



*“Where to now, hospital pharmacists?”*

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(1956)

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## **Ethical Standards: Professional Conduct and Responsibilities**

**P**rofessional conduct is a term we hear repeatedly. What does it mean? Why is it important to us as professional practitioners? What is a profession? After much reading and contemplation among the writings of ancient and modern philosophers and thinkers on this subject, I conclude that a profession is an occupation of man dedicated in some way to his physical, his mental, or his moral welfare. A profession is generally recognized and respected for several distinguishing characteristic qualities. For example, each profession has an organized body of knowledge and prescribed formalities for using it and for imparting its essential data to those who wish to join. A profession has a literature of its own, both in ever growing basic and refined texts and in dynamically current approved journals published reg-

ularly. Each profession demands desirable background prerequisites and cultural and educational achievement. These must be satisfied for admission and maintained for as long as the individual remains a member.

Each profession has its governing or regulatory body composed of its own members, which provides the leadership and the means of participating with other professions in discharging its overall responsibilities of service, being ever vigilant that the obligations towards progress and the technical and scientific advances that time brings become part of its total effort. And finally, individuals seeking the services of a professional person are not in a position to judge the quality of the service given. Rather, they must rely on the reputation of the individual practitioner and the standards of conduct maintained by the profession as a whole. As we say in law, the principle of *caveat vendor*—let the seller beware—applies, not *caveat emptor*.

We hospital pharmacists belong to a true, noble, and blessed profession. For we practice in a setting devoted exclusively to the care of the seriously ill and injured. We represent that specialty of pharmacy that concerns itself with the evaluation, the selection, the control, and the utilization of drugs in hospitals. This encompasses the supplying of medications for inpatient and outpatient use, the preparation of sterile medications, volume compounding, prepackaging, drug formulation, and research. Hospital pharmacy, we know, serves as the focal point in the dissemination of drug therapy information to the hospital staff.

The Constitution of the American Society of Hospital Pharmacists, Article 1, Section 2, reads:

*The objectives of the SOCIETY shall be (a) to provide the benefits and protection of a hospital pharmacist to the institution which he serves, to the members of the allied health professions with whom he is associated, and to the profession of pharmacy; which they will receive through the skill and art of qualified hospital pharmacists; (b) to improve the qualifications and usefulness of hospital pharmacists through high standards of professional ethics, education and attainments; (c) to assist in providing for a future adequate supply of such qualified hospital pharmacists; (d) to promote research in hospital pharmacy practices and in pharmaceutical problems in general; and (e) to increase the dissemination of pharmaceutical knowledge by providing for interchange of information.*

Dr. Hugh Muldoon so ably said in “The Strengths of Pharmacy,” his inspirational Remington Medalist address of 1953: “Specialists in hospital pharmacy form another group in which we (pharmacy) take great pride. These men and women practice their profession in its purest form since in their service the profit motive does not enter.”

Applying the definitions and tests for professions as written by man since time immemorial, one arrives at this one unmistakable conclusion—hospital pharmacy is truly a profession. But nowhere in the various fields of pharmacy, be it manufacturing, community practice, pedagogy, journalism, or name what you will, is there to be found a truer form of professional pharmacy than exists in our specialty of hospital pharmacy.

The word “ethics” is derived from the Greek *ethos*, which no doubt meant the same

as its Latin equivalent *mores* did to the Romans—“character and approved group habits or customs.” Webster defines ethics as “the science of moral duty; broadly, the science of ideal human character.” Poland defines ethics as “the science of the role of right and wrong”; Hill says ethics is “the science of putting order in man’s free acts”; and Horne, another authority, states that “ethics is the science of human conduct. It is not primarily a descriptive science telling us how men do behave, but a normative science telling us how men should behave.”

Ethics relates to all manner of deeds and habits which concern men, either as private individuals or as members of the social whole. Ethics is that science that points out definite standards and ideals of life in accordance with the natural law. It helps one to answer that most important question: “What ought I to do?”

