A distinctive competency

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For the past eight years, I have had the privilege of leading pharmacy services and operations at The Cleveland Clinic Foundation (CCF). The Cleveland Clinic is a unique organization in many ways. First, it is a physician staff model, employing over 1700 physicians and doctorate-level researchers. We educate and train over 800 medical, surgical, and allied health professionals each year. Our annual patient volumes are significant, with over 54,000 inpatient admissions and nearly 3 million outpatient visits. We have the highest case-mix index for hospitals in the country with over 500 beds. And we have over 53 buildings with over 14 million square feet in which we provide care, education, and research activities for our patients. Within the past two years, we opened a new medical school for physician–scientists and are currently constructing a new 1 million square-foot cardiology center and hospital that will open in 2008. Collectively, The Cleveland Clinic Health System, which comprises The Cleveland Clinic, CCF Florida, and our nine other community hospitals in the Cleveland area, is significantly larger than Johns Hopkins, the Mayo Clinic, or Partners health systems in terms of inpatient admissions and outpatient visits.

Yet, when asked to describe what makes The Cleveland Clinic unique, our immediate past chief executive officer (CEO), Dr. Floyd Loop,1 under whose tenure this dramatic growth and expansion occurred, responded: “Our vision is what makes us great. We wish to provide a distinctive competency in every specialty; to have comprehensive care and satisfaction for all patients; and to have a worldwide market for specialty medicine. This is what gives value to people.”

I have often reflected on the elements of this statement from the perspective of health-system pharmacy: a distinctive competency . . . which is widely and consistently available . . . that gives value to people. Does this not reflect the basis of the societal purpose that Brodie2 so eloquently described? Is this not descriptive of the societal covenant that Hepler and Strand3 reminded us of as the basis of our profession? Is this not the vision that we as pharmacy leaders have for health-system pharmacy practice?

I believe it is. And so, I would like to reflect on our profession’s distinctive competencies and the value we bring to our patients and society. Further, I will examine the intrinsic characteristics and key learned strategies that have allowed me to be at least somewhat successful as a health-system pharmacy leader in achieving our professional role and purpose. Finally, I will provide some observations and comments on the future challenges and opportunities for our profession and, more specifically, for those who choose to follow in the footsteps of past and current leaders.

Definitions

The word competent can be defined as “having the requisite ability or qualities,” and distinctive can be defined as “serving to identify a difference in.” What abilities or qualities does a profession possess that allow it to respond to society’s needs such that the public distinguishes it from others that desire or attempt to do the same? For some professionals, the answer is obvious. For example, architects design high-rise buildings and suspension...
History and Background of the John W. Webb Visiting Professorship in Hospital Pharmacy

The John W. Webb Visiting Professorship in Hospital Pharmacy was established in 1985 at the Northeastern University College of Pharmacy and Allied Health Professions. The Northeastern University School of Pharmacy is now part of the Bouvé College of Health Sciences. John W. Webb received his bachelor of science degree in 1949 and his master of science degree in 1951 from the Massachusetts College of Pharmacy. Mr. Webb served as Director of Pharmacy at Hartford Hospital and was appointed to the faculty of the University of Connecticut. He returned to Massachusetts in 1956 when he accepted the position of assistant director of pharmacy at Massachusetts General Hospital. In 1959 Mr. Webb was promoted to Director of Pharmacy at Massachusetts General Hospital, where he remained until his retirement in 1983. Mr. Webb also served as director of the Graduate Program in Hospital Pharmacy at Northeastern University from its inception in 1964 until his retirement. He has made numerous contributions to the pharmacy literature during his distinguished career.

Appointment to the Visiting Professorship recognizes commitment to hospital pharmacy management, experience as a practitioner and an educator, and dedication to excellence in pharmacy management. Each year a hospital pharmacy practitioner is appointed to the John W. Webb Visiting Professorship by the dean of the Northeastern University School of Pharmacy. The Visiting Professor presents a lecture on excellence in management to hospital pharmacy practitioners, pharmacy administrators, pharmacy residents, and the academic community. The Webb Lectures are published in the American Journal of Health-System Pharmacy.

Distinctive competency

It is obvious that a specialized body of knowledge and skills is required, that architects help meet society’s needs, and that the public perceives a difference between architects and others who are not similarly trained and legally qualified who may wish to perform this type of work. Therefore, the profession of architecture brings value to the public it serves.

