"Revision will take place and the level of our practice will be raised."

W. Arthur Purdum

(1950)

At the time he received this award, W. Arthur Purdum was the Chief Pharmacist at Johns Hopkins Hospital, Baltimore, Maryland.

Minimum Standards and the Future

Hospital pharmacy has made great progress since Harvey Whitney became the first chairman of the American Society of Hospital Pharmacists a relatively few years ago—greater progress, in fact, than any other specialized branch of our profession. To cite tangible evidence of the growing interest in and respect for our specialty, I mention the creation of the Division of Hospital Pharmacy by the American Pharmaceutical Association with a $10,000 budget for its first year of operation, the recent introduction of undergraduate and graduate courses in hospital pharmacy by a number of our universities, and only last week the recognition by the United States Pharmacopeial Convention of a delegate from the American Society of Hospital Pharmacists at future conventions.

In large measure, this progress parallels the remarkable growth of the ASHP. The underlying reasons for such rapid development were the adoption of fundamentally sound objectives for the Society and the fulfillment of them. What are the principal

objectives and how are they being achieved? We are pledged to improve and extend the usefulness of the hospital pharmacist to the patient, to the hospital, to members of the allied health professions, and to the profession of pharmacy; to assist in providing for the future an adequate supply of qualified hospital pharmacists; and to promote the dissemination of pharmaceutical knowledge.

This latter objective, that is, the interchange of information, is already developed to a high degree. This is taken care of in part by the information service offered by the Division of Hospital Pharmacy in Washington and is available to all pharmacists. Another medium is the well-established annual institute on hospital pharmacy, which originated in Ann Arbor less than five years ago. Last, but certainly our most potent medium, is our *Bulletin*. Much credit is due Don Francke for this fine publication; and while numerous bouquets have been tossed in his direction in the past, the most recent compliment is the eagerness of large manufacturers to advertise in this journal.

Hospital standardization was born in 1918, and the proud parents are the American College of Surgeons. Its object is to foster better hospital care in all its phases, and the results obtained far more than justify the effort expended. In that year, 692 hospitals of 100 or more beds were surveyed and only 12.9% were approved. By 1926, the figure was well above 90% of those inspected and it has been climbing steadily towards perfection since that time.

Not until 1935, at the suggestion of Dr. Malcolm T. MacEachern, former director of the ACS, was a standard written for the hospital pharmacy. This was prepared by Edward Spease, at that time dean of the Western Reserve University School of Pharmacy and the only man other than Harvey Whitney who holds honorary membership in the ASHP. He was assisted by Robert M. Porter, then chief pharmacist at the University Hospitals of Cleveland. The standard was adopted very soon thereafter by the ACS and is still recognized today by that body. It was an excellent standard in 1935, but pharmaceutical practice has changed in 15 years and there is definite need for a revised standard today. We now have this new standard, and all of you have had opportunity to read it in a recent issue of *The Bulletin*. In this standard lies the key to our first objective: improving and extending the usefulness of the hospital pharmacist.

In what respect is the new standard an improvement over that currently recognized by the American College of Surgeons? The old standard permits a hospital to obtain pharmaceutical service from a nearby drugstore whereas the new standard requires that: "There shall be a properly organized pharmacy department under the direction of a professionally competent, legally qualified pharmacist. . . ." In the small hospital, pharmaceutical service from a nearby pharmacy no longer suffices. No longer shall a nurse be in charge of the "drug room." In fact, no longer shall there be a "drug room." Under the new standard, the drug room is being elevated to the plane of a pharmacy with a competent pharmacist in charge, even though his services may be on a part-time basis. He may be a nearby pharmacist or preferably a full-time hospital employee who has been assigned additional professional or administrative duties.

A chapter on policies, not appearing in the old standard, now vests in the pharmacist the authority to develop and carry out the administrative policies of the depart-

ment. He shall also develop, with the assistance of the Pharmacy and Therapeutics Committee, the professional policies of the department, and he is responsible for their implementation. In keeping with good administrative practice, it is natural that all policies should secure the approval of the hospital administrator.

