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Berkeley, California

Bob Day
Associate Dean of the School of Pharmacy, UCSF: An Oral History

Interviews conducted by
Martin Meeker
in 2013

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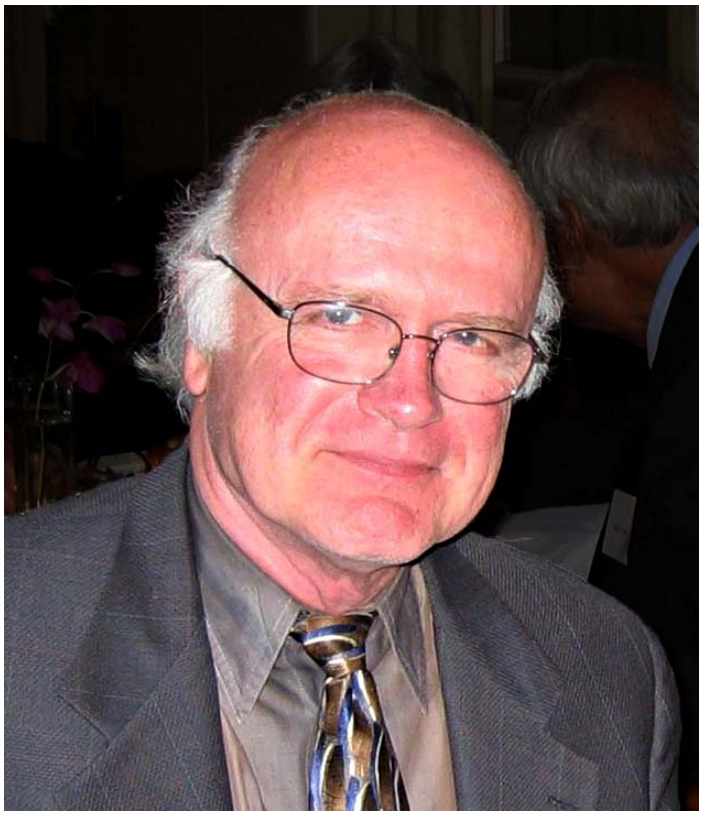

Bob Day, 2012

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Interview #1; January 15, 2013
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01-00:00:00
Meeker: Today is the 15th of January 2013. This is Martin Meeker interviewing Robert Day for the UCSF School of Pharmacy Oral History Project. And I want to begin by asking you to state your name, date, and place of birth.

01-00:00:54
Day: Okay. My name is Robert Day. I'm known more commonly as Bob Day. I was born in Sacramento, California on July 4, 1934.

01-00:01:07
Meeker: Can you tell me a little bit about the family that you were born into? Perhaps the kind of work that your father did, and I don't know if your mother was a homemaker or worked outside of the home?

01-00:01:16
Day: My mother was a homemaker who occasionally worked, in fact, worked much of her life, but there were vast periods there where she was basically at home raising the kids. But during World War II, she worked on the McClellan Air Force Base as a teletype operator. You'll have to look that up on Google. Not on Google but on Wikipedia, or whatever Wiki, to see what it is. Anyway, so she was a teletype operator, then after World War II did not work again. My father never had a college education. He did graduate from high school way back during the Depression, at the beginning of the Depression. He was born in Saint Louis, moved to California when he was six years old, was raised in Oakland, got a job, married my mother in 1930, moved to Sacramento shortly thereafter, and I was the second of three children. My dad was a school-of-hard-knocks heating and air conditioning engineer, meaning that he was the person who would go into buildings and determine the air conditioning and the heating system that they required. This was a field that he was a part of that grew up around him. Later on, people who did what he did had to be engineers, had to be college graduates. So he was an educated man, a fierce Democrat, which rubbed off on me, and lived most of his life in Sacramento. Although there was a four-year spell—was it four years?—roughly four-year spell when we moved from Sacramento to San Francisco when I was in the seventh grade. Moved back when I was entering my junior year in high school.

I went to Immaculate Conception Grammar School in Sacramento, left there in 1946 while I was between the sixth and seventh grade, moved to San Francisco, went to Saint Anne's Grammar School, just down the street from the university. Graduated from there, went to Saint Ignatius High School for two years, when we moved back to Sacramento and I went to Christian Brothers High School, at that time an all-male high school in Sacramento.

I was always interested in chemistry. I viewed myself as becoming a chemist. In fact, would have been a chemist had there not been an interesting

interaction between me and the dean—actually, not the dean, the dean's secretary in the College of Chemistry at UC Berkeley. But in any event, I went to Sacramento, what we called then Sacramento Junior College, it is now Sacramento City College, for two years. Transferred to Berkeley in my third year. Stayed at Berkeley one year, then transferred over to the San Francisco campus because I had dropped my chemistry major and enrolled in pharmacy and entered then the School of Pharmacy in the fall of 1955 when the medical center buildings were not even one year old. I think they were like a few months old when we began to tear them apart in the chemistry laboratories with our experiments.

01-00:04:38
Meeker: And which campus was this?

01-00:04:41
Day: It was the Parnassus Campus, which was where it had been since 1886. So it was just simply some new facilities that had been in planning since before World War II, but World War II stopped their construction and then they built them. That's why Moffitt Hospital has the design of a pre–World War II hospital, even though it wasn't built until 1954. Construction started, I think, in 1950.

So I then went to what was then known as the University of California College of Pharmacy. At that time it was a two- and three-year program leading to a BS degree, meaning you had to have two years of pre-pharmacy, which was basically the same education that physicians—that a lot of science majors—have. We had a heavy science curriculum those years, so we took classes with engineers, with physicians-to-be, with anybody that wanted heavy duty science, and then three years on the San Francisco campus to earn a BS degree.

Shortly before I entered the School of Pharmacy, UCSF had agreed to offer the PharmD degree but I think they offered the first one in '54 or '55, thereabouts. You will find that as a historian I stink. My dates are kind of like vague. I'm not a strict historian. I don't ponder over dates and commit them to memory. I was offered that opportunity to get the PharmD degree on top of my BS degree, which was an additional year of education. At that time the all PharmD program had not yet been implemented by the school, or if it had been implemented, it was in the process of working through the ranks, so that we who returned to get the PharmD degree were graduate pharmacists. I was actually licensed as a practicing pharmacist when I was in my doctorate year. I could work part-time in a pharmacy. Actually, I worked pretty much full-time. Yeah, I did. I worked pretty much full-time as a pharmacist because I was married and got the PharmD after that additional year.

We were the second school of pharmacy in the nation to offer a PharmD degree. University of Southern California being the first, beat us out by a

couple of years. But actually, they didn't really beat us because we started the process before they did. We just had a much larger bureaucracy to convince that we had the right to give the doctorate degree for an additional year of education, for a six-year program. Then, as now, there are people that say, "Well, you shouldn't give a doctorate degree with six years." And I don't know what the argument was because I wasn't a part of it, but we somehow won and were able to convince the regents that we should have a PharmD program.

So I graduated in 1958, got my BS degree there, graduated again in 1959 with my PharmD degree. I should tell you that there was no good reason to get a PharmD degree then. If you graduated with a PharmD or a BS, or both of them, as I had, you did nothing any differently than any pharmacist did. That is to say, you were expected to be in a pharmacy, to fill prescriptions, to work with the front—the people who walked in through the door—and to work in a hospital. There were lots of opportunities. You could be a representative for a drug company, but it didn't matter what degree you had—BS or PharmD—so there was no advantage to it.

The thing that appealed to me and the people who were my classmates—only about a third of us went on to get the PharmD degree—was the fact that the curriculum for the PharmD program was the first critical curriculum that we'd been exposed to, "critical" meaning it was critical of drug therapy. Up to that point in time we memorized that diphenhydramine was an antihistamine, it was used to treat runny nose, all sorts of things. But ask us the dose and we weren't certain of that. Ask us which was better, diphenhydramine or any number of twenty other drugs, we wouldn't know. Were the drug manufacturers good people? Oh, they were wonderful people [sarcastically]. In other words, we were not educated to be critics. We were told then, and it turned out to be true, that the doctorate year would bring us into the realm of becoming experts in criticism, that the world of drug therapy isn't such a marvelous fuzzy warm thing after all. It has all of these things that are wrong with it, it has all of these things that are right with it and we began then to talk about some things that would eventually lead to clinical pharmacy.

My class did not graduate as clinical pharmacists. We graduated as pharmacists, like every other pharmacist in the nation, with more chemistry than a chem major ever had in Berkeley, knowing more about chemistry, knowing more about the physical properties of substances, drugs included, knowing more about how drugs are put together than any other skilled individual. Unfortunately there wasn't a demand for that out in the community. What the physician wanted at that time from a pharmacist was to fill the prescription. What the owner of a pharmacy wanted was not a rundown on the stereochemistry of this drug as opposed to the stereochemistry of another drug. They didn't want that. They wanted you to fill prescriptions. Owners wanted you to run the operation. Physicians didn't expect anything else from you and so, therefore, they didn't ask it. You didn't expect physicians to ask it, so you

didn't learn it. So we were basically trapped, as were all pharmacists, in a role that was primarily dedicated to dispensing. We could consult with the patient. We could talk to the patient, but our role was very, very limited, restricted by an ethic approved by the American Pharmacist Association in the late 1800s that said, "Thou shalt not counter prescribe." Counter prescribing was a dirty term. What it meant was when you go to the counter you're a pharmacist, you're not a physician. Only physicians can prescribe. A patient comes in and said, "What can I take for my runny nose?" If you said at that time, "Neosynephrine," you were counter prescribing. So you were not to do that. You were not to engage in a discussion of drugs. Patient receiving a new prescription would ask, "What is this for?" "Have you talked it over with your doctor?" "Yes." The trick was to ask the patient a question. "Well, what did you go to the doctor for?" "I went to the doctor for a runny nose." "This is very good for a runny nose." You were supposed to be a parrot, but some of us didn't believe that.

01-00:11:13
Meeker: Well, let's pause here for a little bit.

01-00:11:15
Day: Sure.

01-00:11:16
Meeker: Because I feel like we're now already on the verge of jumping into a discussion about clinical pharmacy. But what I want to do actually is go back and ask you some follow-up questions about your upbringing and how it was that you got into, first, chemistry at Cal and then interested in pharmacy at UCSF. So I am actually a little more interested about your personal and family background. You, it sounds like, went to all parochial schools or Catholic schools.

01-00:11:44
Day: I did, mm-hmm.

01-00:11:45
Meeker: So I assume you were raised in a Catholic family?

01-00:11:47
Day: I was. I'm good at guilt.

01-00:11:49
Meeker: Okay [laughter]. Was your family fairly devout?

01-00:11:53
Day: No.

01-00:11:58
Meeker: Cultural Catholics maybe?

01-00:11:59
Day: Yeah, yeah. And they wanted us to be Catholics. I don't know why. They wanted us to be Catholics, too, so we were baptized and raised. And when I was very young I thought I wanted to be a priest. That was one of my thoughts. It wasn't a really serious thought. No, I, take it back. When I was in the eighth grade it was one of my serious thoughts. So I thought I wanted to be a priest because I was, at that time, like any Catholic kid, captivated by religion. I really enjoyed the ritual. I enjoyed Catholicism. I enjoyed Christmas. I enjoyed everything about the Catholic Church at that time when I was young.

01-00:12:38
Meeker: The mystique of it?

01-00:12:39
Day: Mystique. Caught up by the rituals. I was what was known in circles, at that time, as a crack altar boy. I was a dedicated altar boy. I got up and I would serve when no other kid in the world would serve, six o'clock mass at Saint Anne's Church in San Francisco. And I would then turn around and serve seven o'clock. I'd serve funerals. Most altar boys didn't want to serve funerals. They were depressing and you didn't get tipped. They wanted weddings. I would serve funerals because I didn't care because I really wanted to be close to the ritualism. I thought it was God's calling, but I think I was just captivated by the environment. So that was my background. And I was, at the eighth grade, determined that I would become a priest and talked to my dad about it.

01-00:13:33
Meeker: And his response was?

01-00:13:35
Day: My dad was a very intelligent man. My dad also knew that I was too young to make that decision and he needed to find a way—and my dad always found the way—to sort of make me do it, to sort of get me to go along with him. He basically said, "Well, if you want to be a priest, I think that's phenomenal. I think that's incredible. I will be incredibly proud. However, I think it's too early for you to make that decision. Why don't you wait? I'm asking only that you wait until you graduate from high school. By that time you will know for sure if you've got the calling, okay? So although I know you're disappointed because you want to go to the seminary right now," which I did—

01-00:14:18
Meeker: In eighth grade?

01-00:14:18
Day: Right out of the eighth grade. I was recruited by priests because I was an altar boy. They confused that with being the next generation of priests, I guess. Or maybe I would have made the same mistake if I was a priest. I was really into this thing. I served everything. I got to the point where I and another guy, Freddy, were probably the top altar boys in San Francisco. We could get assigned to the cathedral, downtown San Francisco cathedral for what they

called solemn high masses. Then they celebrated something called the fifty-year mass. We were the altar boys selected for that because we'd paid our dues. We had done all these other things, and so we got these things, choice things. We got all the weddings we wanted. We didn't have to serve funerals anymore. We got the children's mass on Sundays. The children's mass was eight o'clock mass and all the kids in the school had to go to that mass. The nuns would cajole them into going to eight o'clock. All the kids were to be there. Well, if you served eight o'clock mass, you were in front of all of your classmates, right? That was a great place to be.

My dad knew that I would discover something while I was in high school, and I did, and that would dissuade me from becoming a priest, and it's called girls. When my dad told me that years later, [laughter] he said, "I was a little worried."

01-00:15:33
Meeker: Did you develop an interest in theology early on or was it—

01-00:15:37
Day: No, no. No. I don't know what your religious background is so I hope I don't offend you.

01-00:15:44
Meeker: No, I was raised Catholic, as well, and I went to a Catholic high school, so—

01-00:15:48
Day: I'm very reluctant to discuss religion with people because my beliefs are not theirs, but I appreciate their beliefs. I was caught up in the ritual. And there's a degree of indoctrination that goes on. This is where I don't want to offend you. I was in Catholic school all the way from first grade up through high school and there's a degree of indoctrination that goes on in that. Catechisms you learn, the way of thinking you learn, the no doubting the Pope. You learn the sense of mortality, the sense of hell, the sense of heaven. Catholic Church was, at that time, not hell and brim fire, but if you died with sin on your soul, damn it, you went to hell. So I was caught up in the abstract of all of that. I felt I was religious, but I think what I was really was, was indoctrinated. I don't mean brainwashed. But I was like any kid. You go with the things that appeal to you. That's why we eat candy. I went with the robe because I really liked it.

01-00:16:58
Meeker: Do you feel like there are any values that you learned during that period of time that continued with you throughout your life?

01-00:17:06
Day: Sure, but I don't know what they are. I would never deny that anything in my life, good or bad, did not have an influence on me. That had to have had an influence on me in terms of my ethics, in terms of my morale... morals... which is quite different from what it was when I was a practicing Catholic. In terms of my hopes for the afterlife, all that kind of stuff. It all affected me.

And it had to have. The hardest thing for me in the world was to commit sacrilege, which I did one time knowingly, because my dad died and I wanted to go to communion and my wife was using birth control and that was against the rules of the Catholic Church. You were in a state of mortal sin if at that time your wife was using birth control. We had three kids in four years. It was time to stop. My dad died and here I was caught without the ability to go to confession, which would have been act of sacrilege in itself because you never go into confession knowing you're going to do it again. And I knew that I was going to do it again. So I accepted the communion host at his funeral and that was the last time I did anything like that with the church.

But the sense of sacrilege was so strong that I was depressed for a long time afterwards, because I had basically damned myself. And then you do one or two things, I think, when that happens: you either go crazy because you're going to be eternally damned, or you start figuring out some stuff. And the stuff I figured out—again, I don't want to collide with your religious beliefs—was to basically rationalize—not rationalize, think about some of the concepts, think about some of the realities of religion and to come to entirely different conclusions than those which I had been inundated with while I was being trained as a Catholic. So I threw away, one by one, some of the beliefs. Now, as a Catholic, even though you throw away one belief, the others are not very far behind because you have to accept them all. You can't say, "I'll take this belief and I'll take that one. Thank you, but I'm a good Catholic." You can't do that. Am I getting off the—

01-00:19:14
Meeker: No, not at all. In fact, I was going to ask, in hindsight, do you think that this was maybe an application of the scientific method to your own belief system once you started to maybe test some of these ideas outside of the realm of indoctrination in our culture and start to them about them more intellectually?

01-00:19:34
Day: I don't know. It could have been self-preservation. Remember I said you can ponder it to death. I was depressed and I suppose you can end up insane or you sort of say, "Well, let's cope with this." Okay, how can I cope with the reality that I'm going to go to hell? Well, maybe there isn't any hell. But people say there is a hell. It's a back and forth and sooner or later you get the notion where it just strikes you as too much of a fairytale. I think that I had a reason to explore those. A lot of people, maybe, don't have the same reason that I had. Remember, I was devout before. But the instant I decided to use birth control was the first crack. My wife is not Catholic. So I was not going to expose her to another baby and I wasn't about to give up sex.

01-00:20:32
Meeker: And this would have been in the 1960s, I guess?

01-00:20:33
Day: Yeah. My last child was born in '62. So that was when we decided.

01-00:20:43
Meeker: So this is actually just about the same time that birth control is becoming more widely available and the Supreme Court is considering the legality of it.

01-00:20:52
Day: The pill wasn't out then. The pill was not yet out at that time.

01-00:20:55
Meeker: Ah, okay.

01-00:20:55
Day: We used alternate methods.

01-00:20:57
Meeker: You had also mentioned your father's devout affiliation with the Democratic Party. I don't know if that's the right word to use. The question was it was a big D as opposed to a small D democrat.

01-00:21:11
Day: Well, he was not an activist in it. Other members of my family are. There's a whole branch of the Days in Texas who are basically unhappy most of the time because they can't get their people elected. But they're out there fighting for them. My dad was never that. My dad was just a Democrat. Somebody used the expression "a Yellow Dog Democrat" or something like that, which means he'll be a Democrat. You can kick him away, he'll sink his teeth into you, you can kill him and his Democrat teeth will still be sunk into you. My dad was that. He was also an intelligent man. So when my dad came out with some of these really strong opinions about Republicanism, I listened to him because he was a pretty smart guy. But he also tried to learn as much as he could about Republicans. He read Republican literature. He read Nixon's book on China. His visits to China, or whatever it was. He called it his seven accomplishments—I forget, there's a name for it, and he put it like a crusade sort of term. And my dad read that book, and he read it page to page, from front to cover. But he also read it with commentary, because I can remember him sitting in the chair and turning the page and reading something and saying, "That's bullshit. Absolute bullshit." That was my dad. I don't know that he was a rational Democrat. He was an emotional one and I think he was an intellectual one.

01-00:22:45
Meeker: Well, looking back to the 1930s when he was having kids and I imagine coming into a real clear understanding of what his beliefs were. This, of course, would have been the New Deal, the Depression. And when I've interviewed other people and they talk about their upbringing in the 1930s and their parents' political affiliations, the big difference, typically, that I've heard people talk about is that the Republican Party was the party of privilege and the Democratic Party was the party of working people. Do you think that that adequately describes your father's attachment to it?

01-00:23:26
Day: I don't know. I don't know. I don't know where Republicans were during that time. I have not studied them. I think that would have been rather consistent but I can't say my dad did that because he was the working class or the whatever it is. Well, the working class is largely Republican now. What we would call the working class.

01-00:23:49
Meeker: Or at least the white working class.

01-00:23:51
Day: The white working class. Yeah. And so my dad, I don't know, I cannot give you a hint as to—I don't even know. We never discussed politics until I [laughter] one time suggested that I was going to vote for Eisenhower. That was when we got into a deep discussion about politics. And my dad had always been Democrat. There's no question in my mind he was. He never tried to convert me, never tried to influence me except this one time. So I don't remember having discussions or hearing him talk to my mother about the damn Republicans. He never did that. He never attacked them, he just disagreed with them. And he was, as I said, I think to the grave he was a dye-in-the wool Democrat. He would have been greatly displeased to learn that my brother became a conservative Republican, and as did his wife, my mother, and as did his daughter, my sister. All of them conservative Republicans. My brother died twenty years ago but he died—what was then the precursor to a conservative.

01-00:24:58
Meeker: It is interesting, because if you look at sort of the trajectory of Catholics in the twentieth century United States, they've moved really from being the core constituency of the Democratic Party, the urban Democratic Party in the north to, by the 1980s, during the Reagan Administration, one of the core constituencies of Reagan Republicans. And there's transition I guess sort of in cultural values in the United States that Democrats kind of started to feel—or rather Catholics started to feel more affiliated with cultural values of the Republicans than Democrats, which became the party of urban minorities and later on of gays and lesbians, of feminists, of all these like groups that there is this transition happening. So I'm thinking about your family growing up. Do you feel like your father maybe kind of in this Dorothy Day, sort of *Catholic Worker* tradition?

01-00:26:05
Day: I don't know Dorothy Day. You mean Doris Day? I don't know.

01-00:26:07
Meeker: Dorothy Day. She was a Catholic activist, a woman Catholic activist, who I believe maybe is under consideration for sainthood.

01-00:26:15
Day: Oh, I don't know her. I will draw an absolute zero when I try to define why my dad was a Democrat or the reasons he was or the things he thought about it. They came out in his act and deed but never with the title Democrat or Republican.

01-00:26:35
Meeker: What does that mean? His act and deed. Can you give me an example?

01-00:26:37
Day: He just acted like a Democrat. He would talk a candidate up. He really loved Harry Truman. When Harry Truman came in, he followed FDR and I can recall looking at this eloquent president, President FDR, followed by this kind of like bumbling Harry Truman and saying, "Oh, yeah." At the time I was only fourteen or so. Hell, I was less than that. I was twelve. And we loved FDR. He became the father image during World War II and I was part of World War II in that sense. I was a kid. My dad was from the very beginning in love with Harry Truman. Would talk about him. During the election of 1948 when the newspapers predicted he was going to be defeated by Dewey, my dad didn't believe that for a moment. "Commentators," he said, "are predicting a victory for Dewey." And he said, "I don't see it. I don't see it in the people I talk to." So I can't tell you a whole lot about where he came from politically. I don't know if my grandfather was a Democrat because my grandfather died at a very young age. No, I'm sorry. My grandfather died before I was born, when my dad was married but not married for many years. I don't think my brother, who is three years older than me, ever met my grandfather or paternal grandmother or our maternal grandfather. They had all died by the time we were born. So I only ever knew one grandparent, and that's my mother's mother.

But getting back to my dad, I don't know what his origin is. I don't know if he was like my sister—like me now—in a group of conservative Democrats, I mean Conservative Republicans. I don't know if he was like me, afield in his family. I kind of doubt it. My dad was also a racist, but not an overt one. He did see African Americans as being inferior and he would use the N word a lot. But it would be derogatory—there's no question of it—he thought that but it was never, ever as an expletive.

01-00:28:58
Meeker: Well, I'm wondering, when you grew up, what sort of interactions, personal interactions would you have had with non-white people who lived in Sacramento and San Francisco?

01-00:29:08
Day: Not much.

01-00:29:09
Meeker: Where was Saint Anne's Parish?

01-00:29:11
Day: Saint Anne's is out in the Sunset District. It's right by the university. I think maybe Saint Anne's is between Thirteenth and Fourteenth on Judah. Judah becomes Parnassus and the university is located on what would be First Avenue. So it's fourteen blocks on Parnassus, which Judah becomes. So I ended up working fourteen blocks from where I went to grammar school for a period of two years.

01-00:29:35
Meeker: What was the first presidential election you voted in?

01-00:29:37
Day: Eisenhower, I think.

01-00:29:39
Meeker: Was it '56?

01-00:29:40
Day: I didn't vote for him. It was the election in which he ran. No, '52.

01-00:29:46
Meeker: Fifty-two.

01-00:29:47
Day: Let's see, in '52 how old was I? I don't think I voted in that one. Let's see, let me think about it. Maybe it was the second time Eisenhower ran. I was born in '34. Forty-four, '54. I would have been too young to vote.

01-00:30:01
Meeker: Yeah, it was twenty-one then.

01-00:30:02
Day: I actually went to a Republican rally in 1952, but I didn't know it was a Republican, with one of my buddies. I could never tell my dad about it. And I'll never forget a slogan at the time, because Truman had not yet announced he wasn't going to run and the Republicans had this cute little phrase going around, "Don't change pricks in the middle of a screw. Vote for Truman in '52." Yeah. So he never ran, though, because he stepped away from it. So it must have been the next election. Frankly, I don't remember.

01-00:30:36
Meeker: Yeah. Well, I could be wrong here and I don't want to get this on tape, but I think it was '56. It was maybe Adlai Stevenson.

01-00:30:42
Day: Could have been. Yeah.

01-00:30:43
Meeker: And I know that he was a big touchstone for a lot of people coming of age in California because he was kind of a different sort of Democrat. Maybe a little more intellectual and thoughtful about certain issues.

01-00:30:56
Day: And I know what happened with Eisenhower. I began to speak favorably about Eisenhower and my dad agreed with me. He said he was a marvelous general. He was a magnificent general. “But we’re talking about the president of the United States, and he’s a Republican!” So he’d discuss it from that point of view. [laughter]

01-00:31:14
Meeker: So you spend two years at Sacramento Junior College.

01-00:31:20
Day: I was a chem major at the time.

01-00:31:22
Meeker: As a chem major. So you actually had a major at a junior college, correct?

01-00:31:26
Day: Mm-hmm.

01-00:31:28
Meeker: Were you living at home during that period of time?

01-00:31:31
Day: Yes.

01-00:31:31
Meeker: Were you working?

01-00:31:32
Day: Mm-hmm.

01-00:31:32
Meeker: What kind of work were you doing?

01-00:31:34
Day: Oh, let’s see. I had had miscellaneous jobs when I was growing up. As a paperboy in San Francisco, delivering the *Call Bulletin* until I moved to Sacramento. When I moved to Sacramento I was too old to do a paper route, so for the next two years I didn’t do much. But when I was either seventeen or eighteen I began to work for a company called Kress. It's a department store but really cheap.

01-00:32:03
Meeker: Spelling is K-R-E-S-S?

01-00:32:05
Day: K-R-E-S-S. In their cafeteria as a busboy. Did that for a year until I got laid off They asked me to bring somebody from the school and they liked him better than they did me, so they had to cut back, so they cut me away even though I’d been there six months longer. But Vince remained my close friend all the way through even college. The guy that I got the job for. So anyway, so

I did that for a couple of years and then I worked for Montgomery Ward's as a shoe salesman, and went away to college and came back in the summertime and worked for Montgomery Ward's again as a shoe salesman. I was not in pharmacy school yet. And got fired, and I should have gotten fired. But I got fired because a friend of mine got married and wanted me to go this wedding, a close friend, and I wanted to go to his wedding. And I went to the manager of the department a month in advance and said, "Joe, I need the Saturday off," whatever it was—May the 15th or June the 15th. And Joe was one of these kind of like guys for whom the world was always gray. "Oh, well, you know, Bob, I—" You asked Joe how things were, "Well, you know, Bob, they could be better." And he was just a depressed kind of guy. And he worked for a company that really exploited the people that worked for it, paid them basic minimum. I think I earned a dollar an hour when I worked for Montgomery Ward's. And then you got commission theoretically, but you only got commission if you sold a lot of shoes. And if I sold a lot of shoes, I took them away from the guys that were selling them who had to support families. So I was not their top shoe salesman, giving all the big boot sales to the guys that—somebody come in and ask for boots—that was the big one that added a lot of money to your sales—I would turn it over. Anyway, I got canned. I got canned because I wanted to go to the wedding and he said, "Well, you know, Bob, it's a Saturday. Saturday we do thousands of dollars," although the department was really kind of slow. But the point of it is that I was really pissed off because I had explained to him this was my closest friend and I knew that the world would not end if I wasn't there for a Saturday. Yes, they'd all work harder, but they'd all make more money, too. And they would not be deluged with people. And he'd go, "Well, people will walk out, Bob, and Wards is entitled to all the sales it can get." I mean, this guy was really depressed.

So basically I decided I'm going to go to the wedding. There was a woman in the department who had once asked me to cover for her. She said, "Would you mind telling them on this Saturday that I'm not going to be here, that I called in sick because I've got to go away because my parents are… and they won't give me Saturday off." So I said, "Sure." So I lied for her, said to Joe that she had called in. Actually, it wasn't Joe but a new a guy that replaced Joe at that point in time. It was the same kind of personality. So anyway, I let them know that she was ill. She got away with it. I did the same thing, only she broke down and told them I had asked her to tell them that. I figured she owed me a favor. So I found that out later from one of the guys that worked there, because I walked in for work on Monday, the boss said, "Don't bother, just leave." I said, "Why?" "You're fired." "Why?" "You know why." "Well, why?" "Don't give me that bullshit. Just get out of here. You're through." Yeah. So I knew why, but I didn't know how until a guy named Herb, bumped into him in a coffee shop someplace, said, "You got screwed by—" I don't remember her name. Basically she went to him and she was nervous and fumbling and stuttered and all this kind of thing and then so-and-so broke her down and she told him I'd asked her to lie for me.

01-00:36:18
Meeker: So was it always understood in your family that you were going to attend college?

01-00:36:22
Day: Yes, all of us.

01-00:36:25
Meeker: Had your older siblings or—I don't know. You were middle—

01-00:36:28
Day: My brother.

01-00:36:28
Meeker: Yeah, your older brother and you had a younger sister.

01-00:36:31
Day: Yes. My brother started college and then he got a commission in the National Guard and he went into the service for two years. But he continued college when he came back. No, that was never a question. My dad wanted me to be an engineer. He was really unhappy when I didn't. He was really unhappy but he was less unhappy than he might have been when I told him I want to be a chemist. Because two things were going on, he told me later on. He always figured, "Well, chemistry's not that far from engineering. And maybe along the line I can convince him to switch." Because Dad wanted me to be an engineer. That's what he viewed himself as. And he was, a self-made mechanical engineer. And he said that was a great future. Doesn't have to be air conditioning. Had a great future in electronics and all this other stuff. But I disappointed him when I didn't. So I went and majored in chemistry and then, when I switched to pharmacy, I thought he was going to faint.

01-00:37:32
Meeker: What attracted you to chemistry?

01-00:37:33
Day: I just had always liked chemistry. I was always doing things when I was a kid. Mixing things together, making gunpowder, blowing things up, pouring chlorine on stuff to see what it did. Tried to make nitroglycerine one time, figuring, well, chlorine is strong, and I had some glycerin. Not understanding the chemistry, I mixed the two together and thought I was going to make something as powerful as nitroglycerin because I thought glycerin was powerful stuff. I was just a kid, a little kid

01-00:37:59
Meeker: Did you ever have any mishaps?

01-00:38:03
Day: Several, yeah. Burned down a garage one time. Another time set fire to a coffee table. My dad was absolutely convinced I was going to be a firebug. I had set fire to curtains one time when I was experimenting with lighter fluid

and an electric razor. I just did really dumb things, but I was always doing that. And I burnt down the dining room table because I was doing a chemistry experiment. Forbidden, because I had burned down a garage a couple of years earlier playing with celluloid film. Celluloid film, that burns like crazy. I don't know if you're familiar with it, but we could make smoke bombs out of it by rolling it up in a piece of paper, lighting it and stamping on it. I didn't stamp this one out and didn't know it, so it burned down the garage. So I was guilty, I did it. Burned down the dining room table because I was doing a chemistry experiment, and they'd had a candle where you heated up the ingredients. I walked away and came back a few minutes later and the entire table was on fire. So my parents were convinced.

So my interest in chemistry started early, when my brother went to high school and he took chemistry. He also went to Saint Ignatius. At that time we were in San Francisco. I was in Saint Anne's Grammar School, He was in Saint Ignatius. Ultimately I would join him at Saint Ignatius but only for two years. But he would bring home his chemistry lessons and his chemistry book and I would study them. I knew more about chemistry than he did by the time I entered college. My brother didn't like chemistry that much. I would help him with his homework. So it was just an intuitive sort of thing. It was just an interest. Some people, it's a hobby; for me it just seemed natural.

And when I went to college, it was a natural for me to major in chemistry and it was a natural for me to get excellent grades in chemistry and to develop and to streamline some of the processes. This is going to sound like bragging but I was taking qualitative analysis, a course that teaches you how to analyze a chemical—not the quantity of it but whether it is present. Qualitative. Is there zinc in this sample? Is there iron in this one? And the techniques they used were time consuming and very slow and I saw how to do two or three of them very quickly, in a one-step process rather than a two, and was able to analyze them rapidly. So I was creative in a sense. I didn't invent anything. I don't even know why the textbooks didn't show you the easier way to do it; I guess these were just time-proven ways. And the same thing happened when I went to pharmacy school. I did the same thing there. Got all my experiments out of the way in two weeks.

01-00:40:38
Meeker: Did this ever cause any rift between you and your professors, particularly when you were at Cal for a short period of time?

01-00:40:44
Day: No, they were impressed. I didn't do chemistry at Cal, okay. Cal is where I ran into an obstacle. But my professors at Sacramento J[unior] C[ollege] were very impressed. They doubted me. One of them said, "There's no way you could have had that result this quick Bob, so who told you what was in it?" And I showed it to him. And he said, "Do it again. Do it again. It works." No, they were impressed. They were not rigid, they just wanted to make certain

that I had done what they had always said: “Think out the process. Just don’t do it blindly. Seeing can be believing if you believe it first,” and all those kinds of things. They were good teachers. And I impressed them and I knew I impressed them and I impressed myself.

01-00:41:31
Meeker: So you moved from Sacramento Junior College in ’54 to UC Berkeley and you were there for about a year?

01-00:41:37
Day: Yeah. I had intended to graduate from Berkeley. So when I transferred from Sacramento JC to Berkeley I was as a chem major.

01-00:41:50
Meeker: How did you find it? How was it? Meaning did it seem different from junior college?

01-00:41:55
Day: Berkeley?

01-00:41:57
Meeker: Yeah.

01-00:41:58
Day: Oh, day and night. Berkeley was an exciting, thrilling place. I got tied up with a fraternity, which was just about the most exciting thing I could do at that time.

01-00:42:07
Meeker: Which one was it?

01-00:42:07
Day: Phi Sigma Kappa. It was up on Warring Street. I got tied up with them and it really didn’t affect my studying, I think, because I was able to survive and do well, but it did affect my growth. I was away from my parents, I was away from Sacramento, which was a little different then. Remember that communications have sort of flattened the United States in terms of culture. But that wasn’t always that way. When I moved from Sacramento to San Francisco in 1948 there was a vast gap between Bob Day, the Sacramento kid and the kids who were raised in San Francisco. They were cliquish, they were sophisticated, they were sarcastic. And I became their pummeling tool. Yeah, I was bullied because I was different. I dressed differently, I looked different—and when I went back to Sacramento, having been in San Francisco for those four years, I was—

01-00:43:10
Meeker: Sophisticated.

01-00:43:12
Day: —sophisticated. Wearing clothing that people would say, “Where did you get that?” “Why?” “That’s really neat.” Because at that time television hadn’t really flattened us, neutralized the cultural differences between vast regions of the country, which I believe it has now, although—

01-00:43:26
Meeker: It would have been a long distance call between Sacramento and San Francisco.

01-00:43:31
Day: Yeah. And the TV stations at that time were all in San Francisco. People had put these vast antennas up on their houses to get them. So not everybody had a TV set when I moved back to Sacramento. But anyway, so Berkeley was exciting. It was an absolute change. I developed what I thought would be lifelong friendships, although I’ve lost them over the years. Fraternities do that to you. Fraternities are another kind of indoctrination. I came into it out of Sacramento and kind of like Joe College, go, go, go kind of thing. Got into it. And I became a part of it. Hazing in those days truly indoctrinated you. It was brainwashing. But I’m not blaming it on that. That’s not it. I just enjoyed it. Once I got through hazing I really enjoyed it. They call it pledge week, where they just basically humiliated you for a full week, brutally, in every possible way, sleep deprivation, whatever. All part of becoming a Phi Sig. “Why are we doing this to you, pledge?” Plebe, or as they called us in those days, “wart.” You were degraded. You were not a human being. You were a wart or something. Frog or something. “Why are we making you do this?” “In order to be worthy to be a Phi Sig, sir.” Okay. And you believed it. Oh, yeah, yeah. That’s why you could go on and do it to the next guy.

01-00:45:02
Meeker: Where in Berkeley did you live? Were you in a dorm?

01-00:45:04
Day: I lived in the house, in the fraternity house on Warring Street, which burned down years later. I didn’t do it.

01-00:45:09
Meeker: You had nothing to do with that one?

01-00:45:09
Day: No. No candles. I wasn’t there when it happened. So Berkeley was exciting. The classes were gigantic. I came from a physics class of thirty people to 450 and was exposed to these exciting professors, and there were bohemians. We called them bohemians on campus that wore beards. Beards! My God, that’s really weird! We were pretty much conservative kids in those days. Truly conservative. I don’t mean politically but conservative by today’s standards.

01-00:45:44
Meeker: Were the lab facilities substantially different from the junior college to Berkeley?

01-00:45:49
Day: No. No. Sacramento Junior College was a very good school. I did not suffer the way some of my classmates in Berkeley did transferring from a JC. I learned later, even when I was on the faculty at USCF, I learned later that Sacramento JC was considered equivalent to Berkeley in the first two years, in what it did, the first two years of college. And it was. I suffered no competitive transfer. I didn't come from Bs and As to Cs and Ds. In fact, I got some As in courses which I had previously at Sacramento got Cs in. I actually have a number of Cs on my record. I was a mediocre student. Actually, I wasn't a mediocre student, I just got interested in things and let other things go by. But anyway, so Berkeley was exciting, truly a wonderful time to be there. I'm sorry it only lasted one year.

01-00:46:47
Meeker: Yeah. So why did it last just one year?

01-00:46:51
Day: Because I was a chem major, because I wanted to go into upper division chemistry. When you were admitted to Berkeley, you had to not only be admitted to Berkeley but also apply for admission to upper division. And I got a letter saying, "You're not eligible to go into upper division." And I had done everything I was supposed to have done, I thought, to get into upper division. I had a counselor who said, 'Bobby,"—this is one of those stories where you wish years later you could have bumped into that counselor because he really depressed me. He said, "Bob, you're not college material. Look at your entrance exam scores." I took the entrance exam—which was totally unnecessary, but I took it—with a hangover because I had been at a party. I don't want to excuse it, it's just that he said, "You're not going to make it." And I thought years later when I got my diploma, "God, I'd like to shove his that up that guy's ass." That statement I wouldn't make it. I never doubted my intellectual or academic ability, I just never over anticipated what it was. I never set my expectations high.

So I went to Berkeley fully convinced that this was a reasonable university, they would listen to me and they would say, "Oh, we made a mistake. You should be in upper division." And this was the week before school had started. Didn't I tell you this story? So I wanted to make an appointment to see the dean, and I walked over to the dean of chemistry's office, which was pretty small then, although it was a major department. And there was a person at the desk, which years later I would learn was a very powerful person, because we had the same kind of persons at our desks at UCSF, okay.

01-00:48:36
Meeker: A gatekeeper.

01-00:48:37
Day: Gatekeeper. I walked in, I saw staff. I had a different attitude then. I was just a kid and here was a woman who worked behind the counter. She was not the

dean so she was obviously a clerk, which meant she was obviously unimportant, right? Judgmental, but that's the way I was. So I walked in. I also remember she was a three pencil-in-hair person. I learned later never cross a person who puts three pencils in their hair. They don't even do that anymore. But in those days, she had a red pencil, she had a red/ blue pencil and she had a lead black pencil up here and she would pull them out while I was talking to her and put them back up there. But I would soon learn to never cross that kind of person.

Because I walked in and I said, "I'd like to meet with the dean." And she said, "Well, what would you like to meet with him about?" And I said, "Well, I have not been admitted to upper division and I would like to meet with him to find out why." I said, "I've been told why, but I don't understand. I've been told I didn't have a one-unit course in instrumentation," which I had looked up in the catalog and "instrumentation" was defined as learning how to use veniers, learning—you know what a venier is? I'm sorry, I don't know your science background.

01-00:49:54
Meeker: A very little bit.

01-00:49:55
Day: Basically a scale, learning how to read calipers, learning how to read liquids and volumes, learning how to measure things. It was a measurement course. And how to handle instruments like DU spectrophotometers and how to dial up a particular wavelength. And it was all pretty straightforward. Well, I had had all of that but they were all a part of the courses I had had. You took analytical chemistry in Sacramento JC and they taught you how to use the DC spec and they taught you how to use veniers and calipers. And when you took quantitative analysis, they taught you how to read the meniscus on what's known as a burette. I had all of that. And at Berkeley, this was evidently an entrance course before you took any of the other chemistry courses. So I said, "I've had that. It was built into my courses. And I have a letter here from my professor of chemistry indicating that this is the situation." So she said, "What is your name, please?" She went and got my folder, which griped me, pissed me off, this person having access to my folder, right? Pulled it out, opened it up, and said, "So, let's see here. Okay, well, you haven't had the course in instrumentation. It's fairly straightforward." I said, "But I have had it." She said, "Well, I don't see it here." Believe me, people like this are very dangerous because they're difficult to read when you're a kid. We eventually got rid of those kinds of persons in the school of pharmacy offices. I and the dean got rid of them because they were devastatingly—

01-00:51:20
Meeker: Too legalistic or—

01-00:51:22
Day: Territory. They were territorial. Everything had to be done a particular way. I don't know that she was totally that way, but the way she treated me was like something that had come in off of the street, maybe because I went to a JC. I don't really know and I don't really care. The point of it is I wanted to see the dean. I wanted to see the dean. I could see him. He was sitting in his office and you know what he was doing? He had a paper, a magazine in his hand, and he was reading it, making some notes. Now, in my mind, of a student, particularly a twenty-year-old student at that time, a guy sitting in an office reading something wasn't busy. Because that busy-ness could be interrupted. I read the newspaper, my dad would say something, I could look up. I could conduct an intelligent conversation. The dean, therefore, wasn't busy. I've since learned, years later, that of course you can be very busy looking like you're doing nothing if you're particularly trying to digest a scientific article. But in any event, so he was doing nothing as far as I was concerned.

So she said, "Well, it's pretty straightforward, pretty clear cut. You don't have the other course. It's a required course." I said, "I know but I'd like to request a waiver." And I was getting really pissed off because I was telling her more than I felt she was entitled to know. I really was a shit. I really was. I just had an attitude that's quite different. Maybe the attitude of all young cocky guys. I don't know. She didn't even say, "I'm sorry." She said, "You will have to complete the course." So this was going further than I wanted. "You realize that in completing that course I'll have to stick around another year because I won't be able to take this course, which is sequential to that course in upper division, which is sequential to that. It's only offered in the fall, winter and spring quarters, the sequence, one, two, three." And she said, "Well, that's unfortunate but you should have checked that when you were applying for transfer," Something like that. Kind of like an admonition. So I said, "I want to see the dean." And she said, "The *dean* is busy." That's when it was triggered. The triggering was I crossed the line, and I remember my words specifically because I was, at that point, really upset. He was not busy. I had this person in front of me who seemed to be prohibiting me from seeing the dean and I didn't know her authority. And I said, "I don't want to speak to a flunky. I want to talk to the dean." Those are my words exactly, burned into my brain because the next thing that happened, the folder slammed shut. She said, "This session is over." And I said, "No, it's not." She said, "Yes, it is." And I said, "Okay. When can I see the dean?" She said, "The dean is busy." "When can I see him?" She pulled out his calendar. This was in September [and she said] something like "the middle of November," okay, which to me, was burying me, okay, because by that time it was academic, right. I would have had to take the instrument course. So I said, "I cannot get to see him any time before then?" And she said, "No." So I stomped out.

Now, so that whoever sees this tape in the future will know that I really am intense and I do think things out much more carefully, my whole career was affected by that slapping shut of that folder, because I was pissed. Now, to

step back in time, not even three months earlier I had bumped into our local pharmacist. I had taken my mother's prescriptions to him. I had never worked in a pharmacy. And he would occasionally chat, but not about pharmacy, just miscellaneous stuff, the baseball team or whatever, because he had a few minutes and we would chat. His name was Art and he owned Womble's Pharmacy in Sacramento on J Street. And I bumped into him in a supermarket while I was shopping for my mother. And he said, "Hi, Bob, how are you?" And I said, "Hi, Art." And he said, "What are you now?" And I said, "I'm a junior in college." "Fantastic." He said, "Where are you going?" I said, "Well, I'm leaving JC. I'm going to go to Berkeley." He said, "Oh, great, I went to Berkeley, too." And he said, "What's your major?" And I said, "Chemistry." He said, "You know, Bob, I was a chem major and I graduated with a BS in chemistry from Berkeley, but I graduated in the height of the Depression and I enrolled in the College of Pharmacy down in San Francisco there and became a pharmacist. And, Bob, I have never once regretted that decision. So I'm saying to you if you ever have reason to want to consider another major, I recommend pharmacy. And if you want to talk to me about it, I'd be happy to..." "Oh, sure, Art, yeah." I was not vaguely interested in pharmacy. I was going to be a PhD in chemistry. I had already talked to people in Davis about the PhD program there. I was plotting my life out, so Art's conversation was the farthest thing to my mind until that folder slapped shut. And when that happened, I got so pissed off that I walked out and changed my major from chemistry to pharmacy.

01-00:5:26
Meeker: So at that point in time did you—

01-00:56:29
Day: No, that is how intensely shallow I was, and, as you can see, I did that decision not knowing anything about pharmacy, never having worked in a pharmacy, knowing what pharmacists did—kind of-but not knowing if I was a match for it. Just that shallow a decision. Which was the best decision I ever made in my entire life. Second to getting the PharmD degree, okay.

01-00:56:52
Meeker: So I wonder at that point in time, did you see a pharmacist as a mercantilist or as a scientist? As somebody who ran a small business or somebody who was involved in the sciences?

01-00:57:06
Day: No. I had no image of him. He wore a white jacket, so he was a health professional, but I had no image. Because I didn't know what he did, I didn't know how a pharmacy operated. I didn't know any of those things. Did I see him as a businessman? No. Did I see him as a professional? No. But did I see him as somebody who had advanced training who was a healthcare professional in a very broad sense? Yeah. But I didn't have a derogatory opinion of him. Not so my dad. I really liked Art. Art was a nice guy. And he seemed interested in my health and my mother's health. "How's your mother

doing? Well, da, da, da. Well, you know, Bob, sometimes it's like this and these diseases, they come and go when you get older and you should be prepared." He was very helpful. So when I thought back about our conversation, it wasn't as though I grabbed entirely at the air, because, the straw I grabbed had some substance to it. My students have asked me that question. "How did you become a pharmacist?" And I'm always embarrassed and proud to tell them. I'm embarrassed because they think of me as Dr. Day, a guy that's got all this knowledge and whatever, built in. At least I think they think that of me. "And how did you make the decision?" "I got pissed off at a secretary in the chemistry office. That's how I chose pharmacy."

01-00:58:35
Meeker: All right. Well, let's change the tape. That's a good point.

Begin Audio File 2

02-00:00:00
Meeker: This is Martin Meeker interviewing Bob Day and this is tape number two. So we had just come to the point of your decision to enroll or transfer from UC Berkeley to UCSF to get your bachelor of science in pharmacy? Is that the degree that you were going to be going for?

02-00:00:44
Day: Yes. Mm-hmm.

02-00:00:46
Meeker: And I know that you had provided a little bit of overview of the BS degree and then the decision to get a PharmD. But I'm wondering if maybe we can step back a little bit and step out of your sort of first person role and maybe more into your position as a historian of pharmacy and maybe tell me a little bit about what you've learned over the years about the state of pharmacy and pharmacist education in the 1950s. What the different options were, what most practicing pharmacists, what kind of education they would have gotten, and then maybe go on to talk about your own personal experience.

02-00:01:38
Day: Okay. Well, some of this is going to be based on my—excuse me—personal experience because in order to understand something about education, not only here but elsewhere, I had to be familiar with what other schools were doing. Let me tell you that when I entered the School of Pharmacy in 1955, the USCF School of Pharmacy was even then probably the leading school of pharmacy in the nation. There had been no surveys, no polls, no determinations of it, but if you looked at the curriculum and at the faculty of the school I entered, it was a school that was loaded with the basic sciences. It was loaded with the preeminent professors in their field, even though they were nowhere nearly as preeminent as they are now because federal monies have changed the scope and girth and depth of their preeminence. But then in the 1950s when federal monies were practically nonexistent, people conducted

research mostly on the basis of private grants. I don't know where they got their money from, but the School of Pharmacy had, probably since the beginning of the twentieth century, been a leader in pharmacy education. It pops up when you read something about what schools of pharmacy thought about the profession of pharmacy then, what they were doing. It pops up when you see the aspirations of our School of Pharmacy as early as the nineteenth century, that pharmacists should be scientifically skilled, which some people thought was a mistake for the longest period of time. And although it probably was, in terms of the role that pharmacists would eventually assume, they would never have gotten to that role if the School of Pharmacy, the UCSF School of Pharmacy, specifically, hadn't walked down the road of heavy duty basic science courses for its pharmacy students.

There was no clinical role then. So in terms of the curriculum of the UCSF School of Pharmacy at that time, it was very heavy in chemistry. And I don't say that in a derogatory sense, although I might have at that time. It was very heavy in laboratory. We would have four to five three-hour labs a week, maybe more. We took botany in prepharmacy because that was a historical course. We took pharmacognosy, which is the study of drugs from plant or animal origin.

02-00:04:24
Meeker: I'm sorry, what's the name of the course?

02-00:04:25
Day: Pharmacognosy. P-H-A-R-M-A-C-O-G-N-O-S-Y. Pharmacognosy. And we took a lot of chemistry and very, very excellent chemistry, very advanced chemistry. Structure action—so-called structure action relationships—were relatively new in the field of chemistry at that time. We were getting it heavy duty.

02-00:04:51
Meeker: Who else was taking these kinds of courses? Were there med school students taking these chemistry courses?

02-00:04:57
Day: No, they were all pharmacy students. All pharmacy. No, we didn't have any courses with med students in those days. We had courses with dental students.

02-00:05:09
Meeker: So the College of Pharmacy and the College of Medicine were quite distinct?

02-00:05:15
Day: Yeah. There were relationships between them but they were kind of like neighbors, next-door neighbors mostly. There wasn't a whole lot of intermingling, although there was some. Our position on campus at that time was nowhere near that, our stature nowhere near that of the School of Medicine. I don't feel that way today. It's just a numerical thing. But in those days, our stature was nowhere near because our sciences—well, we weren't a

School of Medicine. That's frankly what it comes down to. The School of Medicine had fivefold the faculty we had even then.

Anyway, so it was a curriculum that was pretty heavy in science all the way through. The courses we took were classical. That is to say we took pharmacology, which is the study of drugs. We took pharmaceutical chemistry, which tried to tie the chemistry of drugs to the action of drugs. We took some clinical courses, but clinical only in that they were lectures by physicians as to what it was they thought when they prescribed medications. I don't even remember the name of that course. We took public health courses. But even then-and probably from the beginning of the twentieth century-we were the most science-laden curriculum in the nation, and it was an advantage. And everybody there knew it, knew that science was the secret to the future, to this as-yet holy grail of pharmacy that had never been realized, how we were to get from behind the counter and into the patient care scene directly and not necessarily in a hospital, in the basement filling prescriptions, which is what had been going on.

And as I've read about the curriculum of other schools of pharmacy, they had nowhere near the content, nowhere near the dimensions, nowhere near the volume of what we got at UCSF and we got also something else. We got pride. Pride in institution. Only one instructor made us feel limited? What did he do? Oh, taught that restriction, the counter prescribing: "thou shalt not counter prescribe." Which later on, he rescinded.

02-00:07:23
Meeker: So here we're in the mid-1950s. You're getting your BS in pharmacy at UCSF. Actually, in reading a little bit about the history of pharmacy in the United States, there's kind of a transition happening during this period of time in the profession and that is that your small business pharmacist who goes and hangs out a shingle and fills prescriptions for the local general practitioner who's also hung out a shingle is starting to fade and you're starting to see larger companies and chains and Walgreens and all these other sort of businesses employ a lot more.

02-00:08:06
Day: Yeah. Not yet though.

02-00:08:07
Meeker: Not yet?

02-00:08:08
Day: Not yet.

02-00:08:08
Meeker: So most of the people you went to school with, they anticipated that they would—

02-00:08:13
Day: They anticipated one day opening up their own pharmacy one day—yeah.

02-00:08:17
Meeker: Buying a pharmacy or—

02-00:08:19
Day: Chain pharmacy, it was like counter prescribing. No "ethical" pharmacist worked for a chain at that time. And I don't even know where that came from. I guess I can say I felt that way as a student because when one of our classmates went to work for a chain pharmacy we wondered what was wrong with him. He didn't have to. He could open up his own pharmacy. Now, I incidentally, was a little weird, because I had no interest in opening up my own pharmacy. It was not something I entered pharmacy to do. I entered it not knowing what the hell I was going to do but one thing I knew for sure, I never wanted to operate a pharmacy. I became acquainted with that notion the instant I started working in a pharmacy in Sacramento in my junior year, working as an intern in Pucci's Pharmacy and seeing what those guys went through just to make the day work. They were doing well because, in those days, that was what some of my colleagues referred to as "the golden age." Nobody questioned prescription prices then. But I didn't want that. It wasn't that I felt it below me, it was just that that wasn't something I wanted. A physician later offered to buy me a pharmacy and he would be a silent partner and earn money and I turned him down. And we would have made a lot of money because a pharmacy eventually opened up there, it became quite successful, it grew into a chain. Maybe I would have screwed it up and it would have gone bankrupt. I don't know. God knows it might have because I had no interest in it. But the aspiration of a pharmacist in those days was to work for yourself.

02-00:09:43
Meeker: There would have been two other options, at least, right? They could have become a hospital pharmacist.

02-00:09:47
Day: Yeah.

02-00:09:48
Meeker: And then perhaps to work for a pharmaceutical company developing new medicines.

02-00:09:52
Day: Well, yes. Or to work for an independent pharmacy, to be an employed pharmacist at an independent—so detailing, what they called detailing in those days, working for a pharmaceutical company, was considered to be a good deal but it wasn't something that appealed to a lot of people because it was pretty heavy sales Joe Personality. You needed a salesman's personality, and not everybody in pharmacy school had that. I certainly didn't. So I never considered that. Hospital pharmacy was never considered. And that's because

hospital pharmacy in those days had yet to emerge as a patient-contact practice. To me it was working in a basement because that's what pharmacists in hospitals did. That's what I thought. They worked in a basement and they were cubbyholed away from the public.

02-00:10:38
Meeker: Kind of assembly-line pharmacy.

02-00:10:41
Day: Well, not quite that. But no patient contact. I liked going out in front, saying, "Hi, Mrs. Jones, how are you? How's the kids?" and getting her address and saying, "It'll just be a few minutes," and going back and filling her prescriptions, coming out and getting whatever. I liked that interaction. So for me, it was always going to be in community pharmacy, although it was probably also going to be manufacturing. But not working for a company. Or if working for a company, working as a drug product formulator for a company. I'll tell you that story in a little while.

So anyway, so the chains had not yet become the dominant force in community pharmacy that they are today. They were emerging. The unfortunate part of it was they began to emerge strongest when we were developing the clinical pharmacy program. We saw these as roles that pharmacists could perform in the community pharmacy, but at that time these roles were antithetical to making money for the pharmacist and the chains. We learned from experience, probably thought we had learned from experience, that independent pharmacists who own their pharmacies really wanted to be the kind of pharmacist that we were talking about. So there was a lot of interest in that role. It was never opposed.

02-00:12:11
Meeker: Even though they weren't hospital-based they wanted to play that kind of clinical—

02-00:12:13
Day: When clinical pharmacy began to pop up, remember, it was in hospital pharmacy. And so, no, they didn't oppose it. I take it back. When we were developing the program a few hospital practitioners opposed it because it intimidated them. It wasn't something they thought pharmacists should do. "We're supposed to fill prescriptions." Remember the ethic, "Thou shalt not counter prescribe"? It was pretty heavy. And getting involved with drug therapy? "Not our role. That's the physician." It was that abrupt. And, in fact, some of the people who originally opposed the development of our clinical pharmacy program were hospital pharmacists at our place. But we never saw it opposed at the community pharmacy level. In fact, we would rotate community pharmacists through our project just so they could see what was going on and they were saying, "Wow, we never thought we'd see this in our lifetime." They were that impressed with what we were doing.

02-00:13:15
Meeker: Well, I don't want to get too much into the clinical pharmacy just yet.

02-00:13:16
Day: The state of that education.

02-00:13:17
Meeker: Yeah, yeah.

02-00:13:19
Day: So there are speeches in our archives, and I can't put my finger on them, you'll have to trust me, in which we, at a very early stage, talk about what it is we want to accomplish to become the preeminent school of pharmacy. There's a document that was written in the 1890s. We sent a site visit team back east to visit schools of pharmacy because we were designing our new pharmacy building on Parnassus, the first one.

02-00:13:46
Meeker: This would have been what years roughly?

02-00:13:47
Day: Eighteen eighty-six, eight-five. Eighteen eighty-five. Something like that.

02-00:13:52
Meeker: Oh, okay. Oh. So actually back in the beginning, yes. Okay.

02-00:13:55
Day: Back in the beginning. Well, no, it wasn't the beginning. We were founded in 1873 and we were downtown San Francisco for a number of years. Had our own building down there, which incidentally stood where City Hall now stands. So we've got some historical roots in San Francisco. No, when we were still downtown getting ready to design the building on Parnassus, we had the opportunity to create the laboratories to be anything we wanted to. So we sent a site team back to visit what they considered to be the leading schools of pharmacy, finding out that some of them really weren't leading at all. Other ones were. But none of them had exactly what they wanted. So when they came back they said, "We have the opportunity now," it appears in that document, "to make this school the best school of pharmacy, not only for now, but for the future." That's the first time I saw in writing, the aspiration of the faculty that I heard when I was a student, that I heard when I was a member of the faculty and I began to recite as a member of the faculty, the idea that we wanted to be the best. And, so as I told you, the school gave us pride of institution. We were proud of the fact that we were UCSF students.

The curricula across the nation was, for the most part, devoted to traditional pharmacy practice. They had probably taught far more compounding than we ever taught. We don't even teach it now. They taught far more pharmacognosy, far more history, far more business administration, than we ever did.

02-00:15:32
Meeker: Well, that was one thing I was going to ask you about, given that most, or a large number of the graduates would go out and run their own businesses, there was some instruction in the curriculum about business management.

02-00:15:43
Day: Yes, there was, called pharmacy administration. And we had such a course and it was taught and it had the usual stuff, e.g., how to find a site, how to develop the site, store layout, decisions, things of that nature. And these were taught in every school of pharmacy, some to a much greater extent than ours. Some, I would say, probably far more successfully than ours because they had more units to play around with. We were devoting our units to preparing for the future. We saw the future in business but, I'm guessing because I don't really know this, most pharmacy administration courses across the nation were taught by people who didn't do it. They just sort of talked about it. They studied books and they were able to teach it. Some of these courses were taught by practitioners who actually operated pharmacies and I think they would have been the most helpful because they lived it day by day, real life. But pharmacy administration increasingly began to be taught by PhDs in business or PhDs in some area unrelated—maybe even an area in pharmacy called pharmacy administration. You could get, I think you still can, a PhD in pharmacy administration, although don't ask me what their role is today. It's slipped off into surveying, polling, touchy-feely measurements. It used to be devoted to business, what sells best, a package facing north or a package facing east. It was that kind of mundane stuff. Turnover. What's the ideal turnover for a toothpaste?

02-00:17:23
Meeker: Well, another question I'm interested in, unless—I don't mean to cut you off.

02-00:17:26
Day: That's all right.

02-00:17:27
Meeker: Is this question of compounding and as somebody who's quite removed from knowledge about the history of pharmacy in the United States, and also pharmaceuticals, can you give me your perspective on how that's changed? And in particular, what kind of education you received around compounding vis-à-vis the sort of medications that existed in the 1950s. What was involved in that practice?

02-00:18:06
Day: Okay. Let's tell you about how it is today and then I'll go back, okay, because that will give you a perspective. Compounding is alive and well in the twenty-first century. It's alive and well in a limited number of situations where you have pharmacies that have specialized in compounding. Pharmacies that have specialized in developing individualized doses for patients for which that dose is not commercially available. Pharmacists who have been able to develop specialized veterinarian doses because they're not available commercially and

a pig is not the same as a dog is not the same as a cow is not the same as a horse in terms of dosing, dosage forms, in terms of how you administer a dose and so on. So compounding is alive and well but it's limited in regard to the number of people who are engaged in it today. I know people who are compounding pharmacists and you can count them on a couple of hands. If you said, "Well, Bob, I know a thousand pharmacists in California alone who are engaged in that," I'd say, "Oh, yeah? Where? Show them to me." Pharmacists argue sometimes that they're compounding when they take a dry pack of penicillin and add water to it and shake it up. Many antibiotics come available as a dry powder, you add water to them to shake them up and dispense. They're good for maybe fourteen days from the time they're mixed. That's why the water's added to them. They'll call that compounding. That's not compounding.

02-00:19:40
Meeker: How do you define it then?

02-00:19:42
Day: Compounding is when you take a series of individual ingredients, blend them together in some methodical scientific manner, and prepare a dosage form, okay. The modern term for a dosage form is drug delivery system. A pill is a drug delivery system. A capsule is a drug delivery system. It delivers a drug and it's a system. So compounding is the extemporaneous preparation of dosages, extemporaneous meaning you do it from the ground up. You have the raw ingredients, you mix them together, you got a capsule. You have to know how to do that. Mix them together, you get an ointment. You have to know how to do that. Elixirs, suppositories, whatever, okay. So it's extemporaneous.