One studies ethics primarily to understand oneself in relationship to duty. Duty is what one may not violate though he can, that moral obligation from which just men can never retreat.

Concerning professional ethics, Richardson in his text *The Ethics of a Profession* states: “after all the arguments and disputations, after all the theory and doctrine, after all the study and analysis, the conclusion of the whole matter is this, that a professional man does not live unto himself alone and what he does carries an influence far and wide. Every unworthy deed is a power for evil. Every good deed helps the world.”

In short, then, professional ethics and conduct mean simply adherence to ideals, to customs, to habits, and to traditions of service to mankind which the members of a profession build up through the years. To be “unethical” is to violate these accepted “mores” of the group. Professional ethics and conduct are the morality of the profession, the “right way” of practicing the profession. Customs or “conduct codes” are not set by outsiders but by the groups themselves, and the conduct of the individual members of a profession is approved, frowned upon, or tolerated, depending on how ethically strong is the profession itself.

This leads us directly into the professional codes, the codes of ethics or codes of conduct of the individual professions, one of the major identifying characteristics of a profession. These, when properly enforced, unquestionably play a large part in determining the moral fiber and strength of a particular profession and its members.

Mayer and Ross, in *Ethics and the Modern World*, inform us that the main goals of the professional codes are:

1. To insure high qualifications of those who are admitted to the profession.
2. To stress the service motive; professions thus are guided by the ideal of contributing in an unselfish manner to the public good.
3. To develop a spirit of exclusiveness.
4. To protect the public. Unethical behavior is taboo. Codes guide the policy and conduct of those in the profession who need this positive professional sanction in moments of temptation.

5. To prevent governmental regulation of the profession. Most professions believe in the spirit of laissez-faire; they hold that government interference destroys initiative. If the profession tolerates abuse, then the defenders of the people may need to move in.
6. To regulate the relationship between the members of the profession. For example, the Code for Educators determines the respective responsibility of teacher and administrator. Through its code, the American Medical Association attempts to prevent unethical practices between competing physicians.

Let us for a minute or two cull sections of the codes of some of the health professions that are of particular interest to hospital pharmacists.

First, the *Principles of Medical Ethics of the American Medical Association*, adopted in 1848 and as revised December 1953. This code consists, as you know, of four sections: (a) the responsibilities of the physician to the profession; (b) the relationship of the physician to the patient; (c) the duties of the physician to his colleagues; and (d) the duties and responsibilities of the physician to the medical profession and to the general public. Section 3 of this code states:

*Pharmacists. Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in the education of the public concerning the practice of ethical and scientific medicine.*

Second, the *Code of Hospital Ethics*, adopted in 1941 and endorsed by the American Hospital Association and the American College of Hospital Administrators:

*Item 16. Professional Codes of Ethics. It is the duty of the hospital insofar as the hospital personnel and regulations can render assistance, to aid and support the members of all professional groups in their observance of the code of ethics of their respective organizations.*

*Item 25. The Relationships of the Administrator to Vendors. The administrator should bear in mind constantly that, in his relationships with the representatives of the supply houses or commercial organizations, his hospital is almost inevitably concerned. Therefore, his relationships should be courteous at all times and of such nature that under no circumstances will the hospital be involved or obligated in any way. Particularly important is it that the administrator refrain from becoming under personal obligation to a firm or its representative as would be the case by the acceptance of personal gifts or unusual social favors. Personal commissions or rebates should never be accepted. The administrator should not give a testimonial for public use and should not authorize or otherwise permit the public use of his name or photograph in the endorsement of commercial services, equipment, materials, drugs, or other supplies.*

*Gifts or donations should not be solicited from business houses on the basis of making a return for business granted. Unless required by law to do so, the administrator or his staff should not disclose the price to a competitor of a firm submitting prices. Orders placed in good faith should not be cancelled or the goods returned without legitimate reason.*

*Requests for special extensions of credit should be definitely arranged before any merchandise is ordered.*

How fitting and how proper might this section also be for one of the sections of a special code of ethics for hospital pharmacists.

