' nicotine gum, 2 mg and 4 mg, were soon on sale to the public, and Boots' NRT patches 5 mg, 10 mg and 15 mg, followed shortly afterwards.

New NRT presentations appeared. The Nicorette inhalator was introduced in 1998 as a pharmacy medicine. Nicorette Microtabs, delivering a 2 mg dose of nicotine sublingually, were launched in 1999 by Pharmacia. Novartis introduced a 1 mg Nicotinell lozenge in 2000, followed by a 2 mg lozenge in 2004. GSK introduced 2 mg and 4 mg NiQuitin CQ lozenges in 2004.

For community pharmacists NRT represented a worthwhile business opportunity. By 1996 the sale of smoking cessation products through pharmacies had already exceeded £41 million per year [26]. The involvement of pharmacists in the sale and dispensing of these products was considered by the Royal Pharmaceutical Society of Great Britain. In 1989 it published a statement to the effect that 'certain products marketed as medicines contain purified extract of tobacco or nicotine. No objection is made to the sale of such products when intended to help the purchaser stop smoking' [27].

COMMUNITY PHARMACISTS AND SMOKING CESSATION SERVICES

In the late 1980s yet another way in which pharmacists might benefit from the nation's addiction to tobacco emerged. In 1986 the report of a committee of enquiry into pharmacy appointed by the Nuffield Foundation (Nuffield Report) [28] supported extending the role of the pharmacist, including a role in health promotion. There was, however, a long way to go; the Nuffield Report noted that 'The Consumers' Association survey showed that few people thought of the pharmacy as a likely source of family planning advice, or for that matter of advice on diet, stopping smoking, how to cope with tension, or checking blood pressure' [29]. Despite this, the Nuffield Report recommended that 'there is a role for pharmacists in health education, in cooperation with other health care professionals' [30].

This recommendation was taken up enthusiastically by the profession, and in due course the Pharmaceutical Society included a statement specifically about the role of the pharmacist in helping people to give up smoking in its code of practice. It noted that 'community pharmacists are a key contact point at which members of the public may seek advice on giving up smoking. In addition, the community pharmacy environment offers the possibility of opportunistic advice on smoking cessation' [31]. The policy statement was supported by more detailed guidelines. 'The purpose of these guidelines is to set out a framework for a smoking cessation service, and the development of closer working between the pharmacist and other members of the health care team' [32].

The approach was essentially an opportunistic one, in which pharmacists would slip discussion of the benefits of giving up smoking into the conversation with patients when an opportunity arose. To assist with this, pharmacists were to have leaflets available for the public to take away, and through the Pharmacy Healthcare Scheme the profession became co-sponsors of 'No Smoking Day'. Pharmacies that display up to a maximum of eight health promotion leaflets, and provide a range of other services, are entitled to payment for additional professional services.

Some community pharmacists had a more active involvement. In some Health Action Zones (areas identified by the Department of Health as requiring additional support) pharmacists became involved in the provision of smoking cessation services [33]. These included a voucher scheme which allowed the supply of NRT to those patients entitled to free prescriptions. Today NRT is available on NHS prescriptions, and is prescribable by nurses. Patient Group Directives allow for pharmacist prescribing of these products through a combination of pharmacy supply of NRT and smoking cessation support. Under the new contract for community pharmacists Primary Care Trusts are able to contract directly with pharmacists for the provision of tailored smoking cessation services.

PHARMACEUTICALS FOR SMOKING CESSATION

The latest addition to the arsenal available to assist with smoking cessation is a non-nicotine pharmaceutical. Amfebutamone (bupropion, marketed as Zyban) was licensed in June 2000 as a POM available on the NHS, 'as an aid to smoking cessation in nicotine addicted patients' [34], but its introduction was not without incident. Within its first 6 months approximately 276 000 people used Zyban in the United Kingdom, and during this period the Committee on the Safety of Medicines (CSM) received a total of 3457 suspected adverse reaction reports about it. Seventy-four of these reports were of seizures, although 50% of these patients had predisposing factors; 18 resulted in death [35].

On 30 May 2001 the chairman of the CSM wrote to all doctors and pharmacists advising them of a modified dosage schedule and of new safety precautions relating to Zyban [36]. By 24 July 2002 the number of reported deaths suspected of being linked to Zyban had risen to 60. However, in most cases death was the result of the patient's underlying condition, with cardiovascular disorders such as stroke accounting for 70% of the deaths. Furthermore, the proportion of suspected adverse reaction reports to Zyban associated with a fatal outcome was less than 1%, compared to approximately 2% for all medicines.