02-00:20:23
Meeker: So it's not done on an assembly line or a factory?

02-00:20:26
Day: It can be. When you get big, it could be. So there are some, maybe lots of pharmacists that are engaged in this. But in terms of the total population of pharmacists, I don't think it's a massive number. There is a Compounding Association of America that sets standards for compounding, but it's a field that has a lot of science to it and some degree of witchcraft, because when you mix ingredients together, unless you actually perform stability studies, you're not certain what's happening to those ingredients over a long period of time. The philosophy of the past was, "Well, what the hell. They're going to use it right away. It's going to be okay." And maybe they're right. I don't know. The zinc oxide in petrolatum, zinc oxide can't go a whole lot of places. It can't become zinc urate. It's going to stay zinc oxide.

02-00:21:20
Meeker: I guess part of my confusion about this is—and I'm pretty ignorant in all of this—and that is that I understand that the medications that are given to us

generally go through FDA approval. But it sounds like from what you're saying, is that in the compounding process, in essence they are making new medications or combinations of previously approved medications.

02-00:21:41
Day: Right. The FDA has—I don't know whether the word is approved or just looked the other way. Pharmacists have historically compounded. It's almost like the NRA, okay. Pharmacists have historically compounded, so if you come out and say they can't do that anymore, they will—and I think rightfully so—come up in arms because they're doing their damndest in many cases to establish the same kinds of standards as manufactured drugs but they can't. And they are able to defend themselves on various levels. I'm not an enthusiast of compounding. It's there, it's a part of our profession, I respect and admire the people who are doing it, Paul Lofholm for one, okay. He knows what he's doing, okay, and I like to think that every pharmacist who's doing it knows what they're doing. But in many cases, they can't provide the same kind of quality control that a manufacturer can provide. On the other hand, manufacturers cannot provide the same kind of flexibility a compounding pharmacist can provide.

And as we move into the future, it's probable that a lot of the drugs that you take, you somehow get into you, will be individually tailored drugs. Tailored to your genetics. Somebody's going to have to make those. They're not going to do it in a mortar and pestle. They're not going to do it by grinding cactus root and turning it into something else. It's going to involve proteins, it's going to involve stability studies. Probably going to involve very important scientific equipment for the measurements, for the chemistry, for whatever. I have no idea what's coming, but I know it's not going to be done with a mortar and pestle and I know it's not going to be a routine like "Here's a little aspirin, here's a little lactose, mix it together." It's not going to be like that. And I don't really mean to denigrate the profession. That's not what they do with compounding. So I'm simplifying it. I'm just sort of saying the future to me will not be that. It may be compounding but it'll be compounding of an order of magnitude that we don't even know about yet. That would be my guess.

So that's the way it is, okay. Pharmacists are compounding today. They're making capsule, ointments, solutions, elixirs. They're making them in dosage forms that are not available commercially for patients who need them. That's being done in a limited sense. Now, let's jump back twenty years.

02-00:24:01
Meeker: Before you do that—

02-00:24:05
Day: FDA?

02-00:24:06
Meeker: My ignorance is sort of pushing me here.

02-00:24:07
Day: You want to do the FDA?

02-00:24:07
Meeker: Well, it's not so much that. I'm thinking does compounding, the practice of it, require a supremely close relationship between the prescribing physician and the pharmacist because the physician says, "You know, you need to take penicillin or something." And the pharmacist will look at this and say, "Okay, is it a pill, is it a suppository, or an injection?" How are those decisions made and how can the pharmacist decide that he's going to mix in zinc oxide with the penicillin because this can also—

02-00:24:45
Day: You had best address that question to a compounding pharmacist. Remember, I'm not.

02-00:24:47
Meeker: Okay, yeah.

02-00:24:49
Day: Okay. I'm like the guy that taught business pharmacy administration. How to operate a pharmacy, and I've never operated one in my life. So you're asking the opinion of a guy that doesn't do it, okay. I can give you my ideas about it, yes. I think it involves a very close relationship between a pharmacist and a prescriber, because that prescriber has to know you're doing that. And a lot of pharmacists I know will actually detail physicians, go around with a box loaded with the dosage forms they're capable of making, exposing the physician to what it is they're capable of doing and then they consult. No physician writes out a list of ingredients to be compounded and gives it to a patient with instructions to take it to any pharmacy anymore. I don't think they do. They might. But, again, you have to ask a compounding pharmacist about that.

02-00:25:33
Meeker: So there maybe was a point in time in which physicians did not just say X pills of this and X milligrams but it would be—and they would know that that was a manufactured product. Instead they would sort of say the various ingredients—

02-00:25:50
Day: Yes.

02-00:25:50
Meeker: —that they wanted and they would bring it to a pharmacist and the pharmacist, during the period of time that compounding was much more regular, they would understand that it wasn't an off the shelf product that they were going to just—

02-00:26:04
Day: Well, yes, for two reasons. Number one, there was no off the shelf product for the majority of drugs. But in order for that to happen, you got to go back a hundred and some odd years, okay.

02-00:26:13
Meeker: Yeah. Well, let's go back now and you can explain it a little to me.

02-00:26:16
Day: Okay, let's do that. What we're talking about now is a relationship in which there was very close communication between the prescriber and the patient, okay, where the prescriber said, "You've got a cold? This is my formula for cold. A little bit of strychnine, grain one, little bit of this, da, da, grain five. Da, da, da. Powder papers, make twelve powder papers. Dissolve one in a glass of water at bedtime, okay. Here!" You took the prescription, in most cases, to wherever you wanted to take it. If the physician had a particular preferred pharmacist, and a lot of them did, they trusted that pharmacist, they would say, "Take it to Bob Day," okay, "have him fill it for you," or the back of the prescription blank would say, "Take to Schuler's Drugstore." Or even the front of the prescription might say that. Okay. But in general, physicians wrote prescriptions and gave them to patients and they took them wherever they wanted to and the pharmacist then took that and was trained in interpreting it, okay. Now, that was a hundred and fifty years ago when it happened almost entirely that way. And pharmacists at that time knew that Dr. Jones would prescribe this, always one grain of this, and two grains of that in a capsule and they would sometimes pre-manufacture them. That is, when they had a few spare minutes and a bottle that might say, "Dr. Jones cold capsules," they would punch them out so that when a patient came in they could simply count them out. But not all the time. And I don't even know how often because physicians' prescriptions were coming in from any number of sources.

But the one thing all pharmacists had in common then was compounding. Pharmacists slept in the pharmacies at night, for the nighttime prescription that might come in. You brought a prescription to the pharmacy in the 1820s, thirties, forties, and the pharmacist would say to you, "Well, fortunately I have some of that made up," or "I there are many prescriptions ahead of you, so you should come back tomorrow," because it took time. And they had two or three, four, five, six, seven, eight, ten, twelve pharmacists, depending upon the volume that pharmacy had, in the back, filling compounded prescriptions. But they did more than that because some of the prescriptions, for example, would call for tincture of belladonna. They would actually make up the tinctures from the raw roots or leafs, extracting them with alcohol. They'd make elixirs. They would make these basic ingredients for compounding other drugs for a lot of reasons, but the main one was supply. Like here in California in the 1840s, where was the nearest supplier of tincture of belladonna? It was a lot easier to get belladonna, get some alcohol, mix it together and make your own tincture of belladonna. So in any event, that was 150 years ago, okay.

So what happened? Well, the industry popped up, Lilly being one of the first, Upjohn being another one. Upjohn manufactured what they called the "friable" pill. A lot of the dosage forms were in pill form, okay. Now most solid dosage forms are tablets, not pills. That's a modern technology thing, modern meaning the last eighty to a hundred years. A pill was something the pharmacist made by taking the ingredients, adding some licorice to it, some simple syrup, and grinding them down into a tough, really stiff putty, and then putting it on something called a pill machine, rolling out a cylinder, then cutting that cylinder into wheels, then rolling those little wheels into balls called pills. Pill roller? Heard that expression before?

02-00:30:02
Meeker: Yeah, yeah. Ah.

02-00:30:03
Day: That's what my dad accused me of wanting to be when he was showing his displeasure. "Bob, four more years of college to become a pill roller?" Anyway, thus the origin of the expression "pill roller." Okay. Another individualized dose, was the powder paper, where pharmacists measured out the ingredients and wrapped them up in paper and your mother or your grandfather took them out and dropped them in a glass of water, stirred them, and drank them. Other commonly compounded drugs were ointments and suppositories. That began to change when Upjohn came out with a "friable" pill and began to make some of these, what were known as USP formulas and began to establish standards that in the beginning probably weren't any better than the ones that local pharmacists could do. But in the long run, the standards eventually at least equaled those of the pharmacist. But what happened is, slowly but surely, physician-prescribing habits began to change. Pharmacists compounding habits began to change in reflection of that. And by the time we get around to 1910, 1915, 1920, half of the prescriptions—I'm making these figures up—half of the prescriptions are for dosage forms made by the pharmaceutical industry and half of them are compounded dosage forms. You get up into the thirties, the forties, the fifties, the sixties, compounded prescriptions are down like this, in a stack this tall. And you get to today and I don't know what it is. But it's very, very slight in terms of the volume of prescriptions written for pre-manufactured dosage forms. Elixirs, suppositories, tablets all pre-manufactured, all standard, all meeting certain requirements. Even then the manufacturers do screw up.

Pharmacists also screw up. You are aware of some of those screw-ups. The cancer drug that was purposely screwed up by the pharmacist, realizing he could make more money if he diluted the cancer injection three to one. He sold a compounded IV to—or not IV but—yeah, it might have been IV dose of this cancer drug that he prepared and it was not—it was a bona fide drug, he diluted it. Then there was contamination by microbes, people dying from lung infections, from—I forget what the most recent one was. It happens. It happens because pharmacists make mistakes. It happens in industry because

industry makes mistakes, too. People do die from industrial errors, or people get very sick from industrial errors. I'm not defending the compounding pharmacist, I'm just trying to say that that when you have a thousand pharmacists, you're going to have a few in there that really shouldn't be doing what they're doing. Because they don't know shit about what they're doing. They're just doing it because they took a course that they thought prepared them to do this thing, when indeed they should be applying the concepts, such as practices developed by guys like Paul Lofholm today.

I killed the compounding course 1997 for two reasons, but mostly because it was no longer, as far as I was concerned, a valuable use of a pharmacy student's time. It was fun. Students loved it. They loved making these dosage forms. I tried to make the dosage forms interesting. When I taught them elixirs, I actually had them make crème de menthe and crème do cocoa. Because it's an elixir, okay. When they wanted to make a powder paper, I tried to make it a soda fizz, where they made strawberry soda. A material that when they dropped it into water, would fuzz up and they could get a soda drink. I just tried to make them interesting because I figured, why not? Why not make them something they can use? When I taught them how to emulsions, I had them make a sunscreen. That was pretty good sunscreen. They could use it on the beach. Something they could use and sort of added to their motivation to make it correctly. But in any event, I taught it as it had been taught for a long time. Now, remember what I also said. I was not doing it. I hadn't done it since 1968.

02-00:34:11
Meeker: Well, when you're taking these courses as a student, was it understood that these were the kind of skills that you would need—

02-00:34:21
Day: Yeah.

02-00:34:21
Meeker: —essentially as a practicing pharmacist?

02-00:34:23
Day: Well, we accepted it as that. It was taught, so it must be important. So we learned compounding. I really learned it well but I and about four of my classmates carried it a step further. I wanted to be the formulator. So we took formulation courses during that doctorate year, as well. And I actually went into manufacturing pharmacy in the back of a pharmacy back when I worked in Daly City and developed a small, very small, manufacturing unit back there that pushed out hydrocortisone lotions en masse, hydrocortisone creams en masse and body massage lotions in 60,000 units a year, volume sort of thing.

02-00:35:05
Meeker: You had mentioned healthcare or the pharmacy management, business side of it. Was there much instruction about financing? This is obviously the years before Medicare and Medicaid.

02-00:35:28
Day: Yeah. Not much.

02-00:35:28
Meeker: But this is in many ways the golden years of indemnity insurance plans. The 1950s, Blue Cross/Blue Shield. What sort of instruction do you receive about how people were actually going to pay for these medications?

02-00:35:46
Day: We didn't.

02-00:35:48
Meeker: Yeah?

02-00:35:48
Day: We didn't. No, we didn't. It was not a consideration. It was the reality.

02-00:35:57
Meeker: Was the idea then that pharmacists would basically work on a cash basis?

02-00:36:02
Day: In the beginning, yeah, pharmacy was a cash basis. I was practicing as a pharmacist, when the first credit card came out.

02-00:36:11
Meeker: Well, cash basis as opposed to insurance reimbursement or something along those lines.

02-00:36:14
Day: Oh, that didn't exist in those days. That all happened in the sixties, seventies, eighties. Even credit cards. We were cash. You could charge at a pharmacy, but you charged to the pharmacy's internal accounting department. All pharmacies had an accountant, it could be your wife, who tallied up all the charge slips and billed the patient and billed the patient once a month or maybe billed the patient right away. I don't remember offhand. But the credit card came along and changed the way that was done. And in the beginning it was kind of like opposed because the pharmacists saw it as making them pay for something that they didn't have to pay for when, in fact, they did. They had to support these accounting departments, or losing control or some of that. A lot of pharmacists embraced it openly. "I'd love to get rid of my accounting department." Because sometimes they'd gang them together, two or three pharmacies would share an accountant or whatever you want to call that person who tabulated those bills and so on. So it was a cash business until the sixties and then slowly became a credit business.

Pharmacy education in the 1800s was kind of like technicians training. This is how you do it. Materia medica, how you put these dosage forms together, how you do this, how to operate a pharmacy. It was kind of like technical training. That's one of the reasons why pharmacy had difficulty establishing itself as a profession. So it's technical training in the 1800s. In the 1900s it increasingly became more scientifically based—with great resistance by many schools of pharmacy—pushed primarily, I will say, by the UCSF School of Pharmacy then, in the twenties, by pushing the American Association of Colleges of Pharmacy to encourage the increase on the sciences. The role of the pharmacist in the 1800s was to go off and compound, work for somebody else, and maybe open up your own pharmacy if you could. The role of the pharmacist in the nineteenth century, the early part of it, was to compound and dispense, mostly dispense, and to operate your own pharmacy. So the graduate of the eighteenth century was a technician.

The graduate of the twentieth century increasingly became a person who was drug product oriented, meaning, "I can tell you everything about the product, how it's made, what holds it together, what it looks like, what it tastes like, how to mask the taste, how to make it, but I can't tell you a damn thing about how to dose it." It became increasingly that—drug product centered-—and that was a mistake in education. Then it went down. Then it had to go down. And then increasingly toward the clinical role. So the curricula's in schools of pharmacy were changing from technical, to beginning science, to increasing science, to battles over the ratio of science to clinical courses, to no battle and a blend, a logical blend of science and clinical, to train a knowledgeable practitioner who has the ability to be flexible and go off into the future.

02-00:39:35
Meeker: So when you're at UCSF as a student, pharmacists have to deal with some often controversial issues. I'm thinking of two things in particular. One would be birth control, solutions—

02-00:39:56
Day: Conscience-based practice.

02-00:39:58
Meeker: Yeah. And then also certain narcotics that can be misused but also might have a legitimate application.

02-00:40:11
Day: I have an opinion sort of about what you're talk—

02-00:40:15
Meeker: Well, back obviously in the earlier part of the twentieth century you had laudanum. I'm not sure exactly what was going on in the 1950s. Valium hadn't been introduced yet but I know that there would have been certain sort of probably painkillers or numbers or something like that. I wonder, in your education, how did your professors instruct you to deal with certain things? I

know that there would be certain kinds of like vaginal washes, right, that could possibly produce an abortion or prevent a pregnancy from taking hold in some cases. To what extent did your education involve dealing with these more controversial practices of pharmacy?

02-00:41:00
Day: Social issues not at all. Social issues not at all. What do they call it? Abortifacients?

02-00:41:12
Meeker: Yeah.

02-00:41:13
Day: The use of some product to expel a fetus were known, were available in literature, but were not discussed in terms of taught, okay. Controversial. It was controversial. Remember, abortion—didn't matter whether you were Catholic or Protestant or whatever, Jew, whatever it was— in the United States forbidden. It was against the law. You had an abortion, you went to jail. You were an abortion physician, you went to jail. So we didn't encourage the teaching of instruments that were going to enable people to go undergo abortion. And the attitude of many pharmacists was like the Catholic attitude. You shouldn't do that. You get knocked up, you should have the baby, right? Pretty straightforward. It wasn't years until we begin to get into issues where pharmacists were more patient-oriented that I think it began to seriously take hold, to the point where the attitude about narcotics evolved to you had to be very careful because people are going to become addicted to narcotics. But the attitude had been was, "Oh, well, that's a narcotic addict?" Right? Person shouldn't have done that. It's like attitudes about drinking. Shouldn't be a drunk. That was the way it was when I was a student. Shouldn't do narcotics. Well, first of all, we were cautioned against it. Do not go near that narcotic bottle. Don't take that tablet. They're too easy for you to get. Don't even start taking those. So we had an attitude like that about ourselves. Some of us didn't pay attention and lost their licenses, but most of us had this thing about cocaine and narcotics, marijuana.

02-00:42:52
Meeker: So was it made pretty clear to you as a student where the danger areas were?

02-00:42:58
Day: In terms of professional practice, in terms of attitude, narcotic addicts were that. What do they call it? Reefer magic or something like that?

02-00:43:08
Meeker: Reefer madness, yeah.

02-00:43:10
Day: Reefer madness. That was prevailing attitude. That musicians smoked marijuana and that led to heroin use and God knows. They raped people and they went out and destroyed nations. It was really a very, very biased attitude.

I think you'll still find those mixed attitudes out there. It amazes me the attitudes I will find in certain parts of this country about issues like addiction, alcoholism. They're right out of the nineteenth, eighteenth centuries. Hysteria, women. I'm bowled over every time I encounter these artifacts. I would hope they were artifacts. Turns out they're not.

But residual effects of things like attitudes about narcotics, alcoholism, whatever it is. Abortion. Okay. Those have softened. Most pharmacists, including some who were Catholic, way back in the beginning, dispensed contraceptive pills without questioning it. Their role was not to judge others. So Catholics in the beginning, some of them refused to dispense contraceptive pills. I'm not a good example of that because at that point I was not a Catholic. So I can't say I was different. I don't know how I would have been if I was still a Catholic.

I have no sympathy for today's pharmacists who refuse to fill contraceptives or even Plan B. I have no sympathy with those people, because as far as I'm concerned, their role is to fulfill a public health need and not to get into the judgmental thing of this is murder, which is the word they use, or what is their role as a pharmacist? To refuse the prescription? They do it nicely. Some of them give the patient a piece of paper that says, "I cannot in good conscience fill this prescription," and in many cases I think they're now required to find a place where the prescription can be filled for the patient. But think about a person that's bringing that prescription for Plan B in the first place. They're already down. I can't imagine them saying, "Oh, ha ha, here's my Plan B prescription," or "I want to buy Plan B," or "Here's my prescription for this," or you know. I cannot understand being that insensitive because there are different—even if you think it's murder. I don't know. I don't know. So anyway, I probably didn't answer your question but—

02-00:46:04

Meeker: I didn't exactly ask it all that clearly. So I'm thinking about the degree to which you were instructed as a student by your professors and saying, "Listen, these are what are maybe now considered schedule one narcotics. These are the kinds of drugs that you'll be dispensing that are addictive, can cause personal trauma. Pay attention to who's prescribing them. Pay attention to who's receiving them. You don't want this person to take more than x milligrams of this over a month period of time because then they might be getting into trouble. You might want to have a word with the physician or you might want to have a word with the individual." Was there any of that kind of conversation about or awareness of the trouble that can come from these medications?

02-00:47:09

Day: No. The narcotics were taught from a regulatory point of view. What you had to do to possess them, what you had to do to dispense them, what you had to do to order them, and how you could get in trouble if you filled narcotic

prescriptions for a patient excessively. Like a person is a known abuser or something like that. You could get in trouble. How your inventories had to match up to what they said they were. And very little of the social aspects of what you're getting at. Practically none. Remember that we're talking about a different profession when I was in school. It didn't have this patient-centered concern. So if I had to symbolize what a pharmacist did in those days, the pharmacist ethic was to dispense without question unless it would damage or kill the patient. So you come in, you have a runny nose, and the guy has prescribed sixteen antibiotics for you that you know are not going to do anything for that patient, you cannot intercede. You can't talk to the patient about it. You can't phone the physician and say, "Are you out of your goddamn head?" You can't do that. That was the ethic at that time. If it's not going to kill or maim the patient or make him ill in some manner, don't get involved. It's a bona fide prescription written by a bona fide prescriber. That's how pharmacists defended themselves when they got caught filling multiple narcotic prescriptions. One guy in California dispensed more Percodan in a year than the entire state of California. He defended it on the basis of, "I don't know what they're using it for. I just fill the prescriptions. That's my role. Bring me a bona fide prescription written by a bona fide prescriber, bona fide patient. I just filled it. What am I supposed to do?"

02-00:48:48
Meeker: And that was the nature of education in the 1950s as well?

02-00:48:51
Day: No, that wasn't the nature of education. Everybody thought that was bullshit. But we didn't get into it. You developed a lot of those ethics in actual practice. That's where a lot of the ethics came from. Actual experiences in pharmacy. No school could prepare you for those.

02-00:49:03
Meeker: Well, then, why don't you tell me a little bit about the intern work that you did. Well, Keck's Pharmacy was listed on your CV. You had also mentioned one in Sacramento.

02-00:49:15
Day: Yeah. Pucci's. Pharmacy.

02-00:49:20
Meeker: So why don't you tell me a little bit about the pharmacy work you did prior to receiving your PharmD.

02-00:49:29
Day: Okay. In the summer between my first and second year in pharmacy school I returned to Sacramento. Because I used to do that, go home during the summer months, and pick up a job by wandering around, because that's how you had to do it. Wander around, just introduce yourself, and say, "I'm a pharmacy student. I wonder if you could use a student." I got employed by Pucci's. I guess it was Pucci's Pharmacy. They were brothers. They were

UCSF graduates, although at that time, it was the University of California College of Pharmacy. And they pretty much took me under their wing. They paid me a dollar an hour, which was below what I could have gotten working at Sears Roebuck or selling shoes at Montgomery Wards. But it was obvious they didn't really need me. When I got into that pharmacy, I think they were doing it out of a sense of conscience because, God, I mean I did the damndest things. I stocked shelves, dusted shelves occasionally. It was not that busy a pharmacy, but they kept me there and I couldn't bitch too much about the dollar an hour because it was obvious that they were doing something altruistic. It seemed to me at that time that they were hiring me for a different reason. They didn't need me. In fact, they occasionally spent the morning reading the newspaper. They weren't very busy. But when they got busy, they got real busy. And when things got tight on the financial end, I could see all that. That's where I got my first experience, "Is this something I want to do? Do I want to get so distracted with keeping this business open and how to make the right amount of money in the margins, and do I want to do that?" I didn't think about it consciously but that's where I got my first taste of it.

So it was a good experience for me. They took me in. They knew I didn't know dip, and I didn't. I'd only completed my first year of college. There was nothing to do in my first year of courses that had anything to do with pharmacy. It was all science and anatomy, physiology, whatever. So it was a totally new experience. Remember, I had never worked in a pharmacy. Three-quarters of my classmates had. Maybe even more. I was like a virgin amidst them. I'd never had that experience. And they'd talk about pharmacy and I would sit there and lap it up—"Oh, really? Oh, honestly, they do that?" "Yeah." So the Pucci's were really, in one sense, very good preceptors because they took me under their arm. They let me help in front. They let me fill prescriptions, compound prescriptions. They trusted me. And I worked for them for a period about two months. And when I left, I left in good spirits. They said, "Well, Bob, you want a job next summertime, let me know." And I said, "Okay. I don't know if I'm going to come back because I may spend the next year in San Francisco," but we left in good spirits. I liked the Pucci's. They were good pharmacists. They cared, they tried.

I returned to San Francisco where I got a job at a place called CalMed Pharmacy on California Street, and encountered one of the finest pharmacists I have ever known, one of my heroes to today, and one of the biggest assholes I've ever met in pharmacy. Both of them co-owners of this pharmacy. Okay. And the guy that was my biggest hero was a guy named Murray Washauer, who was one of these take you under his wing kind of guys. Philosophical. He owned several pharmacies. He had been in the World War II, a serviceman. He had been drafted out of his pharmacy into the service, came home, picked things up. Owned two or three pharmacies. Was a gentleman. Was a great guy, and I worked for him and his friend Mac.

Mac was a disaster. He was irritable, unhappy all the time, shouted at pharm students, me particularly. Would ask me to do things, impossible things. Like, "Bob, go in the back room, get me a vaporizer" my first day there. Well, I walked in the back room expecting something to say vaporizer, jump out at me. But I didn't know it was buried in all the way the back, up high. It was a large stockroom. So I was fumbling around. "What the hell is going on back here? Did you get that damn vaporizer?" It was like that all the time. I took that for about two months, I don't remember how long it was. And what happened in the meantime was Mac was there 90 percent of the time. Murray was there ten percent of the time. Those ten percent of the times were oases for me. I had begun to feel inferior. I began to really wonder if I was a match for pharmacy because Mac was always on my back. I made mistakes, filled prescriptions incorrectly, began to wonder, did I have the attention span to be a pharmacist, and Mac rammed it up my ass.

02-00:54:23
Meeker: Sounds like Murray didn't want to be there either.

02-00:54:25
Day: No, Murray had the Sea Cliff Pharmacy, which was his pet. CalMed was a joint venture between the two of them, but his major interest was Sea Cliff Pharmacy. And so he was there only when Mac couldn't be there. And, as I say, it was an oasis. We'd talk about pharmacy. We would even talk about Mac. Okay. He'd say, "Well, he's under a lot of pressure, Bob," and I tried to be sympathetic to that.

02-00:54:49
Meeker: When you talked about pharmacy with him, what did you talk about? What were you seeking to learn from him?

02-00:54:54
Day: I don't know. What I learned from him was that here was a man who truly loved the profession and it was evident in everything he said and did. The way he worked with patients, people, customers we called them then. The way he did everything. He was a nice man who was an excellent professional. He gave as much as he took. He was generous to a fault. He donated money to this cause, led this cause, did this, did that. Was just a great guy to the day he died. I told his son this. His son's one of our graduates also. "Your dad was one of my heroes." I wouldn't have made it without him because I was getting ready to drop out of pharmacy school and that was one of my conversations with Murray. Because I felt inadequate. And he said, "What's the matter?" And I said, "I don't think I'm matched up for this. I'm screwing up. I seem not to be able to learn anything." "Bob," he said, "you know something? That's exactly the way it was for me. He gave me these examples. "Bob, you are like me. That was exactly the way I was the first week I worked in a very busy pharmacy when I was a student. I screwed up galore, the boss was always on my back." Murray was the reassurance I needed that I was okay.

And it was very difficult for me to quit because what happened is about two months in, a friend of mine was quitting a job. He was going to graduate in June, even though this was in October/November., and he said that he was going to move on to another pharmacy, and a student position had opened up in Keck's Pharmacy downtown, "Go down, interview the manager." I did. The manager said, "Good, great. I'll take you." He did. The hardest thing in my life was to quit because I knew Mac was going to give me shit, and he did. When I told him, I'll never forget it, Mac was drying a piece of equipment and I told him that I'd been offered a job elsewhere. "Damn it, that'll teach me," he said, throwing the towel to the ground, "That'll teach me. I will never again hire another pharmacy student. Every time I do they quit." He never took responsibility for any of the shit, so I just had to live through it. I knew it was going to come and I had braced myself for it, but it was still pretty bruising, even at that, because he'd threatened that he would never hire another pharmacy student and I said, "But, Mac, it's just me." "Well, you're just like them all." Mac was really down. Murray came on that night. He said, "Bob, I've heard that you're leaving. I don't like that." [laughter] And "Why don't you stay? Please stay. We'll offer you more." He said, "Is it money? Because we'll pay you more." I would have made more at Keck's Pharmacy by a lot, two bits an hour, which in those days was a lot of money, but that wasn't it. And I said that to him. I said, "Murray, it's not the money. If you were here every day and we worked together, I would work for pennies, but I cannot tolerate working with Mac another day—not for all the money in the world. I got to get out of here. That guy is killing me." I didn't put it in those words, but Murray understood and we were friends for as long as he lived. And I've told you he was one of my heroes because we worked together on many projects over the years.

02-00:58:16
Meeker: Did these two guys have differing or similar perspectives on this notion of engaging with customers?

02-00:58:26
Day: No, Mac was a charmer. I had met other charmers in pharmacy who were as phony as a three-dollar bill. Mack was a charmer. He could charm people. He could be very charming with customers. He was the epitome of what it was that he had been trained to be. He filled prescriptions and made money.

02-00:58:45
Meeker: But not to the extent of consulting with the customers about their particular needs and the—

02-00:58:52
Day: I don't really remember. He may have. I doubt it. In many cases, the ethic also proved to be a money saver because it took time to spend time with a patient. So I don't know. I don't want to judge him in that regard. I don't remember. He may have been the finest consultant at that level of education. Remember, in those days, our consulting was prohibited, our hands were really tried. We

didn't even know what was in some of these products that we sold OTC, over the counter, including some tableted products. We may have known what was in them but we had no idea what the quantity was. I mean the label of Anacin used to say "aspirin, phenacetin, caffeine." No quantity present. Kind of like an important thing like how much aspirin, how much of that. Same thing with the antihistaminic products. They'd say what they had to say on the label, but FDA didn't require them to list the quantity. So what were we to advise? We had Vick's Vapospray. Vaporizer you'd spray around the room. It was supposed to replace a vaporizer. What was the pharmacology of that? So when we consulted, we consulted from a very limited knowledge base, which is one of the reasons why I initiated the OTC course at UCSF. I taught it because I began to get into it. I wrote chapters on it and Dick Penna and I got the OTC handbook for APhA, the American Pharmacists Society. We convinced them to publish an OTC handbook because publishers had turned us down, saying there was no need for such a book and we had written chapters on it. Did Mac consult? If he did, it had to have been at a very limited level, as it was with me.

02-01:00:29

Meeker: But they weren't really teaching you? They weren't really giving you their personal insight into these issues that later on become particularly important for you and your colleagues?

02-01:00:38

Day: Murray Washauer did, but more of a philosophical, more of a professional discussion. More of what you should be as a pharmacist. More as a role model sort of thing. And I don't remember the issues we discussed, and I don't remember any specific guideline, like "thou shalt" or "ithou shalt not" coming from Murray. I'm sure he did, because I learned a lot from him. I learned confidence, I learned patience, I learned a lot in the two months I was working with him and for the many years that followed. I told you, I never stopped my admiration of this guy to the day he died. At that point he said, "I admire you more than you must admire me." I said, "That'll never be true, Murray. That'll never be true." Yeah.

Interview #2: January 23, 2013
Begin Audio File 3

03-00:00:29
Meeker: Today is the 23rd of January 2013. This is Martin Meeker interviewing Bob Day. Last time we did talk, actually to a pretty good extent, about your education at UCSF. And I want to follow-up on a few questions about that period of time. Firstly, I'm wondering if we can step back and you can give me a little bit of an overview, again either from your personal experience or your broader institutional knowledge, and tell me a little bit about the evolution of accreditation and then degrees in pharmacy. Because you got your PharmD at UCSF in 1959 and this was the second school, I believe, in the country to actually provide that as a terminal degree. What I'm interested in is this transition that seems to happen in pharmacy education and the granting of different degrees in the 1950s. So maybe you can give me an overview to explain what was actually happening here.

03-00:02:07
Day: In the fifties?

03-00:02:09
Meeker: Correct, yeah.

03-00:02:10
Day: Okay. Well, in the fifties, most of the schools in the United States offered a one plus three program. One year of pre-pharmacy and three years of professional pharmacy education. Pre-pharmacy was just basic science courses, chemistry, physics, that kind of stuff. And then they would enter the professional curriculum, for four years total, would earn a BS degree. And UCSF was no different than that in the early 1950s. However, in the early 1950s, pharmacy education shifted from a four year program to a total five year program. The difference was not in the professional education but in the pre-pharmacy training. That period was extended from one to two years and it really wasn't simply a one to two year extension. It was a curriculum extension where they felt that pharmacy students should be better prepared in the broader sciences, should be better prepared in some of the humanities, should be better prepared for the professional role they would one day assume, which would involve communication, some hopeful knowledge of the world, and so on. I'm being too expansive there. It was basically a scientific curriculum. Mostly chemistry, physics, math, calculus. Not too dissimilar from a pre-med curriculum for the first two years. I would say probably identical because some of the students I took classes with in pre-pharmacy—were pre-med or they were declared pre-meds. At that day it was competitive so I don't know how many of them made it.

And, in fact, I got caught in that one to two year change. The year I decided to drop chemistry and switch to pharmacy was the very year that UCSF went from a one year pre-pharmacy to a two year pre-pharmacy. Had I made that

decision a year earlier I would have been a four year graduate. I could have still earned the doctor of pharmacy degree but it would have been more difficult because it would have required two additional years. Okay, well, I'm getting ahead of the story.

So anyway, it became a five year curriculum. Now, it wasn't simultaneous across the nation. You said, "What role did the accrediting bodies have in this?" Pharmacy schools did not voluntarily go into that dark night called a five year or a six year program. Many of them had to be dragged kicking and screaming all the way to that because they would claim, "We can't afford it, the profession doesn't need it," all these myriad ideas. And it happened at each stage of pharmacy education. If you went back to the early 1920s when they were talking about going from a two year program to a three year program, with no degree in those days, there was kicking and screaming and complaining and arguing on both sides. And when they went to the four year curriculum, same thing. When they went to the five, it was as if history repeated itself at each of those levels. And the most contentious of them all came at the point where in the late 1990s the schools of pharmacy went to the PharmD program. You called it the terminal degree, we call it the entry degree for the profession of pharmacy. And at that point forward, the ACPE, the Accreditation Council for Pharmacy—it changed its name ten years ago but I'm still historically buried in the old name—but it was the Accreditation Council for Pharmacy Education that was the primary stimulus and at that time basically laid down the law. Thou shalt have a PharmD program or thou shalt not be accredited. And up to that point in time, what they had been accrediting PharmD programs on the basis of a BS curriculum because they had not established the criteria for accrediting PharmD programs.

So I graduated with a BS degree in 1958 and the school at that time offered you the opportunity to take an additional year and get the doctorate of pharmacy degree, which at that time was totally unknown across the United States. In fact, we the graduates of that PharmD class of 1959 were not the first to earn the degree, but, for all intents and purposes, we were like everybody else. We were immersed into a profession of pharmacy practitioners, all of whom were BS degree pharmacists, and we felt kind of strange. I and my colleagues in my class never used our title, I didn't introduce myself as Dr. Day. It wasn't that we were embarrassed by it, it's we would embarrass the rest of the pharmacists in the place if we did that. If we had a name tag that said, "Robert L. Day, PharmD," we didn't wear those. We were kind of like an unknown. Were we any better pharmacists than the other ones in terms of what the profession of pharmacy called upon us to do? Yes, because at that time most pharmacists were held by ethics we discussed I think last time, that said thou shalt not interfere in patient therapy. That is thou shalt not advise patients on how drugs are used. Except when you do it, you're in violation of ethics, and pharmacists did that. But there were those ethics. We graduated—for some strange reason in our class, and I think it was strange that it happened in our class—with a different sense of what a pharmacist

should be, almost a yearning, a craving to do something more than that which we had done before. And I think some of it was contributed to us by that unique curriculum that we got in that extra year. So I got my BS degree. I took the pharmacy licensing examination, which I will talk about in a minute, came back working as a pharmacist part-time, got married, while getting my PharmD in that additional year.

The kinds of courses we took were so different from those which we had taken previously. It was almost like day and night. They were courses in adventure, courses in exploration, courses in experimentation. Up to that point in time, we had pretty much had a rote curriculum that trained us to be excellent chemists. Again, as I think I said last time, we had more chemistry than a Berkeley graduate in chemistry and I could talk circles around—and in fact did, in some instances—a Cal graduate in chemistry. I had occasions to do that because the chemistry we had was structure-action related and to things which they didn't even consider. In any event, we graduated a great chemist. During the doctorate year, they gave us an advanced course in public health, which carried into considerations of health provisions we had not thought about. We had a course in which a physician came in and talked about what it was to be a physician. Not "come join me," but what his day was like, what went into his brain when he was thinking about what to do and so on. Not once did that physician say, "This is a role for you guys, this is where I can't do it and you can do it better." Didn't occur to him. But what he did was tell us basically how a physician diagnosed, how a physician thought this out. And while we didn't leap out of our chairs and said, "Hey, I see a future role for us," the point of it is that we had had that education and it excited us. It interested us because we'd never known. That was a mystery. What went on in that physician's office, what he thought about, what kind of information he drew upon when he was making decisions. How he felt about patients. Because at that time, in the hierarchy of therapy, there was a physician at the top and everything else was in, I mean in society, generally held to be below that, including the professions themselves who obediently put themselves in that position. So nurses saw themselves as lower than physicians. Pharmacists the same. We were down on the pecking order. The physician was the ultimate and final decision on all things regarding the patient and we could not cross into his or her threshold. Well, we learned all about that. Then, in addition, we had courses in a brand new area called biopharmaceutics, which is basically—

03-00:10:38
Meeker: Biopharmaceutics?

03-00:10:39
Day: Biopharmaceutics. Biopharmaceutics was all the things that went in to prepare a drug that either facilitated or inhibited its ability to function, meaning when you mixed a drug with lactose it changed its characteristics. If you took the drug pure, it would be absorbed differently than if you took it with lactose or

with all these other things. So how the things that were mixed with drugs influenced the disintegration rate of that tablet in your stomach or the dissolution rate of that crystal when you swallowed it in the stomach or all these factors that had to do with physical aspects of the drug product. So we learned about the drug product. And, again, we knew more about the drug product than any other health practitioner. And that was important, but it wasn't quite the step that we needed to take to clinical pharmacy.

So when we graduated with the PharmD degree, while we had an advanced course in pharmacology, and it was a much more critical course about pharmacology than we'd ever had because up to that time, we had a three year curriculum that was trying to cram into us a lot of information on drugs and their physical characteristics and so on. They really couldn't get much in and didn't go much into therapy. And neither did our advanced courses in pharmacology. But they carried us into thoughts and ideas that we had never had before. The eye-openers were the courses in biopharmaceutics. And in a very strange way. I told you that this was simply about the physical composition of drugs and basically what happened to them, how they dissolved, how they fell apart physically, how an intravenous drug was absorbed, but not another area that's known as pharmacokinetics, which has to do with basically the ultimate fate of a drug. Once you take it, what does it do when it's in the human body?

03-00:12:47
Meeker: So was pharmacokinetics, was that not involved in your education?

03-00:12:50
Day: That was there, but it was like this part of it [gesture]. It was just very small. It was a brand new field. In fact, it was being invented at that time by the very people who were teaching us biopharmaceutics. It was a highly mathematical field at that time, and basically what it ultimately became was the tool by which many pharmacists today have been able to prescribe a drug at the specific amount you need to—knowing your body systems, you need to perform its desired therapeutic effect on your body. It's a precise science. No, I take it back. It's a precise science in a scientific level. It's less precise when you get it down to the human body and it's not witchcraft by any means but it's a tool that pharmacists use in determining dosage for patients.

03-00:13:43
Meeker: It's not a precise science on the human level because humans differ from one another?

03-00:13:46
Day: Humans differ. My enzyme system differs from you, my genetic code. If I'm African American, I treat things differently. My body does. I don't know if you've ever had a Kaiser [Permanente] lab test. There's a line there that says "African American" lab results because there's a difference in some of the tests in terms of the results they get.

03-00:14:08
Meeker: I'm just curious. The faculty who were teaching these courses to you, I'm guessing they were not a BS in pharmacy.

03-00:14:16
Day: No.

03-00:14:16
Meeker: They were probably PhDs in chemistry and so forth.

03-00:14:19
Day: Well, they were PhDs, some of them in pharmacy and the pharmaceutical sciences. Across the country, there had long been a Ph.D. program in what was known as pharmaceutical chemistry and under it you could be what's known as a physical pharmacist, the guy that studied the physical properties of drugs, or you could be a pharmaceutical chemist, the guy that synthesized compounds and tried to invent new drugs. And it was pretty much that narrow. So we had those kinds of people on our faculty. Almost all of them had been pharmacists or had some connection to pharmacists. Not all but almost all. The two critical ones at that time were a man known as Eino Nelson, who was inventor, basically one of the primary inventors, of biopharmaceutics and to some minor extent, I think, pharmacokinetics. And Sidney Riegelman, who was on the ground floor of both of those sciences and ultimately he was joined by a graduate student some years down the road, Leslie Benet, who had a significant impact on that field, as well. We were fortunate to be in the same room with these visionaries in the physical aspects of drugs, the biopharmaceutics of them, and they were so excited by it and they were so attempting to try and find a role for us in it that we caught fire.

When people have asked who was the teacher who had the most impact on me as a practitioner, teacher, it would be Sidney Riegelman. And they would ask me to describe Sidney Riegelman, expect me to say he was a wonderful lecturer, but Sidney Riegelman was the world's worst lecturer. He was confusing, he talked fast, he would sometimes stutter, his brain moved at a pace about six times that of anybody that was listening to him. And at the end of any lecture by Sid Riegelman, all of us in the PharmD class had to get together and compare notes and try and figure out what the hell he said. The one thing we knew was that it had to be important. The reason it had to be important was this man, who we knew to be brilliant—even though he was a stumbling lecturer—if he was excited by it, there had to be something interesting there. There had to be something important there because Sidney was a pharmacist. He never lost track of the fact that he graduated as a pharmacist and he was one of the people that gave birth to the clinical pharmacy program because he was always there looking for a role for us. Even though he was an esteemed researcher, Sidney didn't need pharmacy, that is the profession of pharmacy, to become the person he was in science. He didn't need that at all. This he took on as an extra act of love. So in any event, he inspired us.

03-00:17:18
Meeker: I know this was decades ago, but in his class is there anything in particular that you can remember that he identified as significant?

03-00:17:31
Day: It's an endless list. Remember, Sidney was mostly engaged in physical pharmacy at that point. Physical meaning it's related to physics. Physical chemistry, physical pharmacy. And at that time, when we took his course, he still sought a role for us in industry for our knowledge in physical pharmacy, having something to do with drug formulation, drug product formulation, cosmetic formulations, all of these things. And so his image of the profession at that time— he had a brain that was always seeking—was that we would be some kind of a drug product specialist, that industry would employ us, that we would go off, work in their laboratories, develop drug dosage forms, and advance the profession in that manner. So he saw our school as providing the nation with those kinds of graduates with a PharmD degree. It was unrealistic in the long run—well, let's put it this way: not unrealistic, but an unfulfilled dream of his. It never quite happened, although it happens now. Although it happens now that we have established ourselves as clinicians who have these other abilities and so on. But we were not established as clinicians at that time.

03-00:18:44
Meeker: Well, it sounds like then he was not anticipating a move toward clinical pharmacy. Instead he was more advocating the PharmD be related to laboratory work?

03-00:18:59
Day: No. I can't crawl inside his brain that much. I can tell you my impression and memory of him was, number one, "There has to be something better for you guys to do. Okay? This is one of our ideas, okay. And then this is how this particular field is progressing and I think that there is a role for you in that, in drug formulation and whatever and so on." But that wasn't it. There was more to it. It wasn't as though we said, "Oh, gee, we're going to sit around and wait for his latest, greatest idea." It was that we were inspired. He set off a spark. This man who could barely lecture, he was so caught up in his field, he was so fast and so excited by it. I told you, that's what caught us. We didn't say, "Oh, what an inspiring lecture," not from the point of what he said. It was the way he said it. And every now and then he'd throw out the sentence, "And this is really going to change the way drug therapy is conducted in the United States." He was always putting us in the picture. "This is you, this is you, this is you. You can do this, you can do that." And we'd never thought of ourselves as capable of doing those things or as people who should do those things. And we began to think of ourselves as that and ultimately that led to some of us thinking about a lot of other things pharmacists could do other than just that. Because I did try the drug product formulation route and I didn't quite succeed at it for lots of reasons, maybe one of which is that it really wasn't the route that it should have been at that time because other exciting

things began to happen. So Sidney Riegelman was one of my most important lecturers.

We were proud of the fact, once we learned it, we didn't previously know about it, that Eino Nelson was also a leader in his field. We didn't know about it until after we got our doctorate degrees. But here we had in our midst this man who was a visionary, also another visionary, who invented a whole new field, who died at a very young age. The reason was because he was kind of like a bumbling lecturer, too. But he was a really nice guy and we liked him. But we didn't listen to him with the same excitement or confusion that we listened to Sid Riegelman when we were in Sid Riegelman's classes.

I had the privilege of working with Sid very closely because I was also chemically oriented and I could synthesize some of the stuff he needed. When I graduated, I volunteered to work in his laboratory, and I also worked as a pharmacist. When I completed the PharmD degree, I came back a half day a week, sometimes a day a week, and worked in his laboratory making chemical compounds that he needed for his work because I was basically a pretty good chemist at that time. And I got involved in this. I got entrapped in more of this enthusiastic and completely confounding person. I can recall sitting down with him, and my very close friend, Dick Penna, who also volunteered. Dick and I did a lot of things together, and one of the things we did, we went to the PharmD program together. We were the closest friends for all of our lives, his life. And we would be working in the laboratory and Sid would pull us into his office. He would get excited. This happened maybe once every couple of weeks, where he'd just come over and pull us in, say, "Look at this, will you?" And, "See this and see that? See this? Look at this T curve here and what it does and how this area, the curve here is affected when we do this and that and the other thing." And we would sit there and say, "Oh, yeah, yeah. Hmm, oh, God. Yeah, wow!" And I remember leaving the office one time and telling Dick, who I always considered smarter than me, "Dick, I really admire you." And he said, "Why?" I said, "You understand what he's saying—I don't have a clue." And Dick said, "Bob, I didn't understand anything he said either but I took notes like you did and I'll figure it out later on." So I was fortunate to be around Sid, although he kicked me out of his laboratory, eventually. He blamed me for doing something I hadn't done. And that he thought I was capable of doing, that's what pissed me off. He thought I was capable of contaminating his glassware by casually dumping chemicals in his sink that he had distilled water in, all his—it was messy. I hadn't, but he eventually "forgave" me because he's the guy that was significant to my being pulled back in as a member of the faculty.

03-00:23:37

Meeker: You said Nelson basically invented a field, as well. Is this biokinetic or bio-pharm—

03-00:23:43
Day: Biopharmaceutics.

03-00:23:43
Meeker: Biopharmaceutics. Okay.

03-00:23:44
Day: Eino was greatly involved in that, as well. The two of them were an excellent team. They were both, I believe, graduates of a school of pharmacy. Eino Nelson was a graduate of school of pharm. I know that Sidney got his Ph.D. and BS degree in Wisconsin. I don't know where Eino got his, Eino Nelson. It's funny. I can see that man right now, although he died a long time ago, just a smiling nice man. That's what we thought of him as, a smiling nice man. Kind of a bumbling lecturer, but brilliant. Absolute brilliance. And Sid Riegelman, as well. Just drenched in brilliance. And that was inspiring. We wanted to be like that.

03-00:24:27
Meeker: Well, it sounds like one of the most important, transformational elements in your education, particularly this last year when you're getting your PharmD, is this notion that the faculty members imagined there to be a different future for you and your cohort than simply filling prescriptions behind the counter at a hospital pharmacy or your local pharmacy.

03-00:24:57
Day: Yes, they imagined that. I don't want you to think that the three years I had had before that was devoid of that kind of inspiration. It was not. Troy Daniels often told us that we needed to get more involved in drug therapy. He didn't know how. Nobody knew how. Everybody said that. That was the holy grail of pharmacy. Everybody was talking about the greater roles of the pharmacist in chemistry, then in drug development, then in clinical drug therapy. And running through it was a role as an advisor to the physicians but the advisorial role many of them saw was, "Well, did you know that if you prescribe it as a Spansule® you'll get a more continuous blood level than if you prescribe it in a tablet dosage form? And I therefore advise this particular Spansule® over that particular..." And that's what they envisioned it as, as an advisor to the physician and maybe getting into, "Well, if you prescribe this drug and that drug together they won't work because they're incompatible, because they're physically incompatible. In the stomach they'll turn into a piece of concrete or whatever." So we were always inspired. That PharmD program was basically an eye-opener for some of us. Remember, the other side of the formula was, who was sitting there in class. Whose were the eyes and the ears that those people were radiating their inspiration to? A lot of my classmates just sort of, thought "That's great," went home and became very good pharmacists but didn't particularly contribute anything to the growth of the profession. Didn't do anything different from anybody else, were PharmDs who became drug dispensers only. And please understand I'm not denigrating that, if anybody's looking at this thing in the future. That was an honorable role and I still

believe it is today, an honorable role. It was just not for us the end of the game. And many of my colleagues saw dispensing as the role they should pursue, along with being an entrepreneur, having their own pharmacy. And that alone distracted them in many cases from developing themselves as drug therapists, because they had to operate a business. Many of them, however, were able to do both, become clinicians and also be an entrepreneur. And we have examples of those today, including the guy that got the alumnus of the year award a couple years, Brian Komoto.

So it wasn't just the inspiration. It took some people out there who were freaks, in a sense. And there weren't many of us. We had a class of, I think, twenty-seven that got the PharmD degree, somewhere in that area. And of us, maybe five or six heard the message, went out and did different things, some of us to some greater extent than others. And I really don't mean to sound as though I was out there as a leader, but I was one of those guys that saw things differently, that wanted the change, that bled tears and blood for the change, didn't want this subservient role to the physician, saw that we knew some things more than he or she could ever know and didn't quite know the answer to getting that next step, that is to the patient's bedside. We didn't see those. But we knew there had to be a way.

03-00:28:28
Meeker: From what I understand, correct me if I'm wrong in this, but I believe in the 1950s, and then particularly into 1960s, you're starting to see a real increase in the sheer number of pharmaceuticals and drugs out there.

03-00:28:42
Day: Yes.

03-00:28:43
Meeker: A whole new generation of drugs.

03-00:28:45
Day: It was called the "me too" generation of drugs.

03-00:28:47
Meeker: Okay. I'm wondering how or to what extent was this "me too" generation of drugs a part of your education. Was there a sense of instruction on how best to manage them, how to introduce the new pharmaceuticals or not to the physicians? Was there any role given to the pharmacist in your education for managing the knowledge of these new drugs?

03-00:29:29
Day: No. No, there were no hints on how to do it, but there was a lot of education on what they weren't. So in the BS program and in the PharmD program we had courses in which they taught what were known as structure action relationships, okay. That is to say, this structure had this advantage over that structure in terms of its absorption and sometimes in terms of its therapeutic effect, as measured sometimes by the fact that by putting a chlorine group on

this molecule at this point here, you could change the absorption characteristics of that product, so you only took two milligrams of it, as opposed to having to take twenty milligrams. There were drugs in which those slight chemical changes like that had that order of magnitude of dosage change. Because two milligrams could be just as lethal as that twenty milligrams, except in some systems of the body. But the point of it is you could do a smaller dose. And, in fact, if you looked at the history of what was going on in drug therapy, Merck and Squibb and Lilly, and all these people, somebody would come out with a brand new drug and then, pretty soon, there would be a "me too." Now, a "me too" was not the exact same drug. It was the basic chemical, but with a change to it. A chlorine group, a carboxyl group kicked out of here, a sodium salt, a carbolic acid group sticking over here. It was some manipulation of the molecule in which they used the basic molecule and changed it slightly and came out with their product. And so their product was a "me too" product. It offered no advantages usually over another existing dosage form product, but it offered the same effect and the detail man, the people that pushed the drug, would go into the physician's office, bury him in samples, literature, and convince him that this drug was better because it was a lower dose, or it was a "special drug." It was absorbed in the ear drum rather than the teeth. They went through some silly little things like that. But they'd say, "Our drug is better because it's not plated out in the fingernails." No, that's an absolute exaggeration. No company did that. I'm trying to say what they were describing were trivial kinds of advantages. Not fingernails. Our drug does this or our drug does—it was a tweak and the tweak was kind of like, "Well, yeah, so what. Is it really worth more?" Because those drugs always cost more money than their predecessors.

But not only that, the "me too" of it came to the point of making drug combinations. This was also the period of the drug combinations. And not only drug combinations but the "me too" combinations. If a company made nine mainline drugs, one was a diuretic, and a hypertensive agent, and one was a tranquilizer, they would offer those drugs individually and then they'd offer them, this one mixed with that one, this one mixed with that one, this one mixed with that one, then all three mixed together but in various dosages. I will call them step one, two, three. All four mixed into one. Step one was one dose each level. Step two was a higher dosage level. Step three. So you'd wake up one morning and the new drug section of your pharmacy, which every pharmacy had because that's how you acquainted yourself with them, would have a whole new row of drugs in it because one new drug had been invented. And the company would then mix it with all these other little things. And so it was not only the "me too" generation. It was the combination generation as well. I don't know if anybody came up with a name for that. Have to talk with Sid Wolff back in Washington, DC. They may have had a name for that at that time. But these were just called drug combinations.

03-00:33:03
Meeker: That was actually kind of what I was getting at, which as you said that there's some sort of new drug shelf at a pharmacy. What is the process by which new drugs were brought from being approved by the FDA to common usage and was that process at all part of your education at UCSF?

03-00:33:28
Day: No, no, not the process of how a drug was approved.

03-00:33:32
Meeker: Well, not approved but brought from being approved into—

03-00:33:36
Day: The distribution system?

03-00:33:37
Meeker: Yeah. Well, being like a hit.

03-00:33:38
Day: No.

03-00:33:39
Meeker: Like being regularly prescribed by the—

03-00:33:43
Day: Well, we knew that. It was almost intuitive. You had to open up any medical journal, any pharmacy journal and see the glossy pages. Glossy gold pages in there describing this new drug, ads that are really clever, catchy. You had to see the gimmicks that the detail men passed out. They would pass out toys, gimmicks, toys, little cranks, little motion pictures, little viewers that you'd spin by and they'd show you the picture of the drug with the drug affixed to them. Ways of gaining physicians attention. There were gimmicks like crazy. I'm saying toys. I cannot even remember specifically some of the toys but I do remember disassembling them because a lot of times physicians would dump their samples on a pharmacy and we would take the very active—they were good drugs, they were brand new, they were therapeutic—and we would separate them from the toys.

03-00:34:48
Meeker: Are these adult toys?

03-00:34:50
Day: Yeah, adult toys. Yeah, yeah. No, not kid toys. Adult toys. And if I really bent my mind at it I could come up with some of them, but it's not important. They were just gimmicks. Although the industry really tried to engage the pharmacist in promoting their new drugs, and they did—I'll tell you how they did that, too—we didn't promote them at the physicians' level. They're the ones that did that. And that's how a drug came from nowhere into an overnight sensation. But the industry also used the little trick of press releases, actually writing articles, actually preparing video tapes sent around to TV

stations who wanted to fill their airtime, so they took uncensored whatever it was the industry sent them, touting, for example, the latest new tranquilizer out of Squibb Laboratories, for example. I'm making this up, pushing it as though it was the latest, greatest invention of its kind for the treatment of something or other, and not saying you should get your physician to prescribe it, but nevertheless creating a demand at the level of the public, which had never been done before. Then the physician was getting all this promotional literature saying, "These are better. Look at this one. Squibb's dosage form is given in ten milligram doses. Ours is given in a tenth of a milligram dose. Just imagine." Did that tenth of a milligram cost 1/100 of what the competing product cost? No, same price, maybe more. And they came to the "me too's."

Now, what did pharmacists do? If a physician really wanted to know what was the difference between the new drug and the existing one, we could tell him. We could tell him if it was the same drug with a slight chemical change. Like let's just take the drug chlorothiazide, and then there was a drug called hydrochlorothiazide that followed it. Chlorothiazide was the first organic diuretic that was really effective. There were mercury diuretics before that, but it was the first totally organic diuretic that was effective. Then came hydrochlorothiazide, still prescribed today. Hydrochlorothiazide was given in one-tenth the dose of chlorothiazide. So we could tell a physician, "Doctor, it's a slight change in the chemistry of the drug right here in the chemical structure." I don't even remember today what it was. "But it's a slight change and that effects the efficacy of the product. Is it any better than chlorothiazide? We don't know. We don't know. But this is what it is. It's a lower dose and it's this." And we could tell him that much about the product. Occasionally the physician would phone down and say, "What's the latest in?" Well, the latest in would be what was the newest thing on the drug shelf. Okay. Sometimes he'd call down and say, "What the hell is Ertrafon®?" which was a Schering product that had three different ingredients in it. We'd tell them. And physicians prescribed combination drugs like galore in those days, so the industry knew it had winners. But the industry also knew that because pharmacists—many pharmacists—got what were known as automatic shipments. A new drug came out with twenty different products that were made out of it and its other drugs. You got an automatic shipment. You had to pay for that. They also knew that you would probably return half of that at a later time and they would give you credit for it. But in the meantime they had your money and they had the ability to make interest off of your money, to invest your money in research, to do other things like that. Then they would refund you.

03-00:38:34
Meeker: That sounds like a magazine subscription.

03-00:38:36
Day: Almost. I don't know. I don't know. And I think any industry executive will tell you, "No, we didn't do that. No, no. We were sincere." And I don't know

that they consciously did it, but the fact of the matter is that's the way it worked, which to me sounded like they did. And, of course, they set prices in those days for antibiotics. Every antibiotic. A hundred tetracycline in 1961 cost $30.61 per hundred capsules. It didn't matter whether you bought tetracycline from Squibb or Lilly or somebody else that made it. Okay. It was always $30.61. Collude prices? "No, we didn't do that!" And then along came Senator Estes Kefauver and said, "Oh, yes, you did," not only for that, but for cortisone, for this product, for that product. "You guys, whether you got together in a room, smoke filled room, or voluntarily agreed on the same price, that's antitrust." And so they got in deep trouble over that and said, "Frankly, that's going to be the end of our industry. We're going to lose all of our research." Industry reminds me a lot of the Republican Party Every time industry gets kicked in the ass it says, "This is the end of us." But it comes back. And every time Republicanisms gets kicked in the ass, certain elements within the Republicans say, "This is the end of us." But it comes back. Those are vibrant institutions. Republicanism will never go away. Nor will the Democrats. But anyway, off of that trail.

03-00:40:02
Meeker: These policy and political questions. You talked about Senator Kefauver and his antitrust crusade.

03-00:40:09
Day: Yes.

03-00:40:12
Meeker: Was any of this part of your education?

03-00:40:15
Day: No. We were practicing as pharmacists when Kefauver came in. Now, at that point in time I had my PharmD degree. I was already a critic of industry, as were the nucleus of us that formed a study group upon graduation.

03-00:40:35
Meeker: Well, that was another thing that you mentioned vis-à-vis your PharmD education. Was that during that year, I'm sure it had germinated a bit before then, but it sounds like during that year your sort of critical acumen was really cultivated. What was it, I guess, about the PharmD or the education or the kind of relationships that you built during that year that you started to be more critical maybe of the profession and of the industry and so forth?

03-00:41:08
Day: I guess it was like with some people, the way they lose religion. But for us, we grew up in the BS program—and the school didn't do this, industry did it—loving industry. Oh, Lilly made medicines as though your health depended on it. That was one of Lilly's slogans. Lilly would take pharmacy students back to Indianapolis, and show them all these wondrous things they were doing for the world. Squibb would do the same thing. We toured pharmaceutical plants and saw their wonderful quality control. That is, people come up and give

inspirational talks on Lilly's vision for the future, Squibb's vision for the future, Lederle's. These were major pharmaceutical companies in those days. Lederle's vision for the future. And, "Yes, we, Lilly, Squibb and Lederle, make money but the big issue is people's health," they said. Well, we swallowed that. I did, and I think probably most of my classmates did. If you asked, "What do you think about Lilly?" We would probably answer "I think it's a respectable, loving, concerned." We wouldn't use those words, but we had a very warm fuzzy feeling in our stomach when we thought about those companies.

In the PharmD program, Sid Riegelman showed us how a company had altered a graph to push their penicillin product. I'll never forget that lecture. Lilly was making a product called V-Cillin. Wyeth was making another product with the same ingredients, I forget what it was, and there was a comparison graph published by Wyeth at the time that showed that their product was this much better than Lilly's. It showed a graph of Lilly product and it showed the product by Wyeth as being—these are blood level graphs, okay, the amount that would be absorbed, get into your system. Well, Sidney pointed out to us that in tiny little letters over here, the scale changed. That which was constituted ten measures here, above that line, began representing one measure. So that a 0.1 milligram difference in absorption had been made to look like it was out of sight. It was a shock. A company did that. And that wasn't the turning point. That was just one of many things that made us begin to realize that there was something to criticize. It wasn't all just love and warm and fuzzy stuff that these companies did. They were, ultimately, we learned, industries out to make money. Yeah, it was a health product, but it wasn't as though Lilly was making money as though your health is involved. They were making money as though their shareholders profit was involved. And for no other reason than that. And it may sound strange to you, but that was a birth for us. We were reborn with a totally different awareness in that PharmD program. That's when it happened.

So the crack, as I told you with some other of my beliefs, it was a crack in that belief system. And once you saw that crack you then began to look around for other cracks. And so we, in this group trained with this PharmD education we had had—which was by no means adequate to enable us to become clinicians—was adequate enough to train ourselves to be critical of at least the physical characteristics of the drugs, and we began to look around, and began to get critical about "me too drugs," which at that point in time we had sort of accepted as, "Oh, yeah. Well, that's got to be better because it's a smaller dose." And then we saw studies that showed that it wasn't any better or in some cases could actually be worse, because we had never looked at studies before. We'd never seen the actual studies. We had had people come in to say, "Bob, did you know there are studies that show that this product is ten times as effective as that one?" I'd say, "Oh, yeah? Wow. Wow, that's really impressive." Well, the study didn't say that. The detail man did. And so we

learned to be critical of literature, and it got us into trouble. We formed an association. But I'm getting ahead now. You wanted the PharmD program.