Within health care, similar examples can be found. Physicians diagnose and treat; surgeons explore, repair, and replace human anatomy; physical therapists and chiropractors carefully manipulate skeletal muscles and bones; and nurses monitor vital signs and provide supportive care for their patients. While there may be an increasing overlap of some of the specific functions of each discipline, the public recognizes a distinctive competency within each of, and therefore the value of, these health care professions.

Pharmacy’s distinctive competencies

What then are the distinctive competencies of pharmacy and the pharmacy practitioner? Unlike the majority of health care professionals, especially those just described, most pharmacy practitioners do not diagnose, examine, prescribe, or manipulate body parts as a normal part of their daily practice. Yet, despite this lack of physical patient touch, pharmacy was recognized as having a distinctive competency, and therefore societal value, in prior centuries. Hill described the pharmacist in the 19th century as follows: “the pharmacist . . . was considered an important professional in health care delivery. He provided first aid and triage services for a variety of ailments. He was one of the few learned citizens of the community and was used by the public to solve a variety of homely problems.”

However, as the 20th century unfolded, the role of the pharmacist changed significantly. Drug product selection and refill authority were relinquished to the physician. Drug therapy recommendations differing from those of the prescribing physician were defined as unethical. The advent of commercially available pharmaceuticals reduced the need for compounding expertise. Accessibility to the pharmacist for drug therapy guidance was diminished as increased prescription productivity became the focal point of a successful community practice. As a result, by the mid-1900s, the pharmacist’s purpose had significantly changed from that of a trusted health care advisor to that of a drug dispenser.

In 1967, Brodie described drug-use control within hospital pharmacy as that “system of knowledge, understanding, judgments, procedures, skills, controls and ethics that assures optimal safety in the distribution and use of medication.” He went on to argue that drug-use control was the “mainstream of pharmaceutical service . . . [the] basic professional ingredient” of the practicing hospital pharmacist that could be used as the “criterion by which decision making becomes logical and professionally sound” for both the practicing and administrative pharmacist. For the next two decades, Brodie’s definition formed the basis of hospital pharmacy practice.

In 1990, Hepler and Strand further defined our professional role in medication use as “the responsible provision of drug therapy for the purpose of achieving definitive outcomes that improve a patient’s quality of life.” This concept of pharmaceutical care was further defined as “the process through which a pharmacist cooperates with a patient and other professionals in designing, implementing and monitoring a therapeutic plan that will produce specific therapeutic outcomes for the patient.” In addition, the pharmacist has a responsibility to “identify and prevent potential drug therapy prob-
lems and to identify and resolve actual drug-related problems.” Finally, Hepler and Strand reminded us that this can only be accomplished when there is “a mutually beneficial exchange in which the patient grants authority to the provider and the provider gives competence and commitment (accepts responsibility) to the patient.”

Clearly, our distinctive competency is based on the use of our knowledge base to ensure the appropriate and safe use of drugs in patients with respect to medication selection, dosing, administration, and monitoring of drug therapy outcomes. ASHP defines this role within the profession of health-system pharmacy as “helping people make the best use of their medications.” Further, the profession’s value centers around the design of medication-use systems that provide efficient and safe procurement, storage, preparation, dispensing, and administration of pharmaceuticals.

However, like many other trades and professions, the knowledge base of our profession is no longer the exclusive domain of the pharmacist. The availability of domestic and international travel, the significant increases in medical publishing, and the explosion in communication technology, especially the mainstream integration of the Internet into our lives, have all provided methods by which immediate, almost instantaneous, information is made available to professionals and nonprofessionals alike as new knowledge is gained and outdated knowledge discarded. Possession is no longer nine tenths of the law. How well we develop and maintain our expertise and apply it to our patients will determine whether we have a distinctive competency compared with other health professionals and perhaps even the lay public.

Those who have experienced firsthand the pharmacist’s distinctive competencies know the value of such expertise: the patient whose adverse symptoms were reduced through a review and adjustment of his or her drug therapy regimen, the nurse whose patient was protected from a significant medication error by medication-use-system warnings and double-checking, and the physician whose patient was spared a life-threatening event because of the intervention of a pharmacist on a medication order in the pharmacy or on patient rounds. In view of the increasing complexity and risk of medication therapy today, the need for the pharmacist in the appropriate initiation, monitoring, adjustment, and discontinuation of drug therapy has never been more evident. We are the only profession solely dedicated to the appropriate use of drugs.