Let us reflect here on pharmacy's own Code of Ethics, as developed by the American Pharmaceutical Association in 1852 and as revised in 1922. Much of this code applies equally to the hospital practitioner of pharmacy as it does to the community practitioner. Consider if you will, however, the desirability or need for a special code for hospital pharmacists. There is much that needs to be stated, much that is missing in our overall pharmacy code, much that is vital to good hospital pharmacy practice and which should be stated officially. For those of you who wish to study this matter in detail, I refer you to the complete Code of Ethics. Suffice for us now to note the preamble of the Code and its areas of coverage. The preamble states:

*The primary obligation of pharmacy is the service it can render to the public in safeguarding the preparation, compounding, and dispensing of drugs and the storage and handling of drugs, and medical supplies.*

*The practice of pharmacy requires knowledge, skill, and integrity; therefore, the State laws restrict the practice of pharmacy to persons with special training and qualifications, and license to them privileges which are denied to others. Accordingly, the pharmacist recognizes his responsibility to the State and to the community for their well-being, and fulfills his professional obligations honorably.*

The Code of Ethics for pharmacy then goes on to cover:

1. The pharmacist and his relations to the public.
2. The pharmacist and his relations to the other health professions.
3. The pharmacist and his relations to fellow pharmacists.

Now, what of the professional ethics and code of conduct of individual hospital pharmacists? What are the *mores* or standards for hospital pharmacists? Do we have stated positions for "conflicts of interest" situations? Hospital pharmacy in the United States dates back to 1752, to Jonathan Roberts, the first hospital pharmacist in colonial America, who practiced at the Pennsylvania Hospital in Philadelphia, a hospital founded by Benjamin Franklin. Unfortunately for our specialty, it was not until 1920, when the American College of Surgeons began its hospital standardization program, that hospital pharmacy began to emerge and grow as a professional specialty. In 1956, 36 years later, with over a third of a century of experience behind us, it is time for the leaders of hospital pharmacy to give serious thought to this subject of ethics and to a professional code of conduct designed particularly for us, the members of this professional specialty.

Professional codes, we know, are inspirational. They are aids to the young in a profession. Codes afford inspiration to the oldsters of a profession, like myself. They help to maintain a high moral tone of those in active practice.

An appropriate code for us would spell out the principles underlying our duties, our responsibilities, and our rights as individual hospital pharmacists. These principles of conduct would be considered as they concern our relationships with our trustees, our administrator, our medical and dental staffs, our pharmacy committee, the rank and file personnel, visitors, the hospital itself, the general public, and the community. They would delineate our relationships with other pharmacists, both the hospital and community practitioners, with our co-workers in nursing and in the paramedical disciplines such as the medical record librarian, the social worker, the dietitian, and others of the hospital family. They would crystallize our obligations to the young of hospital pharmacy, to the pharmacy student, to the drug research firms of the country, and to the medical service representatives and other vendors. And, finally, but not of least importance, these principles would include statements of our proper rights as members of a profession. Shouldn't we take a stand now, for example, as to what is and what is not substitution in hospital pharmacy practice? Isn't this an important ethical matter?

If you, the leaders of hospital pharmacy, will pause and reflect on the desirability of an enforceable code of ethics for our specialty, a code that expresses the social conscience of our group, that expresses the convictions shared in common by us all, I would feel indeed as though another valuable contribution to our profession is in the making through this Harvey A. K. Whitney Lecture.

Dr. Mason Gross, Provost of Rutgers University, in his address to the Fourth Annual Rutgers Pharmaceutical Conference, placed particular stress on self-policing as a prime responsibility of a profession. Dr. Gross stated:

*A profession is a profession . . . when it is self-regulating in the sense that it has a code of ethics which determines for its practitioners their social obligations and their moral responsibilities, and . . . when it does not turn over to others to determine what its moral obligations are, but assumes full responsibility for discovering and for enforcing these obligations itself.*

Louis Kazin of *Drug Topics*, in his column "Your Pharmacy and Mine" recently chided the pharmacy profession with his editorial, "It Is High Time to Police Ourselves." Kazin pleads with pharmacy to establish an impersonal, objective approach for handling violations of its overall code by the application of suitable sanctions at state levels. I plead likewise for hospital pharmacy to develop and adopt a well-thought out, enforceable code.