So the PharmD program at that time, as you are well aware, there were only two schools in the nation that gave it. Other schools had begun to show an interest in it and it would take them sometime to do it. And those are the schools that went forward voluntarily. And that was in the 1960s. By the 1990s, probably only fifteen or twenty schools out of the then seventy schools had gone the PharmD degree program. The others, some of them were going to come aboard, but they were putting it off. Some of them were never going to come aboard. Never. And they got pretty contentious and argued that there was no need for a PharmD degree. There was just no need. Nobody wanted it, nobody needed it. It didn't do anything. They had all these arguments and comparisons. I was engaged in debates with these people. So these were the people that actually had to have a gun put to their head to go to the PharmD degree. It's like Nazis in Germany. There are no Nazis in Germany today. There never were. "I wasn't one. My grandfather wasn't one. My father was never a Nazi." You never can find a Nazi or anybody who ever said, "I was a Nazi." Today in pharmacy education you'll *never* find anyone who says, "I didn't believe in the PharmD degree" [but you will hear] "From the moment I heard about it, I was a supporter—"

03-00:46:55
Meeker: Well, in the 1990s when the change happens, when the entry level degree becomes a PharmD, correct—

03-00:47:01
Day: Yeah.

03-00:47:02
Meeker: —there were still programs at that point in time offering the BS in pharmacy?

03-00:47:07
Day: Yeah. I don't remember exactly when the change happened but it was in the 1990s.

03-00:47:11
Meeker: When did UCSF cease to offer the BS in pharmacy?

03-00:47:15
Day: The class that entered in 1958—let me just think that out. They graduated in '62, the four year program. The class that graduated in '62 was the first mandatory class. They didn't have a choice. They couldn't come into the BS program. It was not available, okay. When they applied in 1957 they were admitted to a PharmD program.

03-00:47:46
Meeker: And that was a six year program at that time?

03-00:47:48
Day: They had to come in with two years of pre-pharmacy as a minimum and then four years of professional education.

03-00:47:55
Meeker: Could they get that two years of pre-pharmacy at UCSF or was this—

03-00:48:00
Day: No. They always had to get it elsewhere. Some universities could do that. Remember, they were BS programs, most of them. So they would offer the first one or two pre-pharmacy years on the same campus. University of Wisconsin was a full-fledged campus, so they would offer the first two years.

03-00:48:20
Meeker: Could you meet those—

03-00:48:22
Day: We were always a health profession campus, so we never, ever offered general education. So we had to get it elsewhere.

03-00:48:28
Meeker: So I guess when you did your two years of pre-pharmacy, that was your education that you got at the JC and at UC Berkeley?

03-00:48:39
Day: Right.

03-00:48:41
Meeker: Did a lot of people who came in to the PharmD program after 1962, did they get their two years of pre-pharmacy at a JC or was it a four year university?

03-00:48:50
Day: Most of them were at a University of California campus, one or the other. But not all of them. Not all of them. We always got Cal State students, we always had JCs. The selection criteria for the PharmD candidates in 1968 and the early 1970s were not brutally restrictive. I think the stream was always that we got a majority of our applicants from UC campuses, the biggest being UCLA and eventually UCSD and the UCB and then Davis. They're all up there. And a minority were from the other campuses, like JCs, like Santa Clara University, like, well, eventually Harvard and places like that. But yeah. No. I forget your question. What was it?

03-00:49:46
Meeker: So by the time that this first class of PharmD-only arrives in 1962, it's a four year program at that point, correct? They come in with two years and then it's a four year program onsite?

03-00:50:07
Day: Yes. Yeah. Yeah.

03-00:50:08
Meeker: Was there anything else that you wanted to add?

03-00:50:15
Day: Well, no. But part of that time, actually, they had to come from a University of California campus. Because the Board of Pharmacy required that you have your full education at one institution. And so our students actually had to come to us part of that time from a University of California campus. Berkeley. Or if they didn't—as one person in our class did—he had to stick around an extra year because there was a residency requirement. Not a residency of the kind you're familiar with but a residency in a school of pharmacy requirement of five years. So if he had done his pre-pharmacy at Sacramento Junior College, he could be admitted to UCSF but he had to stay on campus an additional year. He had to involuntarily get his PharmD. On the other hand, there were very few people that got the voluntary PharmD, probably less than a third of our B.S. class.

03-00:51:23
Meeker: Before we lose this strain, I wanted to follow-up on one additional question about the development of critical acumen. And it was interesting the way you were describing it, in which you're a student and you're starting to recognize that drug companies are not all rainbows and unicorns.

03-00:51:51
Day: They were businesses.

03-00:51:52
Meeker: They were businesses.

03-00:51:53
Day: That was quite a different structure, status in our eyes, yeah.

03-00:51:56
Meeker: At the same time, was that realization also related to understanding that maybe pharmacists do have a different role? To a certain extent, playing interference between physicians and drug companies?

03-00:52:16
Day: Not consciously so. I don't think we consciously said what you have just said. I think we saw something and we saw it as incorrect. Not so high as a wrong but incorrect, not right. Something has got to be done about that. And we did something about it. And might be some minor little thing that we did, like sit around and mumble about it among ourselves or it might be after we formed this association that we had formed, beginning with five or six of us, to write an article in a newsletter critical of a drug, which is what we did. And which incidentally was the first time we realized that we could cause a stir, which was kind of fun. What happened is we formed an association called the Peninsula Pharmaceutical Society that was basically a nucleus of UCSF graduates, most of whom but not all of whom had a PharmD degree. Dick Penna, I, Walt Arkush and Bill Bacon, who was a BS graduate of our school,

and then Frank Garcia and one other guy, and Jim Kunde got together and talked about the need for a continuing education society because CE didn't exist in those days and—

03-00:53:35
Meeker: Right. So this was established after you graduated?

03-00:53:37
Day: Immediately after we graduated. A need for pharmacists to continue with their education because we knew that if anything the PharmD program taught us, it was we didn't know anything and there was a lot to know. So we decided that we needed a continuing education program and the only way we could do that was to form a society whose total purpose was continuing education and that was called the Peninsula Pharmaceutical Society. That existed for about twenty, twenty-five years before it was relatively unnecessary. And that association created programming in which in order to become a member you had to give a seminar. And the seminar had to be on some facet of drugs. Could be drug chemistry, it could be drug development, it could be looking at a series of drugs, the "me too" drugs and comparing them. But it had to be a seminar. Had to be a two hour seminar. You had to deliver it and then you were responsible as a member for finding other people to join the society, because, obviously, we needed fresh blood all the time and for our new lecturers to come in. But the ultimate purpose of that association was to continue the education that we had. Magnificent, it really was, that we felt that way about it. Education we had continued among ourselves. That inspiration came from a lot of people, one of whom was TC Daniels, who said, "You guys, twenty years from now the drugs you've learned about today will be obsolete. You'll have to learn about new drugs. How you going to do that?" And our answer to that question, although it wasn't conscious, was to form this association.

Getting back to my story, we decided we should publish a newsletter and the newsletter should be critical. It just shouldn't be "Did you know there's a brand new drug on the market?" It should evaluate the drug. It might actually say it's a good drug but it might also say something else about it. We talked Upjohn into giving us $200 to publish the newsletter, two editions of the newsletter. The very first edition of that newsletter had an article in it that was written by a guy named Walt Arkush and it took on an Upjohn drug. And it took it on in a negative sense. It was, for the most part, a kind of a silly article but some of it was factual. Walter had a style of communicating that was a little bit sardonic. But anyway, it was critical and the criticism was valid, okay. Guess what? Upjohn was pissed off. The guy that gave us the money withdrew future monies from this organization that had the audacity to attack an Upjohn product. We liked that. We lost support so we said, "Oh, we'll publish it ourselves." That was the very first example of paranoia within industry that we experienced and we would experience many of those as the years went by. But it was kind of like fun. I don't mean we did it because of

that. It was like, “Oh, wow.” It wasn’t like, “Oh, gee, we can wound that giant.” It’s, “That giant is easily wounded. How fragile it is.”

Dick Penna wrote an article critical of a new drug. I don’t know what company it was. Let’s just make it up. Buh-Buh-Buh company, okay. A major company. They flew an executive out from the headquarters to meet with Dick in his pharmacy down in Redwood City where he was a community practitioner, to try and convince him that he was wrong. Now, this newsletter went to only twenty or thirty people. It wasn’t as though it had a major distribution. But it was enough to trigger them into flying an executive out from corporate headquarters. We thought that was pretty neat. But it more than ever opened our eyes to—not the fun of being a critic—but it was fun to realize we had that power.

03-00:57:33
Meeker: Well, it seems to me if I had ever done something like that and achieved such a response, it would actually be a red flag to me that I might be on to something.

03-00:57:44
Day: Yeah.

03-00:57:44
Meeker: As opposed to “this is going to be a waste of my time.”

03-00:57:49
Day: Exactly. Well, for example, look at what we saw ourselves as. Just a group of guys. That’s all. Nothing special about us. We didn’t think that when we formed the association. We didn’t think that our cause was a noble cause. It was just like, “Well, yeah, that’s common sense.” So let’s just do it, writing the articles, being critical of drug therapy, being critical of a product, I should say, was—yeah, it’s there, and it’s a brand new drug, they’re pushing it, so let’s talk about it among ourselves, the thirty of us. And who are we? We’re just insignificant little community practitioners on the West Coast who have a doctorate degree that we won’t tell anybody we have. That’s who we were. And all of a sudden an executive flies out. The regional manager of Upjohn drops support of our Peninsula Pharmaceutical Association newsletter. [laughter] That was pretty big stuff. Yeah.

03-00:58:42
Meeker: Were there ever any threats that came with this?

03-00:58:44
Day: Yeah, through lawsuits. Yeah, yeah.

03-00:58:46
Meeker: Okay. So?

03-00:58:47

Day: Oh, I don't know. We were young and naïve. We said, "They're not going to do it." We couldn't believe they would do it. And, in fact, we were right. Later on Upjohn would sue people who did stuff like that. But no, we got threatened by it and we talked to a lawyer who was on the faculty of the University of California, Jim Nielsen and he said, "Ah, they're not going to do that. They're just bluffing you. They're not going to spend a million dollars to stifle a group that talks to thirty-eight pharmacists. They will rumble it. They will carbon copy their attorneys and they'll play all those games. And if you do get sued, what are they going to sue you for? The truth?" But he said, "But, Bob, understand that can be dangerous because it can cost you money to prove the truth." But he said, "I kind of suspect you'd get some people circling around you if you did that." But we really did not intensely concern ourselves about that. We were young. We were the warriors of that. We had become warriors; before we had been just whatever we were. And "warriors" is too enthusiastic a term. We were just doing what we did.

03-01:00:01

Meeker: You never felt like your career was in the balance and these threats might come true?

03-01:00:05

Day: No. No, no, no. Over the course of my career I've had maybe twenty of those things arise. From students, from all sorts of things.

Begin Audio File 4

04-00:00:25

Meeker: This is Martin Meeker interviewing Bob Day. This is tape number four. All right. So where were we?

04-00:00:39

Day: Okay. So you asked about what the licensing process was for a pharmacist when I graduated. And on those days you had to graduate from what was known as an accredited school of pharmacy, which we had done, which, incidentally, wiped out any possibility that a foreign graduate could become licensed in the United States, which I incidentally did have a role in changing in some few years in the future. But the licensing examination was for a graduate of US school of pharmacy that had been accredited. And it entailed completing 1,900 hours, I think it was 1,900 hours, of experience as an intern pharmacist. Now, an intern pharmacist was very poorly defined in those days. There was no card required. It was just generally a person that was in a school of pharmacy. But there were no legal requirements around that other than during your time you're in pharmacy school you had to work 1,900 hours in a pharmacy. There was no prescribed experience. You just had to be in it. You could walk in and stand by a register and be employed for 1,900 hours and never touch a prescription and theoretically would meet the Board of Pharmacy requirements for it. If that sounds that I'm simplifying or in any

way denigrating that requirement, I'm not. It was kind of like a mindless thing that popped out of the days when a pharmacist could become a licensed pharmacist by having completed so many years of experience and not having to go to pharmacy school at all. So the internship period was kind of like a retainer from the days when there was totally an experiential requirement. You didn't have to go to a school of pharmacy in the 1900s, the 1920s, and in some states up until 1937.

04-00:02:20
Meeker: It was like an apprenticeship.

04-00:02:21
Day: You could become an apprentice-trained pharmacist, okay? But when the Board of Pharmacy began to turn over to the school some responsibility that way, they always held on to the experiential part, which shrank from two or four or five, whatever it was, years. I don't remember what it was. I wasn't a part of that period, down to 1,900 hours. I think it was 1,900. It was supposedly a working year. So you had to get that during the summer months or after school. But before you could even take the pharmacy examination you had to have—I think before you could take it you had to have that 1,900 hours. I'm not certain of that point. Because it went back and forth over the next couple of decades. So on top of that you had to pass a licensing examination.

So here we were, graduates of a school of pharmacy, brand new, fresh out. Had this education. Didn't really matter, we could have graduated from Podunk University, the Board of Pharmacy recognized it. At that time there were vast differences in the student bodies of schools of pharmacy and the education they received. There were vast differences. So you'd think, well, the Board of Pharmacy examination would be kind of like an equalizing effect to make certain that at least the sample that passed the examination had some kind of standardization given to it, this examination. The examination was a pile of crap. It was never anything other than the same kind of questions we were asked when we were passing through the school of pharmacy. It was divided into sections. I think it was called chemistry, then it was called pharmacology, then it was called pharmacognosy and then it was another one called, I don't know, experience. I don't remember the exact title. But it was divided into sections. And these sections housed classical questions like "what is the dose of aspirin?" or "what is the chemical name for aspirin?" "What is the species of the black widow spider? What is the name of the venom of the rattlesnake?" This was actually, if you had been a pharmacy student at that time, not stuff you learned in the school of pharmacy. It was like a whole new bundle of stuff you had to study. Although maybe 80 percent of the examination was based upon stuff you had, there was about 20 percent in it that was kind of like weird, you know.

What is panis alba? I remember being asked that. What is panis alba? I had no idea what panis alba was. But a Board of Pharmacy member who devised that

question for that examination, who himself had no experience in writing questions, decided that pharmacy students should know that and have to answer that question in a licensing examination. Panis alba it turned out, is a breadcrumb and basically it was used as a dosage form if you happened to be practicing pharmacy in the fourteenth century or something like that. Because it was a breadcrumb, you dipped in a chemical. And this guy said, in this particular case—because I countered him after with, "What the hell is 'panis alba'?" I didn't say it that way. "Sir, could you please tell me what—" "You don't know what panis alba is?" he asked. Anyway, you dipped it in chenopodium, which was an anti-worming medicine. We were supposed to know all that. We didn't. So that's what I said.

It was like on top of what you learned. You put away your pharmacy books and you started studying stuff you knew that might be on the examination, which was all of this stuff. The problem was the Board of Pharmacy examination was designed by amateurs. It was designed by people who were practitioners. They were well intentioned, but they didn't know how to devise questions. A lot of the questions were ambiguous. There was one guy that didn't like multiple-choice questions, so he gave true/false questions for the pharmacology part. Now, the pharmacology could be like what's the toxic dose of acetone. It was more like toxicology. You'd find toxicology in there. True/false. The lethal dose of acetone is X? True/false. A dose of two grains of stramonium is not toxic? True/false. All true/false, okay. The idiocy is that this guy wanted the examination to be as easy as possible to grade. So he made the first page of answers all true, the second page of answers all false. He really did do that. So what did you do as a practitioner, as a guy taking it. You knew that nobody did that. So you were horrified when you saw a full page of true answers and a full page of false answers. It didn't occur to you, because you were a little bit neurotic anyway, having frenzied over this is an important examination because I'm getting married in September. And you looked at it and you said, "Some of these have got to be wrong." So you went back and you changed some of the answers, right, because they had to be wrong. Anyway, that's the examination. It really was not a test of your competency as a pharmacist. It was a test of your ability to overcome the shortcomings of people who didn't know anything about examination design and ultimately I was involved in changing that system, as well.

04-00:07:26
Meeker: And it was variable by state because it was done by each state board?

04-00:07:26
Day: Done by state. There was no national examination at that time.

04-00:07:33
Meeker: Yeah. Is there now?

04-00:07:35
Day: There is a national examination. And California acknowledges it. We were one of the last to acknowledge it because we were one of the first to change our examination to become a clinically based examination. And that was in the 1970s.

04-00:07:52
Meeker: And you were involved in that process?

04-00:07:52
Day: Very much so.

04-00:07:54
Meeker: We'll get back to that, then, but I want to make a note of that.

04-00:08:01
Day: So it was more like an obstacle course. You had to do it. You were greatly relieved. We all got drunk the night after the examination because we were exhausted. It was two and a half days of this. We also had what were known as "identifications." You had to go into a laboratory and they would give you a bark and you had to identify the bark as Chenopodium bark. If a solution, you had to smell it and this obviously had to be tincture of something or other. Thirty, forty, fifty years earlier, maybe it was important for pharmacists to be able to do these—what'd they call these tests? Organoleptic tests. Smell, touch, look at. Organoleptically decide what these were by smelling and by touching them and so on. But they were antiquated questions. Just totally useless antiquated questions.

And the prescriptions we had to fill. We had to fill a prescription for a dosage form nobody used anymore, powder papers, which is just an individualized dosage form that has to be folded a particular way according to tradition. And the guy that gave it was like eighty years old and his name was Thatcher. I'll never forget him. I'll never forget that man. Because it was the last examination we had to take and I received this prescription for, I think, it was one gram of magnesium oxide, one gram of charcoal, and one gram of some other ingredient, to be folded into a very small powder paper. Now, I won't bother boring you with what it takes to fold a powder paper.

04-00:09:55
Meeker: I was actually going to ask you to do it. [laughter]

04-00:09:57
Day: Well, I will show you off camera, okay. You can do it. I'll show you off camera. Because I taught it, but I taught it as an obsolete dosage form. And I had made fun out of it because I had them make a sparkling soda drink. When they emptied the contents in a glass of water it turned into a soft drink for them. Back to the examination, that was a big mound of powder per powder paper. So we had to make twelve of them, and charcoal, if you've worked with charcoal, is a very fluffy material. It flits around all over the place. Now,

to fold the powder paper you, had to fold it a particular way so that when you folded over the top part, you folded it down, you couldn't have powder anywhere but where it was supposed to be, in between any of the folds. None of it outside of the folds, none of it anywhere else. And it was impossible.

04-00:10:43
Meeker: Well, there's always static, right.

04-00:10:44
Day: It was impossible. You know what the smart guys did? The smart guys folded their powder papers in advance and then opened up at the end and scooted the three grams of material down there and then re-folded. I wasn't smart. Our teacher was a guy named Walt Singer, who told us that you don't do it that way. You have to fold it from the very basics and it had to be folded this particular way and you can't pre-fold. We called it pre-folding, okay.

So I couldn't. And I went to the guy, Thatcher, and I said, "Could you come back? I want to show you the trouble I'm having because the powder paper was small." It turned out that when they set up the laboratory, they accidentally put out the wrong size powder papers. They came in two different sizes. And he said, "Well, here." I remember him saying that. "Didn't they teach you how to do powder papers?" And I was really neurotic and I said, "Yeah. I know how to fold powder papers. I want to see how you do it. Would you mind?" So he folded it and there was powder everywhere, everywhere where it shouldn't be. And I said, "That's what you're asking us to do?" And he said, "Well, you know, with an amount that large and a powder paper that small there's no way you're going to fold that thing correctly." Okay. So I did exactly what he said, right, and then that night, I remember, I was sitting around having a glass of vodka, and I mean a glass of vodka, when it occurred to me that the man who graded that powder was not going to be Thatcher or Hatcher, whatever his name was. It was going to be the guy that taught me how to make them. It was his laboratory.

Walt Singer was going to be the guy who graded it, and I actually got the lowest grade in that examination I'd got in any other. Walt did grade them and I obviously had failing powder papers. I think I got fifty out of a possible hundred. It wasn't enough to pull my overall grade down to where I flunked, but I really fretted that one because I thought, "Jesus, Walt's going to be grading that damn thing."

So anyway, so that was the licensing examination. In other words, it was not related to practice. It was designed by people that didn't understand the design examination process, didn't really know what the function of it was supposed to be. Just assumed that by getting together and knocking heads they could develop questions. And it was totally secret. Nobody who was in charge of a particular section let the other guy know what he was doing. So redundancies were possible. All of these things I discovered when I was a part of the

committee that took it over and saw the way that examination was designed and learned by looking at previous examinations what had gone on. And many Board of Pharmacy members really liked that part, the Board members really liked designing examinations, although a few of them said they were glad to get rid of it when we finally were able to pull it out of their grasp.

04-00:13:49
Meeker: And that was in the 1970s, correct?

04-00:13:51
Day: Yeah, 1970s, 1980s. I'm a little bit vague on the dates.

04-00:13:56
Meeker: All right. We'll look it up. So once you have your license, this is 1958, you're still finishing up your PharmD. You get, what it sounds like, to be basically a full-time position at Westlake Medical Pharmacy, correct?

04-00:14:16
Day: Yes.

04-00:14:17
Meeker: Where was this?

04-00:14:19
Day: In Daly City, California, in the Westlake Shopping Center.

04-00:14:22
Meeker: Okay. And you said that you had just gotten married about this point in time, too?

04-00:14:26
Day: Yeah, in September. We took the examination at the end of June, heard that we were licensed probably a month and a half later, maybe two months later, and I got married in September.

04-00:14:38
Meeker: I remember you saying in passing that your wife was a nurse?

04-00:14:42
Day: Yes.

04-00:14:43
Meeker: And did you meet at UCSF or—?

04-00:14:46
Day: Well, associated with that, yes. She was a French Hospital student nurse and we met because of a party that was going on when we were all studying for an examination and we'd been invited to it and that was it.

04-00:14:58
Meeker: And your first home together was in Daly City or San Francisco?

04-00:15:02
Day: We lived in San Francisco and then we moved to Daly City about a half a block from where I worked, at the Westlake Medical Pharmacy. We lived in the Westlake apartments that surrounded the Westlake Shopping Center.

04-00:15:13
Meeker: So I'm curious. How was the transition from this really challenging, interesting environment at UCSF to then becoming a full-time practicing pharmacist down in Daly City, which is not recognized as the most lively place in the world?

04-00:15:30
Day: No, it really was. No, I enjoyed it. No, I later left community pharmacy reluctantly because I enjoyed it. I enjoyed working with the people. On the previous tape I told you I didn't want to be a hospital pharmacist because that seemed to me that you were kind of like buried in a hospital and you didn't have much contact with people. You did, but not the people who were ill and not the people who would come in and want an OTC product, an over the counter drug medication, and so on. So, no, I liked it. I found it challenging. I found it challenging for two reasons.

As you may recall from the last tape, I worked as a student in a relatively quiet downtown pharmacy. If they filled twenty prescriptions a day that was high speed.

04-00:16:14
Meeker: Wow.

04-00:16:15
Day: I walked into a pharmacy that filled 120 prescriptions a day. I remember my first day at work. I was exhausted. In fact, I thought I'd made about twenty errors, because it was just happening too quick, prescriptions coming in. And I hadn't learned really to regulate my anxieties or to regulate my body with my brain. It was a very unsettling day. And the first week was like that. Then I eventually got into it and I could accommodate it. But no. I always liked it. I never felt it degrading, a step down. None of that. I was a pharmacist. I was what I wanted to be. I didn't see myself being anything else. But the other reason it was exciting was because of the guy who owned the pharmacy and who was on the case—the case means working the prescription department—was just the exact opposite of what I wanted to be as a pharmacist. And so I learned a lot from him. And he was a very smart man, very quick and very quick at putting people down if you weren't up to him. And I was in constant battle with him because he was occasionally unethical. I threatened to turn him into the Board of Pharmacy at one point. I eventually told him he could no longer work on the prescription case when I was on it because he was just so damned unethical and I didn't want to be responsible for him.

04-00:17:40
Meeker: What do you mean by that? What was he doing unethically?

04-00:17:42
Day: He was refilling prescriptions without authorization. He occasionally would switch medications. The medications were substitutions and in terms of therapy, even at that time, I knew that they were equivalent, but the point of it is you didn't do that. You didn't substitute Terramycin for Achromycin. Those were two different brand names. Slightly different chemical entities of tetracycline, okay.

04-00:18:05
Meeker: Why would he have been doing that?

04-00:18:07
Day: Because he was out of one and to him it made sense economically to do the other. He would refill prescriptions without authorization because it was easier to do it that way.

04-00:18:16
Meeker: Instead of having to go through the—

04-00:18:18
Day: Instead of phone the physician, get an authorization to refill a prescription.

04-00:18:23
Meeker: Do you think that maybe he was frustrated with the limitations that were placed on pharmacists in the same way that you—

04-00:18:32
Day: No. No, I think it was all economics for him. He was not a graduate of a pharmacy school. First of all, the man was brilliant. He would have been a Ph.D. had he gone on to college. He didn't. He was an apprentice-trained pharmacist. He was licensed in 1937, which is when California ended the possibility to become a pharmacist by an apprenticeship. So he had never gone to college. His father was a graduate of our school of 1906, so that was another inspiration in my life. It was wonderful working with that man and hearing stories about the earthquake fire, which eventually played into some of my history stuff. But in any event, no, my boss was a wonderful experience because he was just the antithesis of what I ever wanted to be and he was a challenge at every step. I couldn't do anything without being countered by him. He would be critical of this, he would call me "The doctor," and I told him one day to stop that. "The doctor" of pharmacy. We were at blows. I often wonder why I never turned him into the Board of Pharmacy. I threatened to. But it really wasn't until he did one major thing that I reported it, but nothing came of it. But he was a challenge. I learned a lot from that man.

04-00:19:51
Meeker: What was it that he did?

04-00:19:52
Day: I caught him pretending he was phoning a physician's office for a refill authorization. He was pretending it. I noticed it because the lights on a

telephone board weren't lit up, meaning he was not on the line, but he was talking. "Oh, yeah, hi, Ed, how are you? Oh, yeah, I'm good and Elma's good. Yeah, how's your wife?" Making it this conversation for my benefit. And he did know a lot of physicians and he knew them by name. And they really liked him. He was also the most charming man you would ever meet. If he was to walk in the door right now and sat down, you would immediately be immersed in his personality and you would like the man. I liked him. Liked him as a man, hated him as a pharmacist.

04-00:20:43
Meeker: It's interesting. It sounds to me like maybe he was, I don't know if representative, but in some ways typical of a much older generation of pharmacists where although there were these official prohibitions against counter-prescribing and filling prescriptions and everything, I wonder if after a pharmacist established himself in a community and knew physicians, that there was sort of this unwritten culture that pharmacists did in fact take on a measure of the role that physicians did. So that they would engage in counter-prescribing, that they would basically decide that they knew a patient well enough and they knew their doctor well enough that it was insulting or time consuming to have to call and get a renewal for the prescription.

04-00:21:48
Day: No, no, that's a rationalization that I might have heard from the man I'm talking about, but he didn't. We never discussed the morality of it. He never said, "Well, this is this situation." He didn't defend the substitution. That's just one thing. He denied some other thing I caught him in, and it was ambiguous. It could have gone either way. First of all, I have no idea of how every other pharmacist who was practicing pharmacy was and is. I've just been me. My experience was limited to four pharmacies. The one in Sacramento, those guys were straight arrow. I never saw them do anything unethical. In fact, we would talk about it. Murray Washauer, the guy that I think I described in the last tape, was to me the epitome of everything great in pharmacy. Straight arrow. We talked about ethics. He was there. The guy that worked for him, I never caught him at anything, he was just an asshole to work for. And so I don't know that he was unethical in terms of what I would describe as ethical, okay. The guy I worked for in a downtown pharmacy for the most part was okay, but he would do stuff. He would slip some medications without a prescription. He loved to give injections, testosterone, to men who were needing it and justified it because he had been a medic. And I was a student at the time and I didn't know exactly what to do about it. I didn't approve of it but I didn't know what to do about it. I don't know. Maybe I'm rationalizing what I was like then. I don't know.

But the guy I worked for at Westlake Medical was just everything, as I said, all of those bad things rolled into one. He was definitely not the guy like the one at the other pharmacy where he was completely berating me all the time. Just pitched in battles with the guy. And eventually I quit. Three or four times,

I quit. But by that time, I'd become very important to him and I knew that he wouldn't let me do that. But I left. I walked out the door, took off my jacket. Well, this is it. It's going to be this way or not. I came in one time, caught his son filling prescriptions. His fourteen-year old son. Not only that, but taking prescriptions over the telephone. And I was sitting there and he answered the phone. I could hear him talking to somebody, and he walked over to me and threw a piece of paper down and said, "There's a prescription for you." This fourteen year old kid. And I said, "What is this?" And he said, "Dr. So and So just called in and gave this." I said, "You took this prescription?" And he said, "Yes." I said, "Get the hell out of here." And he said, "My dad said I could do this." I said, "I don't give a damn who your dad is. Get out of here. I don't want you." I called the physician back and apologized and said an unqualified person had taken it. Turned out, I think, that he had taken the prescription correctly, but his father, this guy, owner and I then got pitched in a battle over his son. "I want my son to become a pharmacist someday." I said, "Well, you do so, but not at the expense of a patient." Because when his son handed me that prescription, if I had filled it, I'd be trusting him and I don't. I didn't trust him. And I wouldn't trust anybody this side of an intern, and a brand new pharmacy intern I wouldn't trust either. So that was one of the times I quit. "Well, I own this pharmacy, I'll set the policies," he said. And I said, "Okay. Have it your way, I quit. You're going to do it without me." And at that time I had developed a manufacturing laboratory for him that he made a lot of money from it. And I knew he wouldn't let me walk.

04-00:25:41
Meeker: A manufacturing laboratory? What was that?

04-00:25:41
Day: We just made a line of cosmetics and external drug products that we got physicians to prescribe. Sold the body massage lotion in hospitals. And we got it up to about sixty thousand units a year, I think, before we began to get pushed out of the market by companies like Lilly and Abbott, who had an advantage and used their product as a way of getting them to buy Lilly products. It was a body massage lotion that we were able to get up into high production and had it in Saint Luke's and three or four other hospitals and they would give a bottle to each patient and charge the patient a dollar and we would charge the facility, I think it was forty cents. And we would make thirty cents on it, because by the time it was in a bottle, plastic bottle, labeled and ready to go us, it cost us ten cents. But it was a manufacturing facility I had developed as part of my education. Because I took a drug product formulation course from Sidney Riegelman and it sort of inspired a few of us to give it a try, to give drug manufacturing, pharmacy manufacturing, or in this particular case, cosmetics. Also, I developed some external drugs that we had physicians prescribe. So I had become valuable to him and I knew that he would not let me walk. So I eventually had to kick him off the case. I had that power. He needed me that much when I said, "I don't want you on the case when I'm here. I cannot trust you anymore." I was deadly serious.

So I think I may have mentioned before that—maybe I didn't—but he was a valuable part of my education, because I previously viewed myself kind of, like, weak and easily give in to pressure and so on. And the very first test I had was with the old guy down in Keck's Pharmacy in downtown San Francisco when he wanted me to give to a patient a prescription drug without a prescription. And he handed it to me and he said, "Give it to the patient?" and I said, "No, I'm not going to do that." But I had to think about it. He gave it to me and I started to walk to the patient and I stopped and I said, "I can't do that." They sound so insignificant to you, I'm sure, but this was major for me because I could see my life unfolding. I could rationalize it. "Well, I'm just a student and he's the pharmacist." That's what went through my mind. But it was very quickly resolved. So I handed it back to him. This guy at this pharmacy presented me with the same kind of ethical dilemma. And I learned a lot from him. Learned a lot about myself from him and I developed a lot of my ideas about what my responsibilities as a practitioner were from him because he wanted me to do just the opposite of what my belief system was.

04-00:28:40
Meeker: What were some of your ideas that you developed as being a practitioner?

04-00:28:46
Day: As being a practitioner?

04-00:28:47
Meeker: Yeah.

04-00:28:50
Day: First of all, I was a straight arrow, okay. I wouldn't refill a prescription without an authorization. I wouldn't substitute a prescription without authorization—substitute was when you got a brand name and you had a generic product on hand. Which was a big scam of the pharmaceutical industry in those days. They got physicians to write for this brand, which would cost tenfold of the generic product. And so I would not switch to generic without a physician's authorization, although I would discuss it with the physician, and get him to switch. Switch. You can do it by law now. You couldn't in those days. It was unethical to do that. It was called substitution and the drug industry had gotten every Board of Pharmacy in the nation to establish, what was it, a misdemeanor for any pharmacist who independently substituted a generic product for a brand product.

04-00:29:54
Meeker: You had mentioned that as a result of your experience at Westlake Pharmacy you had developed your own sense about what is ethical.

04-00:30:04
Day: Yeah. And I think I sort of explored that with you last time because I was in constant battles with this guy. And he tested me. He really tested my ethics.. I felt if I gave in on any one of these things it was like the first step on the road to hell, so I was determined I was never going to give in to the first one. That

happened the moment Bill, the guy at the downtown pharmacy, handed me that vial and said, “Give it to the patient without a prescription, okay,” and I turned to him and said, “I can’t do this.” “Why can’t you do it?” And I said, “I can’t do it because I cannot let a patient have a product without a prescription.” And he said, “Oh, well, then, give it to me, damn it,” and he went out front and did it himself. I should have turned him in but I could not do that. I can’t even rationalize it now. So these were little tests and I got them to the point where by the time I left Westlake Medical Pharmacy I was a PhD in the school of hard knocks because I had had everything tested at one level. My belief systems in terms of being a pharmacist had been tested at every level by this guy who was totally without any inhibiting factors.

04-00:31:37
Meeker: Well, let’s talk about this transition. Because you’re at Westlake for about eight years, it looks like, until about ’66, by which point in time you had already returned in some capacity to UCSF—

04-00:31:50
Day: Yeah.

04-00:31:50
Meeker: —as an assistant clinical professor. So you had some overlapping interest and overlapping work during this period of time. What brought you back to UCSF in 1962?

04-00:32:10
Day: It started with a half a day job and it started because I had developed this manufacturing facility in the rear of the pharmacy and we had a line of products that I was manufacturing. And Sidney Riegelman, this person whose name I’ve used before, needed somebody to help to teach in what was known as the drug product formulation laboratory. Okay. So he asked me if I would mind teaching in that laboratory, which turned out not only teaching in it, but taking it over within a few weeks, to where I became *the* teacher in the laboratory, decided what they would be doing. And it was basically a cosmetic and external drug products course. It was a one unit laboratory, one unit lecture. I took care of the laboratory. And the laboratory was mine to do anything I wanted in. So I tried to teach the kids up to drug product formulation, meaning cosmetics, external drug products. Those were my specialty.

So in 1962, I think it was ’62, Sid heard what I’d been doing, Sid Riegelman heard what I was doing, and asked me if I would join him. So what I began to teach was what I was doing as a practitioner. I was, in this instance, the fulfillment of some of Sid’s dreams because one of the things he had emphasized was that there were more roles for pharmacists in product formulation, and such things as that, than pharmacists had taken advantage of. And I was kind of like his proof of the pudding.

04-00:33:59
Meeker: Can you explain to me the faculty role at UCSF? For historians it's very sort of cut and dried. I guess the four different levels would be you're either an untenured lecturer that is generally no guarantee of employment. You work for peanuts and then generally you're sort of sent off into the wilderness after they're done with you. Then there's an assistant professor, which is you're there for five years and if you pass muster you get to be an associate professor and then you're a professor.

04-00:34:39
Day: Right. Or in my case I was told I would not be there that long.

04-00:34:42
Meeker: Yeah. From what I understand, it's a little bit different there because they're medical schools and schools of pharmacy. You have long-term lecturers who do in fact achieve a certain amount of status.

I know that you started out as an assistant clinical professor, then I believe you moved into a position of a lecturer with some security of employment. That would be atypical in a history department, for instance, to do that, and I'm wondering if you can sort of describe the trajectory of your teaching appointment at the university.

04-00:35:30
Day: Okay. Well, first of all, when I was appointed assistant clinical professor of pharmacy, I was probably the second one or third one in the entire history of the school of pharmacy, because they'd never had a clinical professor before. And so when I was hired by the dean, although at the instigation of Sidney Riegelman, I was told that I'd be hired for no more than a period of five years and I would be an assistant clinical professor of pharmacy, that would be my title, and that it would be a part-time situation. It was an agreement we had with the dean. He said basically, "This is not a permanent position, Bob. It's supposed to end in five years." What he meant was, if it was to last longer than five years, then I had to come up for review and go to associate and that was not something they were contemplating at the time.

04-00:36:29
Meeker: Largely because of funding or because of—

04-00:36:31
Day: I think because the dean had some kind of a narrow viewpoint of my capabilities. I had been in his office because I'd gotten an F in a course, and that came up at one of our discussions later on. And I'd gotten an F in a course because I frankly just thought it was complete BS and didn't complete the work. It was stupid, silly, rebellious kind of stuff that I was capable of when I was younger, maybe even today. But I did it and I got an F in the course. But I wasn't supposed to get an F. It was supposed to be an "incomplete." So anyway, he had me on the carpet over that; I had to get his special permission to graduate with an F on my transcript. So he remembered all that. So I think

he had, kind of like in the beginning, kind of like, "Well, this is a kind of temporary position." And, in fact, I was something new to the university because I and Dick Penna, my buddy, had been the second persons—the first person had not really worked out—as an assistant clinical professor.

04-00:37:30
Meeker: It sounds like maybe he did this as a favor to Riegelman?

04-00:37:34
Day: I don't know. I don't know. I never thought about it that way. So I was picked up as an assistant clinical professor and told that it was going to be a brief term. But, you see, that was fine. That's great. I was flattered to be asked to do that. I envisioned my manufacturing facility in the back of the pharmacy would outgrow that facility and grow into a small plant at some point in time. So it sort of coalesced with what my available time would be, and I just really liked the idea of having a title. It was really neat. I liked that. And so I began to teach in Sid's external drug products course, because that's what I'd been doing, formulating cosmetics, manufacturing them in this facility.

04-00:38:30
Meeker: Can you define cosmetics to me?

04-00:38:33
Day: Creams, hand creams you can buy without a prescription. You think in terms of beauty aids and stuff like that. I think in terms of formulations and really what they are. So if I wanted to be fancy, I could call them external drugs. But cosmetics to me. The body lotion that I devised that we sold in hospitals was, as far as I was concerned, a cosmetic. But it was also an external drug product. You applied it to your skin for a therapeutic end. Let me tell you, that external drug products was a formulation course, okay. It's where you learned how to formulate for a lot of cosmetics because cosmetics are kind of like the basis of your skin lotions. The products that have drugs in them are basically cosmetics. They start off as that and they will formulate them using cosmetic principles, but it's a drug product.

04-00:39:59
Meeker: So ointments and lotions and those kinds of things?

04-00:40:03
Day: Lotions. Ointments, suppositories. Any number of things like that.

04-00:40:09
Meeker: Basically anything that absorbs through the skin.

04-00:40:12
Day: External drug products, anything you apply to your skin one way or the other. So I taught in that course for, I don't know, a year or two, and then the opportunity came along to teach in the compounding course, which was basically—you might want to think about it as the beginning skill that pharmacists would learn in order to take my cosmetics course. Because you

had to understand emulsions, you had to understand powders, you had to understand the principles of a lot of things. So the compounding course was how to make a lot of basic dosage forms. Within a short period of time, I ran out of the five years and Jere Goyan had come in as the dean and he said, "Bob, we have to get you out of the clinical professor series because we can't promote you." At that time they had no criterion for promotion. They do now, and they did, actually, a couple of years after he told me this.

04-00:41:17
Meeker: Actually the title of clinical professor is interesting because this would have been, what, four years prior to the Ninth Floor Project, which was a clinical project. Was it peculiar that a pharmacist was placed in the clinical series?

04-00:41:34
Day: Well, no. Well, yes, it was peculiar because there were only two others in the history of the school and I was the third. They did it because they considered being a practitioner being clinical. It's a broad extension of the word clinical.

04-00:41:50
Meeker: A different definition than it would have become after 1966.

04-00:41:52
Day: Today it means something else entirely. But in those days it meant that I was a practitioner teacher, because the others were PhDs. They were not clinical. They were not practitioner teachers. I take it back. Walt Singer was. But in any event, so Jere Goyan, who had become dean, then encountered the reality that there were no promotion criteria for a person at my rank. So he then said, "We're going to have to appoint you as lecturer and does that hurt your feelings?" And I said, "No, no. No, that's fine." Because, you see, I was so privileged anyway to do that, and at that time I didn't see myself sticking around much longer. I was getting ready to make other moves. My sequence of events here is maybe a little screwed up. But anyway, I began by teaching one afternoon a week, and then became a half-time instructor when Sid Riegelman asked if I'd like to teach in the compounding course. I said, "Okay." And I still taught in the beginning the cosmetics course, although I quickly dropped that, because teaching the compounding laboratory required teaching four labs a week and I was doing that while I was working at Westlake Medical Pharmacy. That went on for some years.

So I was put in the lecturer series because I had run out of all criteria they had to use to promote me in that other series. They either had to can me or find a way to keep me. Today it would be an entirely different situation. But in those days, there was no other choice. And so it was fine with me because I was never going to be a professor. That was not going to be my career. My career was then pointed toward community pharmacy and manufacturing, I thought, so for me it was not a big deal. It was to Jere. He said, "I'm really sorry, Bob," because it doesn't have the ring. Lecturer doesn't have the ring. Doesn't have the—

04-00:43:56
Meeker: Status?

04-00:43:57
Day: —buzz or the status—I said it's okay. It's not a big deal. And so that's where I became a lecturer and that's the title that stayed with me until the day I retired. Although it could have switched at some point, I figured, "why?" It's okay. It's not a big deal. I never was big on titles. And then, probably thirty years ago, Jere came to me and said, "Guess what? We're putting you in for lecturer with security of employment." And I said, "Oh." Because at that point in time I was permanent. I had quit my job at Westlake Medical, long since quit it and I had been on the faculty probably twenty years. He said, "We're going to put you in as lecturer with security of employment," which I kind of laughed at when I heard the term. I still do. It sounds to me like, "Well, what are we going to call these assholes?" I know. We can't call them tenured, because they're lecturers. Seriously, I could hear in academic circles, oh, SOE, security of employment. You think about it, that's really a trivial term. You think about it, it's a denigrating term. I'm secure. I'm going to be employed. Not tenured. It's not called tenure. It's security of employment. Got to differentiate it.

04-00:45:10
Meeker: That's in essence what it was, though, is tenured lecturer.

04-00:45:13
Day: I think it was. Basically it was the same thing as a tenured, yeah. And he said, "I got it for you." And I said, "Gee, Jere, thanks a lot." To me it meant nothing. Turned out it meant really a lot because I then became eligible for university retirement contributions. Up to that point in time I wasn't. And that made a big difference when my retirement stuff came around. But in those days it was like, "Okay, Jere, thanks a lot."

04-00:45:35
Meeker: Was this a previously established category, do you know?

04-00:45:38
Day: SOEs? Yes. Yes. Security of employment. Oh, yeah. No, there aren't many of them through the university because the university tried to get rid of the lecturer title. In the span of my career, I was there fifty years, they tried to get rid of that title. And I think maybe they don't give them out anymore.

04-00:45:52
Meeker: According to the CV, and I'm just trying to piece this together, and I'm not testing you here, but your term at Westlake ended about the same time that you transitioned from assistant clinical professor to lecturer.

04-00:46:09
Day: No.

04-00:46:10
Meeker: No. Because I have ’66 for both of those.

04-00:46:12
Day: It might have. No, it might have because I went full-time. Because Jere then asked me to go full-time. Yeah, it might have. Sixty-six. I think in ’66 I went full-time with the university. But that’s not when I got the SOE. That may have been when I got the lecturer.

04-00:46:28
Meeker: Correct, yeah.

04-00:46:29
Day: So I went full-time with the university I guess in, I think it was ’66. And that’s when I quit Westlake Medical Pharmacy because at that point in time I had decided that this was a dead end. The owner had pretty much made it clear to me that he was distracted with a lot of other things in his life and that the manufacturing facility, even though he made lots and lots of money from it, was low down in his priorities. So I tried to get rid of it. I then just tried to dismantle it because I had to do that on top of being a pharmacist. I had to go in the back and measure the temperatures of the emulsion and the phone would ring. I’d run out in front, take a prescription, fill it. People would come in. I’d have to run in back and melt the emulsion—then I got the whole process going and run in front. I was doing both jobs simultaneously, so when it was obvious that Charlie was not going to do anything but exploit what I was doing, I wanted to do nothing but get rid of it.

I didn’t sabotage it. I didn’t have to. What I did was exaggerate. So the lab developed a mold in something. I think it was the ephedrine syrup that I was manufacturing for the facility. So Charlie looked at it and he said, “What is it?” And I said, “It’s a mold.” And I said, “It’s the coup d’état to our facility unless we go elsewhere,” because once you get a mold you can’t get rid of it. Lie. Okay. Because I really wanted to go elsewhere where we had our own facility. And he could have afforded it. He probably had made off of the products I had developed, I don’t know, a lot of money. Not in terms of 2013 dollars but in terms of 1960s dollars, it was quite a bit. But he had no interest in it. He was distracted and he wanted to have his thumb in everything, including the facility if it happened. And so when I developed this mold in the ephedrine syrup I said, “We pretty much are out anything but the body lotion business.” So I was able to cut the rest away. I did it almost out of self-preservation because I was getting very busy back there because our orders for the body lotion were increasing. And I stopped product development because I was done developing products.

So anyway, it was very fortuitous and I had yet to be offered this half-time job. I didn’t know that was in the offing. So I needed to preserve my state of mind. And so when I developed that mold, I told him that was it for the sugar based products we were manufacturing, which were quite a few. And so I let it go. I

didn't do it. I didn't contaminate the liquid. They just developed a mold, as they will if they're not preserved correctly. So I had unintentionally screwed up a batch, but I did lie when I came to what I could do about it. And it was because I had no support from him and I saw it strictly as a one way street because he was relatively a greedy guy. And he was involved in this and that and the other thing. He's making big bucks, I'm sure, on those things. And I was getting increasing satisfaction from teaching. I began to lean more toward that side of it.

I had all the time been involved in this association that I told you about, the Peninsula Pharmaceutical Society. I had been its president. We had also helped establish the San Mateo County Pharmacists Association as an offshoot of that. So I had lots of things going on professionally for me. We were giving seminars at state conventions, the very first CE seminars they ever gave. And the American Pharmacists Association, the first one they ever gave. So we were getting active in that. And I had a lot of intellectual things pulling me.

But when Jere offered me the full-time job, strangely I turned it down. I turned it down because I liked being a pharmacist. I really liked it. I loved it. I loved what I was doing. And I had to think it over because he said, "I want you full-time. I want you to take over continuing education for the school and I want you to do this and do that and continue your teaching. But I need a practitioner pharmacist on the faculty and I don't want you half-time anymore." So I turned him down and I came home and talked to my wife, who is the most wonderful logical person in the whole wide world. And after so many very nice loving tender discussions, she basically asked me a question which basically came out as the following, "Are you out of your fucking mind?" She didn't say it that way but basically, "You've been working sixty hours a week. You've been doing this. You've been confronting this guy who's a challenge at every corner. You've been offered something that would give you a five day workweek, two days off, you only get one now and it's like in the middle of the week. Are you out of—" She never put it that way. My wife is quite beautiful. She's logical. She's convincing. And so I went and said, "Yeah, okay, let's do it." So I started July 1, I guess it was '66.

04-00:51:59
Meeker: And, besides, you were going then back full-time to UCSF, a place that you had a deep engagement with.

04-00:52:07
Day: Well, that's what he was offering me, yes. I was leaving something I really liked that had become increasingly difficult to a place that I really liked, to an unknown. I didn't know what I would do full-time.

04-00:52:19
Meeker: Going rather to teach full-time at UCSF?

04-00:52:27
Day: Yeah. I didn't know what that entailed. See, that was a mystery to me because that—

04-00:52:30
Meeker: Oh, because it turned out probably to be more than forty hours a week.

04-00:52:34
Day: No. In the beginning I was going out of my head. I didn't have enough to do. You may remember I had all these pots in the fire, right, filling prescriptions out in the front, testing the emulsion, running to school, teaching, preparing the lecture, setting up the laboratory, getting there at six o'clock in the morning and typing out the lecture for next week and rushing off to go back to the university and doing that. Coming to the university four times a week to teach that course. I was really busy. So all of a sudden everything came to a halt. I was sitting in an office and nobody phoned me any prescriptions, no patients came in to buy over the counter medications. The manufacturing facility wasn't over my rear shoulder with an emulsion brewing. I thought, "This is really boring." So I set in motion all sorts of projects that I later on kicked myself in the ass for doing because a year later all of them came due.

04-00:53:38
Meeker: I actually did have one question about the over the counter medications when you were serving as a community pharmacist. You had talked about the ethical considerations behind the counter. I wonder how you dealt with the ethical considerations over the counter, meaning the sort of prohibition against counter-prescribing and did you find a solution to those?

04-00:54:12
Day: Yes, we did. We did it logically. Remember I told you about this association? The Peninsula Pharmaceutical Society. It had Dick Penna, me, Walt Arkush, three UCSF graduates, PharmD graduates of the same program, plus three or four other guys who were equally inspired. That's a terrible world, I shouldn't have used that. Equally concerned about the future. We formed this association as a think tank in the beginning and one of the things we mulled over was our role in over the counter medication. And we began to say, "Well, why shouldn't we? Who else knows about those products? Who else knows that they're not labeled correctly? Who else knows what vaporizers don't do? Who else knows these sorts of things? So who else can talk to the patient about over the counter medications?" So counter-prescribing we said, we agreed, so counter-prescribing is our role. It's not against our role, it is our role. Who else knows about those products? Physicians don't know about them. What was the pharmacology of Vapor Rub spray, this thing you spray into your room that spells pretty? Did you ever receive a prescription from a doctor for this, for that, for all these? We rationalized our way into it. But it really wasn't rationalization. It was logic. That we began to realize that a lot of these things had come down to us from the medical profession. "Don't cross into our territory." And, in fact, you will find out the AMA had a lot to

do with the ethic the APhA adopted in the 1800s that said thou shalt not mingle with things that aren't pharmaceutical, making products. That's your role, making and dispensing products and so on.

So we began to sort of say, "Hey, wait. We've got some ideas." And so we began to write up some of those ideas in articles. So for us it was a logical extension of our education and what we knew, to develop that. And it came out of group thinking. I didn't invent it solely. Dick Penna didn't. I advocated it ultimately. So did Dick. We ultimately convinced people to teach OTCs across the nation—I instigated a course on over the counter medications at the university. I taught what I believed. The role of the pharmacist as a consultant. Dick Penna did the same thing. We wrote articles for the American Pharmacist Association Journal on that area, the first written by pharmacists, basically proclaiming that you should know these sort of things. We ultimately gave birth to a book that was published by the American Pharmacist Association. So all of those are kind of like direct line extensions of the questioning minds we had become endowed with when we were in the PharmD program. Because we had critical mass. We had people together who were saying, "I don't like this. What are we going to do about it?"

04-00:57:15
Meeker: What was the response, then, you were getting to not only the course but some of these articles that you were writing that were, to a certain extent, beginning to advocate for an expanded role of the pharmacist, particularly when it comes to over the counter medication.

04-00:57:30
Day: The responses in what regard?

04-00:57:31
Meeker: Well, from different professionals in the field, from fellow pharmacists, from maybe regulatory officials, physicians.

04-00:57:47
Day: The response from physicians was trivial. I think the only time I got taken on by a physician was when I wrote an article for a physician's magazine and basically talked about this and got a couple, two or three haughty letters. But those I expected because physicians were traditionally the guys that called the shots. Basically the letters say, "Where do you get off advocating this role for the pharmacists when it's the role of the physician?" I'd heard that a number of times. By and large, I don't remember encountering much opposition. I told you about the opposition we got from manufacturers that never quite went away. But we got minimal opposition from the profession of medicine because they had limited exposure to us. I would imagine that if we at that time in the early stages had had national access to the journals of medicine, that we would have encountered a lot of traditional responses to the pharmacists stepping out of bounds, going "That's my patient, not your patient." The notion that pharmacists could use the word "patient." I got taken

on by a physician one time. “Where do you get off calling that a patient? That’s a customer.” And I said, “Where do you get off calling that a patient? It’s a customer.” The same argument applied to him that applied to me. But that’s because I was feisty in those days. I would be a little bit more diplomatic, maybe, maybe not, today. But anyway, did I answer your question?

04-00:59:20
Meeker: I believe so. Yeah.

[End of Interview]

Interview #3: January 29, 2013
Begin Audio File 5

05-00:00:00

Meeker: Today is the 29th of January 2013. This is Martin Meeker interviewing Bob Day and we are now on tape number five. So let's get started. I think that today we're going to focus on the ninth floor project and the emergence of clinical pharmacy in the United States. And one of the things we wanted to start out, is, before we start actually talking about the specific genesis of the ninth floor project, I'd like to get your thoughts on the history of clinical pharmacy practice in the United States. The extent to which you, in your experience, could identify sort of origin moments, if you will, or prehistory moments of this work.

05-00:01:14

Day: Okay. And so first of all, let me state my credentials or where I'm coming from. I am not today a clinical pharmacist, nor was I one when this whole project was being developed. What I am is one of many people who fed into the project that was called clinical pharmacy in whatever manner I could at that time, but I was never a person on the floors. I do not consider myself a pioneer of clinical pharmacy. I was, if anything, a precursor to it. So if we think of clinical pharmacy like a river, there were all sorts of little streams and tributaries that fed into it that made it possible. And we talked last time about the ethic of the profession of pharmacy, thou shalt not counter prescribe, thou shalt not act like a physician, thou shalt not do anything other than fill prescriptions and make certain they don't kill people. There were a lot of things that led to ultimately this radical, because it was that—when it happened it was like a trap door swinging shut—change in the direction the profession of pharmacy.

And if we looked at the way it was, pharmacists filling prescriptions, doing a very good job with that, being concerned patient care people, but unable really to provide a level of care much more than that of a safeguard in terms of medicine. If we look at the profession then, what changed very slowly within that were voices across the nation that said something needs to be done. The problem is nobody knew what that something was. This was what I have called the holy grail of pharmacy, the notion that the pharmacist should be a first person provider in healthcare, rather than a person who provides healthcare but does it on the beckoning of a physician. And people talked about this. They talked about the pharmacist as an advisor to the physician. You can go back to the 1920s and find pharmacists and physicians talking about the pharmacist's role in assisting the physician in some cases. But in no case did they ever talk about the pharmacist assisting the physician in terms of prescribing. So that was one stream.

Then across the nation little experiments started. They were not an overall part of a big thing. A guy named Dave Burkhalter, back in, I don't remember where, Tennessee, perhaps—

05-00:03:56
Meeker: Kentucky.

05-00:03:56
Day: —established a library. He didn't call it a drug information center, he called it something else, but in which he was there for the purpose of answering physicians' questions. Dave was, in a sense, a pioneer. But the level of his participation in healthcare was basically to go to a reference text and to find information that was relevant to the prescription, to the physician's question. So David was one of those people that started one of the streams I talked about. The stream was not complete. It wasn't full. It didn't connect to the river yet but it was one of those things that contributed to a thought of a different role for pharmacists.

05-00:04:39
Meeker: It was an acknowledgement, perhaps, that physicians do not possess all knowledge at all times.

05-00:04:47
Day: No. I think probably that would be considered an arrogant viewpoint, I mean, at that time. Not now. I think it was the fact that physicians needed additional information from time to time. Not that they didn't know it. Maybe I'm being political now, but I think that the concept was not that we're going to show them up or we're going to lead the way for them, but that they will have questions that they can't answer and it's not their lack of knowledge. Let's get off of that one because I'm overdoing it. Okay. So that was one of the streams. There were lots of other streams.

I was one of the streams. Dick Penna was one of the streams. We began to talk about the pharmacists stepping out from behind the counter. We taught that to our students. You should ignore the "thou shalt not counter prescribe" rule. We developed an association that began to critique OTC medication, over the counter medications. We developed concepts of practice that would be considered to be an element of clinical pharmacy today but not clinical pharmacy. So we had these radical ideas, and they were that, and they were not necessarily agreed upon by a lot of people who were pharmacists at the time.

05-00:06:01
Meeker: So what you described last week basically about the work you were doing and—

05-00:06:03
Day: Yeah. Yeah, yeah, right. And then people were talking about monitoring patients' drug therapy. Okay. Pharmacists, particularly one of our graduates,

Morris Boynoff, developed a prescription monitoring system that basically monitored a patient's drug use. Now, let me tell you what that contrasts with. Prior to that time, I would fill a prescription, any pharmacist in the nation would fill a prescription, give it to the patient, put it in a file. There it would be buried, okay. Had no idea what prescription would follow it. If the patient said, "I want a refill but I've lost my prescription number," the pharmacist would have to do one of two things. Would have to go to the patient's charge account and dig out the Rx number there, or would have to call the prescriber and say, "Mrs. Jones wants some more of her meprobamate. What do you say?" et cetera, that sort of thing. Morris's advanced notion was that this was a monitoring system for the purpose of enabling the pharmacist to retrieve the information easily, not for the purpose of monitoring the patient's use of the drug, which was an important aspect which had not yet been thought of or invented, because pharmacists didn't see themselves doing that. And I don't think Morris ever did that, as well. He used it strictly to keep track of the patient's medication, to make certain they weren't overusing narcotics and such things as that. But it was a very basic system.

Paul Lofholm developed that system even further and even further when he was actually a clinician in the community. But he picked up that system as a student and initially put on his little change to it. Okay.

05-00:07:54
Meeker: What do you call that system?

05-00:07:56
Day: You can't call it a patient monitoring system. It had a name. I don't remember. I honestly don't remember. It wasn't patient monitoring. Or maybe we called it patient monitoring. Maybe we called it prescription monitoring. I honestly don't remember. Somebody else is going to have to provide that answer.

Other people began to talk about the pharmacist as a healthcare practitioner, a professional. And they did it in a very interesting and strange way. Morris Boynoff, again, who was a hell of a pharmacist, is today still one of my heroes even though he died twenty years ago, talked about the profession of pharmacy as a profession, not a merchant, which was a radical notion. He went around and talked to us at the Peninsula Pharmaceutical Society, that continuing education society that I mentioned. He talked to the state association; he published articles on the pharmacist as a professional. His primary push there was not getting involved directly in patient care, but saying we provide a professional service so why should we do a markup on the items we dispense, which is what pharmacists did. They bought a drug for a dollar, and they raised it twofold depending upon the item dispensed or the system they used. There were all sorts of ways pharmacists priced prescriptions. But the final price was based on its cost as a commodity. And he said, "The concept," which was radical, "I'm a practitioner. Why should the act that I do when I fill a prescription cost more to a patient because the

medication costs more? My act is exactly the same. My charge should be exactly the same." So Morris said, "We should all charge professional fees and give the drugs to the patient at cost." So that was a radical thought, okay.

05-00:09:41
Meeker: How did that work out in practice?

05-00:09:43
Day: Some people adopted it. Most of them didn't. Many used charts at that time which pharmacists could buy which basically told them how much to charge for a particular quantity dispensed, e.g., if you dispensed twenty tablets, the price should be $6.25. That got the profession in trouble because it was in violation of the Sherman Antitrust Act. That they would buy and use these charts that set prices.

05-00:10:03
Meeker: But those would have been the professional fees replacing the markup on the product?

05-00:10:07
Day: The professional fees replacing the markup? No, it took many, many, many years for the pharm profession to get that message. We thought of ourselves, and you would hear the expression used, as a businessman professional. Which, as you think about it, is a completely dichotomous relationship. One says I'm going to profit from your illness. The other one says I'm a professional. One says I'm going to make money. What's that word? What do they call military intelligence? What's that word?

05-00:10:48
Meeker: Contradiction in terms.

05-00:10:49
Day: It's a contradiction in terms. It's a something or other. Whatever. So pharmacists had that screwed up notion that they were merchants and professionals and the two were dichotomous in terms of—well, I'm being judgmental there. In my opinion they were dichotomous. Okay.

05-00:11:09
Meeker: This is actually a really interesting point, and I don't mean to interrupt too much. But this notion of moving from a sort of a cost plus arrangement to charging professional fees is something I've never heard before and I think it's worth documenting. Who was the individual?

05-00:11:29
Day: His name was Morris Boynoff.

05-00:11:31
Meeker: Morris Boynoff.

05-00:11:31
Day: B-O-Y-N-O-F-F. And he had a buddy, Marc Laventurier who was a very good copy of Morris, but a copy nevertheless. Morris was probably the intellectual spearhead of this movement. He was an incredible person.

05-00:11:46
Meeker: And did he run a community pharmacy?

05-00:11:46
Day: He had a community pharmacy over in the East Bay, El Cerrito, I believe, and then he moved eventually to Mendocino, where he died some years later. He had never changed. You would meet the man and you would be awed by him. Well, maybe you wouldn't be but, I mean, I was. He was one of my heroes. I was always awestruck by him and wanted to be a lot like him and listen to what he said and believed what he said. And then, again, what he said added to the way I thought about the profession and the things I was trying to do.

05-00:12:23
Meeker: So this new approach to pharmacists getting paid, from a mercantile approach to a professional services approach, what was the process by which this became institutionalized, or did it?