The section on personnel has been perhaps the most controversial of the entire standard. When it originally emerged from the committee at the time of the 1948 convention, it required that: ". . . the chief pharmacist shall be a diplomate of a hospital pharmacy specialty board." (It was anticipated that these requirements would include graduate study leading to an M.S. or a Ph.D. degree in pharmacy and the completion of a recognized hospital pharmacy internship.) It was soon quite obvious that the good intentions of the committee were misunderstood and not appreciated, to state the case mildly. We of the committee envisioned for the future a group of specialists in hospital pharmacy who had become fellows of the yet to be organized "American College of Hospital Pharmacists." This was incorrectly interpreted by a number of protestants as a squeeze play on the part of a few to form an exclusive fraternity. Actually, the statement was written into the standard by a committee member holding a three-year degree, and it received the blessing of another member who is a two-year graduate. The committee's oversight was our failure to append a statement recognizing experience in lieu of advanced education. In its final form, this section requires that the department have an ample number of qualified personnel to furnish pharmaceutical service of the highest quality. Furthermore, steps have been taken to make secure the positions of those pharmacists who graduated during the days of the two- and three-year courses.

The chapter on facilities assures the pharmacist of adequate pharmaceutical and administrative equipment in a well-lighted and well-ventilated area in order to perform properly his many and varied duties.

The scope of the pharmacist's responsibilities has been expanded to a considerable degree. The old standard charged the pharmacist with supervision over eight specific functions whereas the new makes him responsible for 15. Among his added duties, he must maintain a pharmaceutical and therapeutic information service for the hospital staff, he must establish and maintain a satisfactory system of records, he should cooperate in the teaching of courses to student nurses and assist in the medical intern training program, and he should file periodic reports on the progress of the department with the hospital administrator.

The Pharmacy and Therapeutics Committee is an important and influential body in the operation of a hospital. The judicious selection of therapeutic and diagnostic materials plays a major role in patient care—not only is the patient's physical welfare affected but his pocketbook as well. The decisions of this committee also play a major role in the economical operation of the pharmacy. The responsibility of the committee with regard to professional policy was recognized in the old standard. However, the old standard also charged the committee with supervision over the purchase and issuance of all drugs and pharmaceutical supplies which function is purely administrative, and the new standard places this responsibility on the shoulders of the pharma-

cist in charge. A most important new requirement of the Pharmacy and Therapeutics Committee is that it develop a formulary of accepted drugs for use in the hospital.

Our other principal objective concerns our assistance in providing an adequate number of qualified hospital pharmacists for the future. We all appreciate that there is an acute shortage of well-trained personnel. What can be done to alleviate this shortage? Part of the answer lies in our colleges of pharmacy. The school not offering a course in hospital pharmacy should make one available to its students. The ASHP, through a special committee, has already written a syllabus and is now prepared to assist those colleges interested in inaugurating such a course. Where possible, the course should be taught by a practicing hospital pharmacist. This course is not expected to produce finished hospital pharmacists, but it can serve the very useful purpose of stimulating the student's interest in our branch of pharmacy. After this interest has been aroused, the final solution to the problem lies in the creation of more training programs—programs which can qualify under the proposed *Minimum Standard for Pharmacy Internships in Hospitals.* This standard has undergone major revision since it was first published in *The Bulletin* approximately 18 months ago, and the committee feels that we now have a satisfactory and workable standard. The revised version was presented to the Society at the time of the Atlantic City convention in 1950.

This standard recognizes two types of internships: nonacademic and academic. Each consists of a minimum period of training of 1920 hours in the hospital pharmacy. In addition, the academic internship requires one year of graduate study leading to an M.S. degree. The minimum number of hours has been reduced from 2100 to 1920 at the request of pharmacists in government service so that the entire training period can be scheduled in one federal work year of 48 weeks of 40 hours each.

Because we are always seeking to enlist the very best people available, applicants must have a better than average scholastic standing, be of high moral character, and be in good health. The training hospital shall be a general hospital of at least 200 beds and shall have an active outpatient department. The minimum of 200 beds has been criticized as too high by a number of interested individuals. It was the consensus of opinion in the committee that smaller hospitals for the most part would not have adequate facilities to offer the broad training required for these trainees. The pharmacy department of the training hospital must comply with the requirements of the *Minimum Standard for Pharmacies in Hospitals* and shall include among its activities outpatient prescription service, dispensing to hospital divisions and inpatients, the manufacture of pharmaceuticals, and departmental administration.