Yet, in the majority of the public’s view and in some health care professionals’ and administrators’ perspectives, we still are singularly associated with controlling the supply of drugs and accountable for making them available on demand in society and even in our health systems. Witness the recent public discussions in which the pharmacist’s professional role of filling a prescription conflicts with his or her personal religious, ethical, or other beliefs.7 Or, note the objections of other health care professionals when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) recently released the requirement that a pharmacist conduct a medication-order review before dispensing medication in all patient care areas.8 Clearly, we as a profession still have significant work to do in order to communicate the value of our distinctive competency. It is essential we do this, as society will continue to grant us this role only as long as there is a perceived public value that differentiates our profession from others that seek to provide similar or identical services.

If we believe that pharmacy offers a distinctive competency and that it is of value to all patients we serve, how can we as a profession make this competency more widely and consistently available? The answer, I believe, is through the organized development, education, and training of health-system pharmacy managers and leaders.

Leadership in health-system pharmacy: A brief history

Much has been written and spoken in recent years regarding the state of leadership development in health-system pharmacy. A brief history may provide a helpful perspective from which to view this issue. In the early 1960s, programs were established to provide additional education and experiential training for pharmacists interested in administrative hospital pharmacy practice. These programs grew throughout the 1960s and 1970s and provided the profession with well-trained and educated pharmacy managers and leaders who pioneered, championed, and facilitated significant advancements in the practice of hospital pharmacy. In the 1980s, the profession shifted its focus from drug control and medication systems to pharmacy as a clinical profession, primarily as a result of the Hilton Head conference.9 Current practitioners and new pharmacy graduates were highly encouraged to pursue more patient-care-focused roles and job opportunities. This resulted in a de-emphasis of hospital pharmacy management and leadership-degree and experiential programs. Ironically, one of the major barriers identified by the Hilton Head conferees was the lack of qualified pharmacy managers and leaders and the need for further education and program opportunities.

It is interesting to note that this de-emphasis of the importance of hospital pharmacy management and leadership training programs followed the corporate business experiences in the same time frame. Middle-management layers and po-
sitions were slashed in the 1980s and early 1990s, especially within health care systems, as managed care emerged and payment rates, and therefore operating margins, were significantly reduced. Further, it was a popular belief that the need for management skills and leadership development was highly overrated. Anyone, it was thought, could manage or lead in addition to handling his or her normal job responsibilities if given the appropriate organizational environment and self-motivation. Thus, experiments with self-directed work groups, co-directors of pharmacy, and other management- and leadership-sharing arrangements were born.

During the past several years, health-system pharmacy, like many other professions and businesses, has gradually recognized the limitations and, in some cases, the failures of these management and leadership philosophies and, in turn, the need to reinvest in management and leadership development. For our profession, it can and should be characterized as a return to a balance of clinical practitioner, management, and leadership personnel and skill development. White’s pioneering work on the impending leadership crisis within health-system pharmacy supported Hunt, Anderson, Thielke, and others who warned us about the path our profession is on with respect to this issue. While it remains to be seen what will be done and how well the profession will recover, it is encouraging to see the attention and support this issue is finally receiving.

Leadership: Intrinsic characteristics

What are the distinctive competencies and strategies of successful pharmacy leaders? There is an entire industry built upon the examination of management and leadership characteristics, skills, styles, and methodologies. It is not my intent to conduct a didactic review of this topic but rather to offer a personal perspective on my experiences. I believe there are several intrinsic factors and external learned strategies that have influenced my success as a leader in health-system pharmacy.

Respect. The first intrinsic factor comprises an appreciation and respect for people. Wollenburg described this in her Webb lecture as compassion. This seems particularly appropriate, as it has been closely associated as a major contributing factor to Webb’s successful career.

Fairness. The second intrinsic factor comprises fairness and consistency. At the end of the day or the end of your career, those who knew you will likely remember you not for the innovative systems or programs you put into place but rather for how you treated those with whom you were associated. Thus, the first intrinsic factor, appreciation and respect for people, is inextricably tied to the second factor of fairness and consistency in personnel management and leadership performance. The consistent application of performance observation, feedback, goal setting, coaching, correction, and, as necessary, progressive disciplinary measures is essential for the creation of a work environment that communicates and confirms to the staff that excellence and hard work will be rewarded and recognized while, at the same time, substandard performance or behavior will not be accepted. While difficult and uncomfortable at times for the pharmacy leader to address, it is an essential principle for the effective performance of a truly integrated, highly performing team.