05-00:12:42
Day: It's not totally institutionalized even today. But I would leave that to people like Paul Lofholm to tell you the extent to which it is adopted today. It was slowly adopted. It took a long time. The pharmacists went through an intermediary. Okay, let's do cost plus markup plus a professional fee. So we'll be generous. We'll only charge a 20 percent markup. As I said, you'll have to leave with a guy like Paul Lofholm to tell you the extent—oh, but the pharmacists went through a halfway house where they did a markup plus a fee and ultimately many, if not most—I'd say I get a little bit uncertain when I begin to talk about the profession a lot. But it wasn't the pricing method that made the difference. It was the concept that I provide a service and this is my service and I charge a fee for that. A physician, you go in, he puts a spoon down your throat, makes a diagnosis, charges you not for the spoon he put down your throat but for the diagnosis. And so that was a relatively new concept. Not even relatively new. It was a *whole new* concept because—

05-00:13:55
Meeker: About what time was this happening?

05-00:13:56
Day: In the fifties.

05-00:13:57
Meeker: In the fifties, okay.

05-00:13:58
Day: In the early sixties. Late fifties, early sixties was when Morris Boynoff and Marc Laventurier began to push that. And they weren't the only ones. Sooner

or later other people took up the cause. There was skepticism within the profession of pharmacy because, remember, we thought of ourselves as wearing two hats. And that's the expression. "We wear two hats. We're businessmen, so we will fight for fair trade legislation which will secure our profit on a given commodity." I don't know if you ever heard of fair trade legislation. Pharmacists pushed for that. It set prices for retail goods, and if you sold for less, you're in violation of a law. And I'm a professional. That's my other half. Well, anyway, so there were all these streams that were feeding it and I've only touched upon a very few of them.

A pharmacist back in Virginia established what was known as a—what did he call it? Basically it was an office-based practice of pharmacy. You walked into his pharmacy, you didn't see a single drug. He had them all in cabinets and you met him and he sat you down. "Pharmaceutical Center," I think it was called. And his name was Eugene Anderson. He did that. But, again, he was not clinical so much as he was saying, "This is a profession. I'm not a merchant. We shouldn't look like a merchant." And so that was just another element like that. And a guy named Sandy Demetro, one of our graduates, did the same thing in Santa Clara.

Now, this is all in the late 1950s, early 1960s. So there were these changes going on, and there probably were thousands of others that I can't even begin to touch upon here, that ultimately created, shall we call it, an enlightenment in the brains of those people who had the vision to see how to put it together. But one of the precipitating factors at our university, at our school, was the fact that in 1962 or 1963, the dean of our school attended a healthcare conference in Washington, DC which talked about the future of healthcare and what was coming down the line and who was going to pay for it and who was going to do what. And he came back depressed. And the reason he was depressed was because there were nurses there, and there were physicians there, but he was the only pharmacist there. He had not even been invited. He had toe nailed his way into the conference and sat there appalled as everybody talked about what it was they were going to do and what would be coming down the line in healthcare and there was not even one mention of the profession of pharmacy and he came back and he said, basically, "We're in deep shit, because these are leaders of the nation." There were congressional people present, there were their aides. All of them identified important figures in healthcare across the nation, and not one of them mentioned, even glancingly, the pharmacist. It was as though the pharmacist wasn't there. He certainly wasn't there in their line of thinking about the health professionals. So he came back depressed. And he said, "We've got to do something. I don't know what it is, but we got to do something." So, you see, that's another one of those streams that was sort of set in motion at that time that ultimately fed into the creation of clinical pharmacy UCSF. His depression, feeling that we were either doomed, we were either headed toward extinction because it was at that time becoming evident that the chain pharmacies were going to, sooner or later, wipe out most independent pharmacies. Pharmacists didn't want to

hear that. Jere Goyan was one of the first people who said that the chains would largely wipe out independent pharmacy as we knew it. He could see the handwriting on the wall. And if that happened, he was concerned that they would be totally mercantilistic and that the profession would never, ever have a chance to assume a healthcare role. So there were all these factors that he said, "We've got to do something to change the way it is for education and for practitioners."

05-00:18:19
Meeker: So could I be devil's advocate here for a second?

05-00:18:20
Day: Sure.

05-00:18:21
Meeker: I'm actually thinking about something similar that happened to the academic field of geography in the late 1980s, early 1990s. The field was, for all intents and purposes, disappearing as a university level study. And basically those who had a vested professional interest in maintaining their departments, their FTEs, et cetera, started to realize that their academic discipline was in deep trouble. And so they started to do a variety of different things. They, in essence, sold this line. And I hope no geographers will read this. But they kind of sold this line that modernism was about change over time but post-modernism is going to be about spatial differences and it's geographers who are here now to help you understand spatial differences and history is a thing of the past. And it worked to a certain extent.

05-00:19:30
Day: So they were saving their jobs, is what they—

05-00:19:31
Meeker: Well, they were saving their jobs, yes. They were also kind of doing it by giving an injection of new thinking. There were some legitimate studies that came out of it and some legitimate ideas that came out of it. But to me it seems more powered by self-preservation, less powered by a real deep intellectual discovery. Why didn't the dean come back from Washington, DC and say, "You know what? I think that maybe we should close down the pharmacy program. Recognize that pharmacists have a mercantile role to play. What looks like is happening is that physicians and nurses and some other healthcare professionals are going to fill in the gap of the semi-clinical services or expertise that pharmacists were once supplying. This will be good for you because you as a pharmacist will no longer be stuck in this weird in-between space and it will be good for patient care and affordability and all these kinds of things because we'll get rid of a whole profession." Why didn't that happen?

05-00:21:00
Day: I don't know. I can't crawl inside Jere's head. I can tell you what I think happened, because I think most of us felt the same way about it, okay.

05-00:21:09
Meeker: I'm sorry to interrupt. But when you said that name back there, was that Jere—

05-00:21:13
Day: Jere Goyan. Jere Goyan. The first step is the school had, almost from the 1890s, been looking for that role for the pharmacist, okay. So by the 1960s it had kind of like a historical imperative. It assumed on the basis of what it knew about the practice of medicine—and it didn't know a lot—that there was something lacking in terms of the physician's ability to cope with whatever it was. Remember, this was the era of the "me too" drugs. All these things were coming out. Physicians were prescribing the wrong drugs like crazy. And I say that sincerely. The wrong drugs. They were being influenced.

So Jere didn't say, "Let's dump the profession of pharmacy." First of all, you understand, he was a pharmacist, as were substantial other people on the faculty, including the one I mentioned last time, Sidney Riegelman, who had a sincere stake in keeping the school of pharmacy going. So, number one, he didn't say let's dump the school for lots of reasons. The school of pharmacy has never needed the profession of pharmacy. Well, that's not quite true. At that point in time the school of pharmacy had developed an ample, a substantial scientific prowess that it could have thrived on without the professional part of the program. Our scientists were standalone excellent, even in the 1960s at a time when pharmaceutical sciences were certainly not at their peak. But they were the leaders in their field. Sid Riegelman was inventing biopharmaceutics. Eino Nelson ultimately, and somebody else, were developing pharmacokinetics. And these were sciences that were very important that were coming out of our school. So the idea of self-preservation didn't fit into it.

05-00:23:12
Meeker: And so those were PhDs?

05-00:23:13
Day: These were PhDs but some of them were pharmacists. Sid was a PhD pharmacist, as was Jere, so the notion that we should abandon the profession of pharmacy was never even a consideration. The notion was we have all this education. I told you that our curriculum was heavy in science. And there, therefore, had to be something that these creative young minds could be doing other than filling prescriptions and little or nothing else. And there was just always the kind of attitude like, "Hold on, because it's coming, we think." We didn't know.

Now, something else happened. Another one of these tributaries that fed into the growth of the program, and that was there was a study in Washington called the Taskforce on Prescription Drugs, which I think came out in the early 1960s. I'm remembering it was '62, '63, '64, '65, '66, '67, somewhere in that period of time. What they did was they found out that prescribing in the

United States was a mess, that physicians were failing, that they were subject to the latest whim of the detail man—not all of them, but a substantial number of them—enough to make it so that drug companies were making millions off of drugs that were basically not ineffective or unnecessary. Or an unnecessary new product of an old product, the "me too" copycat kind of things I referred to earlier. This report came out and said it's deplorable. Basically that's what this taskforce said. Their solution? More pharmacology training for the physician. Our solution? A toehold. Somebody has identified what it is that we've been saying all these years. So there's a failure in what's going on in medical practice in terms of prescribing and, boy, we're the guys that can do something about it. But what is it? How do we do it? Okay.

So our answer to it was—and the sequence may be slightly shifted here, I'm just not certain of that—was to put the pharmacist in a place where drug prescribing was going on and that was the UCSF Ninth Floor Project. We hired a couple of fairly recent graduates, none of them clinically skilled—they weren't even hospital pharmacists—and we set up the Ninth Floor Project. Bill Smith, I have told you before, is an indispensable part of that history there. It would not have happened as well without him, and maybe not at all. And if at some point you can interview him. I would think that you should because he can fill you in on the day by day, blow by blow stuff that went on.

So all of these streams came together. And, in fact, there's been a paper written by Douglas Hepler in the mid-seventies that basically said everybody had all these ideas, but only at UCSF did somebody have the vision to pull it all together. And we did.

So we got on the floor. "We" meaning Bill Smith, Bob Miller, Joe Hirschmann, Dennis Markowitz, Don Holsten, and maybe one or two others who are equally important. Got on the floor, the ninth floor [of UCSF Moffitt Hospital]. They came with drugs because that's what pharmacists did, right. So in order to gain access to the floor they had to say, "We're going to set up a pharmacy on that floor. And so, nurse, you no longer have to get on the phone and call downstairs for your emergency drugs and say, 'Where the hell is my stat order?'" because one of the great peeves of all hospital pharmacists was nurses wanted everything "stat." Needed immediately. So laxative, stat. It just pissed them off immensely because it wasn't an immediate drug. Stat drugs were supposed to be the antibiotics and the painkillers. But everything, I am told, was stat because they didn't want to wait for them. So we went in with a calling card. A pharmacy. Wow. "We don't have to call downstairs and bawl out the pharmacist or wonder where the hell our next dose is. We got pharmacists here. They're going to dispense." Okay.

05-00:27:38

Meeker: Was it understood at the time that this was sort of a camel nose under the tent?

05-00:27:41
Day: No.

05-00:27:42
Meeker: No?

05-00:27:43
Day: It was understood that it was an experiment. The Ninth Floor Pharmacy and what was going on on the ninth floor was an experiment. Nursing was experimenting with nursing care on that floor. They're the first ones. It was suggested to us by Dr. Dunphy, whose full name I do know, who was at that time chancellor, but he was also chief of surgery and the ninth floor was a surgical floor. And he suggested to Jere Goyan that this would be an excellent place to test your model because there's an experiment going on there, so inquiry is in the air.

05-00:28:16
Meeker: Well, what was being tested was simply a new model to expedite prescriptions? It wasn't originally conceptualized as inventing clinical pharmacy or—

05-00:28:30
Day: What we were doing was seeking a role because the people put on the floor were there for the purpose of being in the midst of the prescribing situation, and drug flows, understanding when patients need drugs, how physicians think when they prescribe drugs, being there, seeing patients. We had no direct contact with patients. Yes, we did when we filled prescriptions but it was a very quick encounter where you got the prescription, got the name, address, filled it, went on, said minimum, and then gave it to them. The hospital was a place where you had patients who couldn't get away from you. They were there all the time. So the calling card was the pharmacy, which was to be an experiment. Bill Smith can tell you more on whether that was a subterfuge. I don't think it was. I think we did it because it could have been what we ended up with. Putting a pharmacist on a floor with a pharmacy.

05-00:29:27
Meeker: So it was well understood that one deliverable would be expediting delivery of pharmaceuticals. But it seems to me what you're saying is that it was also understood that there was going to be other facets to it, even if it wasn't called clinical pharmacy at the time.

05-00:29:45
Day: It was experimental. It was experimental and Bill Smith established a committee to talk about the insertion of the pharmacist onto that floor. Pharmacists had never been on the floor. That was a first. A pharmacist on the floor? What's he doing here? And I say "he" because they were all males at that point. Mary Anne Kimble had not yet entered the scene. And so he was part of the team that planned the insertion. And you've seen the article that I wrote. You will see that they talked about doing what today are not terribly

radical things. In fact, they're kind of mundane. That's what pharmacists today do; in those days it was, as I said, a nuclear assault on the status quo.

05-00:30:35
Meeker: Well, maybe describe some of these things that seem banal today or typical and were revolutionary then—

05-00:30:43
Day: Well, remember, in the beginning that it was to be just the pharmacy. But almost from the very beginning it was planned to be more. It was to be a teaching situation for our students. The pharmacists were to be there to fill any immediate prescription that was necessary. The original list of drugs were the stat drugs, okay, were the drugs that be needed fairly quickly, and including some maintenance drugs, which ultimately led them to develop a system called unit dose, which is another fact of the stream of pharmacy which had to do with the product more than the service. So they did that. They were there then for the purpose of answering any questions nurses had about drugs, and in the beginning it was very basic level. And as they learned the kinds of questions they wanted to ask, they began to be able to answer the more sophisticated ones. And when they got really complicated was when they decided that they needed something called the drug information center, where they could go and refer to the literature and do what David Burkhalter perhaps did and then come back to the floor and answer and ultimately to establish that as a permanent setting in the library, which I said in an article I wrote at that time was a really great commitment on the part of the university. The librarian fortunately was a friend of ours. And to give us a room in that tight restricted area called the library was an immense endorsement. Jenny, whatever her name was, had been the school of pharmacy librarian—we at one time had our own library—then became chief librarian. So questions being asked on the floor, that was part of it. Being able to answer questions about dosage forms. But that quickly led to, well, is this drug any good? And the people who can give you the best story about that would be Bob Miller, Joe Hirschmann, and Bill Smith because I told you before my involvement in this whole thing has been as kind of like a catalyst. I was maybe one or two of the streams that ultimately became part of this river flow but my predominant role was to basically ask questions, to make recommendations, and to endorse. To push to do the things like the videotape you saw, and that was one of several items. To bring a panel forward on continuing education, to talk to the masses, to let them know this was going on in the profession of pharmacy.

So the other things they did were to, quickly, monitor drug therapy. Quickly to interview the patient when the patient was admitted. Because nobody did that. Nobody said, "What drugs are you bringing with you? What drugs are you taking?" Because patients would come with a little bag of drugs that they'd been taking and nobody had evidently previously challenged that. Then when they were dismissed, the notion of the patient discharge involving a pharmacist, where he or she went over the medications with the patients one

by one to make certain that they understood the discharge medications, was another part of it. Pharmacists never did that. Bedside stuff. This all sounds so simple but in those days a pharmacist walking up to a bedside prior to that time, sitting down and talking drugs, what is he doing? And in the beginning people did question what the pharmacist was doing looking at medical records. It wasn't bad because we had a very open minded staff on that floor.

When Bill was planning this pharmacy along with the planning team, Jere and Sid Riegelman and another person, Don Sorby, were the critical upper echelon people that were involved in pushing this project at the university level, at the campus level. Bill almost immediately decided that if we're going to be part of the team there we just can't come in at nine o'clock in the morning and leave at 6:00. We've got to do twenty-four hour service. And that was a massive commitment. That meant bringing pharmacists on. First of all, finding them who wanted to work those hours. So when they agreed that this would be a twenty-four service, pharmacists on the floor twenty-four hours, it was like, "Wow." It was like a statement. We're as important as you are. If you have to be here twenty-four hours, so do we, because by that point in time they were still drawing up the outlines of what the pharmacist would do. I think this was all before it opened. And then ultimately it did open and ultimately then it evolved into those things I told you about. The drug information center, the pharmacist taking on a more important role. And all the time the team was feeding back to Jere, to me, to important people on the faculty, to Sid Riegelman, et cetera, what was going on because they began immediately to see areas that we hadn't trained them in. And Bill Smith wrote a letter to the dean on that, indicating that there was no question the science background contributed immensely to their ability to cope with what was going on on the floor but we needed more of the following and we needed this in addition to what you were giving us.

05-00:36:41
Meeker: What were these areas that came back?

05-00:36:43
Day: Well, drug therapy. We never taught drug therapy, we never taught critical drug evaluation. We never taught anything to do with direct patient care.

05-00:36:51
Meeker: Can you spend a few minutes talking about some of these key areas and exactly what it was that the transformative moments would have been? Maybe provide a definition of that and then give me a sense of how it was that that would have become a critical issue on the ninth floor and then maybe how did Jere Goyan and faculty respond to these requests for clinical training?

05-00:37:25
Day: Okay. I'll try. I'll try. Before clinical pharmacy, ask a pharmacist about a drug and he'll be able to tell you what its chemistry was, what its generic name was, the companies that made it, the dosage forms that were available, the pros and

cons of those dosage forms if he was a UCSF graduate. Not all schools did that. That was biopharmaceutics. The pros and cons of this dosage form over the other. And what it was used for. Okay. Now, what is Benadryl used for? Well, it's an antihistamine so it's good for allergies. It has a sedative side effect, so it's good for sleeping. What's the dose? Well, it's available in a one and a half grain to a five grain capsule. Yeah, but what's the dose? Well, it depends on—see, that's when it got murky because pharmacists had never made the leap to what was an adult dose or whatever. Well, they knew what the adult dose is but prescribing it was much more an intimidation for them. Okay. Well, Benadryl's out because the patient's allergic to it. What can I use in its place? I don't know. You can try this one because it doesn't have the same chemical structure as Benadryl. You can try this one. But there was no assurance. Which of the many corticosteroids should I use on this particular patient? That's before clinical pharm.

So what did they learn and what did they do and what did they feed back? They fed back into it basically the information they needed to make judgments on the floor and ultimately how to prescribe. It eventually led to that. That was not a word that was used openly, although it was a long-range goal on the floor because prescribing was, "Pharmacists don't prescribe." Most pharmacists would tell you that.

05-00:39:20

Meeker: I'm curious: It sounds to me like there was kind of an evolving definition of just what prescribing meant. It seems like it narrowed and became just that moment at which the physician basically makes a diagnosis and identifies a general solution to thus that general solution providing some broader range of choices that a pharmacist can make in response to that general solution. Whereas before maybe it would have been extraordinarily specific.

05-00:40:11

Day: It was very specific. But, you see, it was much more than that. The prescribing thing evolved. Remember, it began as a consultant. First of all, can you tell me about this drug? Oh, yeah. It's available in these dosage forms and it's used three times a day. Okay. Well, then it evolved from that into this is the usual dose given to patients. How old is the patient, how much does he weigh? Okay, this should be the dosage for that patient. But all of that was advisorial to the physician and pharmacists would monitor in the evenings and during the day the patient when they got a prescription. They began to monitor. It was within the parameters of prescribing for that particular medication. That was new. That was a challenge, if you will. All prescriptions had to go to the pharmacist first, ultimately, and that was a challenge. And if he found something wrong he would get on the phone. Could the prescriber overwrite him at that point? Yes, yes. And I assume they did. I never was on the floor. That evolved eventually into "run with it pharmacists, okay?" This is the parameters of the patient's disease. This is my diagnosis. This is the lab test. So in making that decision the pharmacist had access to information he never

had before. Lab tests, the physician's diagnosis. The vital signs of the patient. The age. All this kind of stuff that pharmacists needed then to say, okay, this is the best drug in that given set of situations for this patient. Best drug meaning this is the best drug, best choice, best dose, and best interval for dosing. All of those things were things that pharmacists couldn't do before and did eventually.

And that's the kind of stuff that Joe Hirschmann and Bob Miller and Bill Smith, although Bill was there only a year and a half, and Toby Herfindal and all those fed back into the curriculum. Fed back to Sid, to Jere and said, "We need more resources, we need more bodies. We got to cover the clock." And Jere supported them, so did Sid. They fought the battles at the university level, campus level if there were any, to open the doors that they needed to get open. So, you see, this was not only an evolution, it was a political movement, as well. It wouldn't have happened if we hadn't had strong leaders at the time.

And all of this culminated in a curriculum meeting in which the young Turks, pissed off because they learned that the dean was spending money on things other than hiring more clinical pharmacists, met with the faculty and, as I pegged it, came in with an iron fist. Basically shot down some of the classic courses that had been taught in the curriculum. Because they were young and inexperienced at that point in time, they thought that they had to really shock the audience. They didn't shock the audience so much as they disappointed the audience. Because the audience was looking for this. Almost everybody in that faculty wanted to hear what it was they were telling them.

05-00:43:29
Meeker: This is the 1969 faculty conference?

05-00:43:31
Day: Whatever it was, yeah. Although some of them got their courses gored and they didn't like that at all because some of those were people who had been around a long time, taught the same thing for years, and they were soon to retire. But most of the faculty didn't need to have this thing shoved up their rear end. They were listening for it. But as I said in the article I wrote, this was the time when the clinical pharmacy staff demonstrated that it was actually a full blown member of the faculty. Now, up until that point in time, they were experimental, too. It was unclear what their future was. As yet unclear what their future was. And they acted like faculty. They went in there ready to fight for a point, and the faculty appreciated that. I'm giving the faculty too much credit now. I'm making it sound like, as a universal all love, acceptance. "You're really great guys and we love you. Now you're part of us." It wasn't quite like that. But it was, if you look back on it, the turning point in which clinical faculty said, "No." In which clinical faculty, oh, yeah, said, and were accepted as now an important full—they were always accepted but now as one of us. As a one who's on equal standing with us. Because they listened to them. They voted in what they recommended.

05-00:44:51
Meeker: I'm just curious about the development of clinical faculty. You started out as an assistant professor of clinical, correct?

05-00:44:58
Day: Yeah.

05-00:45:00
Meeker: And after you had run your course of four or five years you moved into the lecturer category. After 1969 did they develop a method of evaluation to bring an assistant clinical professor into an associate or full level?

05-00:45:20
Day: Mm-hmm.

05-00:45:20
Meeker: The track changed at that point?

05-00:45:23
Day: Yeah, yeah. They changed, but you have to understand that the school of pharmacy was the very first faculty to treat an assistant clinical professor as though he was a full-fledged member of the faculty. That was a title that was reserved for the guys who practiced medicine in the clinics, in the school of medicine. An assistant clinical professor of medicine was the guy you would make an appointment to go see in dermatology. He either came in two days a week or four days a week or he was there full-time but he wasn't truly a member of the faculty. He might have students in rotating through but school of medicine hadn't really required anything other than the fact the guy be a good clinician. And they were very serious about that. Had to be a good clinician. And, yeah, they made them money but that was not the critical issue. School of Pharmacy wasn't going to make any money off of these guys but was the first to really truly need these people as one of its faculty and began to look at them as persons for whom it was essential that they be critically evaluated. Because they were going to be up against some pretty strong forces in the schools that might have some differences with what they were doing. And if not that, there was campus prestige. An assistant clinical professor, well, it's kind of like a member of the faculty, you know what I mean, but they're not members of the academic senate. They're not whatever it is. So we began to require of them that they produce not only service wise but they teach and teach seriously and be seriously evaluated and be creative. Not necessarily writing a paper, although that has become the preferred model for the last twenty years or so, but demonstrate creativity, ideally by getting out there and pushing clinical pharmacy, ideally by writing up what it is you are doing and getting it published, because these were the beginning year of clinical pharmacy and it was all brand new stuff. So the three characteristics of service, teaching, research were implemented early. Toby Herfindal did that—early implemented these requirements for a faculty member in the assistant clinical professor series and for his or her promotion. And under

Toby and then Mary Anne Koda-Kimble they established the criteria, and the committees that made these decisions. So does that answer your question?

05-00:48:13
Meeker: It did. So they did become the clinical professors of pharmacy, they did become tenure eligible or not?

05-00:48:19
Day: No. It wasn't really until the university developed the title called professor of clinical *blank* that they became tenured in a sense and are members of the academic senate. Up until that point of time, the school of pharmacy, incidentally, operated illegally. We never, ever required that our assistant clinical professor vote be ignored. We never ignored their vote. We gave them a full vote from the very beginning, even though they were not members of the academic senate and academic senate rules say in matters of education, of budget, of whatever it is, you have to be a member of the academic senate to vote on it. We said no. The rules said that if you want to be a member of a committee you have to be a member of the academic senate or your vote can't be counted. You're an observer, right? No. We said no. We did it from the very beginning. Even before they had come in with their iron fists, we did not ignore their vote. I actually raised that question early because my vote in a meeting as an assistant clinical professor was challenged by one of the guys whose course was being threatened and I had just voted to kill it and he asked the question, "I'd like to ask how the assistant clinical professors voted on this issue." Because it was a close vote. Now, the interesting part of it is there were two of us in the room. One was Dick Penna, I was the other. And we neutralized each other's votes, so nobody made an issue out of it. He said no, I said yes.

Now, what was going on across the nation was we were beginning to get visitors. Even in, God, the first six months of the project, the ninth floor project, we were getting visitors. They were beginning to write up stuff.

05-00:50:33
Meeker: Before we get into the spread of the idea, I want to get a sense about within this first six months, how is the medical team that's already on the floor, the nurses, physicians responding to the presence? Is there much resistance? Physicians are typically extremely protective of their professional status. Is there a difference between sort of interns and residents and the professors that maybe are doing the rounds?

05-00:51:18
Day: It's not a question I can answer because I didn't do it. I can say, "Oh, well, no, yeah, it went well." The fact of the matter is it did work in the long run. But what went on day by day, I have no idea. I can tell you what I think happened but I don't know.

05-00:51:34
Meeker: So you weren't getting any reports from your colleagues who were on the floor?

05-00:51:38
Day: No. No. First of all, my association with the medical practitioners on the floor wasn't that close. I only knew one or two of them and I knew them in an entirely different environment because we had been on committees together or something like that. So, no. We did not have a practice relationship. And really Bill and Toby and Joe would be the guys to tell you what happened, how many bloody noses there were, if any. But you may remember there was that remarkable incident way back in the beginning of the project which did cause, at that time, a buzz around the hospital.

05-00:52:14
Meeker: Can you tell me about that?

05-00:52:16
Day: The situation where it was the wife of the chief resident, I forget what his name was or who, had come down with an infection and she was over here in Marin someplace. And she was totally unresponsive to the therapy so in desperation they transferred her to UCSF on the surgical floor. And she had been running a temperature in the hundreds, 103, 104 and it was serious. She was in deep trouble, in other words, and she was unresponsive to the drug therapy that was going on there and Don Holsten and Richard De Leon, who's another person I've not mentioned, but he was a part of that original team. Don Holsten picked up the fact that she was receiving two antibiotics which were incompatible with each other in the IV bottle, which meant they formed a precipitate that was not going to go into solution. So she was being given, basically, a drug with a drug that wasn't going to work. It had been established chemically and Don said, "We've got to get them to administer the drug differently or to pick another drug." And that advice was initially refused by the prescriber and so the team end-ran the prescriber, went to the husband, who was the chief resident for surgery, I think, and he basically got the prescription changed to where she was administered the drug separately, I think through two IV flows, but I'm not certain. So it was a simple incompatibility thing in which the pharmacist did two things that was part of that nuclear assault on the status quo. Number one, they first of all became a part of the decision of what was going on, recognizing—

05-00:54:21
Meeker: Part of the diagnosis.

05-00:54:22
Day: Well, it wasn't part of the diagnosis. She was infected. It was that she was not responding and was there anything related to drug therapy that could cause that and determine that there was something related to it. They tried to step in, tried to get the prescriber to switch. They were still pretty new on the floor at that point in time. And when that didn't work, oh, heresy! They end-ran the

prescriber, my God, that was the guy traditionally at the head of this whole thing, and I don't want to overdo that. But that was not done. I don't even know the physicians did it, end-ran somebody. But this guy did and his wife was involved. So that's the story as I've been told it.

Now, over the years you'll see that there's several different versions of that story and, God knows, Bill Smith may have another one because both of them came from him. The first one I told that was wrong, this one, even though I did check it out with some of the other members of the team.

05-00:55:24
Meeker: So I'm curious about this one example of two antibiotics mixed together in a solution and given to this patient and the incompatibility of that. Was that knowledge so esoteric that most physicians would not have known it?

05-00:55:46
Day: Yes. It was literature that was available in the profession of pharmacy literature and not in medicine. God, that goes back to the days when we were teaching how to put drugs together. You never mix salicylic acid with magnesium carbonate. Incompatible. The notion of incompatibilities goes back way back when. You don't mix the two because one's an acid, one's a foamer and the two will destroy each other in the process of mixing together. Those are called a compounding incompatibility. So the notion of incompatibilities was not a new one. And you would never see in a medical article, "Did you know that when you mixed salicylic acid with magnesium carbonate you get foaming." They didn't care. And the notion of incompatible IVs popped up mostly, as I recall, in the American Society of Health System Pharmacists literature and I think that's where Don saw it. And eventually this group published a chart showing that this drug was incompatible with that one. And there were such things as physical incompatibilities. There were such things as disease incompatibilities. You don't administer these two together because this one will neutralize the effect of the other one at the receptor side. So there were drug-drug interactions, drug-disease interactions, and then there were allergies and other things like that. Many of those things came out of the profession of pharmacy literature. Remember I mentioned the word "biopharmaceutics" before? That's what it's related to. The study of the availability of drugs. The solution. The physical solution and the impact of the formulation on the final product.

05-00:57:28
Meeker: To what extent was biopharmaceutics part of the medical school education?

05-00:57:31
Day: It wasn't.

05-00:57:33
Meeker: So there really was a distinct knowledge base here?

05-00:57:37

Day: There were distinctive differences. The medical school people didn't have the heavy chemistry training that the school of pharmacy students had. Our knowledge of the drug product formulation, even before biopharmaceutics, was far in excess of theirs. But they didn't want to know it. They really didn't want to know what was in a tablet. They just wanted to use the tablet. Tell me how to use it. To them that was not an important part of their education To this day I would say it probably isn't and there's no reason it should be if you have another expert around who can take care of that part of it where it's necessary. So as I told you, when I graduated, I was a drug product formula specialist. I could do structure action relationships. I could tell the physician what was in this Benadryl capsule. But he didn't care. He just wanted it to work.

05-00:58:34

Meeker: I find it to be interesting and telling, then, that when presented with this kind of information the duty physician who was in charge of the prescription rejected the recommendation.

05-00:58:49

Day: I think he didn't believe it. Remember, the pharmacist didn't have that much credibility. You may recall the physician who told me—I told you about it in another story—"I take away from you forever the right to talk to my patients about drug therapy." He had no respect for my role whatsoever. And I'm not saying that all physicians were that way but I think that most physicians hadn't really thought of the pharmacist as being involved in the cutting edge of anything. And not out of disrespect. I don't know what we were and I'll have to leave it to physicians to say what we were, those who are practicing at that time. What we were in their minds. But I think it's like any other thing. I respect the bus driver, I respect this, I respect that, but I don't want them telling me how to teach pharmacy 115. That's not their role. The bus driver, I respect him, and as long as he does what he does and doesn't stick his nose in my business. Or as the guy who operated a hot dog stand in New York City said when I tried to get a five dollar bill changed "I'm not a bank." [laughter]

Begin Audio File 6

06-00:00:00

Meeker: This is tape number six. Meeker interviewing Day. Okay. Let's see. There were actually a number of things that I wanted to follow-up on here. So you don't have anything to add in particular about the response of nurses, administrators' positions, or other pharmacists to this?

06-00:00:54

Day: No. Only except secondhand, as it was fed back to me, and as you saw going on in that videotape you saw. And as we got feedback from the head nurses who appeared in another videotape we did, a future one. And we got feedback from additional physicians, Donald Fink and some others like him. But it's

totally on my part anecdotal. I don't think that we could have survived on the floor if we had been resented and resisted. The nurses have a way of killing anything they don't like and they liked this for lots of reasons in the beginning and maybe later on. The other thing that pharmacists did was take out of their hands the concern for IV additives, mixing intravenous solutions together.. They didn't like to do that. Or at least I was told they didn't. No, you are receiving the report of a viewer, of an observer, and occasionally, but very rarely, an advisor, because they didn't need a whole lot of help in what they were doing.

06-00:02:02
Meeker: You had mentioned that there was other experimentation going-on on the ninth floor in particular around nursing.

06-00:02:09
Day: Yes.

06-00:02:09
Meeker: Can you give me a sense of what that was about?

06-00:02:11
Day: I don't know. It was about nursing services and they were also experimenting with the way that information flowed. They were experimenting with something called a ward clerk. And I don't know, really was not following the nursing experiment, but it was not a school related thing. It was a nursing service related project. I don't remember whether the school of nursing at that time still taught student nurses. I kind of think they didn't because they changed to a master's program and then to a PhD program.

06-00:02:47
Meeker: Maybe we can talk about the video a little bit because it provides an interesting overview of the work that was done. And this is a video—do you recall the name of it?

06-00:03:00
Day: The one that you have a copy of?

06-00:03:00
Meeker: Yeah, the 1968 video.

06-00:03:03
Day: *Clinical Pharmacy: A New Concept in Patient Care.*

06-00:03:06
Meeker: Okay. Can you tell me about the genesis of this and the purpose of it?

06-00:03:12
Day: Yeah. Remember while I was there these guys were doing the most incredible stuff and I really admired them. I did not at that time have the time to join them because I was doing a lot of other things, one of which was I was

director of continuing education at that time and I was also teaching two or three courses. Oh, that's an excuse. The point of it is I wasn't a part of it. In my role as director of continuing education, I decided that it was time to trot that thing out to the profession. And I instigated several visits we had from outsiders. In fact, I was the contact person for several of the visitors who came to see what was going-on on the floor, and I arranged with the team to tour those people. But I also decided that we needed to talk about this in our continuing education courses. So we had on-campus lectures given once every month for two hours that pharmacists would sign up for. They would come and at that time continuing education was not mandatory. They didn't have to do it, but many chose to do it voluntarily and sit through whatever it was that I wanted them to hear, because that's basically what it was. I was the guy that was designing the sequence and I always tried to give it a little bit of my flair, something a little bit off the beaten path. I wasn't the lecturer, though. Well, I was the lecturer at a couple of them but not many. I was the guy that introduced the lecturer, I was the guy that conceived of it.

But anyway, so I went to Bob Miller and to Joe and I said, "Are you ready now to trot clinical pharmacy out before an audience?" And Bob said, "Yeah, we can tell them some stuff." So Bob and Joe were separately, as I recall, or maybe together, involved in giving a lecture to pharmacists on what they were doing there. Now, the audience was spellbound as these guys were talking about what they were doing. And we even agreed that we would take a limited number of the people around to the sites and see where pharmacists were doing these things. Now, there wasn't a whole lot to see. You got up there and what did you see? A guy in a white jacket who was a pharmacist, a guy in a white jacket who was a physician, some nurses, and our pharmacy up there, and a pharmacist working through some charts and so on. Wasn't a whole lot to see. But it was on a ward of a hospital and they were doing something. Our attendance was at like one or two hundred at the time. Two hundred, I think, each time we did it, and maybe five or ten people would hang around or come trotting through the ninth floor project.

06-00:06:07
Meeker: Who attended these lectures?

06-00:06:09
Day: Pharmacists.

06-00:06:10
Meeker: Just pharmacists?

06-00:06:10
Day: Just pharmacists. This was continuing education in pharmacy.

06-00:06:14
Meeker: People were getting credit for this, I'm guessing?

06-00:06:15
Day: No, in those days it was not mandatory. Later on they did, but no, this was strictly a notion of, "Golly, this interests me, let's go." Remember, I had been president and also one of the founders of the Peninsula Pharmaceutical Society, a continuing education society. That's ultimately, one of the reasons why Jere Goyan, picked me up to be director of continuing education. And also, he wanted a practitioner on the faculty and I taught in the compounding courses how to put the dosage forms together. So I went from being a pharmacist to the Peninsula Pharmaceutical Society to the director of continuing education, and then from that vantage point was able to pretty much dictate what they got. We had been giving CE courses from the time the veterans returned from World War II and needed to be updated. So we sporadically gave a series of six lectures once a year. When I became CE director I did two series a year. And we always had a couple hundred people there and they signed up for the entire series.

06-00:07:33
Meeker: When you became director of this in '66, how many lectures were in each series?

06-00:07:38
Day: How many lectures?

06-00:07:39
Meeker: In each series that they subscribed to?

06-00:07:43
Day: There might be six different lectures, five or six lectures given. Some courses might have two people in them, some might have one. Usually one. Just easier to work with one. And Bob Miller and Joe Hirschmann got up there and talked about it. As more than one person said to me, and this is anecdotal, but more than one person, and I would probably say in the dozens, something similar to, "God, I never thought I'd live to see the day that pharmacists did this kind of thing." Okay. So they were enamored with it. And I liked that so well I invited the Board of Pharmacy to come walking through because one of the fortunate things we realized is that, ultimately, somewhere along the 1970s, we invented something that was not licensable according to the Board of Pharmacy. They wanted pharmacists to dispense. They hadn't taken into account this. They were licensable but we needed them to say this is a part of being a pharmacist, too. So they trotted through and they loved it. These are pharmacists on the board. Excuse me. The Board of Pharmacy is comprised of pharmacists and one or two laypersons. But they're pharmacists and they were really also awestruck, not doubting Thomas's at all. We did get the doubting Thomas's from other schools of pharmacy. And I learned that when people would write to me and say, "Can we come out and tour?" we got one of two kinds. We got the kind that came out and said, "I want to know everything I can about this because this is what we want to do at our school," to the other kind, when, on the basis of their questions, on the basis of the reactions, it was

obvious they came out to disprove what we were doing. And you could usually peg them in a minute because ultimately they let loose the attitude that, "This could only happen at UCSF. You guys have Sid Riegelman, you got Jere Goyan, you got this hospital sitting right here. It's just too pat. It won't work anywhere else."

06-00:09:53
Meeker: Was that the basis of their criticism? Simply that maybe this was a good idea but it was site specific to UCSF and—

06-00:10:02
Day: I think they saw it not a good idea but an interesting idea. I think a lot of them doubted that every pharmacist could be trained up to that. I don't really know. I just know that it became obvious that some of them had been sent here so they could go back and say to their dean, or if they were the dean say to their faculties, "Hey, it's just a figment of UCSF's imagination." Because ultimately it became threatening to them, their status quo. You talked about why didn't Jere close the school down. Can you imagine this thing called clinical pharmacy that was a little like the tidal wave in Japan, sweeping over the nation and you didn't want to be in its path. And some of them, as I said, went kicking and screaming into clinical pharmacy because they didn't think they could get the money to do it. And later, went kicking and screaming into the PharmD program. Resisted it to the very end.

06-00:11:04
Meeker: Before I forget about this, and I think we can go back to talk about some more of this continuing education portion, but was there a financing element to the ninth floor project? How was it paid for?

06-00:11:19
Day: I used to know. And anything I tell you now is going to be like reaching deep down. First of all, it was financed by the medical center. The pharmacists were medical center employees. So Jere and Sid Riegelman and Don Sorby were able to convince these tight fisted administrators to turn over some FTEs to the School of Pharmacy. Well, to hire these people for the purpose of doing this experiment.

06-00:12:00
Meeker: There was additional cost involved? It wasn't simply moving somebody who was downstairs upstairs?

06-00:12:06
Day: No. My guess, no, it wasn't. No. They brought in new people. It's not a simple move. You move somebody downstairs from upstairs, you got to replace that downstairs person. I think that the med center paid for the cost. Remember we had a very positive chancellor at that time, Dunphy, who was a chief surgeon. So I think the med center paid for the construction that was necessary. I can say now with certainty that they paid for the faculty because they were university employees and they had what were called WOS

appointments with the school of pharmacy, without salary, and I think eventually then the residents were paid for by the medical center. They became a part of this. So I think the bulk of it came from medical center University of California campus funds, which is, if you think about it, a remarkable accomplishment of Jere Goyan and Sid Riegelman because those guys are notoriously tight fisted. Every service had to be justified. And they turned loose the salaries for five, six pharmacists, and the construction costs on the ninth floor there. And eventually I think the school paid for the construction of the library room that was Drug Information Analysis Center, called DIAC Well, the DIAC had been just a room. We just converted it to our use. So I think the bulk of it came from the campus and eventually from the library. The chief librarian gave us that room. So those were remarkable campus accomplishments at a time when—I forgot who was governor. Was it Reagan? Somebody who had cut back on the funding of the university. I'm not certain. Reagan's not one of my favorite governors.

06-00:14:01
Meeker: Sixty-six would have been Reagan, yeah.

06-00:14:03
Day: He's not one of my favorite governors. He's definitely not my favorite President. So it was the medical center, as far as I know. And the school kicked in, yes, but it kicked in in different ways. But you think about it, there was no reason for the hospital to do this. It was an experiment.

06-00:14:23
Meeker: So there wasn't an argument at the time that said because of adverse drug reactions or dosing problems or something like that, that this might actually be a money saving approach?

06-00:14:41
Day: No. That was many, many, many years later that they begin to show the cost effectiveness of the pharmacists, okay. And that's because what happened is the way that the hospitalization days are paid for changed. Now, think about it, the 1960s, okay. The way hospitals were paid, they bill their usual charge, right. And they billed insurance companies their usual charge and they billed the federal government their usual charge. So along comes a clinical pharmacist who says, "Guess what? I'm going to be able to minimize the hospital visits of your patients by making certain they don't come down with anything that's going to keep them here longer, related to drug therapy." And as one of the guys at that time, I think it was Rich de Leon said to me, when he said that to an assistant administrator, he said, "Don't you realize that's the way we make our money? You're telling us that what you're going to do is going to cut down our," what do they call them, "beds filled ratios. That's not a good sales point, Rich." But ultimately what prevailed were, I think, sounder minds that were healthcare oriented, saw in it a possibility, and they listened to Jere Goyan and to Sid Riegelman when they talked.

06-00:16:03
Meeker: Interesting about this question about healthcare financing because you were talking about sort of a fee-for-service model, right? That the hospital gets paid for days.

06-00:16:14
Day: The more days you're there, the more money they make.

06-00:16:17
Meeker: Doesn't that change, though, once Medicare starts to kick in?

06-00:16:21
Day: It did. See, that's when the cost effectiveness of the pharmacist and all those concerns—well, maybe this isn't such a bad idea after all—switched. Because even up into that, the pharmacist had no source of income. Their major input was to make certain that the university cut back on its expensive drugs because they became involved in the drug formulary. Deeply involved in it and the drugs that went on the formulary and they were the ones recommended by the drug information service, which provided the reports to the committees and said, "We think this is a good drug to go with. We don't think this one is." And in many cases it was a great loss to the drug company that was going to make millions of dollars off of that one drug they wanted in the formulary. But it might have been no better than the drug that was half as expensive. So the formulary did reflect the influence of the DIAC.

But the word today is to minimize the stay. Get them out as quickly as you can. For a lot of reasons. You don't want to get an infection, which will only make them stay longer. You really want them in and out. Day surgery was unheard of. They kept patients much longer than they do today.

06-00:17:35
Meeker: Because typically now hospitals are reimbursed not per stay from what I understand but per—

06-00:17:43
Day: According to a formula. Per disease. It takes this long on the average to treat this, this is what we're going to pay you. And for the details of that, I'll leave that to others because I have never fully understood it. But it's coded and each code carries with it a certain payment. And if you get them out sooner, you get to keep the extra, I understand. If you get them out longer, that's too bad, buddy. The way the thing falls. And those have changed, those methods of payment. But they didn't exist in those days. It was you used more laboratory tests, you charged more. A physician in those days, there was no skin off his nose if he or she wrote a prescription for the most expensive drug in the world.

06-00:18:26
Meeker: So when you're reaching out to the broader community of pharmacists, teaching them about what's happening at UCSF, was any of the occasional negative response you got simply, "Wow, this is interesting, may be helpful,

but we can't afford to put another professional person in our hospitals because it will eat away at our bottom line."

06-00:18:57
Day: I'm sorry, what was your question?

06-00:18:58
Meeker: Well, I guess the question, in the context of you doing the continuing education and starting to engage with people outside UCSF, teach them about what's happening there with clinical pharmacy: what was the response of the people you talked to vis-à-vis the added expense of adding another professional to the hospital floor?

06-00:19:24
Day: Well, you're talking about outside of UCSF now?

06-00:19:27
Meeker: Correct, yeah.

06-00:19:28
Day: Well, let's just take a look at Bill Smith. And that's why if you can get ahold of Bill, it would be worthwhile. Within a year and a half, I think it was, Bill moved to Long Beach California, the Long Beach Medical Center, and carried with him the demand, or if you will, the interest of that institution to establish a clinical pharmacy program. Now, that was like a year and a half to two years after this whole thing started. So already another hospital had seen something in this and they wanted to be a part of it and Bill went down there and basically rewrote pharmacy services there. He was like twenty-six years old, twenty-seven years old, and he was hired to be in charge of this program as chief pharmacist. And Bill's program ultimately built the second largest, at that time, clinical pharmacy program in the nation.

So how was it accepted outside? I can't say that that was the general thing, but it spread and it spread and ultimately became, as you are well aware, part of the accreditation standards for hospitals. Pharmacists have to do a certain amount of these sorts of things. Or they have to have them done and pharmacists are the best ones to do them. So the sheer fact of it is that it spread and it spread because these five guys on the floor, and then six and seven and then ten, then twelve, and then twenty, didn't sit there and go to work and go home. They were evangelical. They were all determined that this was the wave of the future. Some of them published papers. Some of them got out and talked about it. Our students went through those projects. For the longest time, we were the supermarket for acquiring clinical pharmacy faculty. Our residents and our students were recruited to help other schools and institutions establish programs. Buzz Kerr went to Maryland and was placed in charge of starting up U. Maryland. We were not the Johnny Appleseed, we were the trees that bore the apples, and these guys went off, students. I can recall in those days going to an ASHP, American Society of Health System

Pharmacists, which was the first organization that embraced clinical pharmacy. The American Pharmacists Association in the beginning rejected our plea for them to go this way, Jere's and my plea. ASHP began the program for drug incompatibilities at their meetings, for this drug being better than that drug at their meeting and a lot of our graduates were delivering those original lectures. You have to understand what it was to be a pharmacist and to see another pharmacist do this. In those days, if you wanted a lecture on drug therapy, guess who you invited?

06-00:22:33
Meeker: A physician.

06-00:22:33
Day: Yeah. Can you believe that? Well, yeah, I can believe it because we didn't know shit diddly about it, okay. I hope that this thing can bleep out. I get so enthusiastic, I let my Irish self out. But they would invite physicians to talk about drug therapy. And we broke that mold with the Peninsula Pharmaceutical Society in 1960s and pharmacists began to break that mold elsewhere, too. Their programs began to use pharmacists as an acknowledgement that, well, we are expert in this, too, or there's a better expert out there. But I still get a little unhappy when I see pharmacists inviting a physician to give a talk on drug therapy and I don't know why.. I just think the physicians should lecture in the area of their experiences and diagnostics. But to do a review of the drug therapy available for an ailment—all the drugs available—that's nice, but it bothers me. There are some physicians, perhaps many, who know their drugs in and out but I'm thinking of all the other information that a pharmacist brings to the table that a physician hasn't even been exposed to. So you can look at the programs presented to pharmacists across the nation and see today that most of them are being given by pharmacists. And if there's a physician, it's usually directed at diagnosis.

06-00:24:26
Meeker: Were you starting to get applicants for the PharmD program who were specifically identifying clinical pharmacy as one of their reasons they wanted to gain admission to UCSF?

Just pointing out the fact that UCSF was a hotbed of clinical pharmacy. Were they pointing out that fact in their applications about why they wanted to go to UCSF?

06-00:24:55
Day: You have to understand an applicant's not an average human being. An applicant is, in our case, a very smart, world-experienced person. And I don't mean to be cynical, but they know how to say the things that you want to hear. But, in the beginning they didn't know what we were doing, students, so when they applied to our school they applied because we were, and had the reputation, as the best school of pharmacy. Furthermore, we were the cheapest school of pharmacy, too. It didn't take a real brilliant brain to look at paying

$15,000 a year at USC versus $3,000 a year at UCSF to say, “I think I’d prefer to go to UCSF.” So we were the discount school of pharmacy for the longest time, and still are, in a sense.

And beyond that, our own students will tell you that we’re the number one school of pharmacy. The freshmen will tell you that because they’ve heard it from others and because we’ve told them that. But it really isn’t until they mingle with the other graduates or the other students, as they do at national meetings, that they begin to appreciate the difference. And there is a difference. I think it’s as much in our students because we pick them very carefully, as it is in the education they’re getting, and they’re getting a cutting edge education. So our applicants in the beginning came to us just simply because we were there, because we were cheaper, because we were a good school, because their dad went there, because their mom went there.

Ultimately, and I think it’s pretty much accepted now, it’s because we are good. Better? I don’t know that they’re in a position to make that judgment. Cheaper? Still are. I don’t know about you but if I’ve got two good schools to go there and one’s cheaper, I’m going to go there and I’ll tell these guys, “I chose you because you’re the best.” So, in the beginning of clinical pharmacy, the students came not knowing that they were going to a school of pharmacy that was the best, not knowing that we had an innovative program. In fact, those who were there during the transition, when we were making the transition from the curriculum we had to the new curriculum, some of them resisted it. “I don’t want to be a clinical pharmacist.” These new courses that weren’t there when they signed—“I didn’t sign up for this.” Not many but some. And how widespread that was in the classes in those days I don’t know. Most of them were enamored with it. So we had some resistance from our own students. Eventually the word clinical pharmacy is not a stranger. And, believe me, any applicant who applies to our school, if they hadn’t heard of it before, will do their damndest to find out about it because they’re going to be interviewed and they’re going to be interviewed on the basis of what they know, and not their ability to flatter, and their ability to communicate, and their ability to show maturity in terms of problem solving, and their GPA. From probably the mid-1960s on we were very, very, very selective. Because, remember, our pioneer faculty, these young tigers that went in and fought these battles—overstatement—they went in and established these services, were really possessive of holding on to the toeholds they had gained and every one of them were fearful that a student would come along and say, “Hey, you really need to take this drug rather than that one,” and a patient dies and there we go, we’re out the window because of a student.

06-00:29:23

Meeker: Were there any examples of that happening?

06-00:29:25
Day: No. It was just a concern on the pioneer faculty's part. We had one student we had to dismiss because he had an uncontrollable mouth. He just could not control what he said. And it wasn't that he had bad judgment in terms of his drug therapy. It was because of the other stuff. He had no rapport with the patients and actually told patients things that were deleterious to their peace of mind. And he was just like, bleh, and we had no way of controlling him.

06-00:29:52
Meeker: He told patients they were going to die?

06-00:29:54
Day: Yeah. In essence, he did. He told one patient that the liver that they put in him, because he stood in on a surgery, didn't look very healthy. And that was just one of the many things. But in any event, he was rare. Our dismissal record for incompetence is very, very, very small because we've, number one, picked very carefully and, number two, we'll do our damndest to keep them there once they are admitted. For every student admitted, there were ten other people that wanted to get there. And if, because he's in trouble, we say, "Oh, flunk him out." we would be wasting that very precious position. So we want to repair that person if there's something to be repaired. And it's been that way for a long time. But anyway, so there was this time when students didn't know what they were getting into. I don't think any student can truly appreciate what it is to be a clinician until they've gone through the curriculum. There are no role models on television and so they really don't really get to know about it until they do sticky stuff when they're in the first year, until they go off into the wards with an upperclassman and see it happening. That's probably the first time they catch it. Most freshmen, I think you were to poll them right now would tell you, "I can't do that. How does she or he do that? My God, I will never be able to do that, what the students are doing." And when they get into the fourth year, they're doing it.

06-00:31:35
Meeker: Let's see here.

06-00:31:36
Day: I'm off path.

06-00:31:37
Meeker: No, you're not. I'm moving us around in a peculiar fashion, I'm guessing. Just one last follow-up question about video [*Clinical Pharmacy: A New Concept in Patient Care*] and perhaps other similar kinds of work that you did. What was the distribution? It sounds like you sponsored these continuing education classes where a hundred or so locals would come and listen to what was happening. There was a production of this video, which I believe you said offline was primarily distributed to other UC—

06-00:32:17
Day: University of California campuses.

06-00:32:19
Meeker: Yeah. Did it go beyond that?

06-00:32:21
Day: It did but very rarely. I carried a copy of it with me when I occasionally lectured at other schools. It was at that time in beta format. No, it's actually in one inch helical scan format, which every time I went anyplace had to make certain they had 1" Sony equipment to play it. Then we got it down into beta. So there's been a degradation of it at each step of the line. The copy you've seen is a DVD. That's the fourth generation dub of it. I think it started off as a two inch tape. It was transferred to a one inch tape. It was transferred to beta, transferred to VHS, and finally to DVD. And as you're well aware, aside from what the passage of time does to a magnetic tape, there's a degradation because it's not a digital process, it's an analog process until you get it to the DVD. Now it's digital, it'll never get any worse. But in any event, that tape went with me and a couple of other people, in some rare instances, to other schools. And ultimately when I established the Society for the Continuation of Pharmaceutical Education, which is unrelated to the Peninsula Pharmaceutical Society, that tape was distributed to local pharmacy associations and was shown at their meetings. I think there were ten or twelve county associations that were a part of that consortium. So they saw it. Ultimately we sent it off to the archives for the Institute for the History of Pharmacy so they have a copy of it. That was the first tape.

The second one, and I think there were three or four others, and I'm having trouble remembering the other two. The second one was a major production in which Toby Herfindal and I scripted what ultimately was a two hour production. Well, initially a four-hour production that we prepared basically because we were having a national health manpower conference on campus, and we wanted to trot out our clinical pharmacy program and we wanted to do it not by getting up there and saying, "This is what the pharmacist does." We wanted to show them and so we shot the pharmacist on the floor. We shot our educational experiences. At that time we had something called comprehensive care clinic and we shot a sequence in which a student and a physician and a medical student were teamed up and paired for the purpose of trading off whatever necessary information there was. The pharmacy student would advise the medical student on the drugs. And this is way back in the beginning. Dave Adler, who's been our faculty for forty years, is featured in that as a student. But anyway, so the tape was prepared for this national conference. We trotted it out at that time. That tape was minimally distributed beyond that use, minimally because. I brought it to a couple of places. I ultimately had it copied to beta or to VHS and a copy of that one also resides in the American Institutes of History of Pharmacy, which means—if you ever saw *Citizen Kane*—did you ever see that movie?

06-00:35:44
Meeker: Yes.

06-00:35:44
Day: You remember the warehouse where they stored Rosebud?

06-00:35:46
Meeker: Yeah.

06-00:35:47
Day: Like the creators of *The Lost Ark*. I fear it's been buried.

06-00:35:53
Meeker: I've been in enough archives—

06-00:35:55
Day: Gigantic. Gigantic thing.

06-00:35:56
Meeker: So I'm thinking about the dissemination of this idea of this new practice of clinical pharmacy. Obviously you've provided a really good description of some of the predecessors in the fifties and early sixties and then you have this key moment in 1966, September of '66, that the Ninth Floor Project opens. What do you think were the most successful or consequential means for the dissemination of information about this? Was it through professional organizations? Was it through these continuing education classes? Was it through the physical distribution of graduates of the program? How does the world get to know about what's happening here and to what extent does the UCSF program kind of become the touchstone of this new practice?

06-00:37:03
Day: Well, all of those things went on. So I don't really know what impact they had. I can't say that a pharmacist sitting in a local pharmaceutical association, say, "Oh, I'm going to go off and establish a program." It definitely, I think, influenced practice, considerations of practice, because these guys saw pharmacists were doing these things. And although some of them were doing some of those kinds of things by themselves, they saw a role in it for themselves, too, I think. This is all anecdotal. There's no way to know what a crumb dropped in an ocean is going to do to Hawaii 16,000 years down the road. Because you can't say this led to that. I can tell you that there were some key things that happened. First of all, everybody was curious about it. So when Jere and I and others went back to our meetings of the Colleges of Pharmacy, we presented programs or we would drop a hint. Also in the House of Delegates meeting. And it wasn't intentional. It just was we're doing it, of course we're doing it, naturally we're doing it.

06-00:38:12
Meeker: So you would have had conversations?

06-00:38:14
Day: We had conversations.

06-00:38:15
Meeker: With colleagues?

06-00:38:15
Day: We had visitors who heard about it from us, from others, from these guys who were beginning to write articles. I think probably a key step in the spread of it was when the University of Nebraska decided to go clinical pharmacy. And that was just a couple of years into the program. There dean, and Dick Gourley, one of their PharmD faculty members. wrote me and said, “Want to come out and visit your program.” And that was in the beginning. That was, I don’t know, could have been ’68. I still consider those beginning years because it hadn't taken off like a rocket out of hell. Dick wrote and said, “I want to come out and if it would be possible, we want to tour your facilities and see what you’re doing,” which I chalked up to one of two possibilities. They're serious or will just fly off to Nebraska to go back and tell their faculty they can’t do it.

06-00:39:39
Meeker: Or to visit San Francisco.

06-00:39:40
Day: Maybe to visit SF. My cynicism was toward the latter because I hadn’t an appreciation for what Nebraska was at that time. To me it was a state and not a terribly advanced state. I thought of it in terms of agriculture. But that’s unfair. Let’s just say what happened. Those two guys walked in and, Dick Gourley sat down and I started to tell them what I was going to do for him. He said, “Bob, before we do that, let’s go over the following.” He had an agenda, which was refreshing. He wanted to know a lot of the stuff you’ve been asking. He wanted to know how this happened, how we did this, who did that. He had done his homework. And he said that to me. I said, “Dick, God, I’m not prepared for you.” And he said, “Well, I’m prepared for you.” And basically he asked all of these questions having to do with the mechanisms, the concepts, the "who did what," how did it happen, when? We spent probably an hour and a half in my office, unintended, because I was going to trot him down to the floors, introduce him to Bob Miller, to the other guys. And I did. But it was obvious that he was super serious, as was his dean, a guy named Hackendon, I think. Al Hackendon or whatever. And he left and told me, “We’re going to do this.” And the curriculum they established, that very first one, was a pretty good carbon copy of ours. And they did it in Nebraska. They were then at that time in Lincoln, and I said, “Do you have a major hospital there?” And he said, “No.” I said, “Where’s the major hospital?” He said, “Omaha.” And in less than a couple of years they moved from Lincoln to Omaha because that’s where the school of medicine had its clinical facilities. And so, after us, this was the next school of pharmacy to go clinical pharmacy.

A least one, young USC faculty member one time claimed to me that USC invented clinical pharmacy, that they’re the first aboard, that they did this and they did that. But the fact of the matter is that while they are the first school to

give the PharmD degree, they were still training traditional pharmacists who went out and dispensed. I know for a fact that they weren't the first or even before Nebraska, not only because they weren't doing it when we did it, but because I was part of the team with Sid Riegelman that went down and tried to convince their faculty to go this way three or four years after we had initiated the ninth floor project. Maybe four. Maybe five. It was a while. So Nebraska was the second to go clinical pharmacy.

06-00:42:40
Meeker: How did USC respond to that trip that you made as a faculty?

06-00:42:43
Day: Oh, positively, positively. But the usual kinds of questions and the usual kinds of concerns. They're a private university so they have a great deal more flexibility in terms of what they can commit themselves to than we do because all they had to do was raise tuition and they had more money. And they got the lion's portion of the money that they took in. We don't. It was favorable because they had one of our students on their faculty at that point in time.

06-00:43:16
Meeker: Who was that?

06-00:43:21
Day: I don't remember.

06-00:43:22
Meeker: Is it one of the people you've been mentioning?

06-00:43:23
Day: No. It's a kid that did our mental health clinics. Actually invented the role there.

06-00:43:33
Meeker: We can add it in the editing process if you remember who it was.

06-00:43:37
Day: I'm blanking. But they were aware of what we had been doing, and we always had good relations with them. And then it's almost, as I said, like a slowly moving tidal wave, only it didn't sweep, it sort of appeared here and there. And there were schools that were saying, "Oh, yeah, we're clinical pharmacy." But you looked at them and all they'd done was changed the name of some of their courses—their pharmacology courses were still pharmacology courses—to clinical pharmacy. I met a dean in Des Moines who told me that he was one of the nation's first clinical pharmacists and he had been doing clinical pharmacy for thirty years. Which I just simply inside grinned because he couldn't have. He couldn't have. In fact, his school at that time was like still in the medieval period of pharmacy education.

06-00:44:39
Meeker: Could you get a sense of what he was talking about?

06-00:44:41
Day: No, no.

06-00:44:43
Meeker: That's one thing I want to explore broadly throughout the rest of the interviews that we're going to do, and that is it would strike me a bit—and, actually, the book that you've lent me maybe made this claim explicitly but it certainly was implicit in it—that at various points in that book they provided the definition of clinical pharmacy as it was then. And there's actually been definitions of it maybe even going back to the thirties or forties.

06-00:45:15
Day: Yeah. But it was not a role. It was a wish list.

06-00:45:18
Meeker: Well, this actually gets to my sense of something that we'll return to again in subsequent sessions. After the Ninth Floor Project launches, when do people start to refer to this as clinical pharmacy?

06-00:45:39
Day: Almost immediately.

06-00:45:40
Meeker: Almost immediately?

06-00:45:41
Day: Almost immediately. In fact, our clinicians came up with it. Came up with it a very short time—I think it was even during the discussions to establish it.

06-00:45:51
Meeker: To what extent were there debates going on amongst pharmacists saying, "Yes, clinical pharmacy is the direction we need to go in."

06-00:45:59
Day: A lot.

06-00:46:00
Meeker: Yeah. You've mentioned that. But then what about those who agreed on that basic direction? But then to what extent were there debates within that group of people who said, "Okay, this is how I define clinical pharmacy. You're putting too much in it," or "You're not putting enough in it."

06-00:46:19
Day: A lot of that, too. It was going on. But the definitions of clinical pharmacy, they actually at one point tried to drop the word clinical pharmacy and call it pharmaceutical care because there were so many definitions of clinical pharmacy. Clinical pharmacy at one university by a guy named Glenn Sonnendecker whatever, clinical pharmacy to him was a dispensing course in which you monitored patients' medication use. You filled prescriptions, dummy prescriptions in this laboratory, and then a refill request came in and you said, "Oh, yeah, they shouldn't be refilling it now because it's only fifteen

days since it was filled," et cetera. That course was called "clinical pharmacy." He claimed for the longest time to be the father of clinical pharmacy because he had been teaching that course. Well, he hadn't been teaching it as long as Morris Boynoff had been doing the same thing. So his definition of clinical pharmacy was that.