I am proud to say that up to now there has been no national adverse publicity directed at hospital pharmacists. Hospital pharmacy, we know, hopes to keep things this way. But suppose we should become faced with some of the problems of the community practitioners of pharmacy where, because of a few, many are suspect. Would it not be lifesaving for us to have our disciplinary mechanism, our code of conduct, in order? Tsanoff, in his text *Ethics* (1955), speaks of this prostituting of pharmacy from its offending side as follows:

*In considering ethical practice in medicine our attention naturally turns to the standards and principles in the manufacture and distribution of medicines and drugs. We may appreciate the*

*conflict of commercial and professional motives in a trained pharmacist with some medical ideals who is also a plain trader in drugs and patent medicines. The public danger in the sale of impure and deleterious drugs promoted by nation-wide advertising has roused social reformers within and outside the profession to check this evil by more stringent legislation. The stubborn resistance to this reform shows how strongly entrenched corrupt business is in this auxiliary branch of Medical Service in our Society.*

And note, this was written not in 1852 but in 1955.

As a boy, I was taught by my good Vermont dad that: “There is not so much good in the best of us, nor so much bad in the worst of us, that it behooves any of us to speak ill of the rest of us.” I am sure all of us have been taught not to be “busybodies.” However, the nonenforcement of a code makes of that code a mere pleasantry at best and possibly a hypocrisy of that profession. Individuals of a profession who bring it into disrepute must be subjected to professional discipline, and the respectable members of the profession must accept this responsibility. Tausch states, in his text *Professional and Business Ethics*:

*This is a professional obligation, an unpleasant, distasteful but nevertheless essential part of a profession. It consists of the courage to purge the profession by eliminating from it the unfit members. . . Every professional man is in a real sense his brother’s keeper to the extent of being an example of the right mode of conduct and thereby indirectly admonishing his less conscientious fellow member. Every professional organization is further the keeper of its members by being obligated to exclude from its membership such as those that fail to keep the faith.*

Pharmacy’s code is fairly definite in its statement concerning the proper conduct of pharmacists. “The pharmacist will expose any corrupt or dishonest conduct of any member of his profession which comes to his certain knowledge, through these accredited processes provided by the Civil laws or the rules and regulations of pharmaceutical organizations, and he will aid in driving the unworthy out of the calling.” But note, the actual action of discipline remains, where it should be, in the local or state atmosphere.

The fear of washing “dirty linen in public” by the respectable member gives courage to the less properly motivated in any profession. Witness the courage of the American Bar Association when, last January, it made public a proposed new code for disciplining its unethical lawyers. The proposal, to operate at state levels, sets forth these sanctions:

1. Permanent disbarment.
2. Indefinite suspension from practice.
3. Public censure.
4. Private censure.

The commission, by a lawyer, of any act contrary to honesty, justice, or good morals, whether the act is committed in the course of his relations as an attorney or otherwise, and whether or not the act is a felony or misdemeanor, constitutes a cause

for discipline, the code states.

So I repeat, what of the professional ethics and code of conduct of the individual hospital pharmacist? What is he teaching, by example or otherwise, to those following in his footsteps in this, the most professional of all pharmacy pursuits? What are some of the specific problems that might tempt the not so ethical hospital pharmacist? Does he sanction the nonprescription sale or giving away, by lax controls or otherwise, of barbiturates, amphetamine, and other even more dangerous, more habit-forming drugs? Does he treat subordinates in his department as he would wish to be treated, that is, with a firm, definite, fair policy? Or is he indecisive or wavering in his decisions, constantly changing the rules to fit the “last in” objector; or worse still, is he reluctant to make decisions? Is he mindful of his overall professional responsibilities, keeping an eye on the leadership and the possible future leadership of the local chapter and the national Society? Is he alert to prevent what Dr. Jack Masur, Assistant Surgeon General of the U.S. Public Health Service, refers to as “the fostering of a gerontocratic elite of ancient and outdated leaders bent on retarding progress to preserve their own tenure” or leaders who are trapped by timidity or ultraconservatism?