Excellence. The third intrinsic factor is the personal drive for excellence. In my career, it has taken me a long time to learn and accept the difference between excellence and perfection. A rather blunt differentiation is offered by the actor Michael J. Fox, who stated, “I am careful not to confuse excellence with perfection. Excellence, I can reach for; perfection is God’s business.” In this context, attention to detail in the pursuit of excellence is an appropriate and important attribute.

Persistence. The fourth intrinsic factor is persistence. In my office hangs a plaque with a familiar quote on this topic from the 30th president of the United States, Calvin Coolidge: “Nothing in this world can take the place of persistence. Talent will not; nothing is more common than unsuccessful people with talent. Genius will not; unrewarded genius is almost a proverb. Education will not; the world is full of educated derelicts. Persistence and determination alone are omnipotent.” Regardless of how history has recorded the overall success or failure of the Coolidge presidency, I believe that this one quote has provided the motivation for me and likely best defines the reason for success in my career.

Leadership: Learned strategies

So, if these are some of the key intrinsic characteristics of a leader, what are some of the key extrinsic or learned strategies that I believe are necessary for excellence in pharmacy leadership?

Personal vision. The first strategy would seem to be glaringly obvious, yet I am afraid its necessity is overlooked by many who serve in pharmacy management and leadership roles today. An essential foundation of a pharmacy leader is a personal vision of the role and purpose of the pharmacist and the ability to articulate this philosophy of practice. In addition, one must have both an objective and a passionate commitment to this vision of professional pharmacy practice and the value that it brings to the patients we serve. A passionate commitment without objectivity is simply the definition of a fanatic. Persons who possess objectivity without an emotional commit-
ment are less likely to succeed than those who display both characteristics.

**Organizational and financial responsibilities.** Secondly, health-system pharmacy leaders must take care of the basics of departmental operations and finances within their respective organizations. Mehl17 noted in his Webb address, “As a profession, we must be able to practice our basic service at a certain level of excellence in order to be accepted in new roles by other health professions.” Anderson18 said, “We believe that the department that is poorly managed from a fiscal and organizational viewpoint will be poorly staffed and equipped to provide the unique clinical and professional skills which the pharmacist possesses.” In other words, “no margin, no mission.”

I am always amazed when I speak with health-system pharmacy leaders who misunderstand or underestimate the value of these principles of organizational survival and growth. The practice of health-system pharmacy does not occur in a vacuum or an independent practitioner’s office. It occurs in an organization and, as such, comes with all of the benefits and disadvantages typically associated with any organized entity. Key among these is a finite pool of resources, whether personnel or operating or capital funds, for which there are multiple competing constituents. Pharmacy leaders who recognize these facts and successfully manage the basics of their department’s operation and finances will likely over time earn respect and trust from the “C-suite.” It is nothing less than the basis from which the allocation of new resources to enhance and expand pharmacy services and programs will occur.

**Innovation.** The third strategy of excellence in pharmacy leadership is that of innovation. My current CEO, Dr. Toby Cosgrove, has identified innovation and the measurement of clinical outcomes as the keys to sustaining our success and providing the fuel for future growth at The Cleveland Clinic. Innovation is defined as thinking outside of the box, viewing problems as opportunities, being creative, developing a different perspective or, as Shane19 described in her Webb lecture, “big-picture thinking.” Perhaps all of this sounds familiar, and it should. However, innovation has commonly been viewed as an infrequent, unplanned, *eureka* moment rather than a systematic approach to discovering and creating original solutions to unmet and, in fact, unrecognized needs. While this new perspective on how to harness the power of innovation is clearly a hot topic within today’s management circles, our profession has had its share of innovators in past decades. It is fitting that this lecture honors the career of John Webb, an innovator who understood the problem of the pharmacist practicing in isolation in the basement and the frustrations of the nurse on the floor trying to obtain medications for patients. In the vocabulary of the successful innovations company, IDEO,20 Mr. Webb understood the clients, in this case nurses, and observed them in action to determine their needs. He visualized new concepts to meet the deficiencies noted and identified additional unrecognized needs. He designed, evaluated, and refined a prototype. And in the 1960s, Webb implemented the MOSAICS system at Massachusetts General, one of the first decentralized pharmacist practice models in the country.21

**Personnel development.** I would be remiss if I did not mention a set of interrelated strategies that are necessary to achieve excellence in health-system pharmacy leadership. A pharmacy leader must recruit and retain supervisory, managerial, and other key support personnel whose skills and expertise fill voids and complement existing professional and technical expertise within the department. The leader must achieve timely, accurate, and quality outcomes. The leader must be willing, and I believe has an obligation, to use the institutional resources assigned to his or her department and to look outside the pharmacy profession for personnel who are educated and trained in non-pharmacy areas such as purchasing and contracting, finance, quality, education and training, information systems, utilization review, and so forth.