A pharmacology course which was taught with a critical viewpoint was called clinical pharmacy. It had all sorts of definitions and, frankly, all sorts of fathers across the nation. We didn't do it all and I don't wish this videotape to leave the impression I'm saying that we were the savior of the world, that we did it all, that all other people just copied us. Because what happened is our graduates went out and they inoculated other people who did stuff. They did stuff. When we trained them, we thought they were going to graduate initially and go off into hospitals and do what they learned to do in our hospital. They went off and said, "Yeah, that's very nice but we can do this, too," and they did that, too, and this, too, and that, too, and pretty soon we had a variety of specialties out there and a variety of roles. The only similarity between many of them is the guy at the middle. He's a pharmacist. He's a clinically skilled pharmacist who, for example, saw being in charge of an investigation on new drugs as an outlet for him or her.

06-00:48:36
Meeker: Can you provide me examples of these kind of mutations, if you will, that happened?

06-00:48:40
Day: Well, Glenn. Glenn was his name, the guy that went to USC. Glenn was the first person to establish the pharmacist in a pharmacist in a mental healthcare clinic, and establish him as a consultant—he was a student at the time. Not because Glenn was so super sharp in antipsychotic drug therapy at that time but because he acquired it as he was doing it. He actually basically, as a student, pioneered one of our rotations through that particular clinic before Governor Reagan came along and closed down all the mental health clinics. Every time I see a homeless person, I see a Governor Reagan person. It's a carbon copy of Governor Reagan because that didn't happen before then, when he unleashed all these people. I hope you're not a Governor Reagan fan.

Barbara Sauer went off into a poison control clinic and established the role there. But what I'm trying to say is mostly what happened is we learned that the curriculum we had prepared, that we had at that time, prepared them for the kinds of things that we couldn't even begin to imagine. And other people across the nation who caught the scent of clinical pharmacy did the same thing. That's what that book that I loaned you, that ACCP, published is all about. It's about what they did and how they did it, when they did it. And you will see in it we aren't the only people on the block. Our major contribution is we were the first. We established the most important characteristics of it and that's it. I think we do have a cutting edge curriculum and I do think we have a cutting

edge group of people who graduate and I still think they can walk circles—on the basis of a lot of evidence we have—around graduates of many other schools of pharmacy. But it has to do with our selection process and a lot of other things.

06-00:50:59
Meeker: We have about another ten minutes. There are some questions here that I have written down that I'd like to follow-up on.

So at the beginning of this you provided a good description of your personal role in this, which you claim to be pretty limited. And you weren't a direct clinical pharmacist. When I asked Toby Herfindal about this, he says that what you did really was you that you ran interference for those who were doing the clinical pharmacy practice. What do you think he meant by that?

06-00:51:46
Day: Well, I was at one time chairman of the department of clinical pharmacy before it was a department. I don't know. And I really don't know. You're going to have to ask Toby that. I was thinking, well, maybe this, but I'm guessing. I don't know. I don't know. My role was to make certain that the clinicians could do what they were capable of doing as faculty. My role was to make certain that they had the resources to do what they could do. And I can't say I fought any great battles because, remember, we were onboard for this sort of thing. But they were all new, they were all paranoid. They were all young. They were all this and that and the other thing. And I think I had a stabilizing effect on their emotions, which tended to run high because they felt in some instances that they were not being truly recognized for their accomplishments. And whether they were or not I'll have to leave up to them to say. As far as I was concerned, they just didn't know it. As I said, they were young and paranoid because they were fighting battles. I don't mean to overdo that word "battle" because, I told you, you're going to have to ask them what they were. But they were on the front line. I never was. And so my role was to make their job, if I could, as comfortable as I could and to regulate this group. And I only was in that position for about a year. Prior to that time, I was the guy that made a lot of these things happen for them. But, as I say before, I never was one of them and some people want to give me that kudo but I don't deserve it.

06-00:53:24
Meeker: So there are a couple of other things that I remember that he pointed out in our conversation: one was he suggested that the questions coming from the physicians toward the pharmacists throughout this period of time started to change substantially. Did you have any experience with that?

06-00:53:52
Day: Not personal experience but I saw it happening. And, in fact, Toby would know that because he was on the floor from pretty much about a year after it started. He was one of the early pioneers and he would have seen the shift in

questions as the physicians and prescribers began to become more comfortable with this person called the pharmacist or the clinical pharmacist on the floors. I think all of them experienced that. If they didn't experience the evolution of it, some of the later-ons, experienced it from the point of, "Wow, they're asking those kinds of questions," with nothing to go as to the kinds of questions they asked or the kinds of services they required. So Toby's the best guy to pursue those things.

06-00:54:43
Meeker: Well, maybe another question you can answer, in fact, is the relationship of the doctorate degree and getting called doctor. This is something I think we talked about a little bit already. How did that play out in the context of a clinical pharmacy program? Do you remember any conversations with Herfindal or any of his colleagues about whether or not physicians were going to call these clinical pharmacists doctor or not?

06-00:55:19
Day: No, I don't think I ever discussed it with Toby. I don't think it was necessary. At that point, if you had a PharmD degree, you were going to use it. You don't have to call me doctor on the floor but you damn well better know I got a PharmD degree. Because that, in some instances, was believed, correctly or incorrectly, to be a calling card. I got a doctorate, okay. Big D at the end of my title, okay. You got a doctorate. A big D beyond that M, okay. And I think that many of us believed, without being ostentatious about it, that it at least established a commonality. And I don't mean in comparison to the BS graduates. It's just that this guy's got a doctorate. I don't understand that doctorate. Don't really know where it came from but he got one. And I think they saw it as a calling card. But only as that. I don't think any one of them went out of the way to say, "I'm Dr. Herfindal." It was probably, "I'm Bob," as Dr. X was John. But, again, they'll have to tell you that.

06-00:56:28
Meeker: Okay. So that would have been difficult that first names would have been used rather than last names?

06-00:56:34
Day: I would think so. I don't think any of them went out of their way to say, "I'm Dr. So and So." No, I take that back. I don't know what they did. I do know that some of our graduates, when they graduate, just get really carried away. You'll see their checks that say Dr. Robert L. Day, PharmD. Or Dr. Jonathan L. Jones. And we have to sort of point out to them that that's cool but not so cool because nobody gives a damn in the general public whether you have a doctorate degree. But in a healthcare environment, and you're in a practice role, patient to you, if you want to be doctor then that's cool. But most of our students don't use that.

06-00:57:13

Meeker: But also I wonder to the extent to which it's a generational transformation that happens. I think about history departments and the way in which people were educated in the 1960s. They would walk around, from what I'm told, and not use names but say, "Good afternoon, colleague," or "Good afternoon, Professor Jones." It was a very formal environment. Now it's okay for graduate students to call professors by their first names. Do you think there was a similar kind of transformation happening at the pharmacy school in the sixties and seventies?

06-00:57:55

Day: We would undergo the same kind of transformation as anybody else. So if indeed there was a loosening up of the titles, remember that the turmoil of the sixties, the seventies, the Kent State slayings and all that kind of stuff, the Vietnam War, made all sorts of things seem unimportant and so a lot of people changed their colors at that time. I don't know. I know for a fact when I graduated I was really damn proud of the fact that I had a doctorate degree, even if I couldn't put it in people's noses. I was proud of it and I think there's a pride that associates itself with the degree. Not that we give the degree because we want you to be prideful, but it's just kind of a neat thing to have. You're (Meeker) a PhD, and I assume that you're glad you have that PhD for lots of reasons, but it's a sense of accomplishment and part of that's with it. So in terms of what went on in the floor, Toby will have to tell you whether or not they were awed by the physicians and called them doctor or whether in the environment at that time people just did that because they didn't want the patients to know they were human beings. "Dr. Herfindal will take care of you. He's the pharmacist. I'm Dr. Jones." My guess is that's the way it was in the beginning. But did physicians resist calling them doctors? I have no specific information on that. I have a lot of information later on, in which nobody had any difficulty calling me doctor. Physicians, nurses, whatever. And that wasn't many years.

06-00:59:22

Meeker: Well, that's helpful. Let's wrap it up there.

[End of Interview]

Interview #4: February 6, 2013
Begin Audio File 7

07-00:00:00

Meeker: Today is the sixth of February 2013. This is Martin Meeker interviewing Bob Day and this is tape number seven. So let's get started. There are still a few things that I want to follow-up on and maybe dig a little deeper around the ninth floor project and its immediate legacy at UCSF. And there is just this one point that Mary Anne Koda-Kimble pointed out to me and this is kind of an ongoing theme in our conversations and I'd just like you to comment on it yet again. And that was that she said that really before this project got started and became ingrained in the culture of UCSF, she said that nobody thought pharmacists were scientists and that the leadership there helped influence the thinking of others around them. Is this a statement that you would tend to agree with?

07-00:01:28

Day: Sure. And it goes back to the 1800s in the school of pharmacy. There are statements in our records about science being—in fact, when they had the groundbreaking ceremony, one of the speakers was—Cole, I think it was Beverly Cole, of the famous Cole Hall. Beverly Cole, R. Beverly Cole, in his opening address for the groundbreaking ceremony, which was actually on the Parnassus campus, which was actually about, oh, fifteen years after we had been founded. Talked about science being the future. He talked about the uses of spectrophotometer and this being the future of the profession of pharmacy and the sciences and all that important. He wasn't the first person to note that. Remember I told you that a site team went back east with Beverly Cole among them, actually. He was with the site team to visit schools of pharmacy to pick up from them what they could, the best of their curriculum, how they charge students, how they took attendance, facilities. It was mostly architectural. They wanted to see the facilities. They wanted state of the art for this brand new building they were constructing on Parnassus. And he went with them at the time. And at the time, when they came back, there was a report. It was written up by one of the members of the team who said something like, “We have the opportunity to be a leader in the sciences, not only for now but for the future.” So a long answer to your question, which I always give long answers, is that yes, from the very beginning of the school, the sciences were held to be important. The scientific training of the students was held to be important at a time when other schools of pharmacy were training them how to put things together and how to identify opium from its blossom. And chemistry was way down on their list, except for eventually some schools felt it was important for analysis of the crude drugs pharmacists were buying, so they began to teach chemistry. But we were always there.

We were always kind of like a leader, heavier, and people like Troy C. Daniels, and even William Searby, way back in early 1900s, voiced the message that it was important for a well-rounded practitioner to have a

scientific background, as well. Well, I'm not certain what they saw. I don't really know what they saw because, remember, pharmacists in those days were the guys that you barely even met. You met the owner. You went into a pharmacy in the 1900s and back there somewhere were a team of pharmacists to fill the prescriptions because most of them at that time, before the 1900s, before the late 1800s, were compounded. Were made by pharmacists. You needed a batch of pharmacists if you were a busy pharmacist to keep up with the prescriptions. So you didn't even see those guys. Those were buried in the back and even slept there at nighttime in some of the San Francisco pharmacies. So it was unclear as to how those guys would ever use science. I'm guessing now, but in the days when Searby was dean and he was talking about science, I think he was thinking in terms of pure drugs. Make certain that the drug supply that pharmacists got was pure, that they put it together using sound scientific principles. I don't think any of them clearly saw it as serving as it did in the 1960s as the springboard for pharmacists to spring into the clinical area with their strong scientific background. We would not have accomplished what we had accomplished, for lots of reasons, had we not had that, had those students not been well endowed in the sciences. So that when they had to build upon it, their physiology was down pat, their chemistry was down pat, everything was. Their knowledge of the physical sciences was probably second to none in the schools of pharmacy across the nation. So they had that to build upon. And I also said that science is the language of a practitioner. It's my firm belief that if you can't speak science, and it's like a language, it's like German, if you can't speak science then you should not be a pharmacist because all of the changes that are going to be taking place are going to be taking what it is you know and building on that. Or taking what it is you don't know and building on that and you have to have the mentally muscle exercises of having a profound knowledge of science to do that. Or maybe not so much a profound knowledge but a fairly well based knowledge of it. So yes. Long answer, yes, I agree with it and there's good reason for it.

07-00:06:32
Meeker: When you were perhaps just starting out as a lecturer there or when you were a graduate student—

07-00:06:40
Day: I never was a graduate student. PharmD was not a graduate program. It was post-graduate professional [program]. It's different. Distinguished graduates. We distinguished that early. The graduate division is the PhD division. Think masters of the academic scientist training. Ours is a practitioner training, like an MD. An MD is not a graduate program. You will hear them call it that. Unless the university has changed the classification. And I don't think they have. I think we were referred to as post-graduate professional or professional graduate as opposed to bench scientist who are not—

07-00:07:15
Meeker: Interesting. So like an MBA wouldn't be considered a graduate school?

07-00:07:21
Day: No, no, we would consider it graduate school because it's graduate division. The post-graduate professional program is where we draw the distinction. We graduate persons who are capable of science and research, as they have well demonstrated, and it's our goal to graduate that kind of a person who is science capable but not science competent. But practitioner capable. When our kids graduate they are at the beginning level of being an expert in drug therapy. At the beginning level meaning they already are but the world out there will teach them and us what more they can accomplish.

07-00:08:05
Meeker: I guess what I'm getting at is thinking about some of your professors, people like Sid Riegelman and others. Did they ever communicate to you—and how am I trying to put this—an acknowledgement that others in the health professions did not see pharmacists as scientists?

07-00:08:32
Day: No. No, we learned that by experience. No, nobody ever put us down. I think Sid, if anything, talked us up more than we were at the time. Saw greater possibilities. That's why he did what he did. Sid and Don Sorby and Donald Brody and Eino Nelson and some of our other faculty had a vision for us. Almost a hunger for us to go someplace. That's what motivated Sid, who was a leading scientist, who, at great professional expense, because he was a world-acclaimed scientist, took his precious time and was so dedicated to pharmacy. Truly, he was always a pharmacist—and I've never forgotten that. I'm a pharmacist—did what he did to get the program established. And remember, I told you before, that it was on the basis of the reputation of our scientists that the medical center went along with what we were doing. Troy Daniels was respected. He was the dean at the time. No, I'm sorry, Jere Goyan was respected. He was the dean at the time. Sid Riegelman. If Sid Riegelman said, “The world's square,” about half the world would believe him instantly because he spoke with authority, although you wouldn't see it if you met the man.

07-00:09:54
Meeker: Okay. So moving on from that general thought. I know that we spent a little bit of time talking about the 1969 faculty conference last time. But I'd love to just try to dig in a little more deeply into it and—

07-00:10:10
Day: You're talking about when they adopted the curriculum?

07-00:10:11
Meeker: Correct.

07-00:10:12
Day: The loaded gun, when the young guns came in and shot at the faculty preceded that.

07-00:10:21
Meeker: It did, okay.

07-00:10:22
Day: The 1969 meeting was when the work had all been done. That was where they approved the curriculum. The most radical curriculum of its kind in a hundred years of pharmacy, 200 years of pharmacy in the United States. It was when they approved it. So when the young Turks went in there and shot in all directions it was a meeting of the faculty, but it was not the one where we approved the curriculum. That was when the faculty said we've got to do something. That was when these guys, the Turks, Toby Herfindal, Joe Hirschmann, Bob Miller, basically thought they had to come in like that. But they didn't know that they already had a willing audience. I told you, they were a little bit paranoid. Well, they would deny that. Don't ever show them this tape. But they were a little paranoid because it was tough work and nobody seemed to be supporting them at the level they thought they would deserve. And I think they're right. But there were other items on the agenda, too. It's like anything else. Jere was dedicated to this program. I'll never forget it. When he bought an NMR, the first one the campus ever had, that cost something like $250,000, which in those days was—oh, a million dollars today. They were really unhappy. “What is he doing spending that money when we're starving? We don't have enough people on the floor.” They didn't understand that the budgets that buy equipment were quite different from the budgets that pay for faculty. You can't sort of dip into the NMR fund.

07-00:12:02
Meeker: What was that?

07-00:12:02
Day: Nuclear magnetic resonance. It was an NMR. It's MRI now. But you couldn't dip into that fund and pay faculty with it. They didn't understand those things.

07-00:12:13
Meeker: So kind of setting this up for me: What happens is those working on the ninth floor recognized that they're onto something here, that they need support from the university and that there are certain kinds of knowledges, if you will, that they don't possess that really need to be made part of the curriculum and made part of the curriculum immediately.

07-00:12:38
Day: It was always that way. They always felt that way. And, in fact, Sid Riegelman always felt that way, Jere always felt that way. But remember, in academic circles you certainly have that experience. It's like a pebble in a pond. It takes a little while for that. Or like a tsunami. It takes a little while for that wave to hit the shore. The faculty was always there listening. I never once heard anybody speak in opposition to the clinical pharmacy program. So there was always this very positive attitude about what was going on. The problem is that these young clinicians didn't feel it, and maybe rightfully so. I wasn't them.

07-00:13:17
Meeker: Well, there's roughly a three year period of time between the establishment of the program in September of '66 and then the change in the curriculum in '69. So that if you're twenty-seven years old, that must have felt like a lot.

07-00:13:28
Day: Probably seemed like a magnificent amount of time. But, remember, they had to establish the service. Nineteen sixty-six is ground zero. There was nothing going on, okay, and they had three or four of them, and then there were five and six. And then the program began to become set to where they felt comfortable enough to unleash students on the floor. And they were really concerned about that. I think I mentioned that earlier. They were really worried about these students dynamiting all their hard-gained ground by saying something silly or stupid or whatever. Remember, the students, themselves, were not the product of the new curriculum. This was something we put in as new. We had some students rebel: “I don't want to do that.” They were intimidated or they didn't sign up for it. We had a couple of legalistic minds saying they were going to sue, that when they entered the school this was the curriculum. But it wasn't many. It was very few. Remember, we had some opposition from pharmacy staff to that, as well. But in any event the proof of the pudding in the 1969 meeting was that it sailed through. It wasn't as though people got up and said, “Well, gee, I think we shouldn't do this, we shouldn't.” Remember, that was radical. But it followed, as I remember, a retreat but I'm not one hundred percent of that.

07-00:14:45
Meeker: It followed?

07-00:14:46
Day: A retreat, a faculty retreat. But I'm not certain of that point, okay. I remember the meeting, I don't remember a retreat. I've gone to so many faculty retreats in the beginning and even to today. But the proof of the pudding, of the faculty's endorsement was, number one, it sailed through. But number one, even greater proof of the pudding is that when it was adopted, the chair of the educational policy committee, that is the committee that put the curriculum together was the chair of the department of pharmaceutical chemistry. He was also a pharmacist.

07-00:15:34
Meeker: Who was this?

07-00:15:35
Day: Fred Wolf. If you went across the nation, as these programs were eventually being adopted, those were the kinds of chairmen who opposed it because to them it represented a threat to their funds. And, in fact, those arguments came up on the floor of the American Association of the Colleges of Pharmacy. Beware this red tide, if you will. So those were the kinds of people who felt threatened by it. Now, somebody asked, “Well, why didn't your faculty rebel? You had all these leading scientists. Why didn't they rebel?” And I don't know

if I see the true answer there, but to me it always was, I felt, because they were competent in what they did. They weren't threatened by anything new. These were cutting edge scientists. “Okay, so we're not going to have a big pot of money. I'll just go out and get some. I'll get grants.” They weren't threatened by these guys. They were, in fact, I think for the most part, pleased, because as one of them said, and I cannot say that he spoke for the many of them, “At last I feel like I'm training something important.”

07-00:16:44
Meeker: Is it possible that one of the reasons there wasn't much rebellion was that, although by 1969 we're into the next administration and there's some apparent shrinking of federal spending, I'm not sure if that's actually the case, but there were a number of initiatives in the early 1970s, I believe, that did in fact expand federal funding of pharmacy work.

07-00:17:11
Day: Yes. Yes. You're talking about now the per capita grants that were made available?

07-00:17:18
Meeker: Yeah. And the Manpower Act [The Health Manpower Training Act of 1971].

07-00:17:22
Day: Yeah, yeah.

07-00:17:22
Meeker: So basically maybe there's going to be another slice carved out of this pie but the pie's going to be twice as big as it once was. Do you think that there was this sense amongst the pharmacists, the PhD pharmacists who maybe could have seen this as a threat, in fact, just saw it as an expanding pie for all?

07-00:17:48
Day: Well, in 1969 I don't think that was going on. In fact, I know it wasn't going on because there was no clinical pharmacy as far as Congress was concerned, nor the Health Manpower Commission, and those other things, or at least the money for capitation grants. So to explain for anybody who doesn't know what happened, basically the California senator, senator—God, what was his name?

07-00:18:07
Meeker: Was it Cranston?

07-00:18:09
Day: Cranston. Senator Cranston sponsored legislation which made capitation grants available to schools of pharmacy that decided to go clinical pharmacy. That is to say, you increase your student body X number and we will give you X number of dollars per head for students you take on, okay. Now, that amounted to hundreds of thousands of dollars for schools. But that didn't happen until clinical pharmacy had been established. I will also tell you—

07-00:18:38
Meeker: That was '72, '73, I think—

07-00:18:41
Day: I don't know. Something like that. I will also tell you how it happened. Jere Goyan was the entrée, I was the sticky, who met with Cranston's aides and urged them to put this kind of money available out of the Health Manpower stuff because they had left out pharmacy, because there were capitation grants for medicine, for nursing, for dentistry, I assume. And I don't know about veterinary medicine. But we were being left out of the bill. And Jere had some political connection to Cranston because he had occasionally called Jere for his advice on some health related things, mostly having to do with pharmaceutical sciences, mostly having to do with drug investigations. But Jere, from time to time, and I can't say it was like every day or even every month—I have no idea of the frequency—Jere had an entrée into that office. We didn't actually meet with Cranston that day, the day we went back and made the pitch. We met with him at a later time. But we met with his aide who eventually came out to California, whose name I do not remember, who eventually worked for the University of California San Diego. But at that time she was his key aide and she was the staff person, the point person for collecting information on the senator's input into the Health Manpower Bill.

07-00:19:56
Meeker: His legislative director, perhaps.

07-00:19:58
Day: Well, whatever. I would guess that, yeah. And she really liked Jere. I don’t mean it was a flirtatious thing. I don’t mean that at all. Jere had a brilliant brain and he was a likable guy and she I guess had been and admirer. Well, anyway, so we went in. It was obvious that it was a very positive meeting. And I think we had the same kind of situation going for us that Sid and Jere had when they were trying to push the clinical pharmacy program at UCSF. That is to say, people listened to them because they were credible. And we went in there at that time and told her that we felt that pharmacy should be included in the capitation grants. I say “we.” I did contribute but it was not at the level of Jere. It wouldn’t have happened. Even if Jere had opened the door for me to do it, who was I? Jere was Jere. He was quite a dynamic guy.

We presented her with a description of what we were doing. I take it back. She was a little bit aware because Jere had informed her, but Jere pushed the point that it was essential that pharmacy be included in this. We pointed out to her something she hadn’t realized and something not many people realized, that of all of the health professions, the profession of pharmacy was the one undergoing the most radical change. I think I told you earlier, like 180 degree change in direction, from a person who said, “I can’t discuss drugs with patients,” to a person that says, “I damn well better discuss them with them. That’s my role.” That was 180 degree change. So we informed her of that and said, “While we do respect our colleagues in medicine, nursing, and dentistry,

that's traditional. You're going to support programs that are going to continue them the way they've been and maybe that's cool. We don't know. We're not physicians. But pharmacy now has the opportunity to make dents." And we pointed out the report of the taskforce. I think we pointed out the report of the taskforce on drugs, which said that prescribing was a failure in the United States. And we met several times, several phone calls, and that legislation got written and that saved a lot of schools from having to convince their very tight-fisted regents, or if you will, whatever they call their governing bodies in other universities, to put up the money, because all they really had to do was expand their student bodies and they got this amount of money. And I think it went on for a number of years.

07-00:22:26
Meeker: Do you recall if the legislative aide, or if Cranston, when you actually engaged with him—

07-00:22:30
Day: Her.

07-00:22:32
Meeker: Legislative aide, yeah. But engaging with Cranston, that is. Did you engage with him ever?

07-00:22:37
Day: We did eventually. But it was a very, very brief meeting. Cranston was a very busy guy. This was an important piece of legislation.

07-00:22:43
Meeker: Okay. So in your engagements with Cranston's office, I should say, do you recall if they ever raised any objections or red flags or concerns that this may make the legislation more difficult to pass?

07-00:23:01
Day: I don't know. I don't know. It didn't happen in the meetings I attended. I don't know what happened on the telephone. I don't know what happened in Cranston's back office. I do know that the school eventually awarded to Cranston what was called the Troy C. Daniels Medal for his support. And I can only tell you what I think I recall. But I think I recall that Cranston was positive about this from the beginning. First of all, he was a Californian. He liked the idea that this was coming from California. That much I know.

07-00:23:42
Meeker: So these funds, these capitation funds, were specifically earmarked for clinical pharmacy work?

07-00:23:50
Day: Clinical pharmacy. Not for just expanding your student body. No, that was one of the key points we had to insist on. Because I do remember that was one point when we were discussing it somewhere along the line and I don't know with who and I don't know when, but somewhere along the line, the notion

came up, “is it fair to leave the other (non-clinical) schools of pharmacy out?” And we said, "Yes, it must be tied to clinical pharmacy because if you give them money to expand just business as usual, they will use those monies for the damndest things.” There was no restriction on how they used that money. That was the beauty of it. You didn’t have to use it to buy anything. You could have theoretically taken a trip to Havana. Some schools actually used the money to construct a really glossy, beautiful school of pharmacy structure and then fought it out with their regents to get the money to go clinical. I remember some of those guys. They were very proud of their buildings. They had taken the capitation money and put up these beautiful facilities. We took some money, too, but we didn’t take as much as the others. There are some schools that doubled their student body. It was obvious for them it was a money banking thing. Some schools, which shall remain unnamed, because it’s really not relevant to this, doubled their student body for capitation monies.

07-00:25:12
Meeker: But the whole point of the legislation to begin with was this notion that in the 1970 there was going to be a shortage of healthcare professionals.

07-00:25:19
Day: Yes, that was the beginning of it.

07-00:25:21
Meeker: And so I guess the big transition point is with pharmacists moving into clinical work and this legislation in essence ratified this once radical notion or even then radical notion, that pharmacists were instrumental to clinical work?

07-00:25:44
Day: I don’t know. Remember, the whole thing was to make more practitioners available. You caught that point. And I have something tweaking at the edge of my memory and I don’t think it’s going to become any more than just that. That we were left out initially because it was felt that there were enough pharmacists already. So when we went back there, we had to present the case that, yeah, maybe there is enough of the traditional pharmacists, because at that point in time, remember, chain pharmacy had not exploded across the nation and they weren’t opening up pharmacies every second, meeting pharmacist demand. And I can’t say it was stagnant either. But it was not considered for lots of reasons. We weren’t considered health practitioners perhaps. There were enough of us, as far as they were concerned. And part of our argument was that maybe there are enough of the traditional pharmacists—we actually had to draw the line, it got us into trouble later—but not enough of this new breed that we’re training. And this is the new breed that’s going to effect and to fill in the need of physicians for an expert drug therapist, on the needs of drug therapy. And I don’t remember exactly how we put it. But it had all of those elements mixed into it. It was a very complex picture. Any one of the things I have described probably wouldn’t have swayed the picture. It was all of them together.

07-00:27:13
Meeker: Yeah. So let's go back to kind of finish up the 1969 conference and the events leading up to that. Can you recall any of the details about what the so-called young Turks were demanding and how those translated into new policies, I guess, approved in 1969?

07-00:27:40
Day: Remember, they came in feeling that they were not adequately supported, and they were right. They were conquering the world at great personal expense. They were tired. They were truly—and I don't use this word loosely—dedicated to what it was they were doing. So when they came in they felt that they had to wrench the faculty into an understanding. And maybe they were right. Remember, I was one of the traditionalists perhaps, although I don't think of myself as that, sitting there when they came in. And I heard what they did. Remember, I was also a part of their cheering squad. I guess that's my role, or whatever it was I did. And so when they came in and leveled their guns—what did they do? They came in and they basically went through some of what they called the "deadwood courses." Or maybe they didn't call them that. But it was obvious that they felt that this course was deadwood, this course was deadwood, and at the time devoted to them could be used for greater advantage to the training of the student to be a clinician.

07-00:28:57
Meeker: So they could go through the course catalog and enumerate the courses that—

07-00:29:00
Day: There were some. There were some courses that came in for heavy fire. Some of them were the chemistry courses that were analytical chemistry, as I recall. Toby Herfindal and Joe would be the best ones to recall it. They recall it differently than I because I think they probably even resented the fact that I have called it the day that they really showed their true colors as a member of the faculty. And I think they felt they had to come in with a clenched fist and beat the point home. And as I have said many times, I think they underestimated what was going on in that audience. I think they anticipated severe resistance when in fact it was not there. Now, Toby and Joe will have to tell you—I'm just pie in the sky—whether or not they really did confront resistance. I'm not them. We did talk a lot. And from the very beginning I was obviously a supporter of this thing and pushed for it, but they will have to tell you whether or not it was truly necessary. I think it was truly necessary because I think it served notice to the faculty, "Hey, we got some young Turks among us. Isn't that great?" And up into that point in time, I think they had for the most part been a curiosity in the faculty. And I don't mean that in a derogatory sense. They were like something new, these young clinicians that were doing these marvelous things on the floor. But were they academics? And I don't even know if anybody felt that way, because I always look backwards and try to figure out what was going on in that room.

07-00:31:01
Meeker: Do you think there are some people that thought the clinical direction was the precise wrong direction?

07-00:31:04
Day: I don't know.

07-00:31:05
Meeker: Or that pharmacists should move much more in the bench science direction?

07-00:31:09
Day: Do I think? Let's put it this way. Do I know that there were such people? No, I don't. Do I think that given the number of the faculty, there were a few who felt that maybe this was the wrong way to go? I don't know. I can say I think it's possible there were on our faculty some people who were pretty firm in their ways, pretty set in their ways. So maybe. I never heard from them. I told you before, I don't remember a single argument being raised in opposition, except maybe criticizing some of the weight of the units and some of the movement of the courses around and so on. Faculty will always argue those sort of things.

07-00:31:50
Meeker: Well, it seems to me that if these young Turks were pointing out a list, going through the course catalog and saying that this is—

07-00:31:59
Day: They didn't do it course by course. They just picked out some they thought—

07-00:32:01
Meeker: Okay. This is not meant to be—maybe it is meant to be provocative, but how was it then that your course on compounding was not identified as one of those?

07-00:32:14
Day: I don't know.

07-00:32:15
Meeker: Because at that point in time compounding was already becoming much less prominent.

07-00:32:19
Day: Yeah, no, I don't know. I don't know. Maybe it was because we were buddies. I don't know. You may recall that I, from the very beginning, didn't feel that this was a valuable course. Well, no, I take it back. I tried to teach it in the beginning to be a drug product formulation course. So I exposed in the dosage forms and gave them some fun things to make to show them that you shouldn't limit your thinking to the United States pharmacopoeia, which said, "Add one gram of aspirin and six grams of this and mix it together and you got yourself a tablet." I wanted it to be a stimulating experience for them and I wanted them to think in terms other than compounding, to think maybe in

terms of manufacturing, to get into product design, to get into formulation. I wanted to show them the possibilities of chemicals, not just to make USP formulations, recipes, one teaspoon of this and you've got yourself a cake. So I don't know. I really don't know. I taught the course and for many years told the students that, "This will be a course as much about the history of the pharmacy—more so about the history of the profession of pharmacy than it is about the present, because few, if any of you, will graduate and become compounding pharmacists." And I pretty much stated it that way. So I don't know why it wasn't wiped out. You have to understand that what I did do was preside over the diminution of compounding in the curriculum to where it was when I first took it over. Two units of laboratory every quarter in the beginning of the semester. Two units of laboratory. That's six hours of laboratory, okay, every day. Every quarter. Every student took that and I cut it down. I, we. Similar thinking. Because these were a lot of think-tank things. I cut it down to one unit and eventually to zero units when I dynamited the laboratory in which it was taught.

07-00:34:28
Meeker: When did that happen?

07-00:34:31
Day: The laboratory?

07-00:34:32
Meeker: Yeah.

07-00:34:33
Day: With the opening up of the IRC, with the construction, I think it was 1996.

07-00:34:37
Meeker: Right. And we'll get to that one later.

07-00:34:39
Day: I think it was 1996. I think I stopped teaching in '97.

07-00:34:43
Meeker: So when this 1969 conference happens, the new curriculum is approved. Are there any standouts in that curriculum that you remember, any details that are particularly worth putting in this historical record?

07-00:35:01
Day: In what sense?

07-00:35:02
Meeker: I've never been on a curriculum committee like this, right, or a meeting. Is it a general statement, about three or four sentences, that we will create a number of courses in the field of clinical pharmacy and this is how we define clinical pharmacy or is it sort of an enumeration of these five courses will be taught over the next two years and there'll be this many hours of lab and students

will be required and they won't be required. How detailed was the curriculum that was presented and approved in 1969?

07-00:35:46
Day: It was presented, as far as I recall, in generalities. The curriculum that the faculty voted on in 1969. Yeah. Remember that a lot of it was basically what existed and just moving it around or diminishing its units or increasing its units.

07-00:36:03
Meeker: Can you provide an example?

07-00:36:06
Day: Well, some of the chemistry courses went away. I think an antibiotics pharmacognosy course went away. A lot of the analytical chemistry courses, as far as I recall. I'm not certain of what I'm telling you right now, so in fairness, somebody would have to pull out the catalogue and do that bit by bit. But things were reduced to fit them in. This curriculum established the fourth year as the clinical year. That meant any traditional didactic course, any laboratory taught in that had to be moved out or thrown away or reduced. Because you could only scrunch so far because the curriculum was four years and had been long before the clinical curriculum. And so something had to give. And I remember the implementation phase was really tough because a lot of faculty had to teach double courses. As a course was moved from a third year to the second year, it was moved to sit on top of a second year existing course, so the faculty member had to double teach. Some chose to do it in a bigger audience. Most of them did just that, taught it twice, because you were talking about arranging a second year class schedule to be compatible with a third year class schedule. Just wasn't going to work as they moved the courses backward in the curriculum. So as I recall, some things like over the counter drugs were expanded. Pharmacology was expanded. What was known as clinical pharmacy, I would have to call it lecture didactic was expanded because I think it existed before the curriculum change. And what we called then "the clerkships," which we call now the "APPEs"—Advanced Pharmacy Practice Experiences, in those days called clerkships—were expanded radically. Blown across three quarters, where before they might have been a three-unit one quarter course, they were now fourteen units, and blown across three quarters. And then as the standards were implemented, other things went on. But in terms of what the curriculum committee did, I think, and it's difficult for me to remember, but I think we're talking about the days before the guided—things such as competency statements and competency standards and educational outcomes and educational objectives. I think that there was a target in mind and people sat down and talked about what it was they wanted that to be. And I think they talked about it. Talked about the kinds of skills that were necessary to be that kind of person, then talked about the kind of curriculum it might take to do that. It wasn't until later that we adopted competency standards and today's curriculum development is just totally unrelated to the way we did it in the sixties.

07-00:39:09
Meeker: Well, that whole process right there is, I think, quite interesting and really important. Is this idea where you have basically a new field, a new practice that is being created *sui generis*, right? And the question is what is it? What do we need to teach students in order to actually fulfill what we're promising that we'll be able to do? And this whole transformation of the way in which curriculum development happens over the course of, say, thirty or forty years is I think extraordinarily important in the history of higher education. So it would be great if you can maybe, if possible, provide me a little more sense about how it was that the curriculum development happened for clinical pharmacy to the extent that you were involved in some of the meetings and have a chance to absorb this.

07-00:40:06
Day: Yeah. That's so long ago for me. And it was so exciting. I remember looking down on the Bay Bridge and seeing the golden winged airplanes on the decks of the aircraft carriers during the 1930s World Fair at Treasure Island, but I don't remember a lot of detail about this very hectic and complex event. I can't give you a blow by blow of who said what, then they did, and then they did that. My vague concept is we said, "Okay, you've got a practitioner." And I'm trying to remember when it was we developed the competency standards. I wrote an article on that not too long ago. I ought to remember. But I think it was in the early seventies that we wrote the competency standards. Then they were rewritten and rewritten. Competency statements. A pharmacist should be able, given a diagnosis, given this, given that, a pharmacist should be able to lay these out. I think we had a notion of what we wanted to accomplish. We wanted to accomplish a guy that understood drug therapy. We saw that person being, in the beginning phases, an advisor to physicians, to nurses, to pharmacists, to patients. We saw him or her also being an educator in drug therapy to patients, pharmacists, whatever. And I don't have a whole lot in my brain of sitting in meetings and hashing out how this went on. I was involved in some of them. I can't put a quantity on this. It was a very busy period of my life and I don't have a whole lot of details on the process, which I'm sorry because you feel it's important and I don't. Maybe Toby, maybe Joe, maybe Bob Miller. Who else would have been—Mary Anne at that time was a student, as I recall. But she was on committees, as I recall, having to deal with this kind of thing. But the blow by blow.

I hate to be grandiose in saying that it was just something that seemed so right that everybody wanted to do it. It wasn't as loosely developed as I make—well, "I want to build an atom bomb so let's take some dirt and some manure and mix it together and see if it blows up." It wasn't like that. It was a lot more guided than that. But it was without, I think at the time we did it, a set state of principles. Because, remember, clinical pharmacy didn't exist. We invented it. And it's not like we invented a toy that you crank it up and it runs around and vacuums your floor. It was something that was uncertain, probing. Unclear if it was going to be adopted elsewhere. Unclear if this was going to

be perhaps the biggest mistake we'd ever made. But, you see, the beauty of it is we'd made mistakes before and everybody felt that. So it was okay to make another one, as long as we kept trying. I think the faculty was unhappy with the fact that it had tried a lot of things. It tried the pharmacist as a chemist, the pharmacist as a drug product developer, the pharmacist as an industry person of some sort or another. And none of those had taken hold. So that when this notion came along, it was one more. In other words, thankfully, they were always searching. Then they were willing to say, "Okay, that was a mistake, let's move on." Or if that wasn't a mistake, it's really, rather than the whole thing, a small part of it. Because the thing that became the clinical pharmacist was a little bit of everything. A little bit of a scientist, a little bit of a drug product formulator, a little bit of a person that had an awareness of the human body, and then, as the years went by, those little bits became bigger bits or smaller bits and they all fit together. But even in our areas we did establish ourselves as a scientific leader and that gave us the basis for moving on to the next big mistake, which nobody would say it was a mistake. But I'm saying that in terms of what the final product accomplished, it didn't work. But it was a fortunate mistake because even the notion of drug product formulation equipped our students to go into the next step, which was drug absorption, and then beyond that, drug therapy. It was the stepping stones that worked.

07-00:45:12
Meeker: And so you said that there was a mistake? Were you just talking vaguely?

07-00:45:17
Day: I'm being judgmental when I say that. I used to call it the Holy Grail. This was a faculty that had been searching for the Holy Grail. Well, actually, the nation had been searching for the Holy Grail of pharmacy and it was just always beyond their grasp. Nobody had the slightest notion of how to get to it. They could see it. They could see it in the sky, fluffy and non-existent as an image. But they didn't know how to get there. So in trying to do this Holy Grail thing, they said, "Well, our Holy Grail this year is to train the pharmacist to be very strong in chemistry by this decade or this two decades because he's buying crude drugs and he should be able to analyze those crude drugs because they're going to be contaminated." And they were in the 1890s, 1880s, okay. So the curriculum became how to put these things together but also chemistry entered the curriculum at our school and other things. But rather than being the future of the pharmacy, professional pharmacy, what was going on also was the manufacturers were beginning to do a lot of these things even in the early 1900s. And so it was no longer important for the pharmacist to be able to analyze these things. But he had the chemical background now and it was a part of the curriculum. I don't know if we ever entered the entrepreneurial phase, to where we felt we were training businessmen. I don't remember whether we did that or not. I'd have to look into the 1920s because that's when it would have happened. That's when everybody across the nation was saying we are the future of the profession of pharmacy. We got to train these guys to get out there and make money. And I don't think we ever quite

entered that because we never, ever had a strong wing of our faculty that taught how to operate a drugstore. We did. We had taught the course but it was not a major focus.

Then we went into the phase of drug product formulation. And I don't know if others would characterize it that way but I do. And that was our next Holy Grail. And Sid Riegelman's dream was that we would take over the pharmacy industry, in a sense that we would become developers of their products because the people that were doing it were chemists. Upjohn was hiring not a pharmacist to do their drug products, they were hiring a PhD in physical chemistry or some such thing as that. So Sid said, "Why should it be that? Why should that person be retrained?" But that wasn't the only thing Sid ever saw and I never would pretend to be a person who could climb inside Sid's mind except to see what he did. I saw what he did, right, and so I can appreciate what I think he was thinking. So we had these things that I call mistakes but they were the most benevolent kinds of mistakes for two reasons. Number one, our intentions were good. We were trying; other schools weren't. They just sort of sat there and did what they'd done the previous fifty years and thought that they'd be doing it the next fifty years. I'm absolutely certain if you'd interviewed a faculty member from a lot of schools of pharmacy in the 1940s about the future of the profession of pharmacy, well, pharmacists will have automated counting machines. It would be directed to the dispensing role. And they'll have a big storefront and a drive through. It was this big pie in the sky sort of thing. Well, I mean, some of those things are true. They did happen. But they would have said that's it. The future is in getting the pill or the liquid to the patient.

We never said that. We said, "Yes, that. Yes, that but there's more to it than that." And that's why, as I say, they were benevolent mistakes. Benevolent mistakes, number one, because we were trying. We were honestly trying. And number two, each one of them gave us a toehold in an area that ultimately became the whole picture of the pharmacist, not the specialization that we saw. That specialization was incorporated as a probability and possibility within all of our graduates. So, now, why did my course survive? I have no clue. I eventually was the one that killed it. I felt it was a historical course and I felt that history was important, too. And this is misguided on my part, and I would admit to it. I felt there was something in passing on to every pharmacy student the same things that every pharmacy student in our school before them had experienced and some of them had actually done. That sounds silly. And eventually I realized it was silly because it was expensive time. They could learn those things when they graduated, after they graduated. I felt that pharmacy compounding had become a specialization and that they could learn those after they graduated. And, yeah, this was historical and the kids will tell you, oh, it was fun and games. They really loved doing it. They really did, and they kind of bemoaned it when it went away. But it was an expensive use of their time at a time when we couldn't afford to do that anymore.

07-00:50:43
Meeker: So one final question on this constellation of things. You had said that the fourth year curriculum was what became the clinical year and that had an impact on—

07-00:50:57
Day: And that was phased in over a many year period, yes.

07-00:51:00
Meeker: How did that impact the life cycle of courses that you taught?

07-00:51:07
Day: Well, the course I taught was three courses all aimed toward the same sort of thing. They were reduced. The laboratory was reduced from two to one unit, as I recall, out of a four unit. My course was always attached to a course called biopharmaceutics and there was a lecture portion of the course, which was in many cases coordinated to the laboratory but not totally. But the laboratory course was basically a primer on how to be a pharmacist. I always used the lectures in the compounding course for this purpose.

07-00:51:38
Meeker: So this is the pharmacy 127 course, correct?

07-00:51:41
Day: Well, it's 115, 116, and 127. Eventually it was 115, 116—

07-00:51:50
Meeker: It was a year-long course?

07-00:51:51
Day: It was a year-long course. It had been longer than that. At one point I took over 127, which had been a separate course. I taught three quarters in pharmacy, 114, 115, and 116, I think, that eventually was scrunched into pharmacy 115, 116, and then when Paul Lofholm retired, 127. Which was the so-called dispensing course, which was, when it was first initiated in the 1800s, the capstone course. And it was just an advanced compounding course. But long before I took it over, Dick Penn and Paul Lofholm had begun to evolve that into something else. And when I took it over I evolved it into something else again, to where the emphasis was on things that went on in the profession. But anyway, that's not what you're asking. So it was shrunk over the years. There used to be three units of laboratory. Used to be four units of laboratory in the second year and then more than that. It was a full year course in the senior year when it was a semester system. That was shrunk down to, in my course, the courses I taught, when we went on to the quarter system, it was 114, 115, 116, as I remember. That was shrunk down from two units of laboratory to one unit. And dispensing had been two units of lecture and two units of laboratory. That was shrunk down to where we didn't actually eventually teach compounding anymore in the course. So those courses were scrunched and eventually all went away. So we don't teach compounding at all. Although I was not a part of the curriculum decision, except I voted for it,

I wasn't the person that argued for that. I had pretty much planted the seed because it was no longer possible to teach it because I unilaterally, and I do admit to this, decided to demolish the laboratory and turn it into the IRC, the informatics resources center.

07-00:54:22
Meeker: Computer lab?

07-00:54:23
Day: The computer laboratory. But please don't call it that. It's an instructional learning facility. I had to fight the university to get them to stop calling it a computer laboratory because that was no-no. "No, we don't want another computer laboratory," they said.

07-00:54:36
Meeker: Informatics then.

07-00:54:37
Day: It was an informatics resource center. We searched around for months. I searched around for months for a title of that thing. What were we going to call it? Didn't want to use the word computer.

Begin Audio File 8

08-00:00:00
Meeker: This is Meeker interviewing Day and this is tape number eight. What I actually want to talk a little bit now are some of these contextual issues about what's going on. I know that you weren't working as a clinical pharmacist in the hospital, so maybe you wouldn't have been on the front lines of this kind of issue. But the Parnassus campus right there, 1966 through 1972, is at ground zero of the Haight-Ashbury really. And I'm thinking about the video that you were in in '68 and where you performed as the patient and one of your colleagues was the pharmacist taking the—

08-00:01:10
Day: Robert Miller.

08-00:01:12
Meeker: Miller. Taking the entry interview about your history of taking different pharmaceuticals. That makes sense. But what happens when you are now surrounded by a population of kids who aren't just taking aspirin mixed with a heart medication, they're taking aspirin mixed with LSD and methamphetamines. Did any of that immediate context of what's going on around drug experimentation in the Haight have any impact on the kind of conversations that you had with your fellow pharmacists or perhaps was there any leakage of those conversations into the teaching curriculum?

08-00:02:03
Day: Yeah. Well, remember, Haight-Ashbury is only about six blocks from the university. So we were involved in the Haight-Ashbury clinic from its very beginning.

08-00:02:12
Meeker: Okay. You as UC staff or—

08-00:02:16
Day: I, in the beginning as an individual, although as an individual who organized rather than actually performing on site. I only did a little bit of work on that and it was frankly only a couple of hours. Doesn't even count. But, first of all, the Haight-Ashbury popped up as a notion by David Smith and a couple of other people that we're going to provide healthcare. And what was happening was that I visited the Haight-Ashbury right in the beginning because it was interesting and we had had some street people asking us should they take this drug, and those are other stories. But I don't remember who invited me or whether I invited myself, but I went down there and saw that they were trying to dispense medications and that they were using drug samples that they had collected from various sources. In those days, when a representative from a company, then called a detail man or detail person, went to a physician they always downloaded bundles of free medication in little envelopes of samples. They were sometimes marked samples, they sometimes weren't, they sometimes stamped it. But the way they left an impression with the physician was to give him or her a sample and say, "You know, you can use this as a starter dose, doc, and give them a prescription." So every physician could take you into—and physicians, most of them, as far as I know, maybe all of them, said, "Okay, give it to me," and they'd throw it in a box someplace. Some of them would actually use it. Others of them, like a guy named Saslaw I know, had a room probably as big as this area stacked high with samples because he never threw away anything, didn't want to throw anything away.

So I went down there and I saw this—what they called the drug room, which was basically where they went to get medications to give to the people that were there—there were samples everywhere. There were just bags, bundles, stacks. And so my first involvement was to suggest—this is the summer of '69, I think—that we get some pharmacy students down there to sort through the samples, to categorize them, to throw away the ones that were obviously outdated or falling apart, to organize them according to category, according to similarity, according to the same drug, because they were just all over the place. And I talked to a couple of students, David Adler being one of them, and they went down there and they actually did that and then they began to do a few other things. But I don't know to any great extent what that was because I was not there, okay.

So when you went to visit the Haight-Ashbury clinic, you sometimes had to crawl past kids that were just knocked out of their heads on drugs. And so that gave birth to the notion that maybe we should get involved in education. I

remember being visited by a couple of kids, they were maybe eighteen, nineteen, I call them kids, twenty, they were obviously on something and they had got this wonderful drug and they wanted to know if we could identify it so they could get more of it. Okay. And we said, "Well, what is it?" I had one of my colleagues with me, too. I said, "What is it?" "Well, we don't know." "Where'd you get it from?" "Well, we bought it from this guy." "And what did he tell you it would do?" He said, "Well, he wasn't certain." "But you took it anyway." So we began to get a notion that the drug culture was experimental. "Give me something and whatever it is, I'll try it and see what it does." And so they ate the damndest things. They drank mouth wash, there was a bath capsule that had soap in it, fortunately because soap doesn't kill you, plus some kind of an essential oil in it, that when they swallowed it, the capsule, chewed and swallowed it—how they did that, I don't know—it gave them a high. They were learning to take dextromethorphan, the stuff that's in a cough drop. They were downing that in huge doses—so it became obvious to me they were experimenting. It became obvious to us that they had gone into this thinking that all drugs are safe. And so we decided that it was important to educate students, young students, as to not the evils of this material, but what it was capable of doing and hopefully not to take it in the first place. Okay. Because it wasn't just LSD. That was the start. It was just all sorts of stuff you wouldn't even begin to believe, and it had names like crank. Oh, crank was something else. But it had names like hog and other stuff which turned out to be an animal drug that gave them a high.

So our students fanned out not only to the Haight-Ashbury where they volunteered, and fortunately some of our graduates did it, too, and one of our faculty members did it, and I don't remember who that was. But one of my classmates put in time at the Haight-Ashbury clinic to be a pharmacist on the staff, to volunteer his time to help the students organize the room. And I asked the Board of Pharmacy to stay away from it and they did. They had heard about it. They had called me. "Bob, is it true they're dispensing drugs?" The Board of Pharmacy regulates drug dispensing. And they called me and said, "Well, we're thinking of checking them out." I said, "Would you leave them alone for a while, anyway? Let them get established, because they're doing a good thing, okay." And the Board was pretty benevolent at that time. Let's put it this way. They were willing to look the other way, which is what they did. And it was many years before I think they even went near the place, and that was only when its pharmaceutical services began to be a little bit more organized. And to what extent they did, I don't know because I wasn't in the facility. It wasn't something I went out of my way to discuss with a Board member because I thought any stimulus would only encourage them, the more conservative of them, to look into it.

So in any event, there was this drug room and we began to teach it in the curriculum. Our students went out and gave lectures to grammar schools. They actually prepared video tapes to assist the students in understanding

what these drugs did. Students as low as second graders, third graders. We were invited increasingly. Our students received a national award for that.

08-00:08:42
Meeker: Do you recall what those presentations included?

08-00:08:48
Day: It was just basically a talk with the students about what a drug is and what drugs do when they're used correctly and what drugs don't do when they're not used correctly and the kinds of drugs which brought in experiences which could be harmful to them. I don't know if they went out and said, "Don't do that." The efforts of the students—the students were also pretty advanced, too—they were to educate whoever was listening. It could be adult audiences. They did adult audiences, too, as to what these drugs were. LSD, what it did in the human body, what went on. What were the things you had to worry about with a person on LSD or hog or overdosages or whatever they were. Marijuana, heroin. But it was stimulated by the Haight-Ashbury because there it was going on super, super, super concentrated. These kids were zonked out of their heads when I walked up those stairs and they were all over the place. But I never felt threatened. They were just loving and they were just having a wonderful time.

08-00:09:59
Meeker: I remember actually, and I probably saw this in elementary school or something, and it sticks with me. It was horrifying. It was a video movie that was shown to us and it was about PCP. And I don't remember much about it but it was probably filmed in San Francisco and it was about some young guy who basically loses his mind on it. And to this day it sticks with me, more so than any of the Nancy Reagan "just say no" messages when I was also growing up. That had a very clear message that if you take this drug, then you could suffer these profoundly negative effects. There was also maybe another strain of education around narcotics along these lines that says we recognize that people will take drugs and our approach is going to be if you do take this drug then this is how it should be done or if you're going to take this drug, by all means don't take it in concert with this other drug. Was it one or the other or both?

08-00:11:11
Day: No, it was both, but it was tailored. The young kids, you don't want to give them a reasonable alternative, like this is the way you should take it, okay. It's been so long since I've even thought about this. I think the emphasis was this is what the drug can do and this is the bad stuff. Okay. Because all those drugs, as far as that time, were bad. But what they also believed, the pharmacy students, because they came up in this culture, is that these weren't criminals that were taking the drug. They were people. They were addicts. Some of them were addicts, morphine addicts or heroin addicts or whatever. Cocaine really was not a big drug then. Really was not. It was speed, amphetamine, meth. Those were the big drugs. When they talked to adult audiences it was I

think more of a—and they tailored it. It was more of a, “This is what it can do and this is what it can do bad and if you’re going to do this, this is what you should be thinking about.” Like, “don’t take LSD in a closet alone.” That sort of stuff.

And I think in the very beginning there was this kind of like accusatory attitude. Like, oh, bad people are doing these things. But I think as the students became acquainted with the topic and the people, and that was very, very soon, their material changed. And, as I said, they received the national award for this. They were the first group of pharmacy students in the nation that had done this. It was a pharmacy award they got. They got an award that was awarded to organizations, national pharmacy organizations got it for their campaign in stamping out smoking or something like that. And these kids got it.

08-00:12:59
Meeker: What award was it? Do you recall?

08-00:13:03
Day: It was an AphA award.

08-00:13:05
Meeker: It’s a public service medal or something like that?

08-00:13:07
Day: It was. That was actually what it was called. I think it was called the public service award or the public education award. And it had, up to that time, had been given to organizations. And we were an organization, only a really small one. There used to be a branch of APhA called SAPhA. Student American Pharmacist Association that is now called ASP, Academy of Students of Pharmacy of the American. But in those days it was SAPhA.

But in terms of whatever award it is they gave them, from the very beginning I think our students had the attitude that this could happen to anyone rather than it simply happens to criminals. They only had to go down to Haight-Ashbury to see that the people who were zonked out of their heads were just kids like them, who were not—

08-00:14:37
Meeker: And certainly, if they’re twenties, probably they knew a few people who—

08-00:14:45
Day: Probably.

08-00:14:45
Meeker: High school friends, college friends—

08-00:14:47
Day: Probably some of them did. God knows, one of my classmates smoked marijuana. Can you believe that? Smoked marijuana. Because we were taught no, no, no, no, no, no.

08-00:14:56
Meeker: Well, that's a medicine, right?

08-00:14:57
Day: No, no, no, no. Not in those days. No. God, you smoked marijuana and the next thing you want to do is go for heroin [sarcastic tone].

08-00:15:03
Meeker: Yeah, okay. So on a similar path, the history of the impact of the new left social movements on education, administration, social life at UC Berkeley is pretty well known, beginning at least with the Free Speech Movement in 1964, going on through the anti-war movement, People's Park, the movement to create ethnic studies, all of these kinds of things. UC Berkeley is a real hotbed of what's going on and the interaction between social movements and higher education. You were at UCSF this entire period of time and I'm wondering if you have any insight into the degree to which UCSF was similarly impacted and influenced by new left social movements mid-sixties to mid-seventies.

08-00:16:10
Day: Well, the Free Speech Movement in Berkeley happened—when was that? That had to be like '63, '64.

08-00:16:20
Meeker: I think it was '64 but it might have been '63, yeah. [The Free Speech Movement occurred during the 1964-65 academic year at UC Berkeley.]

08-00:16:24
Day: It was somewhere. I don't remember. I remember Reagan made it an issue. And that was an entirely new experience for anybody, a public university in turmoil. It happened in Europe but it had never happened in the United States, as far as I can recall. So it was kind of like, "Oh, gee, what's that all about?" You're asking what was going on in UCSF. It didn't come to UCSF for lots of reasons. Remember that UCSF always was a healthcare campus. It was never a general campus. So what did it get? It always got an older student. And these guys were going to be something. I don't mean something in the ways of, "Well, I'm really something." But they were going to be something. You didn't come to the school of pharmacy thinking you were going to work in a shoe store. You knew what you were going to be when you graduated, okay. Physician, nurse, dentist. So an unusual collection of students, okay.

08-00:17:20
Meeker: A professional track.

08-00:17:22
Day: A professional track. So they knew what they were going to be doing. And I think to some extent in the beginning they were so focused that they were sort of oblivious. If you were to ask me what our student body was like in the sixties, early sixties, I'd say conservative. Not in today's sense. They were more concerned about where the next beer was coming from I think than what was going on in Berkeley. It was a phenomenon for them that wouldn't take place on the campus here. I think that there were individuals who got deeply committed at that time to what was going on there, but by and large, I don't remember it causing a great deal of turmoil on our campus. I do remember the impact it had on me and the impact it had on me was that it made me for the very first time think about what demonstrations were, what protest was. I had never thought about it before. I had never thought about the concept of a protest as a positive thing. I had been, I think, of a frame that anything that was contrary to the American flow, as far as I saw what it was, was not nice. So I began to think about it and I thought about it and I began to realize that. And I don't mean to blow this up in red, white, and blue but it was for me, and I think for most of my fellow faculty, an expression of democracy. We were not of an environment where everything was rigid. Well, that's not true. It was rigid within certain contexts. But thought was never restrained in the arena in which I was working.

Now, remember, this is the time when I was also a pharmacist. I was practicing as a pharmacist and teaching at the university when the Free Speech Movement broke out. And so I began to think about it. And I think that whatever it is, the influence of my wife, the influence of the university, some thinking about it, I think that most people at the university level had an entirely different take on it. We deplored the destruction of property. We deplored the fact that people were getting hurt. We deplored all of that but the concept of it, protest, I think was so strange and yet so new, and something which none of us were repelled by. In fact, I nearly got in a fight with a dentist in our building at Westlake Medical because he didn't understand. Thought they should take a machine gun and mow them all down. And I tried to explain to him what was going on and he said, "This is a protest." He used to use the word protest like some people would use the word shit. This is violent. This is a pile of—well, anyway, that's another story. So we nearly got into a fight over it. Physically I was going to go after him. I was stopped.

08-00:20:24
Meeker: When you're talking about protest, there's many different ways of protesting.

08-00:20:29
Day: Well, I'm talking about what was going on there with Mario Savio. They were taking over buildings, they were doing all of that. It was a whole new concept for me and maybe for others. And I think this followed what was going on in the civil rights movement. This followed it. I don't think it was before it.

08-00:20:42
Meeker: Correct, yeah. A lot of those who were heading up the Free Speech Movement had been in the freedom summer, for instance.

08-00:20:49
Day: Right. See, but you had to do a cross-section with me prior to the [Selma,] Alabama march and prior to all of that. I was probably as racist a guy as there was, not knowing and not thinking there was anything wrong with my attitude. No, I wasn't as bad as my dad. My dad was a racist. I just didn't think about it. But it's like anything else. When something happens you begin to think about it and you begin to think about what's right and what's wrong, things you sort of take for granted. California was never a Jim Crow state. It never was. It never had a "for blacks only section" in movie theaters. They had smoking sections. That's where people went to smoke, where they were relegated. So all of those things together. So for me this was just another chapter in my learning a little bit about being a human in American society. And our campus did not protest, did not have anything going on then, but it did discuss it a lot. And it discussed it, like happens in academic discussions, a couple of people taking strong positions, being argued out either way and kind of like, "Oh, okay." Because that's the environment I'd gotten used to at UCSF. One of you got a different opinion, you let it out. And if somebody disagrees with you, it's not a mortal sin. Whereas in society at large, somebody disagrees with you, it's almost grounds for a fight. And so anyway, to answer your question, not a whole lot happened on our campus when that was going on, except a greater understanding on my part, and I think probably of many people, of what protests was, what was going on in Berkeley. We deplored the destruction but we saw it as something that rather wasn't necessary and didn't even know if it was necessary but we accepted it as the way things were at that time. Reagan, as you know, blew it into something else entirely.

08-00:23:02
Meeker: So does this ever come home to UCSF? Later on in the sixties. You had mentioned the Kent State shooting—

08-00:23:12
Day: The Vietnam War and the sequellae to it were the first big events that the campus got involved in.

08-00:23:25
Meeker: Okay. How did the campus get involved with this?

08-00:23:27
Day: Well, slowly but surely. Now, this was a healthcare campus and its students were older when the Kent State stuff went on. The student body had tended to evolve a little bit. A lot of these students came out of Berkeley. As always, a lot of our students come out of Berkeley, UCLA. And so when the Vietnam War broke out, it was like everybody else. We didn't know a whole lot about it. That was during the Kennedy years. We talked about it, we heard the stories about how it was necessary. We got the domino theory discussed for

the very first time. And there were marches and some of us went to them. There were discussions. But it really didn't come to a head until the National Guard fired on students in Kent State. That struck home. That act, totally unbelievable, that American troops, even the most, I don't know what to call it, even the most fanatical of them, could fire on an American student, a fellow American for doing nothing other than protesting. Remember this thing? Protest. A lot of people saw that as arrogance that has to be squashed. And I think that's still the prevailing thinking today, too, insofar as it comes to destruction of property. Martin Luther King I think was killed before that.

08-00:25:15

Meeker: Sixty-eight, yes. Kent State I believe was '71 [the shootings occurred on May 4, 1970].

08-00:25:20

Day: Something like that. Martin Luther King's death caused a real pall. That's what began to make a lot of people begin to question their own racism, more so than any other event. Selma didn't do it. Selma? Am I using the right—

08-00:25:42

Meeker: Yeah, Selma, Alabama.