Zyban continues to be available on prescription, where it is indicated 'as an adjunct to smoking cessation

in combination with motivational therapy'. The CSM has issued a further reminder that 'bupropion should not be prescribed in patients with a history of seizures or of eating disorders, in those experiencing acute symptoms of alcohol or benzodiazepine withdrawal', among other things [37]; and the National Institute for Health and Clinical Excellence (NICE) has recommended that nicotine replacement therapy or bupropion should be prescribed on the NHS only for smokers who commit to a target stop date. A second prescription should be issued only if a smoker demonstrates a continuing commitment to stop smoking. If an attempt to stop smoking is unsuccessful, the NHS will normally not fund a further attempt within 6 months [38].

For those wishing to stop smoking the availability of Zyban extends the range of options available, despite the limitations on availability under the NHS. For community pharmacists, it adds a further dimension to their role in smoking cessation; the pharmacist now has not only a steady flow of NHS prescriptions to dispense, but also a worthwhile trade in prescriptions for private patients and those no longer eligible for supplies under the NHS. During 2005 a total of 132 000 prescriptions for Zyban were dispensed under the NHS, at a total cost of nearly £5 million [39]. The pharmacist's role in this area has therefore extended over a short period of time from offering advice, through providing smoking cessation services, to the sale of NRT and the dispensing of Zyban [40].

CONCLUSIONS

This paper has reviewed the role of the community pharmacist in Great Britain in the sale and supply of smoking and tobacco products, and demonstrated how this role has changed, particularly in the second half of the 20th century. The role has encompassed a wide range of activities, including the sale of tobacco products, such as cigarettes, snuff and cigars; the sale of smokers' accessories, such as pipes and cigarette-rolling machines; the sale of preparations intended to help people to stop smoking; and the provision of health promotion literature.

Analysis of the reasons for the shifting emphasis identifies a number of factors which have contributed to change. They include the changing definitions of hazardous substances, perceptions of risk and the impact of research evidence (such as that for the link between smoking and cancer). Another is changes to the regulation of medicines; deregulation of medicines (prescription only to pharmacy only) had a major impact on the availability and use of nicotine replacement therapy. Other influences have been the impact of committees of inquiry (the Nuffield Report on Pharmacy in 1986), and decisions taken by the Pharmaceutical Society of Great Britain in relation to the professional conduct of pharmacists (specifically in relation to the sale of tobacco).

Despite the changes described there have also been elements of continuity. There has, for example, been continuous involvement by community pharmacists with tobacco-related products over several centuries, and particularly during the 20th century. The story of tobacco and community pharmacists illustrates the continuing tension between pharmacy as trade and pharmacy as profession. Tobacco has been an important part of the pharmacist's trade, yet pharmacy has always seen health promotion as an opportunity to extend its professional role. With direct payment for these activities, promoting healthy living becomes both a professional and a business activity.

During the course of the 20th century pharmacy achieved the remarkable feat of converting a profitable trade in the sale of cigarettes, tobacco and cigars into a much more profitable trade in products to help people give up smoking. Indeed, pharmacists have never had a problem with the apparent paradox of selling tobacco products in one part of the shop while selling products to help them to give it up in another. Tobacco has always been a useful little addition to the pharmacist's trade.

Acknowledgements

The oral history of community pharmacy from which short extracts are taken was funded through a history of medicine project grant awarded by the Wellcome Trust, project number 043205/2/94/2. The tapes form part of the National Life Stories Collection at the National Sound Archive of the British Library. Figures are reproduced by kind permission of the Museum of the Royal Pharmaceutical Society of Great Britain.

References

1. Hilton M. *Smoking in British Popular Culture, 1800–2000: Perfect Pleasures.* Manchester: Manchester University Press; 2000.
2. Goodman J. *Tobacco in History: the Cultures of Dependence*. London: Routledge; 1993.
3. Lock S., Reynolds L., Tansey T., editors. *Ashes to Ashes: The History of Smoking and Health.* Amsterdam: Rodopi; 1998.
4. Berridge V. S., Starns P. The 'invisible industrialist' and public health: the rise and fall of 'safer smoking' in the 1970s. In: Berridge V., Loughlin K., editors. *Medicine, the Market and the Mass Media: Producing Health in the Twentieth Century.* London: Routledge; 2005, p. 172–91.
5. Dickson S. A. *Panacea or Precious Bane.* New York: Longman; 1954, p. 15–27.
6. Stewart G. G. A history of the medicinal use of tobacco 1492–1860. *Med History* 1967; **XI**: 228–68.
7. Stewart G. G. A history of the medicinal use of tobacco 1492–1860. *Med History* 1967; **XI**: 234.
8. Stewart G. G. A history of the medicinal use of tobacco 1492–1860. *Med History* 1967; **XI**: 233.