Further, the pharmacy leader must be willing to identify and address performance issues and to take actions that may better use the skills and attributes of supervisory or management personnel in other positions within the department or organization. The leader must create opportunities for leadership and professional development through the delegation of project and work assignments intended to challenge and develop future leaders while balancing this goal with the need for quality and timely completion of such assignments by those who already possess such skills and expertise. Finally, the leader must create a work environment that recognizes the organization’s “need for speed” and holds team members accountable to agreed-on quality and timeliness of work completion while, at the same time, attempting to provide an opportunity for that euphemistic work–life balance or what Healy22 describes, perhaps in more realistic terms, as an “appropriate level of tension” between their professional and personal lives—a task that seems to be increasingly difficult to accomplish.

**Positioning.** A final key strategy of excellence in pharmacy health-system leadership is an effective understanding and use of organizational structure and operating processes. For pharmacy leaders to be effective within their own organization, it is essential that we position our departments and ourselves to have the abil-
ity to be proactive rather than reactive to organizational initiatives, opportunities, and potential problems. In her recent commentary on the rationale for having a chief pharmacy officer in a health care organization, Ivey23 notes, “Pharmacy directors ... can contribute most effectively when there is no more than one management level between the chief pharmacy officer and the chief executive officer.”

It is interesting to note that this is not a new issue within our profession. In the 1964 report, Mirror to Hospital Pharmacy, written by Francke et al.,24 a key recommendation stated that “the organizational line of responsibility of the chief pharmacist ... lead directly to the administrator of the hospital or to one of his immediate professionally oriented assistants.”

The basis for these recommendations is simple. Requiring a pharmacy leader to communicate with the chief operating officer or CEO through additional layers within the organizational structure is at best inefficient and at worst blunts, convolutes, or destroys the intended message.

Further, routine participation of the pharmacy leader in the organization’s decision-making bodies such as the executive team or the medical executive committee can enhance the success of the both the pharmacy department and the hospital or health system. While this can be time-consuming, the benefit of this participation is an improved ability to proactively identify potential opportunities for the pharmacy to assist the organization in accomplishing its mission and goals and to identify informational needs for upper-level administration regarding medication-use system issues and initiatives. It also allows the pharmacy leader to learn the real organizational perspectives and priorities; to learn to speak the languages of clinical, operational, financial, and organizational issues; to see the big picture; and, in turn, to contribute intelligently to these discussions.

These concepts should not be new to health-system pharmacists. For years, we have understood the need for and benefits of a pharmacist practicing on the nursing unit rather than in the basement and interacting directly with the decision-maker—the physician—regarding drug therapy decisions. Likewise, we have understood and supported the inclusion of pharmacists in patient rounds, in order to obtain the full picture of the patient’s health status, even though it may not be the most productive use of the pharmacist’s time. In a similar fashion, the pharmacy leader needs to be in a position to communicate directly on a frequent basis with administrative, physician, nursing, and other key decision-makers regarding patient care and medication-use system issues and initiatives. Further, pharmacy leaders need to be present for the big-picture discussions. In each of these situations, trust is built and respect is gained through direct interactions and frequent and consistent contact with the key decision-makers.

Thus, the recent discussions about new pharmacy director titles, reducing reporting layers, and determining appropriate reporting lines are not about elevating the stature of the director or the pharmacy department within the health care organization. Rather, it is about ensuring that efficient and effective organizational structures and processes are in place for the pharmacy in order to ensure safe and effective drug therapy. For example, at The Cleveland Clinic, we estimate that over 90% of our inpatients receive some sort of medication therapy during their stay. Further, we calculate that a dose of medication is administered to a patient in our hospital, clinics, ambulatory surgery centers, or family health centers every 4.5 seconds. Given the scope of patients to whom pharmaceuticals are provided, the complexity of the drug-use process, the potential for adverse outcomes because of medication misuse, and the cost to the organization for medication therapy, is it not appropriate that the pharmacy department and the pharmacy leader have the same level of organizational position and access as other medical staff and patient-care departments and leaders? I believe it is.