Does he approve, by conformance or by nonobjection, unethical actions in hospital administration, actions unknown to the clinicians whereby drug economies are effected at the expense of the patient, possibly actions that encourage the purchase of substandard, subquality, or unknown brands of drugs? Does he, jointly with his administrator or purchasing agent or by himself, enter into nonethical relationships with his vendors? Does he, in collusion with his administrator or unknown to his administrator, allow nonprofessional individuals (pharmacy helpers) to engage in duties that state law demands be performed by licensed pharmacists only? I refer in particular to certain acts of compounding and dispensing and the filling of nursing station medication containers where no immediate direct pharmacist supervision is exercised.

And again, does he, in hospital charity cases, engage or condone in the cutting of prescribed prescription quantities without the consent of the physician? Isn't this a serious ethical matter? And again, how does he handle mistakes in dispensing or compounding? They do occur, we know, for pharmacists are but human. Does he seek to place the blame on the nurse, the patient, the physician, the manufacturer, or does he obtain and promptly report the facts? Does he act quickly to prevent further possible damage or loss of life? Does he evaluate honestly the error and determine where the fault lies? Does he attempt to set up corrective measures to prevent a recurrence of the error? Ethics and morals are involved. What do his subordinates think of him as they watch him handle these situations? Are they proud of him and of us? Or do they have names for us that we would rather not hear because we do not discipline the man? Does he follow the “Good Book,” the Ten Commandments, and the Golden Rule in protecting not only the property of the hospital but also its good name? And what of the good names of those on the hospital team and the good name of the patient? Does he have a proper attitude towards his responsibilities and duties of professional secrecy concerning diagnosis, prognosis, and medical records? Is he loyal to his institution?

As a group and as individuals, are we recognizing our responsibilities in connec-

tion with the geriatric problem of the nation? (There are over 18 million individuals now over 60 in this country, and 5.3 million are said to have a chronic disease in our national population of 164,764,230.) Meeting the pharmaceutical needs of the aged, the disabled, and the chronically ill will require special types of hospital, outpatient, and home care pharmaceutical services. Also, the projection of better pharmaceutical service into the nursing homes and other long-range illness domicilaries is imminent.

Will we be found lacking professionally because of a want of preparedness, a lack of a plan in this area? Already, criticism has been aimed at the medical profession for their alleged negligence in moving into the preventative aspect of medicine. Robert MacIver, in his treatise "The Social Significance of Professional Ethics," states: ". . . the medical profession has incurred to many minds a serious liability, in spite of the devotion of its service to actual patients, by its failure for so long to apply the preventative side of medicine, in particular to suggest ways and means for the prevention of the needless loss of life and health and happiness caused by the general medical ignorance and helplessness of the poor."

Let it not be said that hospital pharmacy failed in its responsibilities towards the geriatric problems of the nation. How about the small hospital that is unable to support a pharmacist? Are we seeking means of providing adequate pharmaceutical service for patients in these hospitals?

Let us look again at the daily action of the hospital pharmacist. Is he teaching our young that our profession is a live, a dynamic, an ever changing one; that hospital pharmacists are in conscience morally obliged and committed to continuous study, to reviewing their professional texts, and to studying current professional literature; that hospital pharmacists must never cease to seek the latest knowledge in drug therapy? Isn't this one of the more important duties and responsibilities of the drug therapy consultant of the hospital—the hospital pharmacist—a duty from which he cannot, he dare not, shirk and still hope to maintain a clear professional conscience? Pharmacy's Code speaks to this point for all pharmacists when it states: "the pharmacist strives to perfect and enlarge his professional knowledge . . . he keeps himself informed regarding professional matters by reading current pharmaceutical, scientific and medical literature, attending seminars and other means."