08-00:25:44

Day: Well, no. I had an aunt-in-law whose name was Selma. I wanted to be certain I wasn't confusing her.

08-00:25:48

Meeker: Oh, yes.

08-00:25:49

Day: Selma definitely didn't do it. She would have been opposed to it, the march. So Martin Luther King's death was the first depressing event. No, was one of the many depressing events going on at that time, but Kent State triggered everything. And with that, the campus reacted by shutting down. It didn't shut down in that it closed its doors and everybody went home and commiserated. It shut its doors in that teaching stopped. Unessential services stopped. We all unified and we did—well, not all of us. Some students didn't know how to react to it and they did go home. But we all unified. We gathered together in the gymnasium of the campus, all the people who were feeling very badly over this whole thing and wanted to do something, met. And that was workers, that was faculty, that was students, couple of patients, the administration, the chancellor, the dean. I don't know how many days we convened like this but it was event because there was a whole lot of anger tied up in this. People got up and talked about throwing bricks through windows, burning. They did. Actually got up and said, "We ought to show them that…," I forget exactly the context. But a brick, a burning bus, or something like that was suggested. This crowd was not of a mind to do that sort of thing, but there was anger and there was fear that what we'd become, and there was a focus on the Vietnam War such as we had never had before. Everybody had been focused on it

before but it—so we met for I think it was a week, at least. You wouldn't believe what we talked about. And it wasn't a talking session, it was an educational session. It got to things like what does anything in life mean? What does an institution mean? What does money mean? It got into the damndest things. When it left, when it went away, that is when classes re-instituted themselves, and we told the students that they would be held responsible for the material but they would have the opportunity to choose on how to be examined And they would have the opportunity to pick the kind of grade they wanted. Not the grade but the kind. If they wanted to go pass/no pass they could do that. If they wanted to go for a letter grade, they can do that. Some students came up with a wonderful compromise. "I want to go grade unless the grade's a C, in which case I want to go PNP [pass/no pass]." It was marvelous. I thought that's really strength of character right there. But they asked for that alternative. And it wasn't all of them. Most of them chose the hard route. "Give me the grade. I'll pay for whatever it was that I missed."

But what happened when that was over is the campus was never the same. It's not the same today. My suit went into a closet and did not come out again for twenty years, twenty-five years. I didn't own a suit for that long. I grew a beard. Did I grow a beard because that's what one did? No, I grew a beard because it seemed unnecessary to shave. It seemed unnecessary to wear a suit. We dressed differently, the faculty. The dean himself eventually sprouted a beard. Laughed at mine and then he grew a beard himself. Because it was a form of protest in those days. I learned that when I went back east. I was countered by cops, by people on airplane that went out of their way to sit next to me to find out my political beliefs. Because I had a beard, was wearing a peace medal, had on a Nehru shirt, or whatever it was. I don't even remember what I was wearing in those days. Levi's bell bottom, sandals. The whole thing. I did go back partially because I eventually got a suit, but I attended a lot of Chancellors inaugurations in a pair of Levi's and a t-shirt, as a lot of people did.

The students stopped wearing white coats on the wards. The medical students began to dress more casually. I don't think they do that anymore because I think they are concerned about the reaction of patients.

08-00:30:40

Meeker: That one point that you just made about students ceasing to wear white coats on the wards is really interesting because it seems to me that just, say, five or six years earlier, there was a kind of hard won battle to actually get on the wards and to wear those white coats.

08-00:31:00

Day: Yeah. But I'm not saying all students. I'm saying some students felt comfortable not wearing what they considered to be the adornments of authority. The white coat turned people off. They saw it as a symbol of authority and symbols of authority were the things that they were at that time,

anti. If you can recall, that's the time when the word "establishment" was coined as a negative. That's a time when our students would appear before the dean with non-negotiable demands on how the curriculum must change. And there were a lot of kooks. When I say kooks, it's two particular people that I remember who came in and made these non-negotiable demands, and they were doing so because they were exercising what they considered to be their constitutional rights. But they were always behind the thing and it was pretty soon evident that they were simply shit-kickers. They just loved it.

08-00:32:02
Meeker: What kinds of demands were they making?

08-00:32:05
Day: Oh, this course had to be reconstituted immediately. See, there were two words that popped up then, "establishment" and "irrelevant." This is irrelevant. We had freshmen students come in and tell us our curriculum was irrelevant. And my reaction to them was, "Tell me where," because we would listen to them, and, of course, they couldn't. But "irrelevant"" was a word they had acquired. Well, we think we don't have to learn this. And I would say, "Okay, why? Why don't you have to learn that?" And they couldn't provide the answer. And I said, "Give yourself another year before you become an expert in what the profession of pharmacy needs. Wait until you're a sophomore, maybe a junior, maybe a senior, maybe until you graduated because you really won't know until then." But anyway, there were demands. I can recall giving a lecture and one of the two ringleaders, I called them part of the mafia, two of them, one of the two got up in the middle of the lecture and said, "Can you please stop lecturing on this? We've had it before a hundred times. It's totally irrelevant. It doesn't mean anything, et cetera." And I was shocked. I thought it was pretty good stuff. Remember I told you before I tried to teach aspects of practice, and I thought it was pretty good stuff. But it made me stop and I said, "Okay. Class canceled. Let me kick this around, okay." Because the class was quiet. This guy got up and I thought, "Well, okay. Nobody's getting up and saying he's wrong—." After class, the students came to me, two students came to me and said, "We're only two students but he's full of crap. We've not had that before and, frankly, I thought it was interesting." And as it turned out, five or six other students came up to me and said the same thing because they thought my feelings were hurt. My feelings weren't hurt so much as I was thinking like, "Well, I mean, God, I'm out of touch."

So the next week when I came back to class I said, "The class will continue as it was before but I want to tell you, the rest of you, okay, it's my understanding that you didn't agree with John," or Art or whatever the hell his name was. "Is that correct?" And it's hard to take a poll from voices. "No, we don't. No, we don't agree." So I said, "Am I correct in saying that?" "Yes." Okay. "You guys have an obligation. When somebody gets up and begins to do what this guy did, you need to give me feedback. Okay. I need to hear it then, not later, because I took it seriously. It didn't hurt my feelings, I'll tell

you right now. I was really going to reconstitute the course against my own, whatever it was, my own—"

08-00:34:50
Meeker: Knowledge.

08-00:34:51
Day: Judgement or whatever the hell it was. Instincts even. So the students were changed for a long time afterwards and that was the beginning of the activistic student within the school of pharmacy. We had not seen one before. The dean began to appoint students to committees to have a voice in the affairs of the school. I take it back. He had done that before but he had dis-intensified it. Jere Goyan appointed students to our committees before Kent State, but it became much more regular, I guess, after all this. So it had all sorts of changes, some of them almost immeasurable but in the long run being there. But most of it had to do with the fact that we got used to the notion that there would be dissent within the class and that they were to be listened to and evaluated. I think student evaluation of teaching came in about that time. My timetable could be off here. I'm not reliable from the point of view of being able to stack it up like a calendar but I think we got Keith Jacoby about that time.

08-00:36:12
Meeker: Who was that?

08-00:36:13
Day: He was an educational psychologist from Berkeley who assisted us in improving our teaching. And one of the things he did was develop for the school the SET, student evaluation of teaching forms that the students used and to some extent still use today, although they are modified. So we began to get part of the responsibility, part of the contract we had with students changed, that we should be responsive to their needs. We began to teach instructional objectives. We began to teach via instructional objectives.

And so all of these things, are they attributable to the Kent State slayings? Partially, because there's a lot of other things going on, too. The United States was on the move not only in terms of the war but in terms of change. Change in the way we listened to the radio, change in what we did with our time, changes that were technological, even in those days. And so there were a lot of factors that I think swept across the school stimulated by a lot of events but one of them, and a major one was Kent, Kent State.

08-00:37:22
Meeker: So these changes that happened. From your perspective, do you think that the result was a better educational situation, a worse educational system or perhaps a mixed bag of some better and some worse?

08-00:37:47
Day: It was what you said, a mixed bag. But I think it was predominantly in favor of good. Because what was established then, and what Jere Goyan had done

from the very beginning, what Mary Anne Koda-Kimble carried even further, was to basically propose the philosophy that if it's not broken, it needs fixing. Don't wait for it to break. That's too late. So we had always been in search of that Holy Grail and we now seemed to have come upon it. But the Holy Grail, itself, needed reshaping and so there was this, as I said—I don't think Mary Anne consciously operates on the basis of the philosophy I just stated, but if you think about it, if you knew about her administration and Jere Goyan's administration, it really was let's fix this before it's broken. Let's fix the profession of pharmacy before it's entirely broken. Because when he came back from that conference I mentioned during the last session, of health professions, and pharmacy wasn't present and they were talking about the future of healthcare and nowhere in the audience was a pharmacist, Jere was convinced that unless we did something, the profession of pharmacy might well become extinct as we know it. And as we know it, it did. It did, really, but it's because a mutant popped up, and that mutant was clinical pharmacy.

08-00:39:32
Meeker: Let's see here. It's a really interesting discussion about the transformation of pharmacy practice or rather the education at UCSF School of Pharmacy vis-à-vis the fallout of Kent State and moving into the 1960s. Maybe one of the things to talk about in this context is the transformation of the student body. It was very clear, your discussion before, that I imagine most if not all of your students that you entered in with were all men, right?

08-00:40:16
Day: No.

08-00:40:16
Meeker: No?

08-00:40:17
Day: No. It's never been entirely men, not even our first class. But men were by any margin the vast majority. The vast majority. There were seven women in my class of seventy-five. So 10 percent. And if you went back in history, you'd find that was pretty much the same number. Pretty consistent. My class was probably 15 percent Asian, maybe more. I'm pulling that figure out of my head—just as I sit there and think of the room. Could have been more. We had always had a reputation among the Chinese community as a place where you could come and become a professional. So we had that statistic long before any other school, even including New York with a vast Chinese population, as well. It helped that we had a vast Chinese population. Japanese, same sort of way. But in any event, getting it back to your—

08-00:41:18
Meeker: Well, I guess maybe one of the things to talk about is that in the late sixties, early 1970s, affirmative action evolved or changes, transforms is maybe a better way, from the original definition of it was simply taking affirmative steps to reduce discrimination in admissions, for instance, or to open up

admissions to people, women, and then people of underrepresented minorities. Later on it started to become a very clear program that was basically quotas. There were certain percentages of certain groups that were to be met.

08-00:42:02
Day: In the very beginning there was.

08-00:42:03
Meeker: Okay. Well, maybe from the vantage point of the administrative role that you were playing or on the faculty, can you maybe sort of walk me through how it was that that emerged and changed and the degree to which it influenced the makeup of the student body?

08-00:42:18
Day: Yeah. I don't know the beginning of it, okay. I can just tell you, probably jump into it somewhere along the line because I don't remember the beginning. I don't remember when it was that we decided that we needed to, from a fairness point of view, that we needed to pay attention to the statistics of our student body. I don't remember when that started. It was obvious by the 1960s that only rarely did we attract an African American student. I don't think there was a single one in my class. There was an American Indian, which was a rarity. Today we still are struggling to get American Indians—or Native Americans I guess is the preferred term, although I had a friend of mine call himself an American Indian recently—into the student body.

Well, we began to do that at a time when we became conscious of it. The Black Caucus at the UCSF campus and other influences, including the university's concern over discriminatory policies, begin to come to the front. And Jere Goyan appointed Bob Gibson, who's African American, sometime probably in the early seventies, maybe a little bit later than that, to recruit the word in those days was "minorities" to the school of pharmacy. And so we established criteria for doing that and relatively soon thereafter we also established a minority admissions committee, where if you were an identified minority, and in those days you could identify yourself as such, you can't do it today. If you were an identified minority, you would be processed by an entirely different committee. That committee could be composed of pharmacists and students who were of a minority ethnicity themselves. So they were automatically funneled into that group for consideration.

08-00:44:43
Meeker: Was there like a certain number of slots that they were given vis-à-vis—

08-00:44:47
Day: No, no. We had a target. We never had a quota. Some places did. We had a target. You sort of today have to want to increase your student body, do everything you can to attract, and you get worried if your percentage falls. You really want it to increase. I think it's a diffuse thing. In those days we didn't have quotas, we had goals. We didn't say ten. Let me think that one

over. I just don't remember. The minority admissions committee radically increased the number of students for the minority ethnicities that were admitted to the school of pharmacy.

08-00:45:37
Meeker: In response to this, I'm trying to get a sense is did the administration say to the minority admissions committee that, "Listen, we can take up to this number."

08-00:45:48
Day: No.

08-00:45:48
Meeker: There was no upper limit on—

08-00:45:49
Day: No, we were limited by the number of applicants we had. There weren't that many, first of all. Gibson would have to tell you that. No, I don't think they were ever told ten bodies, five bodies, four, three, two, one. The only bodies we ever, ever had a quota for were foreign applicants because at the time we were doing clinical pharmacy we really did become very provincial. This is something that's going to happen here and we've got to get as many of those guys out there as we can. I think the minority admissions committee was told, "Pick. You guys tell us, okay." The way the admissions systems work is the admissions committee made a recommendation to the dean. "These are the students we think should be admitted, okay." The minority admissions committee basically made a recommendation to the admissions committee but the admissions committee knew that it was not to tamper with that, okay. So when it included its list, it would adjust its formulas. We wanted to accept no more than seventy-five students or a hundred or 125, but it was done as a consortial effort. But it was never, in a sense, if you will, a numerical problem because they were coming up with three, four, five.

08-00:47:05
Meeker: So very small numbers.

08-00:47:06
Day: Very small number in the beginning because they were very critical of the applicants. Those guys were probably more critical than a regular committee would have been. I don't know.

08-00:47:13
Meeker: I guess that's kind of what I'm getting at: Did it seem to you that the minority admissions committee had substantially different admissions standards than what the regular committee had?

08-00:47:27
Day: I was chair of the admissions committee when some of this was going on. They were willing to consider a candidate who the regular admissions committee might have rejected right away, a candidate whose grades were

faulty. But they would look for trends. They would look for social economic conditions that may have predicted that this is the way this student would have performed in college. They looked for humanistic characteristics, I think, other than those which the regular admissions committee looked for. That isn't to say that some students didn't get in who wouldn't have gotten in, I'm fairly certain, under the regular admissions system. I think what the admissions committee did was to say there are other factors than just being a real good student, than just coming from a good, white, middle class family, than just doing this. Our admissions criteria weren't that well defined. So they admitted students, I think in some cases recommended admission, and they were admitted, who would not have made it had they been in the regular admissions system. All of them? No. Some of them? Yeah.

08-00:48:43
Meeker: Was this controversial amongst the faculty and the regular admissions committee?

08-00:48:47
Day: No, no. There was an uneasiness about it in the beginning because it was an experiment, but it was accepted. Whether in the long run it made them even more uneasy, I don't know.

08-00:49:03
Meeker: Was there any tracking about the degree to which these students faired or—

08-00:49:06
Day: Yes, yes, yes. It was imperative we do that because at the top of it we had a responsibility also to the public at large to make certain that we weren't graduating practitioners who were less skilled than the others. So, yes, they were watched. Did they perform as well or did they perform as a group more poorly? Therein was the lesson that some students who came to us with mediocre grades did better than students who came to us with higher grades. Okay. Were there problems? Yeah, there were a couple of people that were just on the verge of flunking out. And did any flunk out? I honestly don't remember. But I do remember that way back when we had this policy, stated or otherwise, that we don't dismiss students if we can possibly avoid it. So if you're in trouble academically, let's get you help. Let's get you tutors. And that has gone on for as long as I can remember. So if an African American student was in trouble, he had access to the same services that a Caucasian student had. Did Caucasian students get in trouble and fail? Yeah. Ones that came in with higher GPAs, did they get into trouble? Yeah. Did we have some failures? We did. But by and large, it proved that the admissions criteria used by the minority admissions committee was sound for the most part. And some of them became sterling graduates. One of them got the Bowl of Hygieia Award. He was in the first group. Eddie Boyd got the Bowl of Hygieia, which is the highest honor we can give to a graduating senior, okay. And I think another of them did a couple of years later and she went on to become a member of the faculty down at UC San Diego.

Now, would those students have been admitted, the ones who got the honors, would they have been admitted if there hadn't been a minority admissions committee? I don't know because we had such a committee. And I think Eddie Boyd eventually became a part of that admissions committee, because remember, I said it was students and faculty who were on the committee.

08-00:51:11
Meeker: Was gender treated in the same way that race was in these committees?

08-00:51:15
Day: No. Gender solved its own self. Gender was a self-solving solution. Because what happened is with clinical pharmacy, with a lot of other societal things going on, where more women were going to college, were graduating, were marrying later, a whole series of factors, the fact that they were very good students, changed their admissions. We reached equity for females in our student body in, I don't know, 1981 or something like that, because clinical pharmacy now existed, too, and it was attractive. So I don't think we ever discriminated against women, we just never recruited them. And I think we did eventually recruit them, but only from the point of view as to point out in our recruitment efforts that this was a profession for men and women. And as we developed clinical pharmacy, as more women entered college, increasing the pool, and we checked it from time to time to make certain that our statistics and our student body, did they reflect the applicant pool. And that is to say if 30 percent of them were female, was our student body 30 percent later on. And in a relatively short period of time the statistics were lopsided, that there was a higher percentage of acceptance among females than among males. Not radically different but a few percentage points. Maybe five. Significant. And we did the same thing with the minority applicants and we were learning that the same number that applied to us, percentage-wise, got in. There were times when that wasn't true and we really, really began to question our admissions procedure. So it evolved over the years.

08-00:53:05
Meeker: What do you mean by that?

08-00:53:07
Day: Well, all of a sudden, if we had been getting six, we got three, we would really worry about that. What went on? We would try and find out what had happened.

08-00:53:18
Meeker: Meaning that they were admitted but they did not enroll or—

08-00:53:21
Day: No. For whatever reason, they weren't there. When the class opened up, there were only three African Americans or four and the pool said there should be six, according to the percentage of the applicant pool. So we would dig into it. In some cases we'd find out it had nothing to do with us, in some cases we'd find out that they didn't think that they could make it for whatever reason it

was. I don't "mean make it" but some were worried about it being a hostile environment for them. And in some cases we could come up with no explanation. You may remember that the kind of person we were trying to get then, when we paid it careful attention, were the same kinds of people that schools of medicine were looking for, that schools of nursing were looking. They wanted to increase their minorities, right? And so they were heavily recruited. The pool was still constricted in terms of the minority applicant. They used to call it the pipeline. The pipeline was still constricted. It squeezed through a much lower percentage of African Americans than Latinos, obviously, and other minorities than existed in the population. Chinese were never part of that pipeline problem, but African Americans and others were. And so when they graduated, the few numbers that graduated in engineering, in science, and the ones that met our pre-pharmacy requirements, they were recruited by MIT, by schools of medicine. And in those days, quite frankly, as one African American student told me, "Thank you." I was chairman of admissions. "I'm turning it down. I just wanted you to know," because I had interviewed the kid, "that I got an admissions letter, as you well know, but I'm turning it down." I said, "Why?" He said, "I just got an offer of admission to the school of medicine at UCSF," and he said quite bluntly, "And frankly, if I had to be one of two things, I'd rather be a physician," because you had all the glamour. Well, whatever reason. I can't climb inside his brain.

So we still struggle with that, if you were to talk to the current dean. Well, I don't know. I don't know what happened this year. But I know we still pour over those statistics furiously because, again, the pipeline is still not a free flowing pipeline. Women now comprise 80 percent of our student body, 75 percent, something like that. Yeah.

08-00:55:49
Meeker: Wow. Is there a sense that there needs to be more men?

08-00:55:55
Day: No. Well, you'd have to talk to the women about that. No. Not the faculty. The faculty doesn't feel that at all. At least I don't think they do. It's never been an issue. Look at Mary Anne Koda-Kimble. She shouldn't be a pharmacist? I mean, come on. How many Mary Anne Koda-Kimble's are there in a student body? We would hope every one. How many Paul Lofholm's are there in the student body? We would hope every one.

08-00:56:27
Meeker: After legislation changed admissions in the University of California system in, I think it was the 1990s, right?

08-00:56:38
Day: Yes.

08-00:56:39
Meeker: During that period of time, say the seventies and eighties, were there any substantial changes to the minority admissions practice or committee?

08-00:56:49
Day: As a result of—

08-00:56:50
Meeker: Well, now as a result of learnings or changing opinions about the best way to do this.

08-00:56:57
Day: Were there any changes?

08-00:56:58
Meeker: Yeah, yeah. Any changes during the period of time that this committee would have existed?

08-00:56:59
Day: Well, no. The minorities admissions committee did increase the number of African Americans, Latinos , and Filipinos that we had in the student body. They did.

08-00:57:12
Meeker: And sociologists and historians, as well, are very interested in this, understanding about what the different groups are. You brought up Filipinos. That is kind of interesting. Sometimes demographers will place them in a category of Asians, sometimes they'll place them in the category of Latinos. Actually less often but there is—

08-00:57:39
Day: We don't do that.

08-00:57:40
Meeker: Okay. Did you follow the sort of typical minority categorization scheme that went white, black, Latino, Asian, and American Indian? Is that roughly how it was done as far as trying to find statistics or was it more nuanced?

08-00:58:02
Day: Well, it was kind of like white, brown, and tan skin. It was like that. White and then brown and tan skin. So if you were Filipino, you were Latino, you were African American, you were part of that minority thing. Filipinos, as far as we were concerned, were never considered Asian. We never considered them Asian because there was a definite difference. Hell, we didn't get that many applicants from the Filipino community. There were very few college graduates, same thing as the Latino community, among them. So the applicant pool was suppressed accordingly. And it was obvious that they were out there in higher numbers than we were getting, even as applicants. So our goal became to improve the applicant pool, the numbers. The minority admissions committee was disbanded long before the university threw away preferential

admissions. The Committee said, “We’ve done our job. We trust the system to function correctly now, so we’re closing shop.”

08-00:59:06
Meeker: Roughly how long did it last for?

08-00:59:08
Day: Oh, I don’t know. Bob Gibson could tell you. From the mid-sixties probably to the late seventies I would guess. Maybe shorter, maybe longer. I just don’t remember.

08-00:59:20
Meeker: So well before it would have been impossible to continue based on current legislation?

08-00:59:26
Day: It would have been, but they disbanded before that.

08-00:59:29
Meeker: Okay. Interesting.

08-00:59:30
Day: Which doesn’t say that we didn’t have a definite concern for minority students. We still actually will try and make certain, or did, and I don’t know what they’re doing now—we would always make certain that one of the evaluators was a minority ethnicity. One of the people who evaluate anybody whose identified as such. And it’s hard for us to identify. We have to do it by names. Just because we are convinced that there are things to be seen in a population that somebody without that experience cannot see. And it’s never proven to be a problem or unfair or whatever, but we want to make certain that in fairness, that a peer of some kind, although maybe our faculty are not peers in that sense, take a look at them.

[End of Interview]

Interview #5: March 6, 2013
Begin Audio File 9

09-00:00:28
Meeker: This is Martin Meeker interviewing Bob Day. Today is the 6th of March 2013 and this is tape number nine. So let's get started. We are now moving with all deliberate speed into the 1970s and I want to get a sense of the expansion of your duties as a teacher and lecturer and working in an administrative capacity. But there are some developments that I'd like you to comment on in the general realm of pharmacy practice that happen in the mid-1970s. And it's really just sort of seeking your opinion on it and getting a sense of the degree to which you think this development is part of a predictable natural evolution of pharmacy practice or if it is recognition of a new status of pharmacists in the United States. And that was that pharmacists in Indian health centers, so the reservation health centers across the United States, are given the right to prescribe. And I don't know exactly what year. I didn't write this down. But it's in the early to mid-1970s. And I don't suspect that you would have played any role in the development of this. But do you remember when this happened?

09-00:02:14
Day: The Indian Health Service thing?

09-00:02:15
Meeker: Yeah.

09-00:02:16
Day: Yes. Well, yeah. First of all, it happened after clinical pharmacy had been invented and it happened after people had already learned that there was a potentially new practitioner on the horizon, if not on the horizon, already there. Now, remember, our initial graduates of the program had a limited amount of clinical pharmacy training. But that which they had was not simply an evolutionary transition, it was, as I said in a paper I wrote, a nuclear assault on the status quo. It was so different from what I had been trained to be as a pharmacist. It was so different in its ethical composition from that which I had trained, which was basically don't interfere with the patient-physician relationship, which was held to be a relationship seemingly made in heaven. [The following was spoken in a whimsical voice and intended to be satirical:] That meant shut-up. Don't tell the patient anything that could disturb this fragile patient—that all of medicine was based upon would collapse if pharmacists said, "Well, this is what you need to know." It would destroy the relationship. It truly was that strong a sentiment. And you would catch it in the medical literature. In the beginning, whenever pharmacists would write something that would come to the attention of some physicians, they would comment on it like, "Stay in your place. You're out of line. Get back in line. Pharmacists shouldn't be doing that. Pharmacists aren't being trained to do that." And there were journal articles written about it.

Jere Goyan, who was dean of our school, somewhere in that period of time, in the seventies, wrote an article for *General Medicine*, a throwaway publication sponsored entirely by the pharmacy manufacturers. And in the galley proofs, his article was edited because it said things that the editor perceived were offensive to certain physicians basically who saw themselves as head of all matters relating to drugs—and also to the pharmaceutical industry. So Jere Goyan was kind of like a rebel in his own right and he told them to publish it as written. And, as expected, he got a few letters from outraged physicians, one of which was a carbon copy of a letter the physician wrote to the Regents of the University, suggesting that Jere be removed as dean because he harbored these totally unacceptable ideas and was dangerous.

But in answer to your question, the Indian Health Service picked this up on the basis of stuff that we had been doing and at that point in time other institutions across the nation had begun to adopt clinical pharmacy and began to call it that. Bill Smith, who's been mentioned by me a number of times, who was one of the key people in the establishment of our ninth floor project, went to Long Beach in the early development of clinical pharmacy. It was like it was a year and a half old, maybe two. And he went to Long Beach and established a full-blown clinical pharmacy program there at a time when it wasn't anywhere else in the world except at UCSF. That got a lot of publicity. Bill made certain that it got out there. Bill was a salesman on top of being a really competent and concerned pharmacist and he was able to sell clinical pharmacy even before it was one hundred percent proven. No, that's not correct. *I* think it was proven, but there just wasn't a lot of evidence around it yet.

So Indian Health, by the time the Indian Health came along, as I recall, Alan Chung, one of our graduates on the USC faculty, had done a paper in Los Angeles showing at the VA Hospital the cost effectiveness of clinical pharmacists. I don't remember what he specifically turned up, so what you're going to hear now is just total fabric because I'm not certain what his figures showed. But I think he showed something like one pharmacist could save three times his salary in drug costs if he was permitted to basically involve himself in the patient's drug therapy. Now, those figures aren't exactly that, I don't remember what they were, but they were impressive and it was one of the very first papers showing, at the very least, cost effectiveness. As I said, his name was Alan Chung and he graduated in the class of 1962. So he graduated before clinical pharmacy and then he went off to USC and began—like a lot of people—to catch the notion, catch the idea: "Yeah, that makes sense, let's do that."

So Indian Health Services adoption in certain areas, not all—as you may recall, Indian Health Service is not everywhere and I don't think it happened at every one of their establishments. But the guy in charge of the program at that time I think was a man named Alan Brands, who had discussed it with us and other people. I don't know who can take the lion's share of the credit for

his decision in terms of leading him to that idea or whether it came from his ranks, because, remember, we had students going into the Indian Health Service, as well. Not many, but some. It was considered to be, well, like a nifty idea. Remember, we're going through a "conscience" time now, the seventies, when the students are beginning to become more socially oriented, more socially concerned than, say, the prior generations, which was life was just one great happy big ball. Because that was going on as either an evolutionary or a radical shift in society at that time. Okay. Now, have I answered your question because I rambled so much I'm not certain.

09-00:08:25

Meeker: Yes, but I'd like to get into a little more detail on consideration of exactly what's happening. So what I'm understanding here is that Indian Health Services probably has a paucity of access to prescribing physicians. What you said is maybe the most interesting part, is in fact they did come to UCSF and probably other pharmacy schools and consulted to ask, "Listen, how do we deal with this situation whereby there are not enough physicians to prescribe all that needs to be prescribed?" So the solution is not necessarily to get more physicians but it is to recognize that there is a change happening amongst pharmacists and that we should see them as capable of prescribing in situations that the need really calls for it.

09-00:09:25

Day: Yeah. But I don't want to overplay our direct hand in that, okay. Because Alan Brands didn't come to the University of California and sit down and talk to us, okay. There were conversations with him but more so, I think, probably from his internal staff, that is, people who work for him. Remember, by the mid-1970s—and I'm trying to remember when that happened—by the mid-1970s, two or three schools had gone clinical pharm, Nebraska being one of them and being the first one after we. And then a lot happened in a very short period of time, and then a lot didn't happen. It was many, many years before all schools of pharmacy embraced the actual clinical pharmacy role. You will see in their catalogues clinical pharmacy mentioned, but what they did was strap the word clinical pharmacy on to some of their dispensing courses because it looked good and because they could get money under the capitation grants and such things as that.

But in the beginning, it was a very slow movement, as was the movement toward the PharmD program, the doctor of pharmacy as the entrance degree, because most of these schools, in fact all but a handful of them, were either post-baccalaureate PharmD or non-PharmD schools. They were BS schools. And they did a great job moving in the right direction eventually, but some of them fought the PharmD degree to the end. It had to be rammed up their ass or they would never have done it.

09-00:11:03

Meeker: So we're talking about pharmacists being given the authority to prescribe in these very specific circumstances and locations. Was there a move or a sense

at that point that maybe the next frontier for pharmacy work is that pharmacists should be given across the board authority to prescribe at the same level as a physician would?

09-00:11:35
Day: Yeah. I don't know. I don't really have a good answer to that question. If you would like to get the inside on what went on in the Indian Health Service, I would recommend you talk to Pam Salas. She's a graduate of our class of—I think it's early eighties, maybe even earlier than that. She's in the Indian Health Service, although she may not have been involved in the beginnings of it, she would certainly have a knowledge of the history of it. And another guy would have been the one who followed Alan Brands and it would have been Church, Dick Church, who was in charge of the Indian Health Service program. Those guys would have a better insight.

09-00:12:32
Meeker: Well, just speculatively, perhaps: What would it have taken as far as curricular changes to bring pharmacy students up to speed so that they could in fact be fully prescribing pharmacists? Or if they graduated with a degree in clinical pharmacy from UCSF in the mid-1970s, were they in fact already there?

09-00:13:03
Day: Yeah. They were already there. First of all, if you understand drug therapy, if you really know, you understand the impact of disease and drugs and how they interact and how to optimize dosing, how to optimize therapy, how to pick one drug, the very best drug, from a series of drugs for this given person with these given conditions with this given—I don't know what to call it.

09-00:13:31
Meeker: Diagnosis or—

09-00:13:34
Day: Well, no. physical characteristics of that person. If you know these things, it's a hop, skip, and a jump—not even that—it's just a sort of a sidestep from, "This is the drug I recommend, this is the dosage I recommend" to "this is what I will prescribe." So it was always there, probably even from the very beginning, that is, the capability. Access to this role was not there in the beginning, and, as you know, it's not universal right now. Pharmacists don't universally prescribe, but lot of them do in institutional settings and in community settings. But the capability was there. See, the contrast is that when I graduated, I knew pharmacology. "What is Benadryl?" "Benadryl is a etc., etc." "What does it do?" "Well, it does this, it does, it does that." "How do you use it?" "Oh, that's a good question." I had no idea. "What's the dosage?" "Well, it's anywhere from 100 to 300 milligrams two to four times a day." "Well, that's wonderful, but I've got a patient here. From that range you've given me, what should I give them?" "Gee, I don't know." My training was not such where I *could* prescribe. I knew all the classic information, I could tell you it's chemistry. I could tell you how to stabilize it, I could tell

you how to suspend it, I could tell you how to make a suppository out of it, but I couldn't tell you how to dose it, or I couldn't even pick the very best drug from a given category.

The best we could do with our Peninsula Pharmaceutical Society, that I've mentioned in an earlier videotape, was to try and predict if a drug, on the basis of its physical, chemical characteristics, was any better than that which preceded it. And then to compare its side effects, et cetera, to what we knew about this slight structure shift. Is this enough to really earn it a position in the scheme of things as being a superior drug? And as you're well aware, a lot of those drugs weren't superior. You could take them in smaller doses, and somebody could say, "Well, lesser amount in the body, lesser drug to get rid of, less damage you can do," but it wasn't necessarily true. Those drugs, even though their potency went up, so did the potency of their side effects. So we did that kind of stuff, but if anybody said, "I've got an asthmatic patient, he's got this, he's got that, he's seven years old, he's taking this, he's taking that, and we can't get him off of that, what do I give him to help him breathe better?" It's like, "Oh, that's an interesting question." We couldn't answer it. We would be intimidated by it. So the difference was that we trained the clinical pharmacy students to go for it. Go for it. It's your responsibility where before we taught, "You can't and it's not going to do any good to teach you how to be able to do it because you're not going to be able to use it." So instead we were trained to be good chemists and good pharmacologists. Not from the point of view of research pharmacology, but we knew the pharmacology; we didn't know the therapy. And there's a massive difference.

09-00:16:53
Meeker: So given that you claim that you were not trained as a clinical pharmacist and you don't claim to be a clinical pharmacist, I'm wondering did you participate in any of the national or international conferences on clinical pharmacy once they started to happen? I guess the first international conference happened in 1976.

09-00:17:18
Day: No. Not those. No. My contacts were more informal, more organizational, more at every opportunity you had to talk about it, and that meant in presentations before audiences that weren't there necessarily for the purposes of establishing criteria for clinical pharmacy. I did attend some of the conferences having to do with education and what clinical pharmacy should be in its education, but I attended it not from the point of view of a practitioner, but from the point of view of a pharmacist who was an administrator at that time and in charge of the division, ah, department of clinical pharmacy. Well, at the time it was not a department.

09-00:17:59
Meeker: Emphasis?

09-00:18:01
Day: No. I was a vice chair for clinical pharmacy in the Department of Pharmacy, which meant for a relatively brief period of time—for, I think maybe a year, maybe a little bit longer, because for me it was an interim position—I was in charge of the clinical program. But as an administrator, as a guy that could hear, understood, came from a background that understood what we wanted to do, and relied upon the clinicians that knew how to do it.

09-00:18:24
Meeker: What organizations hosted these conferences? What are some of them?

09-00:18:28
Day: American Society of Health System Pharmacists. Well, there usually was a joint meeting between several organizations. I really can't name for you any specific meetings because I don't remember them. I don't remember which group said, "Okay, let's sit down and let's lay out the criteria." I do remember the American Association of Colleges of Pharmacy saying we have to agree upon certain things like the hours we will devote to what were then called clinical clerkships, basically modeled after the medical experience of training students in a clinical area where they're given clinical responsibilities. We call those clinical clerkships. What hours of those are necessary? What are the components of a basic curriculum? But in truth and in fact, I relied mostly, if not totally, on the people who were doing it. I always felt it would have been presumptuous of me to speak *ex cathedra* about something I wasn't doing. So I think I told you way back when that my role in the whole evolution of this thing was I got some of the initial stuff kicked off because I was doing it. That is, I sort of said this ethic is bullshit. Let's get it behind us. But my major role in this whole thing was to be there to provide encouragement, and if I could support, and if I could go out and spread the gospel as much as I could, to work with Jere Goyan and Senator Cranston's office to get these capitation funds available. I'm not a clinical pharmacist. I'm not even much of a pharmacist now because I got so much involved in just the details. I'm a philosophical pharmacist.

09-00:20:16
Meeker: Well, all academic specialties have their various conferences that they go to. The AMA meetings and so forth. I know that given your teaching interests and your administrative duties you would have gone to a lot of these various meetings and I'm wondering if you can maybe give me a sense of, looking back, what organizations and what meetings in particular were the most useful of your time and expertise, if that's possible.

09-00:20:55
Day: Well, no, no. It's not that. I don't know. I can't tell you what I did. I can't tell you if anything I did had any impact whatsoever because I wasn't there for the purpose of measuring it.

09-00:21:07
Meeker: Not necessarily the impact you would have had but more perhaps the impact that these meetings would have had on you and your thinking. I think about going to these various history conferences. There's the American Historical Association which is basically a job meat market and people go there simply to find work and no one likes it. But then there's other conferences that people go to for true intellectual sustenance and networking and so forth and I'm wondering if you could perhaps describe the landscape amongst pharmacists when it comes to those kinds of—

09-00:21:44
Day: The spreading of the idea, you mean? The cultivating ground for clinical pharmacy at an organizational level?

09-00:21:51
Meeker: Sure.

09-00:21:53
Day: Well, in the beginning, most professional associations, the American Pharmacist Association, then called the American Pharmaceutical Association, the American Society of Hospital Pharmacists, now called the American Society of Health System Pharmacists, those two organizations were the main two. There were other ones but they were not nearly—and the American ACCP, American College of Clinical Pharmacy, hadn't been established yet. So in the beginning there were those two major organizations, APhA and ASHP. American Pharmacist Association, American Hospital Pharmacy Association but now it's something else, as I said.

09-00:22:36
Meeker: Health system.

09-00:22:37
Day: Yeah. American Society of Health System Pharmacists. Regarding the APhA—what happened is, with the APhA, there was kind of like a slow turning of its head toward clinical pharmacy. ASHP saw it immediately and grabbed it because this was originally beginning to happen in hospitals. So it was right down their alleyway. It was their practitioners who were the initial and the original clinical pharmacists. Paul Lofholm was the first guy to carry it off into the community. God, I don't remember when that was. Like in '70 or something like that. But in the beginning it was totally institutional. In fact, that was one of the criticisms. Oh, you guys are training these guys to be hospital pharmacists and nothing else. So APhA represented a broad spectrum of pharmacists. It claimed to be *the* national association because it represented across the board. You could be a hospital pharmacist, a community pharmacist, whatever. It had its Academy of Sciences. You could be a scientist pharmacist.

Whereas in the beginning, ASHP was strictly people who were involved in hospitals and that broadened as time went on. APhA moved toward a more

responsible role in educating its members when it began to adopt continuing education. Now, I was involved in that, as was Dick Penna. We were the first ones to put on a seminar at an APhA meeting. You can't believe what it was before then. They had very little continuing education. Well, their continuing education was to invite a manufacturer in and have them talk about their product. Or invite a guy that sold cabinets in and say, "These cabinets will sell your product faster." Another guy would bring in shelf facing, give a talk on shelf facing. You turn the packages this way, they'll move faster. While APhA was more professionally oriented than another organization called the NARD, National Association of Retail Druggists, it was just beginning to claw its way into a more responsible role in education and a more responsible role in setting the direction of the profession. So in the beginning, it kind of resisted it.

In fact, Jere Goyan and I met with Bill Apple, who was the executive director of APhA in, God, it was 1967 or '68, and said, "Bill, we want you to know there's a new pharmacist on the horizon and he's not going to be satisfied by the kind of programming APhA is currently presenting, he's not going to be as satisfied by the Academy of General Practice. This is a kind of a person who's going to need his own academy." APhA, the American Pharmacists Association, had an Academy of Pharmaceutical Sciences and it had an Academy of General Practice. General Practice was supposed to include everybody and anybody, okay. But we urged them to establish a special academy to attract these young graduates. I guess it was only maybe 1970. No, a little bit earlier than that. We said, "If you don't grab them, ASHP will." At that time, we were much more devoted to APhA than we were to ASHP. And I don't know why, maybe because I was a community pharmacist, Jere had never been much of a pharmacist. Jere Goyan was a graduate of our school and went on and got his PhD right away. Went into education and research, although he never forgot the fact he was a pharmacist. He was like Riegelman, who I've mentioned before. Never lost track of that. It's kind of funny when you are a graduate pharmacist, it puts an imprint on your soul that you never quite lose. You never stop thinking like a pharmacist or you never stop forgetting that you are a pharmacist at the very basis of it.

Basically, Bill Apple, I'll never forget it, said, "Well, you understand that if I were to establish a special section for these young pharmacists, I will be dividing the profession. I will be saying there's two classes of practitioners. And I'm not convinced," he said, "that this is going to happen. That is, that there's going to be a new role added, because you guys at UCSF are—"

09-00:27:02
Meeker: Not sure that it's got legs.

09-00:27:04
Day: He thought, "It's nice, it's nice, but it's not going to be universal." In fact, Bill Apple came out to visit us and I got feedback. I was then vice chair for

clinical pharmacy and I got feedback from the practitioners on the floor that this guy was an absolute pain in the ass because it seemed as though he was there to convince himself that it wasn't going to work. And, in fact, his parting words were, "Well, you know, guys, this is really nice and it's interesting and it's cute and you're doing some important stuff, but it'll never fly anywhere but at UCSF. The only reason it's working here is you got Jere Goyan, you got this, you got that. You got a medical center. You can walk right onto the hospital—not every place is set up like that. It'll never fly." In fact, this is when he really hit our guys with his *coup d'état*. "I would be willing to bet you that if there's a cutback in the hospital, the first thing to go will be clinical pharmacy services." Okay. Now, Bill Apple said that. Bill Apple was a magnificent leader. He actually did have a major impact on the direction of the profession of pharmacy, but he didn't catch this one. And later on he became pretty much an obstacle to change

So APhA very slowly moved in this direction. They had Dick Penna back there then, and Dick was able to incorporate more and more and more and more educational courses into the Annual Meeting. I just came back from an APhA Annual Meeting, which has hundreds of courses going off all the time. So Dick was able then, as a member of their staff, to incorporate more courses. I helped him develop some of those in the beginning. And ultimately Dick saw the clinical pharmacy light, although in the beginning he had to be political. But he saw the clinical pharmacy light. He couldn't help but see it. He had been a part of the original rebel group that founded the Peninsula Pharmaceutical Society and so he was able to ultimately, along with other people that APhA hired from UCSF, to change the—I don't know what to call it—the personality of APhA. But it didn't completely happen until Bill Apple died.

09-00:29:22

Meeker: So historians' organizations don't have these academies. I'm wondering if you can explain how they're arranged. I assume the academies are not actual physical spaces. They're educational tracks within the meetings or specialties or—?

09-00:29:39

Day: In those days the American Pharmaceutical Association had two academies. It had what was then known as the Academy of General Practice and it had the Academy of Pharmaceutical Sciences. Now, those were just basically divisions in membership status. So when you joined you said, "What am I? Am I scientist or am I practitioner?" and if you're a practitioner you checked the Academy of General Practice as you're preferred identification. That meant that you then became a member of that academy. You got mailings specific to your interest. You got a vote. You could vote on the election of the academy's officers. The overall organization had a president, vice president, and a board of trustees, and the academies, which are under these, had their own officers, as well. So the academy had a president and a vice president and

it had its own little board of trustees. They didn't call it that. Governing board, maybe. And the Academy of Pharmaceutical Sciences had the same thing.

09-00:30:58
Meeker: So I imagine when you've got the whole APhA conference that's germinating each year and you're soliciting and accepting presenters, you have probably the selection committee for the academy of the scientists and the selection committee of the practitioners.

09-00:31:18
Day: Eventually. In the beginning it was like right out of the pocket. The academy in the beginning didn't bite into programming. Didn't appoint its program chairs. I don't think the program chairs do much more now than collect ideas. You want to present a paper, you submit it, it's evaluated and decided. You want to do a seminar? I think they do recruit and I think a lot of it comes from the industry saying, "We're willing to support a program in this nature." As you know now, the industry cannot support programs that are dedicated to any product that they make. And the APhA theoretically, if not actually, can't accept money from it any more than the ASHP can. My feeling is that they should not take money from the pharmaceutical industry because as far as I'm concerned there's always influence. There will always be influence. I see guys walk down the hall, pick up fountain pens, pick up gimmicks in the exhibit halls, bring them back. "Oh, you know, these guys are just trying to bullshit me. I'm not influenced by that." But they are. They really are. There are studies that show that they are. And how does that translate into money for the companies? I don't know, but I can tell you that I know that companies are not known to waste millions of dollars on something that doesn't work. They would be a terrible industry if that's what they did.

So in the beginning ASHP was faster to adopt clinical pharmacy, was Johnny on the scene and said, "Hey, wow, this is right down our alley." Because they already had, I think, and I'm not absolutely certain of this, specialization groups within their organization.

09-00:33:10
Meeker: For them the specialization groups were basically the academies, is what you're saying?

09-00:33:15
Day: No, they would call them interest groups or something like that. They had the hospital administrators. That is, the chief pharmacists who in most cases administered. Some of the smaller hospitals, they not only administered, they were the pharmacist. They had the people who were doing IV specializations. They became specialty groups and so this was right down their alleyway. They were excited by the idea of a new role for the pharmacists. To sort of review for you the history of the ASHP, APhA used to be the omnibus organization and it had hospital pharmacists in it. It had pharmacy owners in it, which was a significant body of people because San Francisco used to have

200 independent pharmacies alone. It now has, what, ten, five, something like that. So had a lot of independent pharmacists in it. It had people who were beginning to do hospital pharmacy and in the beginning APhA hired somebody to come in and sort of take care of the needs of these hospital pharmacists because they didn't work in pharmacies where you had to move the antihistamines and you had to know which ones you had and you had to know what they did. Their stuff was in the hospital. They didn't have to know how to operate a retail pharmacy. So APhA reached a point in its development where it felt it was self-defeating to try and represent the pharmacist as a retail person and as a professional, and there was pressure from within the organization to do just that: "We need more retail coursework. We need help to survive, we need this and that and the other thing." So APhA basically put up some money and said, "Why don't you go off and form your own organization of owners?" And they did. They called it the National Association of Retail Drugs. It's now called the National Community Pharmacy Association. APhA still had hospital pharmacists as a part of its organization and the same thing happened there. They didn't see they could take care of the needs of the hospital pharmacists.

They helped form the ASHP, which then went off by itself and some of these beginning guys, John Oliver and some APhA staffers and volunteers formed the ASHP as a separate organization So APhA gave birth to both these organizations and that's why there were, even today, some tenuous connections between them. But probably APhA and ASHP are closer to each other than they are to the National Community Pharmacy Association, although it has gone through an evolution of its own.

So at these meetings, there was a slow adoption of the clinical pharmacy concept by the APhA. The ASHP grabbed it right away. We cautioned Bill Apple that if you're not careful these kids won't join your organization and that's proven to be true. It was true twenty years ago. They're not joining APhA.

09-00:36:46
Meeker: Did APhA ever establish an academy for clinical pharmacy?

09-00:36:50
Day: Yeah. Well, they did so within the Academy of General Practice. Let's put it this way: They offer specialty coursework. But I really haven't paid a whole lot of attention to APhA. Paid much more close attention to ASHP because it was evolutionary for me, too, much to my regret. Because I really always kind of like pulled for APhA.

09-00:37:14
Meeker: Yeah. But you continued to go to these meetings?

09-00:37:17
Day: Well, yes, but this one because I got an award. I had pretty much decided about a year ago that I was not going to attend association meetings of any organization anymore because I sort of—I don't know why. I just sort of felt I'd been active in them for fifty years, it was time to stop.

09-00:37:37
Meeker: Well, you continued to go throughout your career. In other words, you didn't lose interest in one or the other?

09-00:37:44
Day: No. I went to five or six, seven meetings a year.

09-00:37:48
Meeker: Oh, wow.

09-00:37:49
Day: The California Pharmacist Association, American Pharmacist Association, the ASHP, the AACP, American Association Colleges of Pharmacy used to have two meetings a year.

09-00:38:01
Meeker: What did you personally get out of going to these meetings? The evolution of these specialties and practice fields is I think extremely important to document but I'm also interested in getting a sense of what you personally got out of going to these. That's a lot of time to take away from home and there's expense involved in these things.

09-00:38:22
Day: For me, the meetings have always been not necessarily a source of education in terms of prepping my skills. I don't know if you've ever learned a language and then not used it and forgotten it. Well, that's pretty much the way it is with my education in drug therapy. I am not reliable in terms of drug information. Don't ever ask me a question about drugs because I may have to pull up ancient history. So when I went to these things, because I wasn't doing it anymore, my interest lay more in the accomplishments of our graduates because I needed to know that because that affected a lot of my thinking in terms of being a part of the faculty and working with change. We knock heads. It's mostly in the corridors and in the meeting halls. Not for what's going on at the podium but for what's going on in the back. These little quick exchanges, some of them even meetings where you sit down and you're filled in on something that you're curious about. And you go back and apply it sometimes.

09-00:39:38
Meeker: I know that this is probably virtually impossible to do but could you pull out any examples of maybe some of these meetings over lunch or cocktail hour or something like that that you did in fact have a meaningful impact when you went back to UCSF.

09-00:39:56

Day: Well, I'm going to say something arrogant now because this is truly arrogant. It mostly went the other way. Not that I was a source of all wisdom but I came from UCSF and in the beginning, for the first ten, fifteen, twenty years, people were curious about how we did things. Now, how we did things could relate to how we administered the school, how we worked with students because I was associate dean. I wore a whole variety of hats. Associate dean for administration, associate dean for student affairs, in the beginning having to do with the development of the clinical pharmacy program. As the department of pharmacy vice chair. So I had an accumulated group of experiences including areas that had to do with just what became my specialty for a short period of time, and that was drug advertising. But I can't give you a specific example because it did influence my thinking. It's a very trivial example but I can recall one time attending a meeting in which I learned the school could be sued and, in fact, several schools had been for not doing the following. And I don't remember what that was. So it was a minor, minor impact of what I learned at that meeting. I went back and I made certain that we would not fall into that trap if there was a lawsuit. And there have been suits. It was a wide open gap in the students' rights and many universities had not looked into it.

09-00:41:31

Meeker: Was it like student evaluations of teachers or something along those lines?

09-00:41:35

Day: No, it had to do with student records. It had to do with student records, and I don't remember what it was specifically. But those would be little piecemeal things. But understand it was the other way around, too. I was also an ambassador. So when I went to a meeting I was there for the purpose of mingling with our graduates and showing the flag, number one, and number two, listening to what they were doing. Because, you see, they were doing things that we had never predicted they would do. And in the beginning it was like, "Wow," and we would come back and we would talk about that, what they were doing that was not—should that be incorporated? Should we be doing that? Because we learned from our students.

09-00:42:16

Meeker: Do you recall any examples of these?

09-00:42:17

Day: The idea of specializations in pharmacy. I think the very first one was a guy that went off and did mental health. Then we had the pediatric specializations that popped up. We didn't specifically educate our kids in those areas at that time. We didn't educate them in mental health drugs because that seemed to be a very isolated—but it wasn't. It was a big field. And so our original vision of the pharmacist was, as you're well aware, was as an advisor, as a person who monitors patient therapy and says, "Oh, Dr. Jones, did you know that this drug taken with that one will cause the person's feet to turn purple?" We saw our role as monitoring therapy and advising physicians. In the beginning, we

didn't see our role as prescribing, even though, as I said, it was a sidestep. We were capable, we just didn't see it. We didn't see it for lots of reasons. It was not expected of us. The physician was the sole center of the universe in terms of prescribing in those days. So we picked up little bits and dabs of things and ultimately we incorporated them into our curriculum. But, we merely didn't sit there and say, "Oh, let's watch what's going on in the outside." We did a lot of that inventive stuff ourselves. And, as I said, my role was not so much to, especially as I got older, my role was not so much to influence but to share and to pay attention. When I was involved in one-on-one meetings with the dean, we had our own mini-think tank group. I couldn't walk into that room without knowing what was going on to some great extent. I didn't know how what drugs should be given in any given set of situations, but I did know that there were policies relating to that and I did know that there were things that had to be done that required savvy of the kind I had. So for me that was the educational part of attending meetings: I was there and I was like a sponge. But in the beginning I was not a sponge. I was a river source, as was anybody who went to UCSF.

09-00:45:00
Meeker: During this period of time, say in the first part of the 1970s, what role did you play at the university in the recruiting of new faculty members and was it a difficult prospect to recruit new faculty members to UCSF when UCSF was sort of on its own or on the leading edge?

09-00:45:26
Day: It was easy. No.

09-00:45:27
Meeker: You just recruited from UCSF?

09-00:45:29
Day: Damn right. It was one stop shopping. There was no other place to buy a clinical pharmacist than at UCSF, because nobody else was doing it. And the hardest decision we had to make, and was I involved in it—probably peripherally—was to go outside, to admit finally that somebody else could do this, too, and to trust that they had done it. Now, I remember we hired our first UOP graduate, University of the Pacific, and there was concern by me, and I don't know about anybody else, that we might be treating this person unfairly? Could they make it? We learned that they could, and did, because they were exceptional. So we always sought people who were exceptional. The people we put on the faculty, I want you to look who they were. Mary Anne Koda-Kimble? Could there be a more dynamic person than her?

09-00:46:24
Meeker: And a UCSF graduate?

09-00:46:26
Day: Well, that's what I'm trying to say. She joined the faculty early. Dennis Mancowitz, Bob Miller, Toby Herfindal. None of them were leaders in their

class, but they were definitely thinkers in their class. None of them had been elected to an office. Mary Anne Koda-Kimble would be the first to tell you that. I wasn't. I wasn't elected to anything. Mary Anne was always present. There was a presence about Mary Anne that I detected the first time I met her and so did the dean, only more so than me because he put her on major academic committees. So, no, it was very easy to recruit in the beginning. The most difficult part was recruiting outside because even though we paid less than you could get as a community pharmacist or a hospital pharmacist, we were a desired place to be ultimately. And so we began to spread our wings. But we still recruit a lot internally and people have said, "Oh, that's a bad idea." I don't believe it's a bad idea. I think that you have to be conscious of the best person available for a given recruitment.

So how much did I participate in that recruitment process? In the beginning, the first several choices, I was not involved in the planning of the Ninth Floor Project directly so those personnel decisions were made by people who were—like by Jere Goyan and by Sid Riegelman and by Don Sorby. I was not directly involved in those. Later on, when we begin to appoint search committees and go into it in a very serious way, yes, I was involved. I was chair of one committee, I appointed committees, I made recommendations to the department chair or the dean as to faculty appointments. But I don't want to overplay that one either, because in a very short period of time there was an organization of which I was simply a part of which had its own leaders, like Toby Herfindal and Mary Ann Koda-Kimble, who became a part of that leadership in what became the department of clinical pharmacy.

09-00:48:43
Meeker: Well, obviously you would have been involved in more than just the department of clinical pharmacy as far as these faculty searches and hires, correct?

09-00:48:52
Day: No, not so much the other departments.

09-00:48:53
Meeker: Okay. So it was really—

09-00:48:55
Day: Department of Pharmacy, yes. Department of Pharmacy and in what became the department of clinical pharmacy. Yes, I was involved in those but, again, at a very low level role. The Department of Pharmacy was picking up scientists and I was only on one or two search committees over the many years for those guys. And, frankly, I'm not a scientist so I was looking for a pharmacist in them. I don't mean they had to be, but I was looking for somebody who could catch what we were doing.

09-00:49:25
Meeker: You were kind of like the outside committee member or something.

09-00:49:26

Day: No, I was a member of the department, but I was not mainstream, what it was they were recruiting. I was not a scientist. I looked at them from the point of view of would this be a good addition to our culture? Would this person be an effective teacher? Les Benet, and the people in charge of the Department of Biopharmaceutical Sciences or, if you will, its predecessor, the Department of Pharmacy, were looking for all of those qualities, plus a scientist. Their goals were no different from mine up to a point, at the point that they wanted the best scientist they could find. That's where I fell out. The clinicians, that was an easier role. But as I said, as the department became more established and more independent, and my role moved away from being chair of the department and more into central administration, my involvement was less and less and less.

09-00:50:23

Meeker: Are we talking one search every two years, four searches every year?

09-00:50:29

Day: I can't give you a number.

09-00:50:34

Meeker: Does it change when Prop. 13 [People's Initiative to Limit Property Taxation, 1978] passes? I'm wondering if there's like an historical ebb and flow to the bringing in of new faculty.

09-00:50:44

Day: As the program expanded, as we went to Southern California, as we went to other places, and as the program expanded in UCSF itself, that is to say, the Parnassus campus, there was a natural expansion of faculty needed. We began to recruit both salaried faculty and volunteer faculty. And I had a lot to do with the recruitment of the very first volunteer faculty. In fact, I created them. We had not had a volunteer faculty. No school of pharmacy in the nation had until I took charge of an OTC course and then pulled in my old friends from the Peninsula Pharmaceutical Society and asked them if they'd be willing to give up a half a day a week to come to the university and become a teacher and teach over the counter medication? And they did. And those were the first volunteer clinical pharmacy faculty we had. We now have 650, maybe even 700 volunteer clinical faculty. Yeah. Without them, we couldn't conduct our work. We are the poorest supported school in the entire medical center, okay, at the UCSF campus. Our student faculty ratio is one-third that of the School of Medicine and the School of Dentistry and probably even the School of Nursing, and they would argue that, well, we're a graduate program. But the point of it is that we have a full blown clinical program but we're funded at one-third the level of student faculty ratios of the School of Medicine. So we couldn't have survived all these years if we hadn't relied to a great extent on a volunteer faculty.

09-00:52:26
Meeker: As an administrator, how do you possibly manage six or seven hundred volunteers?

09-00:52:29
Day: I don't. It's done by the Department of Clinical Pharmacy and they're the ones who are going to have to tell you that, okay. Of 650 of them, probably only forty or fifty in any given quarter are active. There are some of them that are active every quarter. The Department of Clinical Pharmacy manages and patrols them for quality. They do quality control work. They have educational seminars. They have training courses for them, training them up to be the role of a preceptor in their environment. They have routine communications. But that's not something I did. In the beginning I only had five, six that I recruited, and I nurtured them, worked with them and basically held their hands because all of them were like me when I went to the university as a professor. "Me? A teacher? Wow! That's a really silly idea. I can't do that." And they all had that inferiority complex.

But in terms of recruitment of faculty, how often it occurs, it occurs on the basis of need. And I can't give you a rate, like five a year, ten a year, six a year, two a year for lots of reasons, primarily because I was less involved with the Department of Clinical Pharmacy and it was undergoing major expansion with its decentralized programs. And the salaried faculty that we recruit are on the basis of national search now. They're all pretty good. We pick them very carefully. The other part of it is they seldom leave. I may be unusual in that I stayed there fifty years but that's only because I didn't retire younger. Our loss of faculty from the clinical department is probably at a very slow attrition rate. Yeah. They sort of come and they stay. There have been some major exceptions to that in terms of individuals who have gone off and done other things, like Toby Herfindal and Joe Hirschmann. Some of the originals went off. But one of the things that concerns the administration at our school right now is that our faculty are older. So there's this wave of retirees that's going to go out and I guess the point of it is we're just too good a place to work and so people don't leave. They do leave and they leave for other better jobs, "better" meaning more pay, bigger laboratories, because we have limited space. Better funding because we're not the most wealthy of schools. But then again, these are guys that get federal grants anyway.

09-00:55:20
Meeker: At this point in time, this might be sort of precipitous, but who are the biggest competitors to UCSF at this point?

09-00:55:29
Day: I don't know.

09-00:55:30
Meeker: You don't know? Or you just don't want to admit? [laughter]

09-00:55:32
Day: No, no, no. It has nothing to do with that. I wouldn't be able to tell you that. Joe Guglielmo could in terms of clinical faculty recruitments. I don't think there are many. Well, I know people who have told me at meetings—you remember, I told you I'm out there, I'm a sponge—that they would never apply for a position at UCSF because we expect too much of them. Our clinical faculty are treated as though they're ladder-rank faculty. That is, they have to produce. They can't just be good clinicians. They have to be good teachers and they have to contribute to the literature. They have to show creativity one way or the other. And I've been told a number of times that it was just too intimidating: "I don't want to work for you at UCSF."

09-00:56:20
Meeker: They have to participate on research products or develop new—

09-00:56:22
Day: They have to develop themselves as a faculty member, not strictly as a clinician. Now, that faculty member, their research might be their clinical role but you can't go to work every day and come home at night and say, "Gee, I saved sixteen lives today," and then go to bed and not talk about it. You have to do something that's creative. You have to share and you have to be a good teacher. And we're pretty serious about that. But, on the other hand, there are a lot of people that just look forward to it because we are a hotbed. First of all, we're in the city of San Francisco. You'd be amazed, if you haven't traveled a lot, the reputation this city has. What an interesting place. If you're a deep ultra-conservative, you don't want to go near San Francisco, but we generally attract people who are attracted by the area, by the beauty of the area, which I see so much of that I don't even realize anymore. So I don't know who our number one competitor is and I guess it would depend upon whom you're trying to recruit, what you're trying to recruit for. We have great difficulty recruiting African Americans to the school, not because they're one of those intimidated people, but because if they're good, they're offered the world because a lot of schools don't have any African Americans and feel that they have a moral conscience to fill that emptiness. And I mean it that way. It's not like, "Oh, I've got to satisfy the federal government." I've never known a school to approach it from that point of view. They approach a deficit in a particular minority ethnicity as just that. It's a deficit. It's not that we got to do that, it's that we have to do it. We owe it to society and to ourselves. Anyway, so Joe Guglielmo will have to tell you who we compete with in that marketplace and the chairs of the other departments, like pharmaceutical chemistry, will have to tell you. But I think we compete pretty well there. The difficulty here is we're competing against MIT. We don't compete against Joe Podunk College. We compete against Harvard, MIT, Cornell because they want the same kind of people as we do, and they're Ivy League.

But anybody that's got any brains wants to come here. I mean that sincerely. That medical, Mission Bay Center, is incredibly intense in its opportunities and its camaraderie and its collaborative spirit. Anybody that comes there is

going to be suddenly booted into the future and it's because they have the ability to do that.