Challenges and opportunities

Admitting potential leaders to pharmacy school. So what are the opportunities and potential for our profession and health-system pharmacy leadership? First and foremost, a general observation is in order. As noted by Hunt,11 Wollenburg,14 and Thielke,25 there is concern regarding changes over the past two decades in the admission processes for pharmacy students. I have had several informal discussions with my colleagues on this topic, and the outcome is almost always the same. Many of the current health-system pharmacy leaders today, including myself, would likely have not had a career in pharmacy under current admission standards and processes. This is not to say that some of today’s graduates and young practitioners will not be successful in management and leadership positions. However, if we are in fact in a leadership drought of significant proportions, this concern must be taken seriously. We must collaborate with colleges of pharmacy to ensure that we are admitting students with an aptitude for management and leadership skills, as well as those whose grade point average indicates a higher ability to successfully study the pharmaceutical and human sciences.

Accepting responsibility in medication use. Another significant challenge for health-system pharmacy leadership is to truly accept responsibility for the medication-use process. We profess to be the drug-use experts and that no other profession has or can provide our depth of
knowledge of appropriate drug use and safe and accurate delivery systems. If this is true, then we as practitioners and pharmacy leaders must resist our own willingness to let other health care professionals take a primary role and, in essence, abdicate by default our responsibilities in any process that involves the use of medications. As an example, how many of our colleagues are not involved, at least through an oversight role, in the selection, ordering, storage, medication order review, preparation, or administration of drug products such as anesthetic agents, blood products, respiratory medications, contrast media, and other diagnostic agents? If we truly bring value to patients through our unique knowledge base of drug therapy and safe medication-use systems, then why are these areas commonly self-excluded from our purview?

Another recent example is the lack of involvement of many pharmacists and pharmacy leaders in the implementation and measurement of the Centers for Medicare and Medicaid Services (CMS) core measures, six of which directly measure whether a patient received a recognized therapeutic regimen that directly affects positive clinical outcomes. If we continue to delegate our responsibility and accountability for appropriate medication provision and outcomes within our own practice sites to other health care professionals, it is my belief that we assist in facilitating what Anderson26 referred to as “the peril of depprofessionalization.”

Other challenges. There are many other significant challenges facing our profession and leadership from within. Many of these challenges are like old paintings that have simply been reframed for our generation. In 1960, Foster27 identified the need for expanding the role of the pharmacist as a member of the health team in local community disaster planning, long before the events of September 11, 2001, and, most recently, Hurricane Katrina. Bowles28 spoke about a leadership gap in 1962 when he asked, “Where do we go from here?” In a reversal of current leadership concerns documented by White,19 Bowles went on to describe his concerns about the potential for the maturation of hospital pharmacy as a professional specialty practice area given the fact that “40% of chief pharmacists in the country are under 40 years of age and 33% have practiced in hospitals less than 6 years.” Reimbursement for medication therapy management services was discussed by Parker29 in 1967 when he stated that “the pharmacy practitioner will have made a monumental step in improving his public image when he fully accepts the professional fee concept and divorces his professional services from the cost of the drugs.” (Coincidentally, this sounds a lot like what CMS has told oncologists.)

However, as I reflected on today’s significant professional and leadership challenges, I kept coming back to one central issue: patient contact and communication.

Connecting with patients. If a group of individuals is recognized as a profession by society due to the presence of a distinctive competency and the profession’s value lies in using this distinctive competency for the benefit of individual and collective members of society, then the failure to use that competency consistently will ultimately lead society to no longer recognize a value from this professional status, and the profession will cease to exist.

Throughout my studies for this lecture, I have been struck by the volume of literature that has called for improving the pharmacist’s communication with the patient. For example, in 1971, Anderson30 stated, “The missing link in the professional expertise of the pharmacist has always been the absence of contact with the patient at the time and place that the patient receives his drugs.” In 1978, Brands31 outlined the need for a pharmacist assessment of the patient’s drug therapy history and clinical response. In 1999, Gouveia31 stated that “We must place our highest priority on increasing the amount of time we spend . . . face to face with patients, time spent solving patients’ problems with drug therapy, time spent teaching groups of patients about their drug therapy, and time spent with other professionals addressing patient care issues.” Anderson12 reminded us in 1992 that “there is a need for pharmacy to actively demonstrate and communicate its value in health care.” Finally, in 2003, McAllister32 reminded us that “Our patients must become our strongest advocates and they will, once they appreciate our expertise, understand our value, and demand our active participation in improving their health.”

