Leading healers to exceed

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The greatest leadership sin is to remain passive in the face of challenges.
—Toby Clark

Now what?” I asked myself. At the time I was the assistant pharmacy director at Sinai Hospital of Detroit and had just been appointed acting director until the permanent director of pharmacy was secured. I was one year out of my residency and a graduate student with the summer to devote to the operation of the hospital pharmacy. I was “as green as a stick” and did not have much of a clue about so many things. The outpatient supervisor, pharmacist Lester Atkins, told me he had his area covered, so we would have no problems there. But in the inpatient area—oh my . . . so much to do! We had just started an intravenous admixture program and 24-hour services. So I decided to call one of my professors, Robert L. Ravin, who at the time was a member of the ASHP Board of Directors and director of pharmacy at St. Joseph Hospital in Ann Arbor, Michigan. Mr. Ravin was very generous with his time and advice to me. He told me to call him regularly, work to solve pharmacy staff problems, and hold on for just a little while longer until the new director was hired. I called him more than frequently, got the staff a raise, hired several more pharmacists, and could not wait for fall semester to start and have the new director in place. This business of being the director was exasperating work! As promised by hospital administration, a new director of pharmacy was hired—Robert B. Williams. I was ecstatic and very relieved. Soon I found out that Mr. Ravin was a consultant to hospital administration and was very involved in the recruitment of Bob Williams. What a lesson in politics, faith in one’s fellow man, and building self-confidence for me. Mr. Ravin was advising me what to do on one hand and consulting with hospital administration to support hospital pharmacy on the other. Wise Bob Ravin was certainly right, Williams was a leader and a change agent.

But Robert B. Williams was more than a change agent; he was a mentor and leadership model. One of the first things he gave me to read was Peter Drucker’s The Effective Executive.1 This was only the first of many books, articles, and pamphlets he distributed to me and others in our department. Williams was a true leader and an inspirational individual who built, molded, and modeled his team. As the first recipient of the Webb Lecture Award, he practiced what he preached and gave us a continuing glimpse at his successful and effective management style. His 1985 Webb lecture2 and 1991 ASHP presidential inaugural speech, entitled “Empowerment,” continue to be inspirational. Williams’s3 message engages us to “empower ourselves, those around us, and our practice sites so that we become a profession that focuses on taking full responsibility for people receiving medications.”

My remembrances and reflections of Williams are manifold. How to improve the quality of management and leadership is but one concept that has been a lifelong quest for many of us due to his inspiration. In addition, he taught us to develop our own leadership philosophy and style. The leadership-improvement search is never-ending. A concept that can...
serve us well is this: Leadership is not about being number one; leadership is about organizing your resources and focusing your attitudes to ensure that your customer is number one.

It is my plan today to give you a bird’s-eye view of my perspective as a health-system pharmacy traveler—a person that has the good fortune to visit for several days a multitude of pharmacy operations and observe the many good things that are occurring to help sick people attain better health. I will also offer several reflective thoughts on and recommendations for health-system pharmacy. These observations have come from several sources, first as a consultant to over 350 hospitals in the past 35 years and second as a pharmacy residency accreditation surveyor for ASHP. It has been my privilege to see during these visits what I call the “upward spiral” of management and leadership. Everyone participating in the “upward spiral” is a pharmacy leader trying and to bring about improvements in the quality of pharmacy and medication-related services. These leaders are constantly aspiring to be better and bring out the best in their employees and residents to better serve patients.

Healers

Of the many groups that have been defined as customers of our management and leadership are those pharmacists who provide services to patients. These people should be thought of as healers! What is healing? According to Webster’s, healing is “to restore to health or soundness; to cure, to set right; repair: to become whole and sound; return to health.”4 That definition almost sounds kind of magical or mystical, but it is not. Healing is a sacred process to which we have been exposed through our education in pharmacy school and residency training programs. But do we think of ourselves as leaders and servants of healers? Do we treat those who we lead as healers? So who are these healing people we are leading? These pharmacists are very well educated and trained in drug use and drug therapy. They are caring, sensitive, attentive, introspective, and very smart. They have a reserved exterior and are, by and large, tranquil. They are empathetic and bring health and integrity to others. In my travels, I have observed that they seem to be deeply committed to their ideals. They are so very caring and emotional about their patients. And yet they have a fiercely independent streak, which is the root cause for their effectiveness in many cases. They truly know more about drugs and drug therapy than any other members of the health care team and are frequently so recognized by physicians. Because of this knowledge, they have much power in the processes of helping patients to heal. As such, they are healers in a very large sense, and we need to be more respectful of them.