9. Gerard J. *The herball or generall historie of plantes.* London: J. Norton; 1597.
10. Stewart G. G. A. history of the medicinal use of tobacco 1492–1860. *Med History* 1967; **XI**: 241.
11. Trease G. E. *Pharmacy in History.* London: Bailliere, Tindall and Cox; 1964, p. 127.
12. Beresford R. *Inventory*. Lincoln: Lincolnshire Record Office, Lincoln Castle; 1607.
13. Berridge V. Science and policy. the case of postwar British smoking policy. In: Lock S., Reynolds L., Tansey T., editors. *Ashes to Ashes.* Amsterdam: Rodopi; 1998, p. 145.
14. Tallis N., Arnold-Forster K. *Pharmacy History: a Pictorial Record*. London: The Pharmaceutical Press; 1991, p. 67.
15. Doll R., Bradford Hill A. Smoking and carcinoma of the lung. *BMJ* 1950; **2**: 4682–8.
16. Royal College of Physicians. *Smoking and Health.* London: Pitman; 1962.
17. Royal College of Physicians. *Smoking and Health Now.* London: Pitman; 1971.
18. Council Statement On Sale of Tobacco Products. *Pharmaceut J* 1987; **238**: 317.
19. Raw M. *Clearing the Air: Guide for Action on Tobacco*. London: BMJ Books; 1991.
20. Anon. *Medicines, Ethics and Practice: A Guide for Pharmacists*, Number 3. London: Royal Pharmaceutical Society of Great Britain; 1989, p. 91.
21. Anon. *Medicines, Ethics and Practice*, number 30. London: Royal Pharmaceutical Society of Great Britain; 2006, p. 93.
22. Anon. Woods Cure for the tobacco habit. *More Secret Remedies.* London: British Medical Association; 1912, p. 141.
23. Todd R. G. *Extra Pharmacopoeia: Martindale*, 25th edn. London: The Pharmaceutical Press; 1967, p. 1596–7.
24. Todd R. G. *Extra Pharmacopoeia: Martindale*, 25th edn. London: The Pharmaceutical Press; 1967, p. 1605.
25. *British National Formulary*, number 30. London: The Pharmaceutical Press; 1995, p. 217.
26. Mason P. Action on smoking: can pharmacists make a difference? *Pharmaceut J* 1996; **256**: 263–5.
27. Council Statement On Nicotine Replacement Therapy. *Pharmaceut J* 1989; **242**: 236.
28. Nuffield Committee of Inquiry Into Pharmacy. *Pharmacy: A Report to the Nuffield Foundation.* London: Nuffield Foundation; 1986.
29. Nuffield Committee of Inquiry Into Pharmacy. *Pharmacy: A Report to the Nuffield Foundation.* London: Nuffield Foundation; 1986, para 3.61.
30. Nuffield Committee of Inquiry Into Pharmacy. *Pharmacy: A Report to the Nuffield Foundation.* London: Nuffield Foundation; 1986, para 3.63.
31. Nuffield Committee of Inquiry Into Pharmacy. *Pharmacy: A Report to the Nuffield Foundation.* London: Nuffield Foundation; 1986, para 3.61.
32. Royal Pharmaceutical Society of Great Britain. *Smoking Cessation. Medicines, Ethics and Practice: A Guide for Pharmacists*, number 30. London: Royal Pharmaceutical Society of Great Britain; 2006.
33. Bednall R. Smoking cessation: evidence based intervention. *Pharmacy Pract* 2004; **11**: 125–9.
34. McRobbie H. Zyban: non-nicotine aid to smoking cessation. *Prescriber* 2001; **12**: 23–8.
35. Medicines Control Agency. Zyban safety reminder. *Current Problems in Pharmacovigilance.* London: Medicines Control Agency; 2001, 27, p. 5.
36. Committee on Safety of Medicines. Zyban: modified dosage and safety precautions. Message from chairman, CEM/CMO/2001/7. London: Committee on Safety of Medicines; 2001.
37. *British National Formulary*, number 50. London: BMJ Publishing and Royal Pharmaceutical Society of Great Britain; 2005, p. 261.
38. National Institute for Health and Clinical Excellence. Smoking Cessation. *Bupropion and Nicotine Replacement Therapy.* Technology appraisal, TA039. London: National Institute for Health and Clinical Excellence; 2002.
39. Prescription Cost Analysis England 2005. London: NHS Health and Social Care Information Centre, Health Care Statistics; 2006.
40. McNeill A., Armstrong M. The impact of amfebutamone (Bupropion) on National Health Service smoking cessation services. *Pharmaceut J* 2000; **265**: 860–2.