Begin Audio File 10

[Off camera beginning of discussion about pharmacy licensing board examinations and curriculum standards.]

10-00:00:06

Day: First of all, remember, by the seventies, late seventies, I was a member of the Department of Clinical Pharmacy but I was not deeply involved in the standard setting and policy setting, having to do with curriculum. My input was that as a member of the faculty, not particularly in a leadership role. So in terms of those, what are they called, sign post things you asked about, I don't think I had any direct role in the development of the new standards act. That came out of, I think, the associations in California, working with the legislature, and I don't remember that I had—I testified. I testified before a legislative panel, but I don't remember having a whole lot to do with that sort of stuff.

The kind of stuff that I had a role in was that early in the game of clinical pharmacy I worked with the Board of Pharmacy because basically what happened is that—well, let's back it up. When I was the equivalent of chair of what would become the Department of Clinical Pharmacy, a member of the faculty came to me, and this is like 1968, '69, and he said, "Bob, we're in trouble." And I said, "What do you mean?" He said, "I got a fourth year student who can't cut it in a clinical clerkship. Just can't do it. Gets paralyzed, makes all sorts of mistakes. Cannot pass the course." And a fourth year student! A fourth year student who has flunked a course, and I said, "So we give it to him again." He said, "Bob, this is the second time he's taken it. So this kid is never going to complete this course." Now, the repercussion of that is that for the very first time in our history we had a fourth year student who couldn't graduate, because you needed to pass that course to graduate. We had never had that happen before. It had been that some students would flunk out, but very rarely, and they'd flunk out the first two years. Once they got to the third year or fourth year, it was smooth sailing to graduation. I didn't know exactly what to do, so I turned to Sid Riegelman. The faculty member and I went to Sid, knowing that he would give us some sage advice. Well, maybe even say, "It's a tough decision but you got to flunk him. And he can't graduate because we can't do a waiver." But, instead, Sid said, "Well, how is it that he's not passing?" And the faculty member who was involved in it said, "Well, he's not able to do the following." And Sid said, "Does the student know that he's supposed to be able to do that?" "Well, yeah." "Well, how does he know?" "Well, because that's what we teach." And Sid said, "That's not the same. Does he know what he's supposed to be able to do? You said he couldn't do this, he couldn't do that. Did he know he was supposed to be able to? Did you give him any instruction on how to do it?" And we were kind of

like going blah, blah, because we had expected to get like, “Gee, you poor guys. Oh, you’re going to have to make this tough decision.” But instead, he basically said, “You have no standards for evaluating him in the course, so how can you say he’s flunked? And he’s had no opportunity to meet those standards.” So he said, “I want you guys to go off and I want you to develop competency statements for the clerkships, okay?” He didn’t call them that. He just said some statements of what they have to do. And I’d been working on something that was new called "instructional objectives" for some time so to me it seemed a hop, skip, and a jump from them to competency statements.

So I appointed a committee to work up the standards. And the standards were such things, “Upon being presented with a prescription, the students shall, number one, be able to either correlate or acquire the physical characteristics of the patient that might influence drug therapy. Number two, be able to evaluate the disease.” It was a list of competencies: “Be able, at the end, to plot it, to be able to monitor it. Be able to recommend an appropriate drug.” It was quite complicated. So I appointed these teams to go off and do this and at the end of about three months had accomplished very little because everybody was saying, “Oh, we can’t do that. We can’t possibly put down in paper these esoteric wonderful qualities of the clinical pharmacist. They just defy definition. It’s intuitive, Bob. Yeah?” And I said, “No, do it.” And Sid said, “No, do it. Do it.” So they bit the bullet and they came down with some competency statements. So we collected them and now we had maybe fifteen or twenty of them and I presented them to Sid and he looked at them and he said, “They’re great but they’re not thorough enough.” Then Sid sat down and must have added another fifteen or twenty.

10-00:05:51
Meeker: Thorough enough meaning there simply weren’t enough of them?

10-00:05:54
Day: Not comprehensive enough. Not comprehensive enough to define the clinical pharmacist. So he did that. We presented the bundle to the department and to the faculty which approved them as competency statements. And then Sid and I took a deep breath because we realized to our horror that we had just approved the training of a pharmacist that was not known anywhere in the nation and that there was a Board of Pharmacy out there that had the ability to say to a school of pharmacy, “We will not accept your graduates for licensure if you’re not training them the way we think they should be trained.” So we said, “Oh, Christ!" We’d developed this thing and we were committed to it but what happens when the Board of Pharmacy catches wind of this, because, in our view, they were, up to that point in time, a complacent bunch of great guys, a buddy network of store owners. They were a gregarious bunch of guys that got together once a month and tried to create an examination. Or once a year.

10-00:06:58
Meeker: Well, you provided this great example of your own experience, in your own—

10-00:07:04
Day: The examination I took?

10-00:07:04
Meeker: Yeah. Exactly. On the certification process.

10-00:07:07
Day: But the issue was competency. The issue was not the Board of Pharmacy licensing examination. The issue was at that point in time, we feared that we were going to be disavowed by the Board of Pharmacy. So we said we had better get very close to them very quickly.

10-00:07:25
Meeker: Why would you be disavowed? Because?

10-00:07:28
Day: The Board of Pharmacy has the authority to say, "We do not acknowledge the school as capable of training practitioners who are eligible for license." They list the characteristics. They had nothing on the books saying what a pharmacist was.

10-00:07:42
Meeker: Why would that have been a threat?

10-00:07:45
Day: Because it meant that our students would not become licensed.

10-00:07:48
Meeker: No. Why would the new list of competencies have been a threat to the old regime?

10-00:07:57
Day: Because pharmacists had been trained not to do anything. Remember, the standard of practice was "don't interfere." Christ, this was major interference. All of these things were everything that pharmacists had been taught consciously or unconsciously that they shouldn't do.

10-00:08:13
Meeker: So the fear was not that UC, through these competencies, was adding something on top of what the board would recognize as the necessary base of knowledge?

10-00:08:28
Day: No.

10-00:08:28
Meeker: But it was adding something that ran contradictory to—

10-00:08:30
Day: Diametrically opposed perhaps. We thought. We didn't know. We didn't know. But we knew what the board had been like and it had been just a group

of nice guys that loved the status quo. And the status quo was an examination. Well, that came later. And we weren't particularly close with them. Even though a couple of them are our graduates. So we felt it was time to get close to them. So we plotted a meeting. They were having a board meeting. We asked to be put on the agenda and we compiled lists of our competencies, brought enough copies for every member of the board to have one, sat down in the audience, and one of those serendipitous things happened that occasionally happens and turns out to be beneficial. We were on the agenda and there was a discussion that arose from Jim Gates, who was one of our graduates. A member of the board. I think he was president of the board at the time. They were deeply concerned about the pharmacy licensing examination. I should tell you that at the regional meeting of the boards and the schools, I presented a paper that castigated the pharmacy licensing examination. Jim Gates came up to me later and said, "You know, Bob, if you don't like it, why don't you do something about it?" I said, "What can I do? The board writes its own examinations. You know that."

Well, anyway, so there was a seed there. So Jim who had either picked up on that or had been plotting his own course of action, brought up the notion that the Board of Pharmacy examination did not test pharmacists on what it was they should be doing, okay. And so there was a discussion about that. Sid and I poked each other in the ribs because what they were saying was that they had not defined what it was they wanted to test. So Sid talked and I talked and the two of us basically said the following. "That the reason your examination is suffering is because, number one, you do not have skilled examination designers, because, no insult intended, you guys are not pros at designing questions. Number two, you have no standards that you're testing on. You just sort of say pharmacology and let's test on pharmacology. Oh, Benadryl's a drug so let's ask about that. But what you really need is a series of competency statements that define," etc. Talk about serendipity, okay! "We just happen to have [laughter] some competency statements with us." So we put them out there. And they looked at them and they really liked them. And then somebody said, "Do all the schools of pharmacy agree on this?" And I said, "No, no. We just got these out of our hopper a couple of weeks ago."

10-00:11:25
Meeker: This must have been rather challenging and threatening because I imagine those competency statements would have appeared to be extremely aggressive and perhaps beyond the competencies of many of the examiners.

10-00:11:40
Day: Well, yes, but we had misjudged the board, because what had happened, unbeknownst to me, even though I thought I knew most of the board, was there had been a shift. There had been some young lions on the board, maybe five or six, and there were only like eight or ten. I think like ten members of the board, maybe twelve, but enough to shift toward this discussion that Jim led, which was, as far as we were concerned, unexpected. Completely

unexpected. When he started talking about the examination, we thought he was going to talk about, "We need to make it longer or shorter," or whatever. But Jim was talking about revising the examination. So I said, "Once you've got the competency statements down, it's just a simple matter to devise an examination to test those." So Jim asked me to chair a committee of the schools and some board members, to get together and sort of agree upon the competencies. I did. I brought our list of competencies and the other schools, USC and UOP—I don't remember who the representatives were—diddled with them a little bit. Academics will never leave anything totally alone. So they diddled with a few words here, added a few things. But by and large the competency statements came out as Sid and our faculty had written them. Minor changes. So we presented those to the board and I presented the notion that the board needed to appoint an expert committee to devise an examination.

Now, I take a lot of credit for that, but there were other people involved. Jim Gates was definitely involved in it and may have even had a stronger role than I'm giving him right now because this is something that happened forty years ago.

10-00:13:25
Meeker: When did this happen?

10-00:13:27
Day: Oh, like early seventies. Very early seventies.

10-00:13:30
Meeker: Oh, it's early seventies. Okay. I guess what I've been looking at is something a little bit different here.

10-00:13:36
Day: What are you looking at?

10-00:13:39
Meeker: Yeah, actually, no, you're right. So the competency committee was the California State Board of Pharmacy. It looks like you were first appointed in '71.

10-00:13:51
Day: Seventy-one, yeah.

10-00:13:52
Meeker: Okay, all right. And then the continuing education committee, you were first appointed in '72?

10-00:13:57
Day: Yeah, yeah.

10-00:14:01
Meeker: The competency committee, I'm sorry to interrupt, but when you were appointed in '71, is this the first time the competency committee is established?

10-00:14:10
Day: No, but don't confuse what we call the competency committee with what I was talking about before.

10-00:14:13
Meeker: The competencies.

10-00:14:14
Day: We developed the competency statements as an unnamed ad hoc committee to get together to go through those things and say, "The schools agree on these," and present them to the board and let the board decide what they want. The board also diddled with them a little bit. But not much. This ad hoc committee should not to be confused with the Competency Committee, which was the name given to the special expert examinations committee that I had proposed. They didn't want to call it the examination committee, they didn't want to call it the testing committee, so they called it the competency committee. And that was not my title. I didn't care what the hell you called it. And so the design of the competency committee was that there were a couple of board members on it and one member from each of the schools. Or was it two? I think in the beginning it was just one. And maybe two or three board members. And the chair of the committee was always a member of the Board of Pharmacy. But in the beginning, you may recall that one of the things the board did was to devise the examination entirely. And Jim basically submitted our proposal. I argued for it, but Jim basically said, "Okay, let's do this." He recommended that the board turn one section over to this expert committee. Because, remember, the way they did it was if there were ten members of the board, one got the pharmacology section, another got the compounding section, another got the toxicology section, another got the pharmacy math section, and so on, because they had divided the examination into these same academic topics that schools taught. That was one of my criticisms. I said, "You're testing the hell out of them academically. They've already had that done to them. They've already been tested in chemistry. They had a chemistry section. They've already been tested in chemistry and compounding. You want to test them in real life examples of the pharmacists' role, in fulfilling these competencies."

Although they liked devising the examination—it gave them a sense of accomplishment— they were reasonable men. In the beginning, they were reluctant to turn even one section of the examination over to an unknown, outside body. First of all, we were not enfranchised. They were governor appointees. They were state officials. They'd let an outsider group do this? But they did. So they turned over to us one section only and we formed the committee and we began to devise that section. We revised not only the testing methodology but the testing evaluation. And on the basis of that one examination that we devised from the field of ten, they asked us for additional proposals, and one of them was that we take over the entire examination, that we switch it around from topic oriented examination to basically a knowledge orientation, practitioner orientation, and that we apply the competency

statements to each and that we divide up the competency statements and test them on the basis of the competencies rather than on the basis of pharmacology, toxicology, etc. And they agreed to that, so we did that. And that's what we did for twenty some odd—maybe more, thirty years. I was on the committee for I think twenty-one years. I don't remember. But then we had an influence on the basis of the national licensing examination because they heard what we were doing and. I was appointed to one of their committees. And I'm not trying to say I had a lot of influence, because I was one of maybe eighty bodies.

10-00:18:04
Meeker: Well, I think this is something that we maybe talked about offline. I don't remember it being recorded. But you had mentioned that one of the flaws with licensure exams throughout the United States was that they were different according to every state. I guess what we're looking at is probably later in the 1970s, that you start to have a broader national—

10-00:18:30
Day: The national examination was devised. Yeah. And that became the adopted examination. California was the last holdout there.

10-00:18:41
Meeker: What was the process by which the national exam was devised and what role did California play in the development of this national exam?

10-00:18:52
Day: I think not so much a direct effect as much as effect by influence, sheer bulk of influence. I'll tell you what I mean by that. I was appointed to the committee and I went back there and I espoused my ideas, but I don't know that I had that great an impact. The people in the room were still testing on the basis of sections. Pharmacology, et cetera. I was able to introduce the concept of testing on the basis of patients. I was able to do that by presenting them with examples of what I was talking about, examples of questions that could come from that. And in the long run they did that, but I don't know that they wouldn't have done that anyway because at this point in time they were beginning to get a conscience about competencies and so on. And they also developed their own, something they called "propositions," which were competency statements turned around and called "propositions." Were they the same as ours? In terms of territory, yes. In terms of wording, no. So did they take our competency statements and turn them into propositions? I don't know. I wasn't a part of that. I was only there for some of the refining of them. But I wasn't a part of that original decision, that original development. But it happened after we did what we did in California, and this is where the influence comes in.

Almost immediately, almost the instant there was a NAPLEX, a national pharmacy licensing examination, they wanted California to come aboard for lots of reasons. We would be a major purchaser. If we bought that

examination—we licensed, I don't know how many, two thousand pharmacists a year. No other state had anything like it, not even New York. We were a major target. Montana licensed ten, Idaho twenty-five or thirty. They wanted to impress us, and so every year they came out and said, "We've improved the examination. We're doing this, we're doing this, we're doing this," and they'd show us their statistics. We'd ask them some questions. They didn't have the answers, they were sent away. Because we had an examination that we could justify by point biserial correlations, etc., by testing them against competencies. We had a process for weeding out the bad test items. We had a well-developed process for generating items.

10-00:21:18
Meeker: Why wasn't there a lobbying process by which California encouraged the national standards to adopt California instead of vice versa?

10-00:21:25
Day: I don't know that it ever was stated that way. We basically said, "Don't come back to us until you've got an examination that's as good as ours." We didn't put it in that impolitic way, but we basically said, "Well, you're working in the right direction." We must have been viewed really as arrogant. Maybe we were. The point of it is we had something that we had developed and we had worked on and it was working in terms of testing competencies and we could validate them. We could prove that the questions were effective. We had a way of refreshing the item pool. We had a way of deleting items. We worked at it constantly to change it, to make it better. And I think we succeeded. I'll leave that to somebody else. But in terms of all the metrics applied to examinations, we had done it correctly and we wanted them to do it correctly before we went aboard.

10-00:22:26
Meeker: What organization was it, I guess, out of DC or where? I don't know where.

10-00:22:31
Day: The organization that had the NAPLEX?

10-00:22:32
Meeker: Correct.

10-00:22:33
Day: National Association of Boards of Pharmacies. So it's an affiliate organization of all the boards of pharmacies in the nation. It's an organization. That's all it is. It's an association. It's not even quasi-governmental. It basically represents the boards. But the boards had delegated some authority to it. It's a little bit more than that. It's a little bit like an accrediting body, too, because the board, NABP, developed national standards and then the states had to adopt them. Anyway, it's a national association of boards of pharmacy, administers to the state, excuse me, that examination.

Can I lay out the statistics and say this proves that we had a profound impact? The fact their examination changed may have been evolutionary, but I think it was more marketplace pressure. I think they wanted to get California into their market. I was told one time, "You guys are a pain in the ass. You're a fishbone in our craw because we can't get California aboard."

10-00:23:56

Meeker: What was to be gained? Was it simply institutional juice? Was there a financial consideration? Was it just a trend toward not federalism but centralizing of power in the federal?

10-00:24:12

Day: I don't know. I will have to answer on the basis of what I think. Actually, one of the facets I do know, and I'll tell you what that is. I don't know. I think probably any organization that has been given a degree of control, wants to make certain that it's living up to the maximum of that control and may even want more control. But I don't know. I was not involved in any discussions with them. I do know for a fact that they hungered to have California. And the reason was it costs money to take that examination. It costs money to develop that examination. And it doesn't cost proportionally a lot more money to give it to 2,000 more people than it does to give it to 2,000 less. But it does affect the budgets. It affects the cost of developing. It's a non-profit group. It does affect their ability to hire consultants. It affects a lot of things. I think it was as much that, if not more that, than the latter. But I also think that we were a philosophical craw in their throat. California was snubbing the NABP, and they'd already been snubbed by California because under Governor Reagan, board members could not use state monies to travel out of state for a national meeting, and so they were snubbed by board members not going to their national meeting. California was not present. So I think that there was a historical prelude to their chagrin, whether or not those same people were around. Well, federally it was around then. So the guys in charge of it now wouldn't be aware of this history that much. They might be, I don't know, but I doubt it. Fred Mahaffey who was executive director of the NABP for years and years and years. A nice guy. But anyway, I don't know how to go any further in that one.

10-00:26:37

Meeker: Okay. Well, one thing that I'm interested in, based on your really rich description I think of your own licensing exam experience, and just the way in which it was so idiosyncratic: The exam was so idiosyncratic to the interest of the examiners in those specific fields. And it seems like those examiners were the ones who were basically grading and determining pass, no pass, et cetera. How did that then change when it becomes a national exam? How are the exams evaluated? How is the performance of the test taker determined, whether it's a pass or fail? Does this become much more standardized and become less idiosyncratic—

10-00:27:37

Day: It's more standardized. They use standard scores. There's a standardization to it, which in the beginning bothered us because the passing score was established by the poorest performing state. I want you to think about when you have a national examination. So everybody sits down and takes the examination. You have California that has a 99 percent pass rate. You have another state, which I will not name, that has a 43 percent pass rate. Okay. Well, that state says, "Wait a minute." They don't say, "There's something wrong with our graduates." They say there's something wrong with the examination. And that's a political influence. And so we were concerned that the passing standard would be decided on the basis of the lowest performing rather than on the basis of an average of the highest performing schools or highest performing pass rates per state. How that is determined today I don't know. I haven't been involved in that circle for at least ten years, maybe fifteen. I have listened to it but I haven't really paid close attention to it because I trust the system now. I saw that they set in motion a lot of safeguards. I think a state can still establish its own pass rate, that is the passing score. But that affects mostly the people who want to come to the state from outside of California. See, the big issue with the national exam was that prior to it, licensing reciprocity did not exist. When a state adopted the national examination, it had to adopt reciprocity as well. With reciprocity, you could live in Idaho and come to California and as long as you had the entrance requirements in terms of education, in terms of having passed the NAPLEX examination, had an acceptable pass rate, you could migrate to California. Up to that point in time, California wouldn't let you come here. You had to take its examination. So there were two forces at play that really wanted that to work. The NABP, which actually charges a fee for the reciprocity situation. So it's an income maker for them, not to be cynical. And the employers in California—particularly the chains—were increasingly demanding more and more pharmacists than the schools could. The chain industry was opposed to the universal PharmD because its adoption would delay graduation of one class nationally. Can you believe that? Because when a B.S. school adapts to a PharmD degree, it has to add a year, so you lose a year of graduates and they were having trouble filling their pharmacist positions. But they also felt that lack of reciprocity in California was restricting the supply of pharmacists they needed, as well. So there were two forces at play for this reciprocity thing for the NAPLEX.

10-00:30:28

Meeker: When you have the emergence of the competency based exam in California in the early 1970s, it's kind of part of this larger revolutionary change that you've been describing in pharmacy practice in the United States. And then you serve basically on the California State Board of Pharmacy Competency Committee for the next twenty-five years.

10-00:30:51

Day: Something like that.

10-00:30:52
Meeker: Well, it says, on your CV at least, from ’71 to ’96. So we’ve got twenty-five years there. In that subsequent twenty-five years, what evolution or what change happens in the competencies or does it remain relatively static?

10-00:31:10
Day: No. No, no. The competencies were reevaluated two or three times. We had to add to them. Some of them were so basic that we had to reword. No, they evolved.

10-00:31:27
Meeker: Can you think of any examples of the ways—

10-00:31:30
Day: No.

10-00:31:30
Meeker: —[laughter] during that period of time that they evolved? Okay.

10-00:31:31
Day: No, no. I do know that a few years ago, the Board of Pharmacy abandoned the competency statements, feeling that they had been incorporated by NAPLEX, it was no longer necessary for the state of California to have its own competency standards. So they threw them out about six, seven years ago.

10-00:31:52
Meeker: When did California adopt NAPLEX?

10-00:31:54
Day: About ten years ago.

10-00:00:00
Meeker: Okay. Yeah. So shortly after the end of this committee, that was really when the final integration happens.

10-00:32:08
Day: No, the committee still exists.

10-00:32:09
Meeker: Oh, it does. Okay.

10-00:32:09
Day: It still exists. Because there’s something called the jurisprudence section, which tests on California law and regulation. See, pharmacy law is not universal. So there’s a jurisprudence and I think there’s a pharmacy math section of the California exam. I say "I think" because I don’t know. One of the things you have to understand about me is I don’t cling. I sort of move on.

10-00:32:33
Meeker: Well, you can describe your knowledge based on when you were participating in it. You don’t have to project it to now.

10-00:32:40
Day: Yeah. Okay, yeah. But the committee exists and it still devises that portion of the examination. Or at least it existed as of a year ago. And basically the components are still the same. Two members from each school of pharmacy. Although I don't know now because we have so many more schools of pharmacy. We only had three when we started this.

10-00:33:03
Meeker: Well, so during this twenty-five year period of time when the competency based test emerges in California in the early seventies—maybe the comparison is before the competency based version of the test was established and then under the regime that you took, was there a significant change in the pass rate?

10-00:33:35
Day: Oh, yeah.

10-00:33:36
Meeker: Yeah. So what happened?

10-00:33:37
Day: Yeah. Nothing politically because it wasn't a concern. No. The pass rate changed incredibly. We had statistics to show that if you went to UCSF, maybe one of you wasn't going to pass it. If you went to UOP, maybe thirty of you weren't going to—in the beginning, okay. Thirty of you. Remember we went to a licensing examination that was clinically based. And it wasn't because it was too early, it was because many schools had not yet developed a curriculum that graduated a sophisticated clinician. And that persisted for a long time. So we had school by school, nation by nation statistics on the pass rate, all of which were lower than they had been before the competency committee took over the examination. And we established the pass rate on the basis of standard scoring which gave us some margin of error in there to adjust it. And that dropped. That dropped the number of people who were licensed. It was one of the critiques made by the major employers when they felt their backs were pressed up against the wall for manpower.

10-00:34:54
Meeker: And I suspect also the pharmacy schools in California, when their graduates are no longer able to pass the exam?

10-00:35:02
Day: No. The pressure there was for them to learn why they weren't passing. No, it was not a time of animosity. I remembered Louis Martinelli, the dean of UOP, came in, and we thought he was going to come in to protest because they had a 70 percent pass rate. It was as low as any low school in the nation. He came in concerned. He said, "What is it I'm not doing right?" He didn't say, "What is it that's wrong with this examination?" Because Louis was also a UCSF graduate. Got his PharmD and his Ph.D. there, so he was then dean of the school at University of the Pacific and he said, "What is it we're doing wrong?

Can you give me some statistics that I can confront the faculty with showing areas in which they are not being trained, at least to pass this examination?" But he didn't say it that way. He said, "They're not being trained correctly because obviously there are deficits in their knowledge." So, no, he saw it differently. USC had a like 90 percent and they were okay with that. UOP had a seventy and they weren't. They wanted to change it. UCSF had a ninety-nine, ninety-eight percent pass rate and people said, "It's because you're on the committee." I said, "Hell, you ought to see the items I devised. They're like Mickey Mouse, one and one is twos," because I'm not clinically skilled. I took the basic questions because I could handle them. So no, the response of education in the beginning was not negative. It was not there's something wrong with it. I think all of them had participated in the development of the competency statements and I think unbeknown to us, that was a boon because they had had a say in those competency statements. They knew what they were going to be used for. Louis came in after that had all been done. He came in as a brand new dean. He actually lasted three years and they unfortunately booted him out because he was too radical for them.

10-00:36:55
Meeker: At UOP?

10-00:36:56
Day: At UOP. But UOP's not like it was in those days. It's an entirely different establishment today and the pass rate's pretty good, as I understand. As I say, I'm not compulsive about what's going on with those things today.

10-00:37:12
Meeker: That's pretty remarkable though, actually, that this new regime of testing comes into play pretty quickly. It does change pass rates. And it doesn't precipitate a massive revolt amongst the schools or perhaps the employers or even the students who are now confronted with a different testing regime.

10-00:37:39
Day: Well, I don't know what the students felt. We never asked them. At one point I developed an essay question for the examination. I felt that the multiple choice question didn't get to communications. So we developed an essay examination. But essay meaning they had to write an answer out and so we gave them the opportunity. We would present them with a patient, Mrs. Jones, a thirty-seven year old mother of three, enters the pharmacy and comments that her youngest kid has been coughing, blood's been coming up, and she's taking aspirin and so and so and so and so and so and so and so and so. What in your estimation is wrong? What in your estimation would be the therapeutic remedy? It didn't require diagnosis because it was already there. The kid's diagnosis and any other thing they had to write out like, "Well, I would ask the patient the following...." The reason I'm telling you this long story is that at the end of one of the essay examinations, someone in a kind of like trembling hand had written something of the following: "I seem to be having trouble passing this examination as this is the fourth time I have taken it. But

I'm hoping that I can pass it at someday in the future so that I can take care of my poor, sick mother." [laughter]

10-00:39:10
Meeker: [laughter] Wow.

10-00:39:13
Day: And we didn't know if the guy was BS-ing or just being funny—because I might say something like that—or whether it was real. But it's something I have never forgotten.

10-00:39:21
Meeker: That actually seems, if it's on your fourth exam, desperation. [laughter] Might be serious.

10-00:39:25
Day: I think it was. Yeah, and there were people who had taken that examination four, five, six times. There are some who aren't licensed yet. There's one guy—[laughter]. We knew about him because he would protest it. "This is not a fair examination." "Why is it not fair?" "Because I've had to take it seven times and I have not passed." His solution was there was something wrong with the examination. So I think he had up to his ninth or tenth time, had not passed the examination. We had no requirement regarding that–you could take it as many times as you wanted to—and he finally passed it and everybody said, "Wow, Mr. Smith finally got through it. Can you believe?" Wow!" Because we'd been getting these letters and complaints and a legislator's office would call down and ask us to explain this poor man's predicament and so on. And we had to respond to that. "He passed. Wow." Six months later it was revealed that there was a Board of Pharmacy staff person, who was selling passing grades. You paid him a thousand dollars, and he would change your score.

10-00:40:39
Meeker: No kidding?

10-00:40:39
Day: Because the records were turned over to him for permanent recording and he was changing their scores for about ten people. The Board actually withdrew licenses because they were able to identify these ten people by reviewing the original examinations.

10-00:40:57
Meeker: Including this guy?

10-00:41:00
Day: And added up the scores. Yeah, he was one of them. He never did make it.

10-00:41:06
Meeker: Were there established prep courses like you have for the bar or something like that?

10-00:41:10
Day: Yes. Yes, there were. [A portion of text has been sealed until 2038.]

10-00:42:19
Meeker: Were the test questions changed annually so it would prevent these kinds of cheaters?

10-00:42:28
Day: There was a pool that was established. In answer to your question, once a test item proved itself to be an effective one, it was a candidate for the pool until it proved itself not to be effective. But the pool was large enough to where its chance of coming up, even though we would select randomly on the basis of the point by serial correlations and some other characteristics, put it in there and had to be balanced because you couldn't have two similar questions in a row or whatever. There were items in there that were in every examination, but the bulk of them were previously used items that were rotated from the pool and they didn't always stay the same because when the pass rate began to change, we began to suspect that the word had gotten out and we would then DC it and do another item, write another item or change it around or change the answers. So we were constantly evaluating the pool. Probably spent a day of every one of our meetings. We would meet three to four days a year to devise examinations. Another two to three days to grade the essay portion of the exam. That was a major output of effort. And we would then repair any of the items that came up as being weak—and some of them were first time items—so we would look at them and see if we could repair them. And if we didn't figure we could repair them, or couldn't figure out in our own way why it went wrong, we would just DC them.

10-00:44:10
Meeker: So in the last ten or fifteen minutes we've got here today, I want to switch gears a little bit and spend a few minutes asking you a little more about your teaching. And I know that we've already really gone through a discussion, I think, of your main courses. But there are a couple of your particular interests on here that I wanted to get you to comment on. And in particular this course that you taught, it looked like for many years, on human sexuality. What was this?

10-00:44:42
Day: I didn't teach it.

10-00:44:46
Meeker: Okay. So you've got thirty hours of instruction over, I guess, a quarter.

10-00:44:47
Day: Yeah, yeah, yeah. Because we did small group conferences after each session. That's where those hours came from. It was during the sexual revolution, the Haight-Ashbury. All of that was going on and I became aware of the fact that there was a human sexuality course being made available to the school of

medicine. The guy in charge of it was a guy named Herb Vandervort. It was an elective course and I asked him about it.

10-00:45:23
Meeker: What specialty was he in?

10-00:45:25
Day: He was a psychiatrist and he had been involved with the Human Sexuality Institute. So I asked him about it and he said, "Well, Bob, rather than tell you about it, we're going to do a prep course for the section leaders this coming weekend. Why don't you come and see what it's all about." So I went and it was basically heterosexual, gay, bisexual, exposure to all the lifestyles that they could configure at that time and desensitization on sexual language and issues and attempting to put verbiage, words, four letter words, whatever they are, in proper perspective. So the primary reason was to desensitize people against the ambiguous feelings they may have had about sex and to enable them to open-mindedly participate in the human sexuality course. Basically it was a microcosm of the course that was being offered in the school of medicine.

10-00:46:25
Meeker: Perhaps a recognition that as a health care provider there's human sexuality and venereal disease and all this kind of stuff are central to the practice.

10-00:46:36
Day: The big deal in those days was gay, okay, was the reaction of health practitioners to gays. And this was one of the reasons for it. The other part of it was just being judgmental about human sexual behavior. Attitudes such as there's good sex and there's bad sex. Good sex is missionary, bad sex is anything else. Really, those were attitudes that were alive in those days, even in the kids, the students. Basically what I decided was that health practitioners did not have any right whatsoever to become biased about sexual activity. Some people might at some point tell them some things and if it put them off, then they were not going to be as effective as a health—might not be as effective as a healthcare provider. So that was the purpose of it, and maybe it's not as lofty as that, because I thought it'd be fun, too, to have a human sexuality course. So Dott [Dotti Day] and I went to it and we came away with a lot of attitude changes, which of course, they all wear off with time. But we came away from it slightly different than we went into it.

10-00:47:41
Meeker: How so?

10-00:47:44
Day: Just much more liberalizing sense about sexuality. Dotti will have to speak for herself. What it did for me was basically to eliminate many inhibitions I had about sex. Any inhibitions, personal or whatever. I began to think about it and it made me think about sex, which we had never done. We did it, we just didn't think about it. So it made me think about it. But I'm putting more into

that than I perhaps even felt at that time. Let's just say that I liked what I saw and I thought it would be important to make it available to pharmacy students. I went to the dean and suggested it as a mainstream course, but then I found out how much it would cost to put it on for the entire student body, because it had many instructors in it who were gay or straight, who were bisexual, who were deformed, who had handicaps.

10-00:48:43
Meeker: Talking about personal experiences or—?

10-00:48:45
Day: Who got up and share their own personal sexuality. And there were movies depicting sexual performances and whatever and talking about desensitization and ways of prolonging. It was a course on human sexuality. So we decided we couldn't afford to put it on for the entire student body, so we made it an elective course. I am by no means an expert in human sexuality, and so I relied upon a guy named John Holland; Herb sent me in his direction.

10-00:49:18
Meeker: John Holland?

10-00:49:20
Day: John Holland. As the instructional coordinator for the course. I was a coordinator, too. I basically got the rooms, got the assignment, worked with the speakers, got the course materials, introduced the course, and then we had breakdown discussion sections afterwards and I was a conference leader. Because we felt we're going to put them in this room, going to expose them to lots, they needed to talk it out rather than just sort of saying, "Oh, that was a nice thing, leave the room." And some of them were actually conflicted by what they saw. It was conflicting with religious beliefs. We actually had a married couple who reacted really negatively to it and we had to get counseling for them. But we had to be aware of that because we knew that there would be negative reactions to it.

10-00:50:06
Meeker: They maybe felt like they were being psychologically abused or something?

10-00:50:10
Day: They felt it was opposed to all their Christian living principles and that's the word they used. I heard that later. So we put it on and we insisted that 50 percent of the course be female and 50 percent be male. So when you signed up, we had a sign-up list outside my office and we could only take fifty people, twenty-five female, twenty-five male. And we had people begging to take the course but I couldn't do it. I could only handle fifty at a time. We did it for a number of years. But basically it was two hours of lecture, basically, and videotapes, and movies, and discussions, open discussions. Then we broke them into groups of ten apiece. So we had five sections go off and meet in a room with two people, one of whom was me, and another was a female, to sit there and just discuss. "Okay, let's talk about it. What are you feeling, what

are you thinking, what do you believe? Anybody having any trouble? Now, let's talk about it," and da-da-da-da and so on. And at those meetings people opened up. I don't think they opened up to the point where they regretted it later, because we never really got deeply personal. It was more of inquiry and more of discussion. So anyway, that was so successful that we did it for the number of years we did it. And the competition for the 50 places was always the same. We always had maybe twice as many people wanting to take it and people asking me if they could be on the list next year. And so I had to establish a pool to pull names. Anyway, so that was that course. But I am not an expert in sexuality and I did not pretend to be one. I was simply the guy that introduced the course and John Holland took it from there. And I was in the room and I was doing the coordinating and I was doing one of the sections. I needed to know what was going on in the sections.

That led to a continuing education course, quite accidentally, because I was a speaker for Lederle at the time. Hate to admit it. Lederle was a drug company, and I gave a talk related to a human sexual topic, menstrual products, OTC menstrual products. There is such a field incidentally. And I was picked up by Lederle to join their CE symposia and did five or six of them at various schools of pharmacy for practicing pharmacists. So I was sitting there talking to the guy that was the director of marketing. I said, "How come you never asked us to put on a CE course at our school?" And he said, "Well, we didn't know you wanted to do one." I said, "Hell, yeah, I'd love to do one."

10-00:52:38
Meeker: A course on?

10-00:52:38
Day: I didn't tell him, okay, because he had already told me once before that they don't tamper with these courses. Whatever it is the school tells them they need, that's what they get. And when Lederle sponsor its, it comes with no strings attached. Okay. So I said, "Oh, really?" So I went back. I was in charge of our continuing education unit then. I had always wanted to take this course that we gave to the undergraduates and put it on as a post-graduate education course for pharmacists. The problem is it was so expensive. I wanted to do it in San Francisco, but that meant paying transportation, meant paying the speakers, and there were twenty speakers and each one got fifty to a hundred dollars. In those days that was one hell of a budget. So when he said that, I went back to Ken Lem and I said, "I want to do a CE course on human sexuality," and he said, "Well, it's going to be really risky." Ken Lem was the guy that worked with me. "It's going to be really risky, Bob." And I said, "I know it's risky but at least it's going to be subsidized by Lederle." So he called me a week later, the Lederle guy, and he said, "What do you want to do?" And I said, "I want to do it on human sexuality." And there was this pause like the end of the world. He said, "Well, gee, that's an interesting idea, Bob. Oh, yeah, well, okay, good. Well, let me get back to you, okay." He got back and said that his bosses wouldn't permit them to do that. And that's

when I said, “Ed, I am no longer one of your speakers. You can go to hell. As far as I’m concerned, what you told me was absolute bullshit. You said that you trusted the schools to pick the topic. I picked the topic. And you said you wouldn’t tamper. You’ve just tampered.”

10-00:54:21
Meeker: And it wasn’t unrelated to their—

10-00:54:23
Day: It was totally unrelated to anything they did.

10-00:54:25
Meeker: Oh, it was, okay.

10-00:54:26
Day: Yeah, they didn’t do any drug having to do—that’s what he said. “We insist that it be not related to a product, okay, that we make.” My talk on menstrual products had nothing to do with anything Lederle did.

So I went to Ken Lem and I said, “I want to do it anyway.” And he said, “Well, it’s really risky, Bob.” So we put it on. It was our single-most successful course. We had 400 people sign up at fifty bucks a head and we told them they could bring a spouse for another—I think it was $15—because I felt it’d be great for them to have that experience with a spouse. We charged fifteen bucks for the spouse because we had to buy a lunch and it cost fifteen bucks. So we did it that one time. I said, “We've got to do it again, Ken.” We did it I think about ten times before we retired it. Every time we had three hundred, four hundred. We did it in Lake Tahoe, Los Angeles, Fresno, San Francisco.

10-00:55:23
Meeker: Were these one-off deals or were they part of larger pharmacist conferences or—

10-00:55:27
Day: No, they were standalone. We would advertise the program in a given area and then we would go there. So we would blanket Southern California with brochures. And we had people coming.

10-00:55:39
Meeker: So the continuing education course, was it modeled similarly to the course?

10-00:55:44
Day: It was. It was a microcosm of the bigger course and it had instructional value, the Board of Pharmacy approved it. It was *bona fide* continuing education.

10-00:55:55
Meeker: Did you ever engage with John De Cecco at San Francisco State?

10-00:56:00
Day: No, no.

10-00:56:01
Meeker: Okay. He taught this famous course on human sexuality over there.

10-00:56:04
Day: Yeah, no. I know there were other people around, but we had our own resources and John was phenomenal. And Herb Vandervort was really great, too, although he didn't have anything to do with our course.

10-00:56:16
Meeker: So what was, for this course, either the continuing education or the university based course, what was the pharmacy angle on it? Was there?

10-00:56:27
Day: The pharmacy angle was if any professional had—that no professional had any right intruding his opinion, his relationship with a patient, on the basis of sexuality, sexual ideas, what's right and what's wrong. It was prompted by two things. Pharmacists refusing to fill prescriptions for contraceptive pills, which in a sense was related to that. And then pharmacists treating gays differently. And there were documented incidents of that. Not many. Not many. Please understand not many.

10-00:56:59
Meeker: Sure.

10-00:56:59
Day: But still, remember, I was caught up in a wave of also the—what are they called? The sexual freedom? Whatever the hell it was.

10-00:57:09
Meeker: Sexual revolution.

10-00:57:10
Day: Sexual revolution. I was a part of that. I was a young guy at that time, thirty-five years old. It was important. You attacked all sorts of things. Remember, we're talking about the Kent State slaying, the Vietnam War, human sexuality, sexual freedom, all that kind of stuff. And it was all part of the same thing. I told you before it affected my attitude when I took that course and it was measurable and for the better. I didn't become a sex freak. I began to see things differently because I'd never really thought about them. And you understand this is the day before porn was available. It was the day when *Playboy* magazine at best showed a tit here and there and that was it. And it was all kind of like snicker, snicker, snicker stuff. And so to me any health professional needed to have this exposure. That may be totally presumptuous on my part, totally judgmental, but it was what I felt.

10-00:58:22
Meeker: So it sounds like it wasn't about the relationship between sexuality and pharmaceuticals. It was more about bedside manner—

10-00:58:29
Day: A health professional.

10-00:58:30
Meeker: —and professionalism.

10-00:58:32
Day: Professionalism. I considered it to be a basic language of all pharmacists. Yeah. No, it had nothing to do with I'm going to fill your prescription better or faster. Just had to do with relating as a health professional.

10-00:58:45
Meeker: Well, this is a course that's taught, it looks like, through the 1980s and clearly in the very early 1980s you start to see the appearance of AIDS. Did that play much of a role in the conversations or in the curriculum associated with this course?

10-00:59:04
Day: No. No. The course always taught safe sex. The course always did teach it. So when AIDS came along—remember, in AIDS we didn't know a whole lot about AIDS. It was an epidemic before anybody even admitted it was an epidemic. So we talked about AIDS, but we talked about it more from prevention. We did talk about preventative. A lot of people actually had misimpressions about foams, what vaginal foams would do. I don't know if they still make them. But they had misconceptions about the ring. There were no misconceptions about a rubber but there were misconceptions about a lot of other things.

10-00:59:46
Meeker: Well, there were natural rubbers that were lambskin rubbers that were used for a period of time.

10-00:59:50
Day: Yeah, there still are, there still are. But still, it was introduced as a part of sexuality, but more from the preventive point of view. Not the attitudinal, because we didn't know a whole lot about it. We knew it was transmitted sexually. But there were still discussions then. Could a man transmit it to a female? The arguments went something like this: "Well, the female vagina gets pounded all the time so it's got natural defenses against this sort of thing whereas when they do it rectally, that's not. So that's why men get it more than women." In the beginning that's what they said. It's why men get it more than women, because women have a natural defense against these things, because that's what the vagina does. The rectum doesn't. It was that simplistic.

10-01:00:37
Meeker: Shades of [Todd] Akin. [laughter]

10-01:00:37

Day: Yeah. But it was in the beginning. So it was a part of the course but not a major part.

[End of Interview]

Interview #6: March 13, 2013
Begin Audio File 11

11-00:00:05
Meeker: Today is the 13th of March 2013. This is Martin Meeker interviewing Bob Day. This is tape number eleven. So I think that we'll be able to wrap up today but I do have a list of some final topics that I'd like to talk about and I'm not quite sure how long we'll need to spend on each of those. So we'll see how it goes. Some of them I suspect you'll have more to say about than others.

The first one I actually don't know how much you'll have to say about. It's kind of a fishing expedition. But one of the things that was quite interesting and seemed quite important in reading through this book, *Clinical Pharmacy in the United States*, particularly when you get to the 1980s and the 1990s, is the expansion of residency training for clinical pharmacists and the expansion of the number of specialties, from just a few to well over a dozen. You just end up having specialties in—

11-00:01:28
Day: Pediatrics, psychotherapy, all that. Yes.

11-00:01:31
Meeker: Correct, yes.

11-00:01:33
Day: Cardiology, diabetes.

11-00:01:34
Meeker: Oncology and it goes on and on. And so what I was wondering from your perspective at UCSF is twofold: One, what was the role of UCSF in pushing for and enabling these residencies and expansion of specialties that happened? And then on the other end, how did UCSF respond when some of these expansions or new ideas maybe came from outside?

11-00:02:12
Day: Okay. Martin, could you do that question again because it's really a complicated question.

11-00:02:17
Meeker: Sure. Let me just do the first one, which is we're looking at, particularly in the 1980s and the 1990s, residency training programs for clinical pharmacy specialties. And it starts out as just a few specialties and grows to well over a dozen.

11-00:02:37
Day: Yes. More than that, actually.

11-00:02:42
Meeker: Probably more than that now. It's probably two dozen now. The question is then what was the University of California San Francisco's role in instituting

the residency programs and then once those programs are established, in taking the lead on developing new specialties within those programs?

11-00:03:07

Day: Okay. I will try but the best person and the most accurate person to address that to would be Toby Herfindal, okay, because he was in charge of the Department of Clinical Pharmacy. He was also an associate director or director of pharmaceutical services at the time of the greatest expansion of our residency program. Now, we started off originally with just two or three residents. We'd had them since 1940. And not every hospital had residencies. But the residencies at that time, before clinical pharmacy, were not therapeutic residencies. They weren't clinical pharmacy residencies because they didn't exist. So they were administrative residencies. Theoretically the people who graduated from them were in a position to move into an administrative position, at least as a trainee, and in some cases they moved directly into them in smaller hospitals. So our place, and every other school of pharmacy that had an associated residency over the years, and there weren't that many of them. The American Society of Hospital System Pharmacists can tell you how many there were. Not every school of pharmacy had a residency. Actually, not every residency had a school of pharmacy, because some of the major hospitals had had residencies for pharmacists because they were pushed by the chief pharmacist, who at that time saw an advantage to having such a trainingship. So in the beginning they grew up associated with academics but they weren't necessary totally academic based. And their initial purpose was to basically provide training in pharmacy administration. In fact, some of those programs were associated when the university gave a master's degree. So you will occasionally come across a master's. I think it's called a PhM rather than an M.Ph, not to be confused with a master of public health. MPH. M.Ph rather than MPH. That may have been, not always, but may have been a person who completed a residency elsewhere. We never did that. We always had just the BS program. And if you were a resident at that time, there was nothing that got attached to your name after you completed the residency program. So we did that for the longest time, until it became evident that we had a program that needed emissaries, people who would carry—and I don't know that it was such a conscious step as an evolutionary one: "Well, we're doing this, so obviously we're going to be training residents to do this, as well." And we originally envisioned it—not necessarily as the people who would go out and establish programs only. I say that only because remember, as I told you earlier, in the beginning we were the only market available for clinical pharmacists and so a lot of our PharmD graduates in the beginning went off and got positions on faculties right out of school. But no residency. Now, that would be impossible today. Well, in some smaller schools, maybe, but usually they require a residency now.

So in the beginning Toby was in charge of the Department of Clinical Pharmacy. It was then called the Division of Clinical Pharmacy. And the program expanded greatly under his vision and guidance. It grew for two

reasons. Clinical pharmacy was here and secondly, there was an evangelical beat among the people who were doing this. They wanted others like them around the nation, I guess, naturally. And we needed residents ultimately to assist in the education of other students. So we used them almost from the very beginning as teachers, practitioners, always. That was the model: learning and practitioner roles. That's what we saw in the hospital, that's what we saw in the residency. So we were training teachers, practitioners. And we never quite lost the administrative part of it, because that was kind of like always there in rotations. But in any event, that was our original goal, was to train teachers. And we taught them how to teach by assigning them to our coursework involving clinical pharmacy, like the small group conferences that broke out of the third year courses. And we put them in charge of students when they would hit the clinical clerkships, now known as the advanced pharmacy practice experiences, APPEs. I'm so old, it's hard for me to get out of using the term "clerkships" because we used it for so many years. So they put them in those two areas of teaching, on the wards, or if you will, in the clinics, on the wards in a real practice situation. And also in the classroom, where they had them in small group conferences. So that was kind of like a matter of necessity also. And our program expanded accordingly.

Now, the program is paid for by the hospital. It's not our program. And I'll get around to the nation in a minute. It's not paid for by the school, so that we, at each step, had to convince hospital administration that they needed more clinical pharmacy residents available. And Toby is the only one that can tell you how that was and how that went. I make it sound like he walked up one day and said, "We need thirty more residents," they said, "Sure." It's not like that. There has always been a need to be competitive at the University of California San Francisco and Toby was a perfect match for that at the time.

Now, what was happening nationally? Toby can tell you much better than I can. I can only tell you my view of it as I recall it because I wasn't actually out there pushing residencies, since your question is about residency. You may recall that we were evangelical from the very beginning but we didn't shout it. We never published in that beginning area and that's why a lot of the original papers you will see about clinical pharmacy will not be from UCSF. In fact, I got pissed off at our faculty a couple of times and said, "You've got to publish. They're robbing what it is you've done." And I think I told the story of Rich DeLeon, who developed a patient monitoring form, and sent a copy of it because a friend requested it, only to see that reproduced in an article in which this person claimed to invent monitoring patients in a ward and, here was the form that he or she—I think it was a he—used at that time. Rich was really pissed off and asked what he could do and I said, "Not much. Next time just get smart and publish it yourself." So we urged them to publish. They didn't. And, in fact, that was why it was so paradoxical we often got accused of seeing ourselves as elitist and the sole founder of clinical pharm—which we did, of course, claim to be in our own circles, but never on a platform. We didn't get up there and say, "We invented clinical pharmacy."

And in fact, I used that as evidence when I got jumped on by my colleagues as to, "Oh, you're always putting yourself out there as the leader, as the big pusher of clinical pharmacy." And I said, "Show me. Show me where we've done that. Show me any paper where we claim to be the founder. Show me any paper by us where it basically says this is the way to go in the future, in the beginning." There were such papers, but I said, "You will find a torrent of them from schools that climbed aboard later on. So don't tell me we're pushing it, we're elitist, because we weren't." But we were evangelical. Although our practitioners had their writing hands frozen in concrete, they were actually doing it and pushing it and getting it accomplished. They didn't write, yes, but they did it and they talked about it and they talked about it at meetings and they put themselves on committees.

Toby, forgive me if you ever see this videotape. I don't remember. I think he became president of ASHP. Toby was definitely in charge of a commission in the early nineties—I think it was probably the early nineties, late eighties maybe the early nineties—to encourage more schools of pharmacy to establish residencies. There was, I recall, a meeting at the American Association of Colleges of Pharmacy urging them to establish that almost as a requirement of being a school of pharmacy because of the great need for it, the great demand for them and so on.

So did we push it? Yes, we did. Toby can tell you the details far better than I, and maybe even correct some of the stuff I have said. But insofar as I can see, we were always on the front line and we did it by example. Whether or not we published the papers, I think we drew a great deal of attention. I say, "I think" because I can't say, "Oh, you know, twenty-five schools said this." But I think there was a great deal of attention being paid to what UCSF was doing and a lot of our practitioners, like Mary Ann Koda-Kimble. Where she walked, the ground turned to gold under her. People bowed before her. So if Mary Ann Koda-Kimble said something, it became *ex cathedra* for the nation. And Toby had a great following.

Of our initial leaders, Bill Smith, didn't stay with us that long after he established the program, but he went down to Long Beach. And the fact that he was able to establish the nation's first clinical pharmacy service in a non-university based hospital in Long Beach Memorial was a hell of a step in that day. He was an evangelist for it. And Bill is never quiet, so he went off and he talked a lot about it. Can we take credit for that? I don't know. It all started with us and he went off and he carried it further. But it's an example of how we planted seeds or how Bill actually was the planter who then carried the seed also.

11-00:12:56

Meeker: Well, what about then the expansion of residency programs into these various specialties? It seems like, to me, they match pretty closely.

11-00:13:05
Day: To medicine?

11-00:13:06
Meeker: Medical specialties.

11-00:13:08
Day: Yeah. Well, that was the analogy we used. As I recall, and, again, this is where Toby would be of much greater assistance. The idea of a specialization grew up simply because of the necessity to be able to teach appropriately in certain areas that is within our school. Well, way back when, this guy who is now on the faculty at USC, came to us and said, "Hey, we need to do a clerkship," in mental health." And I think he was a resident at the time or he could have been a fourth year student. That was kind of strange to us because we hadn't done anything like that. We hadn't done actually anything that hadn't been pretty much mainline-based with our program. If we went to another facility, it was to do what we were doing at UCSF. No specialization at that point. But as I recall, he was the first one to suggest that we needed to establish a clerkship in mental health. I don't remember his name but, ultimately, he became the preceptor, in a mental health clinic in which that particular specialty thrived, although it wasn't called that yet. Thrived, that is, until Ronald Reagan came along and closed down every mental health clinic in the state. We don't have the money, he said, and the patients could take care of themselves. And they have and became what we now call the homeless. So he closed down. But basically, that's where it started.

Then I can recall something coming up about pediatrics and very shortly after that diabetes. Mary Ann Koda-Kimble. They arose because practitioners said, "This is what my interest is," and that ultimately became a specialization. There arose in the American Pharmacists Association, something called—what do they call it? Something to do with specialties? The Board of Pharmacy Specialties. It's basically a subgroup of APhA, American Pharmacist Association, in which they established certified specialties. Now, the first specialty they established was in radio isotopes, or radio pharmacy. A pharmacist who knew how to mix together radio isotopes was their specialization. And they've since expanded into others. But then, within a period of time, the ASHP began to talk about specializations, as well. And I'm not quite certain what the certification process is. There is a specialty called pharmacotherapy, which pharmacists can take an examination and they're basically a generalist in pharmacotherapy. I don't know what's required beyond that. But it spread, slowly in the beginning, but it spread as a natural process.

11-00:16:11
Meeker: Well, so the basis of differentiation of the specialties when it comes to pharmacy is in fact understanding very deeply the drug therapies that are specific to oncology or specific to diabetes?

11-00:16:27

Day: Yes, yes. They are capable of general practice kinds of concepts. They don't forget their other drug therapy but, they either actually are practicing it as, for example, pediatric pharmacists. You will hear that title used in a lot of institutions. "I'm a pediatric pharmacist." They will identify themselves as such. "I'm an anticoag pharmacist." "I'm a diabetes specialist," or whatever it is. You will hear those terms used within the practice sites. But as I said, they grew initially as an evolutionary step, a natural evolutionary step. The blocks fell in that direction. Let me back it up. The message of clinical pharmacy in the very beginning was that no physician in the nation can keep up with all the drugs and the diagnostic procedures and the testing procedures and the treatment, okay. Can't do that. It's just too much for any given person. The Taskforce on Prescription Drugs pretty much identified that. I mentioned that earlier a long time ago. That was 1960 some odd. We could have kissed them for what they said because they basically gave us not the ammunition we needed. We said, "Look it, we didn't say this. It's being said by a commission that has no pharmacist on it," in fact. But they didn't use the word pharmacy. The solution from the Taskforce on Prescription Drugs was to give physicians more pharmacology training. That's how much they understood what was going on. Which we said, "That's great," except we said, "you can't do that for every medical student or physician." So that's where the specialties arose. Every pharmacist can handle all drugs at some level but you can't become an expert in any one unless you are an expert in that area because each one is so complicated.

11-00:18:29

Meeker: So what we're looking at here is a historical transformation by which physicians in the late fifties and early sixties are beginning to acknowledge that they are no longer capable of—maybe they didn't say it like this—holding all medical knowledge, including drug therapy, in their heads and that maybe they're going to sort of farm out a branch of this, which would be the drug therapy to pharmacists?

11-00:18:55

Day: No, no. I don't think there was ever that conscious admission. I think what happened is you got next to a clinical pharmacist and pretty soon you recognized what that guy could do. I had been involved in situations where there were discussions with physicians who had never encountered a clinical pharmacist before, in which—well, I remember one specifically way back in the beginning. Buzz Kerr, was one of our early graduates who went off and established the program at Maryland, was placed in charge as a brand new resident. So talk about residencies paying off in the very beginning. Buzz graduated in the seventies, early seventies. He went off to Maryland and was put in charge of developing the clinical pharmacy program there. I had invited Buzz and a physician to be part of a program that we were presenting at the American Pharmacists Association and we had dinner the night before. And the physician had never met a clinical pharmacist, okay, and obviously Buzz had worked with a lot of physicians. So we were having dinner and the

physician kept asking Buzz drug questions, but it was pretty obvious to me what he was doing. He was testing him. So he kept throwing him these complicated questions and Buzz kept responding. And it went on for about fifteen minutes, and I said, “Okay, Buzz, now you ask him some questions, okay, about therapy. Let’s see what this guy knows about therapy. Yeah, diagnosis. Let’s see what this guy knows about diagnosis. Or better yet,” I said, “let’s see what he knows about therapy. Why don’t you run him down the diabetes corner.” At the end of it the physician said, “I never realized that the pharmacist could do these things.” And Buzz said, “Not all of us, but a lot of us. And if you seek them out, they will let you know who they are." So it wasn’t that I think physicians consciously said, “Oh, we've read the reports, oh, we’re deficient.” I think clinical pharmacy arose, they had contact with it, and I think out of, in some cases, just due to the sheer burden of handling so many patients, they sort of said, “Yeah, sure.” That’s what nurses did. When we first went to the 9th floor, we said, “Oh, we’ll mix those drugs for you, the IV meds.” And they said, “Wow, thank God for that.” We had to come with a card that said this is our entrance to the ninth floor project and that was in the form of a satellite pharmacy.

11-00:21:08

Meeker: So is this same process then happening amongst pharmacists come the 1980s and nineties when there’s a recognition amongst pharmacists that the universe of drug therapies for a variety of different conditions, whether we’re talking about pediatric admissions or adult oncology is so vast and diverse and complex that now the universe of knowledge demands a greater specialization and a greater expansion of the number of specialties for pharmacists themselves?

11-00:21:44

Day: I don’t know. I can’t give you a good answer for that one. I think that pharmacists became interested in it because as they were going through school, or whatever it was they were doing in practice, they developed an interest in that area and ultimately, if they were still in school, they could select a specialty and go for it. I think it was kind of like that. When I graduated, a kind of apprentice drug product formulator. I actually did it—I formulated drug products at a very low level of sophistication—but that’s what I did at Westlake Medical Pharmacy. I developed external drug products, a whole line of them, that we actually dispensed or sold and that was what I did. I was a product formulator. I got that in school, but it was a specialization because I was really interested in that area. And I think that’s what happens to students and maybe happened in the beginning to pharmacists, who at some point maybe had already made the decision. “I really like pediatric therapy or diabetes. I’m going to learn all I can about that whether or not there’s a role in it for me.” I think people just osmosised toward that which really interested them and that was in the beginning. Later on, a student would be in a curriculum and say, “Oh, look at this. I’ll have a little bit of strawberry, some vanilla, and that, and will pick out their flavors as they’re going through,

because there were opportunities that were available. It was no longer academic, to play on words there. No longer were they taught, "Well, learn this and then go off and don't do it." There were practice roles.

11-00:23:19
Meeker: Well, the thing I think I'm getting at is, I wonder if, say, in 1965 the drug therapies available to treat cancer are so few and far between that it would be pointless to try to develop a real specialization.

11-00:23:40
Day: In oncology?

11-00:23:41
Meeker: Yeah.

11-00:23:42
Day: What year did you give me?

11-00:23:43
Meeker: Sixty-five.

11-00:23:45
Day: Oh, well, in '65 so much was unknown about the whole field of it. Yeah.

11-00:23:49
Meeker: Well, then, let's fast forward to 1995.

11-00:23:51
Day: Yeah. Well, by that time we had long since developed a specialty in oncology. And, in fact we had an oncology pharmacist who was on the ninth floor who was assisting in the therapy associated with oncology patients.

11-00:24:04
Meeker: Or you can take any of these conditions. Diabetes or—

11-00:24:08
Day: Yeah. Okay, is there a question in that? I'm sorry.

11-00:24:11
Meeker: What I'm trying to chart here is just what's powering this increase in the number of specializations that the pharmacists decide that they're going to go into. Is it, like you said, a longer program of education so people just simply gravitate to areas that they are interested in or are we seeing a vast expansion in the number of drug therapies in the entire universe of medical therapies that demand specialization not only from physicians but from pharmacists.

11-00:24:55
Day: Yes. We're increasingly seeing that. In the beginning there were those existing areas like cardiology, diabetes, pediatrics, geriatrics. A little kid is not the same as an eighty year old guy in terms of the way he or she handles drugs. And so they arose. There were just substantial numbers of people who were

the target. It wasn't as though Joe next door was the only guy in the world with this problem. There were statistics to show that certain people didn't get what they were supposed to be getting and that, along with other factors—there's no single reason for a growth of a specialty. It wasn't, "Wow, it's there so let's do it." It was, "There's a need. Wow, it's there, there's a need, and it was identified by some people who then developed a specialty in that area, proved that it was effective, and then they got other people to do it." Somebody just didn't say, "Oh, look! He's doing cardiology." No, no. "There's cardiology. Think I'll do cardiology." It had to be shown that a pharmacist could do something in that area, because in the beginning, pharmacists were doubting Thomases as well. So there had to be a need and that need was filled by people that said, "Okay, I either like that," or "I want to do that," or "I think I can be of assistance there. It can be anywhere, a whole range of reasons why." In terms of what's going on today, you are right. It is exploding. We're talking about genomically-based pharmacists. We're talking about genetically based pharmacists. We're talking about people who will make predictions in drug therapy based upon your individual metabolism and your DNA ultimately. And so, yes, the whole notion of therapy has gone from let's slap a band-aid on it and cure it after it's become a problem, to let's slap the band-aid on before it gets there and block it from happening and all that will involve some form of sophisticated therapy, whether it be in the hands of a pharmacist or in the hands of a physician, I don't know. We're moving into strange territories in terms of health care.

11-00:26:56
Meeker: Would you care to make a prediction how this might impact the work of the pharmacist?

11-00:27:01
Day: No, no. I wouldn't. But it's based upon history that I won't make that prediction. The future's opaque to me. The damndest thing can happen. Tomorrow there could be a computer invented that replaces humans. I'm using that as an exaggerated science fiction thing. So what are we humans going to do? And all predictions we had about us driving cars becomes unnecessary because it's all being done by computers right now. No. The future has too many snags in it for me to do anything other than make funny things. I mean, I can tell you today what could likely become tomorrow's joke. That's what my prediction would be. This is what it's going to be and somebody would quote me in the future. "Did you know back in 2013 Bob Day said the following? Ha, ha, ha!" It's not that I fear that laughter, it's just that I've seen it happen. I've seen people eat their words, including me. So, no, I know that I cannot predict the future. And I would never say this is the way it's going to be. I can say there's lots of opportunities there and if things go on as they are, that would be great. But the future's never linear. It's never been linear in my experience.

11-00:28:10
Meeker: So what I want to talk about next is something that I believe we talked about offline and that is the international exchanges between UCSF and basically other pharmacy programs around the world. I know that there were a series of exchanges with colleges in China. You had mentioned a program that Mary Ann Koda-Kimble established with Japan.

11-00:28:36
Day: Yes.

11-00:28:37
Meeker: And then I also know that you received some sort of acknowledgement from pharmacists from Vietnam, correct, or those were Vietnamese Americans?