These healing professionals need a leadership philosophy to serve others. As their leader, it is your responsibility and professional duty to give guidance and direction to them. In its simplest form, you as the leader need to study the management and leadership literature in great detail. Excellence in leadership requires continuous immersion in learning. You must have an unquenchable thirst to learn to be a better manager and leader. You must always be asking yourself, Am I preparing myself to be a better leader? Remember, this is a journey and a learning process that is never-ending. You will need to read past and present issues of Harvard Business Review and an abundance of other journals and more books and website postings than you thought possible. In addition, you need to choose a guru or two to fol-
low and then read all of their writings as a basis or foundation of your own philosophy and system of leadership. Perhaps you will read many different professors and authors and combine ideas to structure your own management vision, values, and beliefs. But rest assured, you must have a style, purpose, and belief system in place or your chances of success in leading and managing these healers will be greatly diminished if not completely thwarted. So are you an agitator to increase the “upward spiral” of your team? How do you agitate to lead your healers to exceed expectations?

One example of a philosophy and concept to consider is “relational coordination,” fostered by Jody Hoffer-Gittell and defined as “communicating and relating for the purpose of task integration.” Relational coordination is particularly useful for improving the quality and efficiency of performance under conditions of task interdependence, uncertainty, and time constraints. This concept also embraces coordinating work through shared goals, shared knowledge, and mutual respect. Because of the general way the medication system is organized, weak links exist throughout the chain of communication. Hoffer-Gittell believes that relational coordination strengthens those weak links, enabling providers to deliver high-quality, efficient care to their patients. Using Hoffer-Gittell’s innovative management methods, quality can be improved and efficiency maximized, causing more effective completion of tasks. Using the power of relationships to improve quality to higher levels will result in greater satisfaction for employees and patients.

Shared leadership is an understandable concept. Bradford and Cohen told us that heroic leadership was the old way of leading (or managing) people. They said that we are in the age of postheroic leadership, in which managers share power with people. It could be thought of as shared leadership. A key point is that the role of the manager does not become redundant in a shared leadership setting. Instead, what is needed is a transformation of the manager’s role in the organization. Managers can become transformational leaders. Bradford and Cohen made the following comment:

Shared leadership does not eliminate the leader’s role or deny hierarchy; leaders still have plenty of work and remain accountable for the unit’s performance. But they must now encourage and build a shared responsibility system, where the leader and direct reports collaborate in the management of the unit . . . . Power determined by management level cannot work where knowledge is widely dispersed, where changes in technologies, markets, and competition are rapid, and where employees (read healers) are highly educated . . . leadership extends in all directions. It is too narrow a definition of leadership to focus only on managing down. Everyone will have to manage sideways and upward.

This reminds me of Sara White’s assertion that all pharmacists are leaders.

This message is even more relevant in today’s hyperdrive health care world. A very important observation to stress is that all employees must accept responsibility for the future of the organization. It is not just a senior management issue. However, it is essential that leaders and managers understand that they are not abdicating power or responsibilities. Today’s leaders must be completely engaged with their employees. This type of leadership is more difficult because it is more dynamic and requires personal courage, yet it is also easier because once it is internalized, it becomes part of all managerial elements. William Halal told us that “Leaders must cultivate the art of helping others to share the responsibilities of management.” Again, employee engagement is an essential key element in achievement. Are you an advocate of shared leadership? If you are a manager, do you share your power with your team members? Just as important if you are not in management, are you willing to take on leadership responsibilities?