Thus, we come full circle to the beginning of this lecture: a distinctive competency . . . in every specialty . . . which is widely and consistently available . . . that gives value to people. And yet, as a profession we do not fully embrace or we completely miss the opportunities to engage our patients that can further demonstrate our value to them and to members of the health care team. As proof, let me offer three contemporary issues that each health-system pharmacy director is dealing with.

Continuity of care. The first is the recently mandated continuity of care, or medication reconciliation, standard from JCAHO, which is a significant opportunity to redefine the practice model of pharmacists in a health care system and to demonstrate value to the patient and to health care providers. The literature that supports the benefit of a pharmacist medication history taken at hospital admission is clear and convincing. We recognize the dangers of polypharmacy and its direct relationship to increased emergency room visits, inpatient admissions, and length of stays. Yet, there are those...
within our own profession who view this mandate to improve patient outcomes as an imposition upon the pharmacist’s practice model. Practitioners and pharmacy management often cite time and resources as a barrier to conducting a pharmacist medication history with each patient admission. Apparently, we are unable or unwilling to identify current pharmacist functions that provide minimal or indirect benefits to our patients that could be replaced by a pharmacy service that actually increases our direct contact time with the patient. Apparently, we are unable or unwilling to identify other practice models involving other health care technical or professional workers while still providing for direct pharmacist–patient interactions in a more efficient manner. Or perhaps there is an element of elitism in our profession and our practitioners that causes us to consider our interactions with patients less desirable and less important than those with physicians and other health care professionals.

So instead, we set what Tye33 calls an “anemic goal” for ourselves. We focus on developing a form that documents what the patients tell the nurse or nonhealth care provider about the medications they are taking. Seminars and conferences abound to teach us this approach. We feel good because we have expanded and perhaps segregated this data collection from the other elements of a nursing admission history. Because it is now in the patient’s paper chart or electronic record, everyone involved in the patient’s care can view it. We feel good because we have reached our goal, the JCAHO standard has been met, and we have improved patient care. Or have we? Where is the application of the pharmacist’s distinctive competencies to review and assess the medication therapy of the patient? How have we improved patient care if decisions are made on patient medication histories that have not been verified for accuracy and thoroughness and assessed for appropriateness of therapeutic indication, dosing schedules, patient compliance, adverse effects, and other factors affecting therapeutic outcomes? As indicated by Raehl14 in 1994, “we may think of patient information as records and forms. But patient information comes from patients. From talking directly with patients. From asking simple, open-ended questions. How are you feeling? Are you having any problems with your medication? This is how we begin, not by listing 20 potential adverse drug effects and ticking off yes or no responses.”

Drug therapy selection. Another contemporary issue that illustrates a missed opportunity is our profession’s involvement in drug therapy selection. Once again, we assert that we are the drug therapy experts and that our mission is to help people make the best use of their medications. Yet, we are apparently content to remain silent while other nonphysician health care professionals, with much less education and experience in pharmacology and pharmacotherapy, pursue and obtain dependent or independent prescriptive authority. In apparent deference to interprofessional harmony rather than what is best for the patient as our primary focus, we even assist in this effort by providing these newly recognized prescribers educational programs that give a baseline understanding of drug therapy prescribing.

If we in pharmacy are to meet our stated societal purpose, should we not be on at least an equal footing with these other nonphysician health care practitioners with respect to drug therapy selection? Or are we simply satisfied to serve in the historical role of attempting to influence a prescriber’s decision and thereby attempt to fulfill our promise to our patients once again in an indirect manner, most likely with this new group of prescribers through a reactive practice model? Is this consistent with our pharmaceutical care model of the pharmacist’s direct accountability to the patient? I do not believe so.