11-00:28:47
Day: That was a different thing. But we did have an influence on Vietnam. It wasn't me. It was Mary Ann and some other people. No, no, stuff like that from Vietnam was something I did for the Vietnamese pharmacists in the United States.

11-00:28:57
Meeker: Okay, all right. So Vietnamese Americans basically.

11-00:29:01
Day: Yeah, American Vietnamese. Yeah.

11-00:29:03
Meeker: Well, let's talk a little bit about the consulting arrangements between the United States and the colleagues in China. How did that come about?

11-00:29:11
Day: In China?

11-00:29:12
Meeker: Yes. Because I know that we had talked about it and you said that there was an exchange established that turned out to be less of an exchange and more of a knowledge dump.

11-00:29:24
Day: A one way street.

11-00:29:26
Meeker: So what was the nature of that exchange? I'm curious here about the global dissemination of the kind of work that's being done at UCSF to developing countries and programs around the world.

11-00:29:41
Day: Well, okay. So initially, going way back in the beginning, we attracted international interest almost from the very beginning. But they really didn't get serious about it until the eighties, like 1986, '87, '88. Quite frankly, we weren't interested in international involvement in the very, very beginning

because we had enough to do just getting our program off the ground, firmly established, and growing and blossoming and enough to do in the United States without expending our limited resources by trying to do what we had done for certain schools of pharmacy in the United States and not serve as a specific role model for them. We just didn't have the energy or the resources or whatever. Or if we had the interest, which we sort of did, it was always enticing, but every time we thought about what it would take, the resources it would take, because even if we were to sell it--which we have never terribly been very successful in doing—we worried about the resources. We worried about what it would do to us, because who would we send? We would send our key people and our key people were needed here because they were doing key things or they wouldn't be key people. We didn't have enough of them to do that. Over the years we had been visited by various people. Pharmacy associations from UK would be in town and they would ask to have a tour of our facilities. Did not lead to anything. I don't really know why. Toby had much closer ties to the international scene than I did, okay, because he was an international figure. He became a part of a group of Australians and others, who called themselves, Austral-Asia, or Pan-Pacific, whatever they call that area down there. He became a part of a consortium that exchanged ideas that he could tell you about involving New Zealand, Australia, I think. It involved Dick Gourley. Maybe it involved six or eight deans. Toby could tell you all the international connections, okay.

But the first one I can recall where it was formalized is when we were contacted by Shenyang University in China, and asked would we be interested in an exchange program? Now, whenever we heard that in the beginning, it usually was not the practitioner program that they were primarily interested in but research. If you visited them, you would see that their big emphasis was on their research, not necessarily on practitioner education. Nevertheless, they were grappling with the same thing we were grappling with. What do we do with this person we're training? But we never lost track of our undergraduates. We never ever said "Thank you for paying your tuition because that assists us in doing our research." It was that's our job along with research. And I'm not being chauvinistic when I say that. We always were that way. It was one of the nice things about the school. And I don't mean they did this consciously. But if you met with some of our Chinese colleagues, it was obvious that their biggest source of pride was not their graduates, it was their research program.

Shenyang University had a school that was training technicians basically, medical technicians. They were pharmacists, but if you looked at their curriculum they were chemists. They were what we had done thirty years earlier, with some difference. They were specializing in manufacturing. They were specializing in herbal remedies. They were specializing in research. Because, remember, they had just gone through the revolution—what did they call it? It had a name. The Cultural Revolution.

They'd just gone through the Cultural Revolution maybe five years earlier, six years earlier, and that had stripped them of their ability to conduct advanced research. All of their researchers were put out to the fields. They had to be rotated through the people's jobs. Didn't matter whether you were president of the—well, I won't go that far. I do know some of the members of the faculty that I met with ultimately had to work a certain amount of time doing something else, working in the fields because they were all paid the same amount of money and they had this egalitarian notion of what society should be. "We're all the same," they said A physician should be working cleaning out sewers. That's extreme. But in any event, so they'd been stripped of their pride, they'd even been made to feel embarrassed because of their "elitism." So they wanted to catch up.

So when they first contacted us, they dropped the calling card. "Yeah, we're interested in your teaching program and your Ph.D. program." So in the beginning it was that kind of a connection. They wanted their sciences and, hopefully, maybe even their schools to be suddenly booted into the future. They knew about our clinical pharmacy program, and I believe in all sincerity they were interested in it. So it was kind of like, "Oh, yeah, that would be interesting." And when we went over there, they dropped the word. So we basically established an exchange program. It started off with a visit from us to them. We sent to the dean and the chairs of our departments: Les Benet Department of Pharmacy and George Kenyon, Department of Pharmaceutical Chemistry, and Toby Herfindal, Department of Clinical Pharmacy, went over and visited with them and talked to them about all of these things. They will have to give you the details. At least George and Les Benet and Toby, if you're really curious about that. The dean, Jere Goyan, has died. And they came back really elated and happy that there was such a progressive spirit swinging through this school, although they had been weakened by their having the research strength stripped from them. They were rebuilding basically. The campus was impressive. It had something like 20,000 students, as I recall, pharmacy students. It was a small city. I visited years later, maybe in '77 or '84. And it was like a small city. But that was the beginning of the program. Okay, now, by program it was—they—

11-00:36:52
Meeker: Just on your CV you had Shenyang College of Pharmacy '87 to '95 so—

11-00:37:00
Day: Yeah. They appointed me as a voluntary member of their faculty because I was in charge of communicating with them in certain areas, and I actually visited the campus. You shouldn't see any significance to that. They just loved giving titles to people and since they'd given it to me, I put it in the CV. Yeah. I'm trying to impress people, too. I'm an international professor. And, in fact, I was the one that had to erase it because as far as they were concerned I still have the appointment. Anyway, so the original exchange program was they sent over three scientists, maybe four. I'm trying to remember how many. Dr

Sun is the only one whose name I fully remember. And basically what they did while they were here was they poked around in our clinical pharmacy program. I met with them and shared with them some of the notions of the clinical pharmacy program. But they also were able to get assistance in their research projects. In fact, we gave them them access to our mass spec, which was an incredibly important and powerful analytical device for chemists and physical chemists and so on and we let them use it.

11-00:38:10
Meeker: What is this?

11-00:38:12
Day: It's called a mass spectrometer. I'll leave that to the scientist to tell you about it. I know what it is but I don't want to make a fool out of myself on videotape as I fumble around for the proper words to describe it. But they were given priority. Actually, the guy in charge of it, Al Burlingame heard they were here. I went to him and I said, "They would like to have access to the mass spec." He said, "Okay, we'll move them to the top of the list." It was a campus resource and it had a waiting list to get on it to use it because it was such a phenomenal device. It was one of three in the nation, or two, and the only other one I think was at that time at Cornell. But in any event, so they were given access to this incredibly powerful device because Al Burlingame felt an obligation to assist them in their research. He knew all about them. So they came over and stayed, I think it was about a month or so. They paid for their stay here. They were wined and dined excessively. We had them all here in this house for dinner. That was in '86, seven, eight, nine. That then led to eventually a request on their part to have an exchange program. It was obvious, and I don't mean to say this as an elitist statement—they had nothing to offer us. They were so fascinated with herbal remedies that their chemistry was retro. They were doing the old stuff. They were looking at what was in stuff and trying to find active drugs. We hadn't done that in years. We weren't looking for drugs but the basic knowledge that led, perhaps, to new drugs. There's a difference. As they were doing thing like sorting out all the alkaloids, which are chemical components of—God, I wanted to say yohibine, but it's not. What's this drug that looks like it's a human figure?

11-00:40:22
Meeker: Buddha's Hand?

11-00:40:23
Day: Ginseng, ginseng. They were taking ginseng and they told me they had identified 179 constituents and this fraction had hypertensives, this was a tranquilizer, this was good for diabetes, this one was good for this and that, so they were doing retro stuff. They were looking at stuff. And I'm not trying to say that's not important today, but it wasn't the kind of stuff we did then or now.

11-00:40:45
Meeker: So it's sort of deductive reasoning as opposed to inductive, is that right?

11-00:40:48
Day: Well, no, no. It was the model for drug research in the past. There were people that would cultivate bacteria from around the world in hopes that it would give forward a new antibiotic like penicillin. And, in fact, they did find antibiotics that way. So it was like looking at what something does and saying, "Let's extract it. Now let's try and identify it." So their kind of research was to look at drugs, and particularly native drugs, natural drugs, because a major part of their therapy in China was, and maybe still is, what is known as traditional medicine. Traditional medicine is herbal-based and it has centuries of experience, therefore centuries of either bias or centuries of effective use. But they discovered ephedrine, the Chinese, and other such things as that. Mahjong. Was it mahuang? I forget what they called it.

So the first part of the program was where they people sent to us and then they asked us to send people over there. And we did. We sent clinical pharmacists over there. We sent researchers over there for brief periods of time. Clinical pharmacists might stay a month or two. And we did that for a couple of years and I don't remember how long. But it ended because, as I said, they had nothing to offer us in exchange. And I feel so terribly bad when I say that because they were conscientious, deeply concerned, and expert in their fields, but they weren't expert in fields that we had an interest or expert in fields that could assist us. We were never completely turned on by traditional medicine, if you will. And as you're well aware, a lot of stuff going on today about so-called home remedies and supplements that just says much of it is a lot of it's crap.

11-00:42:38
Meeker: Well, there was an interest, particularly in the United States in the late eighties and early nineties. A popular culture interest, at least. I remember there was this famous Bill Moyers special, a multi-episode special, looking at alternative medicines, right, and Chinese traditional medicines was one of these. And the way that it was communicated popularly was that these have been effective remedies in China by use.

11-00:43:12
Day: Traditional use.

11-00:43:13
Meeker: Traditional use for millennia.

11-00:43:15
Day: They must be good then, right?

11-00:43:16
Meeker: They must be good, so now it's time for the west to in some ways catch up with the east to find non-toxic remedies. Was there interest amongst your

colleagues who were going to China in learning this? Were they taking this seriously?

11-00:43:38
Day: They were taking it seriously because they wanted to understand what they were confronting when they encountered almost a, I don't know, devout culture of people who were onto family remedies and what became known as supplements. The whole history of that industry is shoddy as crap, if you look at the way they influenced Congress to exclude them from the FDA. Why? Because they would be shown to be ineffective. So, no, any doubt that anybody ever has about these remedies is not that they don't work, it's that until proven to me that they do work, and proven to me by means of scientific measurement, not by, "Oh, I feel better stuff," then we're not going to accept it as mainstream. I'm not going to. There may be other pharmacists who will. I won't. I need evidence. I am a doubting Thomas, okay. And I don't say it doesn't work until they prove it. I'm saying it shouldn't be used until they prove it. And then when it's proven, and if it's so damn good, why aren't there more studies out there to show that it is by the very industry that's making billions of dollars off of it? And so therefore they don't. They don't do it because they know—I don't know what they know. I know that they don't do it.

So our interest in remedies was that we needed to know, yes, something about Chinese traditional medicine because maybe there was some stuff in it for us. If only our understanding of some of these things that are used in the United States, particularly in the Chinese population—and as you're well aware, some of those drugs from China got on the market here and they had in them prescription drugs that actually hurt people. Yes, phenylbutazone was found to be in some of these. Phenylbutazone was a drug that was used for arthritis. It's not used anymore because of its side effects. And they used to give it to horses because it let them run faster because their joints didn't hurt. But it was popping up in some of these remedies, home remedies that were sold through the traditional Chinese medicine outlets. So call them contaminants or whatever they were. I'm off the track. We were not fascinated that much by the opportunities that had off—and it cost us a lot of money. And ultimately that particular program faded out, okay. We didn't write as often and then ultimately we didn't write at all. But it died a slow death because I forget the last guy that went over there was in the late nineties or early 2000. Went over to China, not necessarily to Nanjing. But there are other places. And we just had like a sister relationship.

Now, China at that time was on the move. We weren't the only school that they contacted. Nanjing University always wanted to establish a program with us and they always came over. Guo Gie Lieu, who was a hell of a guy in China, world renowned professor at Nanjing, wanted a program with us. But he was never able to come up with a program that worked. And it wasn't because we said "no." Every time he would visit us he'd say, "We need to do

this." And we would say, "Okay, what is it you're willing to do?" And he'd go away. And it wasn't because he wasn't willing, it was because he lacked the resources to go any further. Here you had this massive giant that was beginning to emerge and that story comes up later and I'll tell you that there was a major potential for wonderful relationships between research institutions and China and it wasn't happening. For some reason it wasn't happening. It was all one-way. They had the money to send their people here. Toby can tell you the details. I think they paid for our faculty's sustenance and their transportation and their housing, but I don't think they paid for their salaries. So when we sent a guy over there, we lost a faculty member for a month. But that would have happened anyway. But we also lost his or her salary. So that faded out.

Over the years, we had other countries contact us. I don't know the exact story behind TUPLS University, T-U-P-L, Tokyo University of Pharmacy and Life Sciences. I don't know who did the original contact with TUPLS, but with TUPLS, we went into it from the very beginning feeling that we were fulfilling, in a sense, an international obligation, but we weren't going to take it in the shorts in terms of money. And so from the very beginning, probably stimulated mostly by Mary Ann Koda-Kimble, our understanding with them was we will provide you with the following and this is what it will cost you. And they went for it. And I think that's still going on, but I do know it went on for a long time, if it isn't. And TUPLS University now has a major clinical pharmacy program. And I don't think it's the only one in the nation because there, as well as here, there are seeds that get planted. And Japan was hardly a third world country. They were aware of what's going on. You could go anywhere in the world right now and say, "Is there a clinical pharmacist around?" [finger snapping] "I'm one." There'll be one right away. But they aren't. But they think they are because their definition of clinical pharmacy is quite different. I'm doing something different from the other guy. But in many cases, that guy will be a clinical pharmacist. Man or woman will have been either self- trained, stimulated to learn this by themselves, and put themselves in positions where they can do it. There aren't many of those. But some. Or had been trained in a foreign country. So in the beginning China began to establish these things, where for some schools they would buy positions in a pharmacy school. That is to say student positions. I think USC had such an arrangement with them. But if you were to ask for a show of hands at a meeting of deans as to schools that had some kind of a contractual relationship with China, I would imagine you'll see a fair spread of hands. I wouldn't say unanimous but I mean five, ten, fifteen. Significant. And each of their programs might be different. But some of them were where they actually pulled in faculty and trained them. Which we did. We trained the TUPLS faculty. We've had other visitors. Our Department of Clinical pharmacy began to become a little bit more entrepreneurial in that it would offer kind of like a two or three month training spell if somebody wanted to send a faculty member over. And they have had a number of those over the years, not a massive number, but a number and the reason they're doing that is because we

can't afford to give it away. It would be very nice to say we have this obligation to the world, but our obligation to the world extends only insofar as the university is willing to pay for that and they aren't. And so therefore it always came out of our hide, whatever our good intentions were. And so therefore we had to put it on a pay-as-you-go basis.

[A portion of text has been sealed until 2038.]

Meeker: So it sounds to me like the contrast of Shenyang and this Tokyo program is pretty clear. That it's possible to do successful international training programs but there has to be sort of a mutual commitment on both sides in order for them to work—

11-00:59:07

Day: Right. And our faculty are still going over there. Steve Kaiser, Don Kishi. I think last summertime they were over there. I don't know where that contract is. And it's probably scaled down now because I think that they may have reached a critical mass. But, again, keep in mind that I was not directly involved in that project so everything I tell you is what I think. And if you really need details on that you need to talk to Steve or to Don or to Mary Anne.

Begin Audio File 12

12-00:00:24

Meeker: Just one last question about the relationship with China and sending faculty over to Shenyang or other universities. Apropos of this question about traditional medicine and thinking about being at UCSF, and there is a very large Chinese and Chinese American population here who does continue to use these traditional medicines, where there is not a lot of knowledge about what's in them and how they might interact with Western medicines. Was that one of the motivations for sending UCSF pharmacy faculty to China to engage or observe their research to get a sense of possible negative drug interactions? Not necessarily what good traditional medicine might do but perhaps how it might complicate the delivery of western medicine.

12-00:01:28

Day: Well, that was of great concern for the emergence of this industry, to where it began to really push. But they didn't do that at the time we were going to China. The folk remedy industry in the United States was tiny in comparison to where it is today. So it wasn't perceived. There were folk remedies and that was the thing that we were curious about, because people were taking those things and they were taking drugs. By drugs I mean prescription drugs or drugs cleared through the American system of drug approval. And we were concerned about interactions, because, remember, one of the things that gave birth to clinical pharmacy was drug interactions. We were concerned about physicians prescribing things together that shouldn't be for whatever reason, and there are a lot of reasons why. And so in those days we were, in the beginning, concerned about folk remedies, but, remember, not traditional

Chinese medicine but folk remedies as we knew it. And ultimately a little bit about traditional Chinese medicine. I don't want to either overplay or underplay that because I was not a part of that thinking at that time. I was more concerned with the logistics of the program and what it was we could do, although I did go over there with a group later on unofficially and was poking around for ideas and so on. But our initial concern about folk remedies was just that, things that people have been going out in the fields and picking. And did these two have some problems? Should physicians and pharmacists know that they were taking these drugs? Because some of them did have an adverse effect on their disease or on whatever it was they were taking that had been prescribed for them. We no longer have that deficit in our curriculum. We actually do tackle it. We have people on our faculty right now who are specialists in folk remedies and I don't know to what extent they would contradict what I have said. I doubt that they would contradict it. They probably just wouldn't be as cynical as I am. I don't know. I'll leave it up to them to say that.

12-00:03:39
Meeker: Maybe they see the folk remedies as more benign than anything else.

12-00:03:43
Day: I don't really know. I don't know. We've never had that conversation. These are not people that I don't admire. They're not quacks. They're not, "Oh, well, that's Jacob. He's a little crazy anyway." It's not that at all. These are mainline practitioners who have taken this area seriously, who look at it seriously and who are much more attuned to the literature than I am in terms of literature of this stuff. And the literature of this stuff, if you ask me, because I don't dig into it every day, is shoddy. I don't trust most of it. It's published in magazines like *Naturalist* and *American Vitamins of Today*. I don't know.

These crazy popup journals. I've become so cynical about journals anyway, knowing how many of them are basically sponsored by the drug industry and are made available to physicians and pharmacists, that are there for one reason only, because they work. But they're paid for by an industry and I'm always suspicious of that. And I'm not saying that all these are. But there's a whole vitamin supplement industry out there that has to have an outlet for its propaganda and I am sure it's found it.

12-00:05:00
Meeker: Well, that was a good segue because the thing that I want to ask you about next—I'm going to try to ask you specifically about something that we have been talking about in general through most of these interviews. And that is your role in the administration of the school pharmacy, in particular the various positions you've held and then the final position was associate dean, correct?

12-00:05:29
Day: Yes. It was preceded by an associate dean "for," okay.

12-00:05:33
Meeker: Yes. So an associate dean for clinical pharmacy?

12-00:05:38
Day: No, for professional affairs. Associate dean *for* continuing education, associate dean *for* student affairs. I always explained as the following: there are all sorts of associate deans *for*. I'm the only one that's not for anything. I'm associate dean.

12-00:05:50
Meeker: And that was the position that you attained in 1984. Is that about right?

12-00:05:56
Day: Way back when. I don't know. Maybe. I've lost track. It's been a long time. Could have been.

12-00:05:59
Meeker: Well, let's say for the sake of argument that it was about 1984.

12-00:06:03
Day: Yeah, I think that sounds about right because Jere had come back from the FDA and Neil Castgnoli left. Yeah.

12-00:06:10
Meeker: Does this position still exist now that you're retired?

12-00:06:13
Day: I don't know. Joe says no. He hasn't reappointed yet. Joe says that he's learning what it was I did because Joe Guglielmo is the interim dean. And I'm in the audience so Joe's being very kind, I think, when he talks about how much he misses me. But you'll have to ask him. But I know that I've not been officially replaced.

12-00:06:43
Meeker: This is helpful then, I think, this conversation—

12-00:06:45
Day: That means I was useless. [laughter]

12-00:06:47
Meeker: What?

12-00:06:49
Day: "Bob Day's gone? What?" "Oh, was he here?" [laughter]

12-00:06:53
Meeker: That's one way you can look at it. Well, I guess what I'm trying to get at is since maybe he's only now learning what it is that you did, I'm wondering if

you could give me a sense from your own perspective of when you became an associate dean for nothing. Just an associate dean.

12-00:07:15
Day: *For* absolutely nothing.

12-00:07:18
Meeker: What were some of the main activities that you did? There's a negative way of defining it and this is what Mary Anne Koda-Kimble said. And she said that it's anything the dean doesn't want to do.

12-00:07:32
Day: [A portion of text has been sealed until 2038.]

I was there as a member of the faculty and I worked well with students, initially as half-time, then as full-time. But I was always at student functions. It was obvious that I was pretty well-liked by students. At that time we had no student affairs office, we had no dean for students in the School of Pharmacy. There was a campus-wide one, but he really wasn't anything other than—no, he was a nice guy but he could not reach down into the depths of a school and act as their dean. So Jere Goyan was nudged by a couple of students, one of whom was student body president, said, "Why don't you get Bob Day to become dean for student affairs? We really need somebody we can go to, et cetera," because I was there because I was one of the guys, went to their parties, drank beer with them, all that kind of stuff, because I was also advisor to what was then known as the American Student Pharmacist Association, the student branch of the APhA. I took on this title and I was the first assistant dean, because that was my title, for student affairs. And basically what followed was that I began to develop the role of the assistant dean for student affairs. Took on such things as scheduling, and the people who did the admissions work reported to me. I held that job for I don't know how many years, until clinical pharmacy came along, and I did it even then for a while.

And then a successor was appointed, Bob Gibson, I think succeeded me. And at that time or shortly thereafter Jere appointed me as associate dean for continuing education because I had been doing that unofficially. I had been sort of like giving continuing education courses from the day I'd been employed, organizing them, I should say. Organizing them, because that's one of the reasons I was picked up half-time, was to do the continuing education courses. Let me think about that a second. No, I'm sorry. It was one of the things when I was appointed full-time, that became one of my tasks. But I had no title for it. Director of Continuing Education was my unofficial title. So Jere then appointed me as associate dean for continuing education and under that, working with Ken Lem and others, our continuing education effort quadrupled. And our involvement in continuing education on a national scene increased and at the state level. I was chairman of the committee to establish the continuing education requirements for the State of California pharmacists. The first such in the nation, because there had been a law passed that made

continuing education mandatory for pharmacists. We were involved in that law only from the point of view that we fought a section of it, because originally it was seen by the California Pharmacists Association as an income maker for them because they pushed for the establishment of a law for mandatory continuing education, but established the CPhA as the only source of it in the proposed law. So we fought, that section basically was removed and it passed. So now California had a law but no regulations. So I became part of it because I had been involved in CE and we pulled in people from the other schools, formed a continuing education committee which then proposed regulations for the Board of Pharmacy to adopt or if not the policies and procedures, and formally established the accreditation system for the State of California in which we in the future approved or disapproved of courses for continuing education credit. We established the criteria, et cetera.

So I was associate dean for continuing education for a while and then Jere decided we needed to expand into the professional area and so I became associate dean for continuing education and professional affairs, which meant I attended meetings, I got the school's flag waived. I made certain that UCSF had a presence and it didn't mean wandering the halls. It meant getting involved in the associations. And so that's why I began my long career of attending a lot of association meetings, which actually never ended. So in the beginning that was it. CE and professional affairs.

And then in 1984 the associate dean of the school retired. Or didn't retire. He resigned because he went off to go some other place and Jere came to me and asked me if I would take over his job and I said, "Jere, I really am not qualified for that." I looked at all my predecessors, Gene Jorgenson, Neil Castagnoli and they were all PhD scientists. And the associate dean of the school, as far as I was concerned, well, at that time had to write up the promotions for everybody in the entire school. And I said, "How can I possibly write-up a promotion for a scientist?" Jere said, "You can do it." Well, fortunately there was a separate movement afoot in the Department of Pharmaceutical Chemistry. They had the same concern I did and so they asked to be excluded and asked that some other person be assigned, a scientist be assigned to write-up their promotion packets. And I was totally relieved.

12-00:13:28
Meeker: So is this writing up the evaluation of tenure cases, those kinds of things?

12-00:13:31
Day: Yeah. No, for everything. For merit increases, for promotion, for tenure, for step six, step seven. That was to be my job. And it was for a very short period of time. And it was a drudgery. It truly was. Because I was not in a position to analyze the magnificence of our faculty from a peer point of view. I was kind of like a hero worshiper of them. So it was George Kenyon, then chairman of the Department of Pharmaceutical Chemistry, who said, "I love Bob but I don't want him doing the write-ups." And I didn't care. In fact, I was relieved.

12-00:14:13
Meeker: Did you continue to do them for the clinical faculty?

12-00:14:16
Day: Did it for the clinical for a long time, until my job, frankly, got so complicated that at some point it was turned over. Brian Alldredge became the associate dean for academic affairs and Brian had the ability to do the write-ups for clinical and for the professional and he asked me would I mind if he took over the clinical and I said, "Not at all. Not at all." It was not something that I said, "Oh, this is my territory. I really love it and I got to hold onto it. It's what makes me." It didn't.

So then we come to what it was that I did. Well, there was a time there where George Kenyon was dean, and the associate dean for administration of the School of Pharmacy resigned. And there was concern about his successor and the school was not prepared for this resignation and that's a really tough job. And the potential successor was considered a less than—what's the word—ideal candidate because that person also was disliked by the staff that was in that department. The associate dean for administration's department. Not disliked. That's too strong. Considered less than ideal. I'll have to leave it at that because I don't want to besmirch that person and I never did understand the staff's reaction to it. Because I was not a part of it but they asked me to become the interim associate dean for administration, which I was for a year or two. And I don't remember how long. But at the time I was asked to do it I said, "You're out of your head. I don't even know what a ledger is and you want me to be in charge?" And it was quite clear it was a scheme basically connived by Les Benet and by George Kenyon. It was Les Benet's impromptu idea that this would give them time to recruit. I knew that from the very beginning. This would give us time to recruit a person for the job who would be acceptable to everybody at an equal level and that my job in the meantime would be to work with the staff as the interim associate dean for professional affairs and keep them together if any such things as that were necessary. So I did that, and I needed a lot of education. But that was a period of my career where I was all things. I was then associate dean for professional affairs. I was teaching a major course. I was also associate dean for administration interim. And thank God for the people that worked in that unit because I relied upon them more I think than any administrator at my level ever did before. Or maybe they all did that, but I don't know.

I sat them down one day, basically said, "Look it, I am nothing without you, which is probably true of every guy in this position, except me more so. So I will need a lot of guidance, a lot of help. You see me step out of line, I need to hear that. If I think you step out of line, I'll tell you. And it was a pretty smooth period. I cannot tell you what my contributions were because I don't think I made any." I may have. And, in fact, when we recruited the person who came aboard she said, "Bob, why didn't you go for the job?" I said, "One

very good reason. I may have the ability to administer but I lack vision in this particular area. I don't have a clue what the next step should be."

So that ended and I then fell back on what it was I did, which then brings me to the story of what did I do. And my first line I always told everybody, "I have no idea what the hell I did." I cannot tell you what the hell I did. Mary Anne says the associate dean does what the dean doesn't want to do. That may have been true. That probably was true. I, in some cases, anticipated she wouldn't want to do something so I did it. I was given a great deal of authority. It was something I'd always done with George Kenyon. A lot of it I'd done with Jere. First of all, remember, I was associate dean under Jere Goyan and my job then was, God, whatever it was he didn't want to do, plus I was a speechwriter for him, which I had been when we were colleagues, just simple colleagues on the faculty, although at one point he became dean. I don't know what I did. Honestly, I continued to go to associations, continued to voice the school's concern in terms of policies the association worked with, meet with the Board of Pharmacy, continued to establish myself with them, continued our relationship with the Board of Pharmacy. Was involved in an effort to establish a statewide committee of associations in schools of pharmacy and the Board of Pharmacy that would attempt to present a united front for pharmacy in the State of California? That wasn't my idea, it was created by somebody else. I'm one of the few people that tried to get it off of the ground. There were others with me. It failed and then somebody wanted to renew it again and I did that for a while again. It's called the California Council of Pharmacy and it was to be kind of like a front for the entire profession. But it was impossible and I know they still kind of exist, but I told them they're doing exactly what I didn't want to do and I don't know that they're doing this now. But it got to a point there where I didn't attend meetings anymore of that group because I said, "I don't want it to be a BS session." I don't want to come here and say, "Hey, this is what we need to change," and then go home. Or, "We need to know this, everybody," and then go home. I want it to be an action group if I'm going to waste my time. No, I didn't say it that way. I'm going to spend my time with you. And they were unhappy because Mary Anne Koda-Kimble never attended those dean meetings and they had established in their constitution that the official representative from the school would be the dean and Mary Anne never attended and I acted on her behalf, pretended that didn't exist in the constitution. Anyway, so much for that, that organization. That's one of the things I was a part of.

12-00:20:42

Meeker: There's the joke, right, that the vice president just goes to funerals. Our current lieutenant governor has said that they should probably just get rid of the role of the lieutenant governor because he does nothing. On the one hand you have these kind of vice positions, right, that those who occupy them are constantly trying to figure out what it is they're supposed to be doing. On the other hand, think about in administrative positions it's the dean in this case—I

don't know in the case—but let's say a dean is the sort of head, who's the ultimate decider. But it's actually the associate who—

12-00:21:28
Day: The top sergeant of the thing.

12-00:21:31
Meeker: Yeah. Actually goes to the meetings, engages in management, and is accessible to the proletariat, right?

12-00:21:43
Day: Yeah.

12-00:21:46
Meeker: Was it one or the other for you?

12-00:21:46
Day: No. It was all of those things. So, first of all, let me tell you I found no disgrace in cleaning up the shit, okay. All of the things that you say that are disparaging about the vice president or even about executives, if they're true, to me that's fine. I don't really know. But let me tell you something. That whatever I did I was always me. I was Bob Day. And whenever I did anything, I never saw it as cleaning up shit or putting out fires. I saw it as doing stuff, as getting something accomplished for whatever it was, for whatever reason it was. Somebody didn't want to do it. I was not always a follower. A lot of these things I initiated myself. But, see, I have a great deal of faith in myself and I don't think at a dangerous level. I have a great deal of faith in myself. So I never, ever felt that I had a subservient job. And Mary Anne Koda-Kimble was never the kind of person to make you feel like that either. Now, let me tell you, I worked for three deans and with each one of them my role changed, okay, and my persuasiveness changed and their need of me changed, okay.

12-00:23:07
Meeker: Can you walk me through that a little bit?

12-00:23:09
Day: Yeah, okay. I'm going to try. Jere Goyan, the first guy that appointed me, and we had a very close working relationship. We talked about programs, we talked about the future of the school. And when I say "talked about it," I mean we mused about things. But I do not in any manner want to detract from Jere. Jere was a decisive guy. He was a visionary. He saw. And I was a part of that vision in many instances, and none that I can say, "Oh, here I was really a part of it." I can't do that. We had an ongoing relationship. A part of Jere's role as dean, as dean of the UCSF School of Pharmacy, was to present the school's face to the nation and perhaps the world. That was part of his goal. We had a role to play. We had a position of authority. We were wise in many ways. I don't mean to say it as arrogantly as that. But he felt he had an obligation to go out and say things that were well thought out and provocative and that's where I came in, because I could write speeches like that.

Now, let me tell you the way Jere Goyan and I wrote a speech. In the beginning Jere would write it and then I would get it and I would edit it and I would change a sentence around. Jere was a person who could speak fantastically. Give him his notes off and he was great. Never flub a line. Quick, cohesive, the speech was well put together when he had to do it on his feet. But as he became more and more important in the world of pharmacy and the nation, he felt that his words could be recorded and could be referred to in the future. And I don't mean he did that with a—out of sense of proportion of who he was. It was just a reality. He was that kind of a guy. So he became a little bit more concerned about his speeches and relied upon me much more for input. Over the years that input grew from he wrote a speech and I would touch it up to he would write half the speech, and I would write the remaining half. But at the beginning of it, we would always sit down and exchange ideas. And, for example, he in some cases had no idea what the hell he wanted to talk about, so we would talk about that. And by talking we would come up with a theme, a goal. And in some cases the goal was one deeply buried in him, and in some cases it was deeply buried within me.

Because, you see, I had a reputation as being kind of like Bob Day. He's a funny guy. He's kind of a quirky guy. He has a beard, he wore a peace medal, he never wore anything but Levi's to any association meeting, and he had this Gandhi shirt on. He was a hippie. So I had that reputation of being that way. And I knew that. In fact, I cherished that reputation. Never, ever tried to be like everybody else. I never tried to be different. It was just me. So I knew that when I got up and said something they would just simply say, "Oh, that's Bob Day." That's really a nice point and it's funny and it's interesting but it's just Bob Day." Incidentally, that did change over the years. But then, when Jere was dean, I knew I could put words in Jere's mouth and they wouldn't say, "Oh, that's Bob Day." They'd say, "Hmm, provocative. Really thoughtful." Jere knew this. Jere became a way that I could, by cooperating with his speeches, get some of my ideas out there.

Now, did any of these ideas change the world? I don't know. I don't know. I can't tell you that. Were they provocative? Our speeches were always provocative. They always took on somebody. They always proposed a particular idea. They always advanced a particular thought or notion. I am skilled at speechwriting and I developed that skill over years of writing speeches. I would spend two weeks on a Jere Goyan speech. So ultimately it came to this. Jere would have a title, we would sit down, we would discuss ideas, I would go back with a sketch of where he wanted to go and I knew where I wanted to go and I would write the speech.

12-00:27:20

Meeker: Did you ever have to write a speech or put some of his ideas in it that you were lightly or strongly opposed to?

12-00:27:28
Day: No, never. No, we didn't have that kind of a relationship. No. So anyway, so the relationship I had with Jere at the end was, basically, we sketched out the ideas. In some cases there were no ideas from the very beginning, as Jere had a propensity for giving a thing a title before he knew what he was going to say. I had to write out of that hole many times. I'll never forget one. "Under the Counter and Over the Counter" was the title he gave the people who asked him to talk. And he didn't understand what "under the counter" meant. That wasn't the concept he had in mind. "Over the counter" meant prescription and the OTC drugs. The pharmacist would sell those over the counter. "Under the counter" were those things he kept under the counter because he didn't want to have them on display. It used to be Kotex, it was prophylactics, it was things that—it was OTC narcotics, like some syrups that had a lot of codeine in them. He would keep them under the counter because they shouldn't be readily available. Contraceptives. Someone, I guess, thought that a little kid seeing a contraceptive would just faint, so they had to be out of sight. And what Jere had envisioned was a totally unrelated topic. I spent hours looking into that. So that's what I would do. He would create a title. And I also gave him some really crazy titles, which I already had an idea of what we were going to do. And I forget. One of them was "On Matters related to Perpetual Motion, Pyramid Schemes, the Tooth Fairy, and Ingenuousness." I knew exactly what I was going to say with that when I gave him that title. And then everybody said, "Oh, what's that all about, Jere?" So at the end of it, the relationship was just that.

And Jere fought most of his battles. I did not clean-up for Jere's work. In fact, Jere actually controlled a lot of things that ultimately I took over, having to do with student discipline. Jere always insisted that he be in charge of that. The dean. Only near the end did he turn that over to me and only near the end did we come into our major battle over that because of something he did, which I will leave out because it's not important. And that had to do with students. And we got in a real pissing match over it just as he was leaving.

12-00:29:48
Meeker: You sure you don't want to give any insight into that?

12-00:29:51
Day: Oh, no, no. No, I don't mean to be a teaser. It was an incidental note and it's more fun than it is anything else. I think it divulges something I don't want divulged.

Okay. So then along came George Kenyon. Now, when George Kenyon became dean—he was a pharmaceutical chemist and he would be the first to tell you that while he had a strong appreciation for what it was we were doing, that hadn't been his main thrust. And while he had an appreciation for clinical pharmacy he didn't have an intense knowledge of what that was. And so he didn't understand the relationship with the alumni. He didn't understand the relationship with associations, the Board of Pharmacy, none of these things.

So all of a sudden, I was much more important than I'd ever been. I think I was important to Jere because I did a lot of other things. I say speechwriting. Believe me, there were hundreds of other things that just came up that I handled as a matter of routine. And I think that's what Joe's feeling a little bit now, because he doesn't have that person that said, "Oh, this is coming up. I've got to do this. Mary Anne, do you want to do this because this is a letter you should send." That's what I think.

12-00:31:11
Meeker: Like a traffic manager.

12-00:35:54
Day: Yeah. Yeah. Or, I don't know, an anticipator of I don't know. Anyway, so George needed me more than anybody else did. That's why George was so upset when I went to him and said, "George, the university has this take five retirement plan." I was then fifty-nine and three-quarters years old and George was the brand new dean of the school of pharmacy. And I said, "George, I can't turn down the retirement plan. It is too good. It's adding ten biological years to my age. So if I retire now," and I was then fifty-nine, "It'll be like I retired at seventy and so I will get this great retirement plan," which was truly great. Okay, it really was. You will never see a retirement plan like that again. But they wanted to get rid of us higher paid faculty. "So I'm going to accept it, George. I want you to know that." And George turned white because at that point in time he had just become dean. And I said, "But, George, I want to tell you something. Although I have been offered a job by the United States Pharmacopoeia," and I had been, "I will give you first call on bringing me back on what is known as recall." Okay. And the recall at that time was 43.5 percent. But I said, "If you want to do that, you can appoint me and it'll be a year by year appointment. You can appoint me to do the same thing I'm doing right now and although it's only 43 percent I will give you four days a week. The fifth day I will take off. I will be home." I thought I would have a day off. I never had that day because I'd stay home but, believe me, the university had a way of getting in through the front door. So George was very relieved and he said, "Yeah." He would have, I think, done anything. I could have said, "And throw in a Mack truck and," I don't know, "16,000 cases of Twinkies," and he might have done it. And he would have done it, because in the beginning, George really relied upon me.

So my role with George changed considerably. George didn't give speeches except very rarely. So I had to write very few of those for him. And he was very uncomfortable with audiences in the beginning. George later on grew into the role, but this was a total change for him. He had been department chair for ten years but he had never been quite in the public eye as he was as dean of a school of pharmacy. So my role then was an advisor to the dean on affairs to do with pharmacy.

[A portion of text has been sealed until 2038.]

So my role as a speechwriter almost went away entirely. Although I continued it at some level and I continued to write his dean's page for the newsletter. I was the editor of a newsletter and had been for, I don't know, some number of years. I ultimately quit and then I took it up again for ten more years. But for a total of about twenty-five years I'd written a newsletter and there was an eight or ten year sprint in between them where I didn't do it. So I wrote his dean's page for the newsletter. If there was a major press release or something like that that came out of him I would write it up for him.

And George didn't like confrontation. So where Jere sort of relished it, George didn't like it at all. So that's where George used that expression on me, "Well, you're my bad cop." Because I'd go off and I'd sic myself on people, administrators, other things that I felt had done something inappropriate. Or I would be not his errand boy, because I would go to him and I'd say, "George, you want me to take care of this?" And he would say yes because he really disliked confrontation.

[A portion of text has been sealed until 2038.]

But my job did change considerably, to where I had much more authority, much more than I ever had with Jere. I had much more influence than I ever had with Jere.

12-00:35:54
Meeker: Did you ever regret that or—?

12-00:35:58
Day: Regret?

12-00:35:58
Meeker: Well, maybe regret's not the right word. Did that transfer of authority but also you moved into position of being more of a flak catcher, too, I guess. Did you ever resent that?

12-00:36:17
Day: No.

12-00:36:17
Meeker: No?

12-00:36:17
Day: No. No. I told you I liked what I did. I had the best job in the world, regardless of how it changed. Yeah, and it changed a lot. And I always liked that. It was under George that I became associate dean for administration. That's a considerable amount of authority, even if he gave it to an amateur. And so, no, I have no regrets about any portion of my career having to do with the fact this dean wanted this, this dean wanted that, this dean wanted that. I never had an ambition to be a dean.

12-00:36:53
Meeker: So in essence that is the definition or the job description of the associate dean.

12-00:36:58
Day: Don't know. I guess. I guess. I'm deadly sincere when I tell you if I told you what I had to do, what I did, it would have to be a series of anecdotes of just things that I did, things I did automatically. And I was asked to do things, too. But the things that I just did were there to be done and I did them and I anticipated them having to happen. And sometimes it meant taking on people and sometimes it meant consulting with the dean first and sometimes it meant consulting with the dean after. With Mary Anne it was always consulting with the dean before because a lot of these things were things she was already on top of. With Jere I never did that because Jere did it himself. With George I did it a lot and George always appreciated what I did and George never, ever once told me I had done something he didn't want me to do, although he was compromised when I was deep throat for a revelation that took place within the school that led to a nationwide slap down of a pharmaceutical company. Do you want to hear this story?

12-00:38:11
Meeker: Yes. [laughter] Sounds fascinating.

12-00:38:13
Day: Betty Dong. Betty Dong was a member of our faculty. She was one of my students at one point. Betty Dong had conducted some research on the—I forget the name of the product. On thyroid products, okay. Synthroid. And she conducted some research and actually said some favorable things about Synthroid, which was a product for which there were about twenty different generic copycats on the market. Not copycats. They were exactly the same chemical but if you're familiar with the generic versus brand name controversy, it is that brand companies want you to believe their drug is better than the so called generics, which basically contain the same ingredient. But the company that manufactured Synthroid had gotten it across in physicians mind that if you prescribed any other product, and they had some information to back it up, any other product than Synthroid, you were going to prescribe a drug whose bioavailability was not the same. Do you know what the term bioavailability means?

12-00:39:20
Meeker: You can define it.

12-00:39:21
Day: It means when you take a drug, two different drugs, one made by this guy and one made by that guy, that contain the same ingredients, same excipients, one drug may actually be absorbed better and get to the site in a higher concentration more effectively than the second drug because due to all the physical characteristics that go into compression, design of a drug product, et cetera. And the inference being if it was generic it was inferior, and generics are usually about one-tenth as expensive as the brand. I can't even remember

the name of the company. It was a major pharmaceutical house. Synthroid had the market. It was their major seller. It was a multi-billion dollar item. So Betty published some papers that they kind of liked. They said, “Oh, this is pretty favorable.” So they came to Betty and said, “We’d like to give you a grant, if you’re willing to do it, in which we’d like you to test, as nobody has before, our drug product against generic products. And it’s our hope that you will show that the product is superior.” At least if they didn’t say that, that certainly was their expectation, that it would be in line with their advertisements that said, “We’re the only drug approved by the FDA,” which is in the orange book of the FDA. If it was in the orange book, it meant it was bioavailable and you could use it for welfare patients, and Medicare would pay for it, et cetera.

So Betty had already had some preliminary data to show that. Let’s just make a long story short. Betty conducted a very thorough investigation, chemical analysis sensitive to the Nth degree of sensitivity with all sorts of input from experts to make certain she did. The company asked for results but it said, “Code them. We just want to see how things are going,” to see if there’s a variation between the products. We won’t know which is ours, so don’t give us the name of the product. Just give us the data, the raw data, and we will diddle with it because we’re curious. What they expected to see was, of course, one drug, drug X, whose bioavailability was superior to drugs Y or Z. They didn’t. So they saw that they were all pretty much the same on the basis of this preliminary data which was by no means complete. The word I heard was that that they had actually, somehow, broken the code and knew which one was Synthroid. I don’t know. It seemed to me more likely that they would have seen that there were a lot of products out there whose bioavailability was similar. The point of it is is that all of a sudden they begin to get a little bit hostile. They got mostly hostile when they saw the final results of her study. Betty wrote up the paper along with another guy, submitted it to the American Medical Association Journal, and basically what it showed was, and what it said was that Synthroid is not the most bioavailable product around. There are other products that are equivalent in their bioavailability, okay.

While it was in press, the company was acquired by Boots and subsequently by Knoll Pharmaceuticals which had acquired Synthroid from Boots, did everything it could to discourage her from doing that. They threatened her with suits. They sicced a couple of detectives on her. They got records of her phone calls, seeing if she had phoned anybody, another generic company and had a conversation with them about their products, and they did everything they could. They prohibited her from publishing the study. Now, that is unknown in academic circles. The reason was because Betty, being a conscientious—but at that point somewhat naïve professor—after having discussed this with an attorney, let them have equal rights on publishing. That is to say one or the other of them could decide not to publish, okay. Now, no other researcher will do that. Betty did it, I think, thinking it was not right, but she discussed it with an attorney, a campus attorney, and he said, “No, I don’t

see anything wrong with it." Whatever the story was is unimportant. The point of it is that she signed a contract saying that either party had the right to prohibit publication. And so that's what they had. And they were threatening suit. They were going to sue the university, they were going to sue a lot of people, okay. And this was all going on in the circle of the university and the company, okay.

In the meantime, Betty was really discouraged. And the story really gets dirty. It gets really dirty, to where they flew an expert out, a bioethics person who basically told her that her study was flawed, that her concepts were wrong, that she was wrong, that it would be unethical to publish this study. They got a hired gun, a pharmacist who specialized in bioavailability but was a hired gun from some campus. He came out theoretically for the purpose of meeting with her and going through the results with her and making certain that they were correct, but basically berating her for doing this, that, and the other thing. And adding to this thing, here was Betty being hung up to dry by threats of suit, okay. Okay, I think I'm going to tell this in sequence.

I was associate dean at that time. George Kenyon was dean. Remember I told you he hated controversy so he didn't want a whole lot to do with this thing. So I was really pissed off. Our attorney, campus attorney, was not showing any interest whatsoever in defending Betty. In fact, they claimed that in signing this contract, she had put herself outside of university protection and so on. The fact of the matter was that a university professor was being threatened for her research. Skip the fact that she signed this thing. So, I argued with the attorney's office, and they argued that this was really something that they couldn't defend her with because it was something she had done on her own and she shouldn't have done it and did I know that even if she's right, the university can be sued. And, "Bob," she said, speaking from her throne as chief attorney for the campus, "I will not permit this campus to go into bankruptcy because of a professor who signed her own contract." Now, you see, I kept saying to her two things. "Number one, that's not your decision to make. This is an academic institution and academic integrity is what's in order here, number one." So I was on a high horse, too. "And, number two, no company would sue the university on the basis of this. You want to know why? Because no other university in the nation would take their research grants anymore. Nobody would. They would be shit on their list." And she said, "Well, it's nice for you to say, Bob, et cetera." So they didn't want to defend her.

[The following discussion was partially rewritten in the editing process and thus does not closely follow the original recording.]

So I was frustrated, and talked it over with a friend of mine. I had done some work I'd done with him on for the FTC on consumer rights affairs and we became close friends. And I was telling him how pissed off I was with the University for its failure to do this and that the Journal of the American

Medical Association was being threatened by the company and that they would not publish the paper without a release from Betty saying that the university stood behind her.... However, the Journal had this article ready to roll in the presses and when that particular issue of the *Journal* was published, if you were to go to it, you would find eleven empty pages in it where the study was to have appeared, because they didn't publish it. And the company was also threatening Betty's co-partner in it, a wonderful guy named Felix Greenspan who had the patients on the study and so on. And he was a nice guy and they were threatening him as well with a suit. But it was not only "We are going to sue you," it was, "We're going to pulverize you," okay? And I'm deadly serious. So I was bemoaning all this to my friend and he said, "Let me talk this over with a buddy of mine who worked for another consumer outfit," a law firm. And so we met and he said, "Bob, I have a friend at the *Wall Street Journal*. Would you be interested in talking to that friend?" I said, "I would love to." So I did. And I blabbed the entire story and I gave the reporter the names of people. He said, "Well, can I quote you?" I said, "You can but all you'll be able to quote me on will be what I think of as a non-scientist and what I feel about this." I said, "You got to talk to the scientists." So I sicced him on Les Benet, who was an expert in this area, some other people. And the reporter wrote an article that just blew the company out of the water, okay. And I don't remember the sequence of events, okay.

But in any event, so I had to tell George about this. And I said, "George, we have to prepare a press release because they're going to ask about Betty." So the company was then slandering Betty's reputation, and as I say, the sequence of it all is kind of like a little bit muddled right now, but they were slandering Betty's reputation. They'd already gone in, taken her results of here study, and published them in a journal, if you can believe that. And it was an industry-sponsored journal. The author of the article was a guy in charge of research for this company. And the article used her data as a demonstration of the way that data could be twisted to show a result that really wasn't there. And that was the title of the article, something like that. So it was totally shoddy from the very beginning and all the way down through the end.

So the word got out and George had to write a response to the article. And George wrote this milk toasty response. He brought it to me. I said, "George, you can't do that. You're saying that history will tell whether Betty did the right thing. You got to back Betty. It's got to be like the School of Pharmacy has all the faith in the world in our faculty member and the validity of her research and stands behind her 100 percent." I don't remember the exact wording, but in any event it was toned down a little bit because I was pretty pissed off and aggressive at that time and George rightfully edited some of my anger away from that response. But ultimately the company withdrew due to the pressure caused by the article in the *Wall Street Journal*. And it got a lot of press at the time and it got a lot of discussion in science about the arrogance of an industry to suppress a *bona fide* study it had funded. Whether or not it

believed it owned the study was something else entirely. To suppress university based research, et cetera. So they got a bloody nose over it. Turns out the real reason behind all of this was not simply the fact that they could slowly lose the monopolistic market they had, because it takes many years for that message to get out and sales would fall, but over time. But they were also selling the company. It was Flint, then Boots, then Knoll while all this was going on and it is very possible that Betty's paper might have, in the minds of the companies, botched up the sale, or led to lawsuits.

I'm a forgiving person, but never did quite forgive the person who was in charge of our legal division at that time for her lack of understanding. First of all, her association with the University of California, what that meant as an attorney. You defend some things that if you were to advise a client you'd say don't do this. But it is, after all, your client and you do defend that person. "I can't stand behind a possibility of a suit that would bankrupt the University of California." I'll never forget those words or their like, which was absolutely, as far as I was concerned, a "stick your head under a pillow and it'll go away" kind of response to it. It was demeaning, as far as I was concerned to Betty. Betty came out of this scarred. She's a wonderful person. She goes on, she's a productive member of the faculty but she came out of this scarred. We told this story while introducing Betty at a commencement ceremony about five years ago and one of the things I did when I wrote up parts of the script for the commencement ceremony was to tell the story about Betty and she got a standing ovation because through it all, she persevered. She had done some things. Betty today will defend what she did, saying that she got advice and the advice said it was okay. So we would disagree on that. But Betty stood behind it and paid the price for it and it was brutal when it was going on. So I was "deep throat" in that.

One of the few things I've ever done that I felt that I had something I can measure, because what happened is now science and other journals and universities across the nation make certain, absolutely certain, that every member of the faculty knows that at no time are they to sign away their rights to a publication. No time. It's university's property always and it maintains the sole decision-making authority. And so our procedures were changed and they were changed in various places across the nation.

Okay. So what I did with George then was that kind of stuff. With Mary Anne it was less than I've ever done before because Mary Anne was another Jere Goyan. Mary Anne didn't need me as a speechwriter because she's dynamic, writes fantastic speeches on her own. And I have greater difficulty telling you what I did with Mary Anne than I did with any other dean because it was in a position of less influence because she didn't need that influence and I didn't feel a need to arise as much as I did with Jere or even more so with George.

12-00:55:03
Meeker: And you continued on in this recall position?

12-00:55:06
Day: I did, yeah. When George first took the position, I told him the situation and told him I was going to be on recall, and he had the authority to kick me out at any level anytime he was unhappy with me because it was a year by year contract. When Mary Anne became dean, I went to her and I said, "Mary Anne, if you wish I will offer my resignation. I advise you to get a younger, more ambitious, perhaps more tuned-in guy than me." And she said, "No, I want you." And I said, "Well, I will come to you ever year and give you the same reminder," which I did for three years until she finally said, "Bob, will you stop this? I will let you know if I want you to go away." [laughter] And so I stopped going to her and didn't see her again until two years ago when I went and tendered my resignation. No, told her I would, told her how much money she would save, told her I'd be willing to come back for a couple of days a week and pitch in. And she said, "No, Bob, please don't do it now. Wait another year because I'm going to resign." So I was one of the first to know that she was going to resign and I kept it under my hat. But she wanted me to hang around another year because she didn't want to put up with a new associate dean, having to train him up to doing the automatic things I did.

12-00:56:23
Meeker: So the two of you retired at the same time?

12-00:56:26
Day: We retired at the same time by agreement. I was going to retire a year earlier and she asked me to stick around another year. Which was fine with me. I didn't reach a point where I got up in the morning, said, "Oh, I got to go to school." None of that. I didn't wake up a morning where I said, "Oh, goody, goody, goody, I'm going to go to school." It was just something I did and I liked it and I did fairly well at it. And so when I resigned it was a conscious decision against something that I liked, but felt that it was time.

12-00:56:55
Meeker: And when was that? What year was that?

12-00:56:57
Day: I don't know. I retired this last July so I would have retired a year earlier, 2011. I would have retired in 2011 but I retired in 2012. And I saw her in 2010. It was like in December because I wanted to give her like six or seven months to adjust to me and that's when she said, "Why don't you stick around another year? I don't want to save the money."

12-00:57:25
Meeker: So she was dean for fifteen plus years, right?

12-00:57:26
Day: Yeah, yeah. She started in '94. Ninety-two, I'm sorry. Oh, wait a minute. Yeah. I think she started in '92.

12-00:57:32
Meeker: So twenty years.

12-00:57:33
Day: Fourteen. Fourteen years. Let's see. Ninety-two, 2002, two thousand and—for some reason, maybe it was '94. I think she came aboard in '94. So it was fifteen years or so. I think she was up for her fifteen year cycle. Well, maybe more. Anyway, you will find that I can't tell you when Jere Goyan became dean or when George Kenyon became dean.

12-00:57:56
Meeker: That's all in the record somewhere so I'm not testing you on that. Okay.

Begin Audio File 13

13-00:00:00
Meeker: This is Martin Meeker interviewing Bob Day. This is tape number thirteen and I think what we're going to do is wrap up now. And the question that I wanted to ask you is that yesterday when I was reviewing some of my notes I came across your 2003 commencement address to the graduating class of the UCSF School of Pharmacy and it is a fun lighthearted piece that obviously ends on a note of gravitas. But that was ten years ago. I'm wondering if you have any additional thoughts or revised thoughts about what kind of advice you would give based on your career, where you've seen the practice of pharmacy go over the last fifty years to now ten years later the graduating class of 2013.

13-00:01:06
Day: Okay. To answer your question in a sentence, and then I'll gloss it over with some explanation, I would not change a word of it. And the reason I would not change a word of it is because when I'm given the opportunity to say whatever it is I want to say, not held by any boundaries whatsoever and feeling in my own heart that I have no great wisdom to put forward—and I'm not being humble, it's just that I get a little pissed off at "this is your role, this is what you should be doing," this sort of stuff, although I will do it at levels. I always feel a little bit intimidated when I'm asked to do stuff like that because I don't think I've got any kind of great wisdom or foresight built within me. I may have, but I don't think I have. So I will use every opportunity I have to do something else. To take something which may be somber and what may be boring and something which may be a call to action, a la, "This is what you've got to do to save the future and mankind," and twist it around in my own way to make it, hopefully, an enjoyable experience.

The speech you're talking about, the commencement speech, came about as a matter of a lot of writing. From, "Well, these are the opportunities you face for the initial future. This is the education you've had," to come down with what it was, which as you probably saw, was a parody of myself. I took it as an opportunity to not exhort the vast audience that was out there that didn't give a hoot about what the profession of pharmacy did. They were there because people they loved were graduating. They weren't there to hear some guy get up there. So I did address the students, but I addressed them with

humor and I addressed the audience with humor, which is what I will do if given the opportunity and not told, “Bob, you got to save the world with your speech.” And that’s what I did.

So you will find that when given the opportunity to do that, I will be myself. See, if you were to talk to people who know of me, or people who know me, they will tell you they expect me to be funny. I don’t expect to be funny, it’s just the way I am. They expect me, whenever I got up, to take the microphone on the floor of the House of Delegates of any organization that knows me, and where I’ve done it before, they’re almost giggling before I say anything, even though I may not be thinking I’m going to say anything funny. Although, believe me, when I do say something funny, it’s intentional. I know what I’m doing. I have a very quick sense of humor. So they know me to be that way. So it’s just me. What I’m trying to say is it was me that did that. Nobody else might have done it that way, and that for me is really cool. Nobody would have wasted that opportunity to exhort the graduates into some fantastic future. I didn’t waste it. I did me. They got me. If you want another more recent example of that, I just accepted a major award last week in which I did precisely the same thing. Turned it into a humorous moment. As people said, a hundred, and I’m not exaggerating, people came up to me and said that it was the best acceptance speech they’ve ever heard. Because it wasn’t serious. Well, it was serious, but it was laced with my humor. So therefore, it’s just me. It’s what I did. I wouldn’t change a word. I wouldn’t say, “Oh, gee, I’ve got an opportunity now. I’ve made a mistake. I wouldn’t do that again.” I didn’t waste it. As far as I was concerned, I accomplished what I had set out to do. I didn’t bore the audience. I did give them a little bit of an exhortation near the end and it was, as I said, a parody on me, on speakers in general of that kind.

13-00:04:58
Meeker: Well, it’s self-effacing and I’m wondering have you found that having a self-effacing demeanor or sense of humor has been helpful over the course of your career?

13-00:05:09
Day: Yeah, yeah.

13-00:05:11
Meeker: How so?

13-00:05:12
Day: Well, because people know that I’m not serious about that. They know the self-effacing part is just what I do. Nobody in the world will tell you that Bob Day is a shallow worthless human being who substitutes humor for deep thought. I don’t. I lace humor with deep thought. I lace deep thought with humor.

13-00:05:29
Meeker: And that’s a difficult balance to achieve.

13-00:05:32
Day: Yeah. And I have screwed up. Believe me, there have been times when I've gotten before an audience and I've said something totally ridiculous, which I expect them to laugh at and one of two things happen. They sit there and look back at me and I think, "Oh, Christ, I've done it again," and I have to explain I'm just joking. Or it takes a while, it settles in, they get it and then they start laughing. It's risky but it's fun when it works. When it doesn't work it's not so fun. So, yes. Do I have a reputation of being self-effacing? I don't know. It depends upon the arena. I'm not always funny. I sometimes go for the throat and I go for the throat with no humor whatsoever. When I'm glued on a fact or something that has to be said or done, I won't always spend the time to lace it with humor. But as I said, when given the opportunity where I can think it out and do it, I will. So I told you before there was a period in my life where people I think would have said, "Oh, that's just Bob Day. He's a California hippie." And I substituted myself for Jere or Jere for me in his speeches and got what I thought were really great ideas out there. Well, whether they were and whether it made any difference, I don't know. But to answer your question probably for the fourth time, no, I wouldn't have changed a word. I liked what I did. I could read it today and enjoy it. See, I actually do that. I read my stuff. It's terrible, I know. Most people will tell you don't do that. I will read my stuff. I have watched a videotape of my acceptance of the APhA Schaefer Award because I have it upstairs. I've watched it ten times. I enjoy it every time I look at it.

13-00:07:00
Meeker: So did you really call the Bush White House?

13-00:07:03
Day: I did.

13-00:07:04
Meeker: Really?

13-00:07:05
Day: I did. Yeah, yeah, I did. Yeah. And they answered the way I said they did. "He can't come to the phone now," or something like that. No, I wanted to—

13-00:07:15
Meeker: [laughter] He was busy bombing Iraq.

13-00:07:18
Day: I wanted it to be authentic and I knew that they would say "who did you ask to speak to? The President? Is President Bush there?" I did it. I think I got that from somebody, the notion of calling somebody that you knew wouldn't be available to you. I don't remember. I don't know. Somebody had done that.

13-00:07:37
Meeker: Like a Michael Moore trick or something.

13-00:07:39
Day: Yeah, Michael Moore or yeah, Michael whatever his name is.

13-00:07:42
Meeker: Moore.

13-00:07:41
Day: Moore. Or the guy that's in the Senate now from Minnesota.

13-00:07:47
Meeker: Oh, Al Franken.

13-00:07:47
Day Al Franken would do that. So I did it knowing what was going to happen. "Hello, White House, I'd like to speak to President Bush, please," and then a pause and them saying something like, "Oh, who is calling?" and I said, "Robert Day, associate dean at the University of California School of Pharmacy," and they said, "What is the purpose of your call?" "I have to write a speech and I notice he's given several of them and I'd like some advice on what I could say" I did all of that. And there was this pause. It was perfect. It was absolutely perfect.

13-00:08:21
Meeker: You could tell. Just the way that you wrote it and you presented it. It seemed like they really weren't quite sure what to make of this person calling. Like there was just an inkling of sense that maybe we should take this guy seriously but then—

13-00:08:35
Day: Well, that's the advantage you have when you're putting something over on someone. I don't like that kind of humor ordinarily. You know that one about hidden camera, whatever it was called? There was a television program which—

13-00:08:47
Meeker: Oh, yeah, "Candid Camera."

13-00:08:48
Day: "Candid Camera." It's entrapment. And ordinarily I would not like this because that person had no idea. I mean, she must get a million phone calls a day from people saying, "Oh, I'd like to know what time the White House tours are." I mean most of them are going to be that way. And a guy that wants to speak to the President. Come on. So it put her at a great disadvantage. But that's what I wanted. I wanted that to convey that itself, and obviously I just was calling for color to the speech. So it worked.

13-00:09:25
Meeker: So any final thoughts? Anything that was just not covered to the extent that you think it should have been in the course of this conversation?

13-00:09:32
Day: There is nothing. You've been very thorough. There's nothing that pops into my mind. I'm sure there's a thousand more stories I could spin but what would they contribute to this other than just more gloss. So as far as I know I've said it all.

13-00:11:04
Meeker: All right, good. Thank you.

[End of Interview]