Does shared leadership parallel the concept of servant leadership? Yes, I believe so. A principle has emerged, which holds that the only authority deserving one’s allegiance is that which is freely and knowingly granted by the led to the leader. This is in response to and in proportion to the clearly evident servant stature of the leader. Those who choose to follow this principle will not casually accept the authority of existing institutions. As Greenleaf writes, “Rather, they [the led] will freely respond only to individuals who are chosen as leaders because they are proven and trusted as servants.” These leaders have a philosophy of sharing the power in decision-making.

Attaining excellence in leadership is the result of trustworthy relationships and the sharing of decision-making. With this sharing of responsibility and authority, leaders still remain accountable to higher authorities for the overall processes and outcomes of their responsibilities. This is a balance that may differ based on the situation and therefore is difficult. Much communication and trust must exist to make this balancing act of risk sharing work well. Leaders need to define the authority and responsibility of their team members for individual processes. The leader is still in charge and is ultimately responsible for the outcomes of the team.

Quality standards

Today’s leaders must be quality zealots in every sense of the word if they wish to exceed expectations. Quality must be a part of their mission and vision statements as well as all departmental practices and
actions. They must talk the talk and walk the walk. While we wave the quality banner at every turn of the road, the leader and the leadership team must define it and measure it for all pharmacy services, distribution and clinical, processes and outcomes. The leader must weave together the concept of practice standards and quality measurement in a way that is well understood by the healers. The healers must understand that standards are tools that can be effectively used for the purposes of education, control, evaluation, and planning for the future. Leaders should know that professional practice standards exist for the purpose of improving the quality of our services to patients and that standards need to be used as the basis for measuring quality. Hospital pharmacists have promulgated professional practice standards in health-system pharmacy since before the inception of ASHP. Professional practice standards provide practitioners, health systems, and other health professionals with an evidence-based sense of direction on the best approaches to ensuring patient safety, quality, and optimal medication outcomes. So why don’t we use ASHP Best Practice documents more? Are we evolving away from standard-based practices? In my travels I see far too many practices quite contrary to ASHP Best Practices documents. Too many pharmacists do not know such material exists, and even more practitioners simply do not use them as a basis for determining the quality of operations and professional activities. These suboptimal practices must be changed if we are to exceed expectations. Leaders must greatly foster the use of ASHP professional practice standards for pharmacy activities.

Boldness

If pharmacy leaders would put as much time into ensuring proactive clinical services for all patients as is done for ensuring procurement and drug distribution, I am convinced that medication-related patient care outcomes would be much improved. We have had a myriad of debates, journal articles, conferences, and discussions on the topic of clinical pharmacy expansion since 1985, when the Hilton Head Conference was held. One of the most recent of those efforts is the ASHP Pharmacy Practice Model Initiative (PPMI). We should give strong kudos to ASHP leadership and members who participate in this important and expansive effort. But PPMI is about much more than clinical pharmacy expansion. Observations made during my travels and from my viewpoint indicate that the PPMI is working, but slowly and perhaps not fast enough. Manasse was masterful to ask us “whether we are content with the slope of the innovation curve [for clinical pharmacy], which is now approaching 40 years. If we are not content with the rate of diffusion and adoption, then we must move forward to build entirely new models for pharmacy services in hospitals and health systems.”

Charles Hepler, in his 2010 Harvey A. K. Whitney Lecture, told us “the dream is still alive . . . . It is time for the dream to explode. We must set goals and objectives, get to work, and keep moving toward the dream.” The dream he is referring to is the proposition that providing pharmaceutical care will be the central function, purpose, and responsibility of our profession. I strongly encourage each of you to read and reread and take action on Dr. Hepler’s landmark lecture and make sure your residents do the same.