Ambulatory and community care. A third and final example of these missed opportunities is in the area of ambulatory care and retail pharmacy practice. Certainly, these practice settings have been well recognized for the lack of a pharmacy practice model that supports the value of pharmacist communication with patients. I have discussed the change during the past century of the community pharmacist’s role as a trusted patient and family health care advisor, to pharmaceutical compounding, to dispenser of commercially available medications. The exclusion of the pharmacist behind the dispensing counter is all too common in community pharmacies, and even in ambulatory care settings in health systems, despite innovative professional practice models developed in the past several decades by visionary community pharmacists such as White.35 While patient counseling by a pharmacist is mandated as a result of the Ombudsman Budget Reconciliation Act of 1990, the actual performance of this function is fairly infrequent and fleeting. Once again we accepted an anemic goal, the completion of a paper form to comply with the minimum legal requirements of this legislation rather than use it as an opportunity to redefine the pharmacist–patient relationship. I believe that when patients sign this form, we are acting as law enforcement agents and should recite a revised version of their Miranda rights as follows: “You have the right to speak to a pharmacist. If you give up this right, one will not be afforded you. And if you have any problems with the medication that’s just been prescribed for you, you’re on your own.”

What a wasted opportunity to review and improve the patient’s drug therapy regimen—an opportunity to demonstrate the value of pharmacy
services to our patients. If form is supposed to follow function, then why are our ambulatory care and community pharmacies not designed like many optometry stores, where these professionals also deliver a product and a service? Imagine, just for a moment, that the patient walks into our pharmacy and is initially met by a qualified technician at a workstation in the middle of the store who reviews the patient’s prescription and gathers the necessary insurance and other information. While the patient waits, the prescription is sent to the back of the store where other qualified technicians process and fill the physical product. The pharmacist’s primary role is to review the final product and to greet the patient to review the new medication therapy and make adjustments as appropriate based on discussion with the patient. How is it that this model is appropriate for fitting and dispensing eyeglasses but not for dispensing pharmaceuticals with all of the potential risks, not to mention wasted resources, that an ill-fitted prescription can have on a patient? Would not this practice model be much more patient centered than our current design in most ambulatory care and community pharmacies?

All of these examples speak to the need for a radical revolution rather than an evolutionary approach to redesigning inpatient and ambulatory practice models, a revolution that truly values and puts the patient first. Why are our ambulatory care and community pharmacies not designed with nurses or physicians differently? Can automation offer practice solutions? Is there a way to work with nurses or physicians differently to improve efficiency?

Clearly, addressing these issues will require appropriately trained pharmacists with management and leadership skills who have the courage to change and the skills to implement and manage change. Through the development of these pharmacy practitioners, we can fulfill our societal covenant and professional role. Perhaps then we will have truly achieved our obligation as a profession that offers our patients a distinctive competency.

Conclusion

It is widely recognized that no one individual accomplishes anything on his or her own. The support and encouragement of others are absolutely essential for an individual’s success, whether personal or professional. On a personal level, I have been blessed with the love and support of my wife, my children, and my parents throughout my life. Like many of us who are truly engaged in a profession dedicated to helping others, at times I have wondered if I have successfully pursued my career with the appropriate balance of time spent between family and professional activities. As I look at my three children, Matt, Tim, and Melissa, who are now adults pursuing careers and collegiate studies, it is comforting to know that any deficit in the work–life balance that the pursuit of professional excellence may have caused was more than adequately covered by the love and support of their mother, my wife Denise, without whom I would not be standing here before you today.

On a professional level, there are so many individuals who have taught me about our profession and management and leadership skills. These individuals include Dr. Jack Calvert, the Albany College of Pharmacy professor who encouraged me to pursue a graduate degree and residency; my residency preceptor Don Bennett and master’s program mentor, Dr. Cliff Latiolais; my first director, Dennis Messier, who gave me my first opportunity to excel in hospital pharmacy management; Robert Scholz who gave me an opportunity to expand my professional experience within academic health-system pharmacy practice; and, of course, all of those individuals who I had the pleasure of working with or interacting with during the course of my career. The professional friendships, guidance, encouragement, and support that I have received from many of you and many other leaders in health-system pharmacy practice have truly been remarkable. I believe they have been a very special part and benefit of being in a leadership role within health-system pharmacy. Through spoken and written words, through actions within and outside of practice settings, many of you here today and others have constantly encouraged, inspired, and perhaps most importantly, at times reignited the fire within me to improve and promote our profession to be true to our societal covenant and purpose. My sincere appreciation and gratitude for all that you have given me, perhaps even unknowingly, during the past many years.

I am truly blessed and fortunate to be in this profession we call health-system pharmacy. And I am equally appreciative of and honored by the recognition that you have provided me today as the John Webb Visiting Professor. Please accept my sincere wishes for continued success in your professional careers and personal lives.

References