The supplemental elaboration to the standard spells out many details not given in the basic standard itself and is intended to be a guide for pharmacists offering training programs and for examiners. Certain sections, no doubt, will be subject to criticism, but no standard ever developed in the past or to be developed in the future will be completely satisfactory in the eyes of all concerned. It is almost a certainty that no pharmacy or training program exists that can earn a perfect score. Nevertheless, we must all strive for as high a rating as possible.

Even though we have come a long way during the short history of the ASHP, our forward movement must continue; there are still jobs to be done.

At the present time, the new standard for the hospital pharmacy carries the approval of the ASHP, the APhA, and the American Hospital Association. Before the end of this year we hope to receive the approval of the American Medical Association and the approval and adoption of the standard by the American College of Surgeons.

Speaking before a sectional meeting of the American College of Surgeons about a year ago, I found fault with the point-rating system for hospitals on three counts. First, and of least significance, was the allocation of only 10 points to the pharmacy out of 1000 for the hospital. Since then, pharmacy's points have been increased to 20. Of greater consequence was the fact that only three questions had to be answered satisfactorily to earn these points. No pharmacy can be evaluated properly on this basis and, during the past year, several additional questions have been added. The questionnaire is still inadequate, and another should be written based on the new minimum standard. My chief objection was that pharmacy is found among the adjunct and service divisions of the hospital rather than with the essential divisions where it should be. Today we are still recognized as a complementary service department, and we must continue our efforts until pharmacy is regarded as essential.

I would like to see the standard for internships reviewed and approved by the Executive Committee of the Society at an early date and forwarded to the Division of Hospital Pharmacy with the recommendation that the Division undertake the responsibility for organizing the procedure of accreditation and act as the accrediting body for hospitals offering such training. One tool needed by the Division to carry out this function will be a questionnaire or checklist based on the standard, and I hope that this can be accomplished in the near future. Those of us who offer training programs now must arrange to meet or exceed the requirements of the standard, and it behooves all of you who can qualify and are not offering internships to initiate such programs as soon as possible.

Several months ago, Don Francke presented an excellent editorial in *The Bulletin* entitled "Needed—a Standard of Practice." While we now have an excellent minimum standard to control the board practice of pharmacy in hospitals, I concur with Editor Francke that a detailed standard of practice will prove of great value to the hospital pharmacist, and I urge that such a standard be written.

As time passes, we will recognize our new standard as insufficient, revision will take place and the level of our practice will be raised another rung on the ladder of progress. We should keep in mind the future creation of that specialty board, mention of which was withdrawn from the standard because of current opposition. Such a board will serve as an incentive to all of us to improve ourselves in order to earn what I hope will be a highly coveted diploma.

What will be the ultimate effects of these standards? While we are only one wheel in the hospital machine, through better pharmacists, better facilities, and better management, we can expect to render a more efficient and economical service to the hospital, to the other medical care professions, and, above all, to the patient.

A final consideration is the threat of compulsory national health insurance. Our public servants in Washington have made John Q. Public well aware of the high cost of medical care. The paying hospital patient is indignant over the high per diem cost of hospital care, and it is true that these costs have risen considerably in recent years. But he overlooks the important fact that advances in the pharmaceutical and medical sciences have substantially reduced the term of his stay in the hospital. He also overlooks the fact that he now pays $75 for a $35 suit of clothes and $1.50 for a $0.60 cut of beef. I am opposed to the federal program for the socialization of medical care and believe that we as pharmacists can assist in forestalling this dangerous enemy of free enterprise by doing all within our power to supply the highest type of pharmaceutical service at the lowest possible cost.

Compliance with the minimum standards will assist immeasurably in realizing these goals. We must not wait for an accrediting agency to require observance but rather, in the interest of immediate improvement in pharmaceutical service, we should begin our own program of self-enforcement and have our house in order before the inspector arrives at the door.

Harvey A. K. Whitney Award Lectures (1950–2005)

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