Ladies and gentlemen, it is past time to take the bold offensive for our patients and be much more proactive in our leadership efforts. Leaders need to be bolder, that is much bolder in obtaining resources to properly staff for clinical services for all patients. I am talking about the actions of pharmacy leaders who will be especially proactive to serve the needs of patients—who will be a bold leader who may be willing to risk shame or rejection in social situations and willing to slightly bend the rules of etiquette or politeness. An excessively bold person could aggressively ask for resources, money, or persistently push to fulfill some request, and so on. Boldness does not necessarily mean obnoxiousness; it is possible for one to be bold while staying quiet. Excessive boldness may thus be regarded as impertinence or arrogance. Outside a social context, boldness can also refer to a willingness to get things done, despite risks, and is therefore broadly synonymous with bravery. Calvin Coolidge recognized that “Nothing in the world can take the place of persistence . . . . The slogan ‘press on’ has solved and always will solve the problems of the human race.”

Boldness is not always in a rash context but can have a great positive connotation to the word. Being bold can be a huge step in social development for the leader.

It is the time for a new boldness to emerge in our leadership of pharmacy services. It is time for us to take a strong and bold stand that we need proactive clinical services for all our patients. If we do not fill a medication order or verify an automated cabinet medication request, a nurse calls or communicates in some way to get the medication. Many of us measure turnaround time events for quality reports and report them monthly or quarterly. Hooray for drug distribution! But when we do not perform proactive clinical patient assessments based on eliciting drug-related problems or participate in rounds, who complains in your institution? Does a nurse call to say that no pharmacist notes are written on the patient and that no drug reviews were completed? Not nearly often enough! We have not been bold in setting others’ expectations of our most important services—that is proactive clinical pharmacy. When is the last time a pharmacy leader in
your institution got a call from a physician or chief of medical service to complain that no clinical pharmacist was on rounds or reviewed patients’ drug regimens on the weekend.

We need to set expectations of clinical services for all patients of each medical service. We need to be telling physicians what to expect from our clinical pharmacists. Most physicians do not know what to expect from us other than to get their patients the needed drug. We must perform an analysis of the needed clinical services for every patient, produce a master plan, and establish an expectation of our proactive clinical services for physicians concerning all patients. We need to be bold to do this! As leaders, we have not done a good job of being strategic in our thinking. We need to be thinking more boldly to build a house not one wall at a time, not one room at a time but the entire house with a well-thought-out scope-of-service plan. What I am suggesting is to use your boldness and entrepreneurial spirit to lay out a plan to provide proactive clinical services to all your patients— inpatients, outpatients, home care patients and remote clinic patients—and provide all other medical services of the patient care enterprise. What I am suggesting is that health-system pharmacy leaders become architects of the pharmacy plan. Using the analogy of planning for a building structure, we see complete drawings for the foundation; each elevation; the roof line; the door schedule; the heating, ventilation, and air conditioning systems; the floor plan; the telecommunication wiring; the plumbing configuration; the electrical system; and the security system, to name a few planning documents. These house construction plans are used to tell owners, contractors, suppliers, builders, and financiers what is needed in the construction process. The plans vividly show the concerned parties the product quality and further establish an expectation of the final product. These detailed drawings give to the reader the vision and specifications of the architect for the finished dwelling.

The bold pharmacy leader must lay out the detailed plans and vision for clinical services—service by service or patient care unit by unit—for the staffing and programmatic needs required to optimize the medication system for each set of patients. How many pharmacy leaders have such a detailed plan for the delivery of the necessary clinical services? How many pharmacy leaders are bold enough to tell executive hospital management that perhaps a 30–40% increase in clinical pharmacy staffing is needed to meet the existing ASHP Best Practices and patient care needs of today? It is time for us to be bold in our planning and setting expectations for the care of patients.

We need to have planning discussions in our pharmacy and therapeutics (P&T) committee meetings and engage medical leaders at every level to better serve their patients. After all, they and they alone were the admitters to our health systems! We need to be forming new and stronger alliances with physicians at all levels, not just with the chief medical officer. We need to do exactly what drug representatives have been doing for years; we need to detail and sell all attending physicians on what we have, who we are, and what we can do to assist them in caring for patients as we optimize the medication system. We need to be bold in setting expectations with attending prescribers, some of whom may be nonbelievers in what we can do for them. Some of you may be saying you do not want to set expectations for services you cannot deliver because you do not have the staffing. Some will say that they have tried to get staffing for services but get turned down each time requests are made. You are not bold enough—take more risks. Leaders need to plan and calculate the number of healers required for proactive clinical services and go after it. Set those expectations, and engage your supportive physicians to help get more resources. If we are not performing well enough in being clinical pharmacists so that our physicians want all their patients served by us, then something is wrong with what we are doing as clinical pharmacists and pharmacotherapists. Richard Hutchinson told us in 1968 that we need to be important, vital, and absolutely necessary for physicians to practice. The concept has not changed whatsoever since that time. If pharmacy leaders are unable to demonstrate this concept with planning and action to physicians, then they have failed. Failure is an unacceptable situation. The failed leadership needs to be replaced with those who can get the mission accomplished. But we are optimists who do not fail and will not fail; we will be successful, and patients will get our services if we are bold. We have had a few successes in this regard as leaders who have made no small plans but rather have been bold. Look at the successes we have had in the past. In my professional lifetime, we have seen 24-hour pharmacy services become the norm. We have seen the initiation of centralized intravenous admixture programs. With both of these service expansions in the 1960s, we were told by the naysayers (who were mostly pharmacists) that we could not afford to have pharmacists on duty all night, that we could not find people to work those shifts, and that we certainly could not get technicians under pharmacists’ supervision to make intravenous admixtures because nurses would not let that happen. And we politely listened to a mountain more of reasons why we could not do it. With bold leaders like Harold Godwin, we did it, and it became the norm and an expectation of pharmacy service. We can do the same with proactive clinical services for all our patients.

Dr. Richard Allen Hutchinson from
the University of Illinois was a bold leader who did these bold things throughout his pharmacy career. Dr. Dennis Helling is another bold leader who maximizes clinical pharmacy services to all the patients in his ambulatory care health system in Denver.

Having clinical pharmacy services for all your patients is purely and simply an issue of leadership and leadership excellence if we choose to be bold.

Quality assessment

Strong leadership is needed in the processes and outcomes of quality assessment. I am a firm believer in the adage “You cannot manage what you do not measure.” We have all heard that well-used phrase before, right? But are we doing it? In my travels, I would say not very much and not very well. You say many leaders know such facts as turnaround time, how frequently the hood filters are changed, and how many personnel evaluations are completed on a timely basis, all per the Joint Commission. But how many leaders know the quality of the clinical services that have been provided to patients? What are the quantity and quality of the medication history, development of the therapeutic regimen, construct and completion of the drug therapy monitoring plan, and the quality of the permanent chart note? These and other quality indicators need to be a part of the pharmacy clinical quality plan. Leaders need to be bold in performing clinical service quality analysis on all medical services, covered and uncovered by clinical pharmacists round-the-clock. We need to do this at a level of sensitivity to discern that less-than-adequate or satisfactory clinical services beget a low or unacceptable quality score. Do your clinical quality indicators substantiate or verify the absence of clinical pharmacy services on a particular patient care unit or during a particular time of the day or week?

Do you consistently report these poor results of uncovered services to your P&T committee or executive quality committee? Bold leaders do! Boldness does not just apply to ensuring full and complete clinical services coverage for all patients in your health system. Boldness coupled with an entrepreneurial spirit must permeate all efforts and opportunities related to pharmaceutical services and the medication system. Boldness includes seizing opportunities to provide services and improve quality and margin. Ask yourself: Do discharged patients leave with prescriptions to be filled elsewhere or have home care medication needs that will be met by other pharmacy operations outside of your system? Bold leaders do not let transitions-of-care safety opportunities or profit margins go outside their own organizations. Some bold leaders assign cost-reduction quality-improvement projects to each pharmacy resident. In those organizations, hospital administration believes each resident is worth at least $300,000 in cost savings per year. The hospital executives want more pharmacy residents; wouldn’t you?

Exceeding expectations

Leading healers to exceed is really about exceeding expectations that you have established for others to experience concerning your pharmacy service. The principle “under promise and over deliver” is a very reasonable concept. It makes total sense to establish written service standards, follow through on your commitments, and exceed what you said you would do. It sure seems like this is a good approach to all facets of life, not just in leading and managing for pharmacy. Your boss asks when you can get a project finished; you give a date and manage to complete it two days early, perhaps with enough time for some feedback and to create another version. Your spouse wants you to help more around the house, and you commit to walking the dog every morning (and end up putting on coffee and taking out the trash at the same time).

One of the best ways to make an obligation to someone is to honestly appraise (to yourself) what you or your people can do, then pull back a bit to give yourself a “fudge factor” (e.g., quote a slightly longer delivery time, slightly higher cost, slightly lower quality). If the project takes longer (or is more expensive), you will still be able to fit within your original estimate. In my travels, I have reviewed a great number of P&T committee minutes and talked with an equal number of P&T committee chairs. In far too many cases, those physicians have a paltry expectation of the role of the clinical pharmacist. In many cases, little or no expectation has ever been elaborated. This too is a leadership problem. All too frequently, those physicians’ expectations have never been discussed in any detail by the pharmacy leader. We have not led those decision-makers and policy influencers to expect a pharmacist to routinely review patients’ laboratory test values, problems lists, medication histories, and chart notes for the purpose of optimizing drug therapy. Bold leaders have had those expectation-setting discussions.

Inspiration and hope

In today’s health care workplace, many situations arise that confuse and confound the faithful caring pharmacists whom we lead. News stories in the lay press and professional tomes tell of potential cost shifts and reductions in staff. Each week, e-mail communications relate hospital mergers and staffing layoffs. And then we read about how hospitals and health systems add new jobs and help to bring added resources to the communities they serve. Health systems continue to be some of the largest employers in cities and towns across the country. These and other news stories frequently build apprehension and confusion and con-
found some of today’s well-trained work force. Excellence in leadership replaces fear with hope and disbelief with trust. From my vantage point, leaders have yet another mission to cause their people to exceed expectations. Leaders need to work to have people feel good about themselves and the environment of care where they work—not just in the pharmacy service, but the health system and the overall industry we work in. Leaders need to be very mindful of their responsibilities to motivate and drive out fear from the workplace.

James T. McCarty of the University of Houston College of Pharmacy taught many of us to act on the concept of “people who do good work feel good about themselves.” Jim is right in so many ways. Thank you, Jim.

In closing, permit me to thank the ASHP Section of Pharmacy Practice Managers and the Northeastern University, Bouvé College of Health Sciences, School of Pharmacy, for this award. I stand on the shoulders of those who have gone before and have given much to me. Any accomplishments that have been achieved are because of others with whom I have had the privilege of tutelage and a partnership. Time does not permit me to acknowledge all who have been supportive. A sincere thank-you goes to my residency program director, Kenneth W. Huckendubler, ASHP colleagues, and faculty and staff at the University of Houston, University of Illinois at Chicago, and the South Carolina College of Pharmacy—Medical University of South Carolina. Special acknowledgments to Robert L. Ravin, Richard A. Hutchinson, Peggy Bickham, Barb Bilek, John McBride, Connie Larson, Trish Balow, Glen Schumock, Linda Grider, Gloria Sporleader, and Jerry Bauman. William Chamberlin, M.D., was the best boss anyone could ever have, anywhere, anytime. Dean Henri Manasse, Paul Bush, William Zellmer, Harold Godwin, Sara White, and David Zilz are very special people in my professional and personal life. A sincere thank-you to Max Ray and Bill Gouveia for the critical review of my draft document; I take responsibility for any errors. To my wife and friend, Patricia Kruger, thank you for all your caring love and sage advice, inspiration, and counsel.

Remember, the greatest leadership sin is to remain passive in the face of challenges. Are you a BOLD leader who builds other leaders and leads the healers to exceed? Do you think of yourself as a builder who shapes the attitude and outcomes of those who provide care? This is a gigantic responsibility. Are you exceeding their expectations? Are you up to the leadership challenge of ensuring excellent clinical services for all your patients? You must decide for what you stand, all the time, every day. And then stand for it, all the time, every day. After all, patients deserve it.

References