Let our code, if we decide to have one, remind us that like the physician, the dentist, and the nurse, the work of the hospital pharmacist is of such a nature that he is obligated in conscience to require and maintain sufficient knowledge and skill to discharge these professional and moral functions. Important functions? The people of this country believe so, for before one is allowed to serve in our sphere of pharmacy or that of the community practitioner, he must devote years in formal study (four now and soon five) and then be examined by peers, appointed by state officials, to insure that he is capable of executing properly this public trust.

We hospital pharmacists, unlike our esteemed colleagues of the pharmaceutical profession who practice as private individuals as the community practitioners of pharmacy, serve in institutions as public employees. As such, we are subject to supervision and direction which normally constitute restraints on unethical conduct not present

in the case of the community practitioner of pharmacy. Like the hospital-employed physician, dentist, and nurse, the hospital pharmacist recognizes that administration may state “where” and “when” to practice but never “how” to practice. This is an important concept that must not be lost sight of. In the final analysis, this “how” is the practice of pharmacy for which the state has licensed the individual, not the hospital, not the administrator, not the Board of Trustees. The hospital pharmacist stands alone before his peers, be it a practice or grievance or ethical standards committee or a state board of pharmacy, for any unethical acts or questionable professional practices, regardless by whom suggested or ordered.

Let us not misunderstand this position and responsibility. An employer (the hospital) has the right to control the activities of the staff member (hospital pharmacist). However, the hospital pharmacist is responsible professionally, morally, and legally for his own acts. Besides following the administrative directions of the hospital and professional instructions of physicians, hospital pharmacists have the additional moral responsibility, one binding in conscience, of cooperating with all who are concerned with the welfare of the patient—the dietitian, the nurse, the medical record librarian, the social worker, the technicians, and others on the hospital team.

Earlier, I mentioned the rights of professional men and women. Let us explore this area. Do we, by our acts and deeds, indicate that the hospital pharmacist is “worthy of his hire”? “Probably as much harm is done to professional life and society,” says Taeusch, “by the failure to assess sufficiently high fees and secure a large enough income [to us—salaries] to provide the necessities of professional dignity as has been done by overcharging.” Are we hospital pharmacists, as a group and as individuals, too servile to demand proper financial recognition? Isn’t this a moral obligation of hospital pharmacists? It has been said that “any professional man who fails to take all pertinent economic items into account in his charges and fees is a menace to his profession, and conceivably to the economic order.”

What of the ethics and code of conduct that are to be expected of a national professional society, the local branches, and our leaders? Much that I have already cited concerning the ethics of the individual hospital pharmacist is applicable here. There are no real distinguishing features in many areas between the responsibilities, the duties, and the rights of the individual and those of his society. The cardinal virtues of prudence, justice, honesty, fortitude, and temperance apply to group action as well as to individual action.

Our national leaders, for they are the voice of the Society, and the leaders of our local chapters act, we know, with the prime object of the Society’s *existence* in mind. This objective is the promotion of better care for the patient through better utilization of our talents. If this be not true, then our Constitution and Bylaws and our actions here this week would be but fraudulent statements and acts, and we, hypocrites. We must not, we cannot, be a group interested primarily in what we can obtain for hospital pharmacists. We must, to be a true profession, be a group interested in that which is morally right and ethically good for pharmaceutical service in hospitals. We must not be interested in that which is politically expedient, selfishly beneficial to our membership, or personally advantageous.

A great part of the stability of any professional group is due to the spirit of sacrifice, earnestness, and loyalty—in a word, the motivation which characterizes its members. It has been my privilege these past 10 and more years to know intimately the leaders of hospital pharmacy in this country, its oldsters, its middle-agers, and its youngsters. Hospital pharmacy has nothing to fear, considering the wealth of leadership among us, from dreaded professional stagnation or the fostering of the “gerontocratic elite.” Our leaders are forced to and wish to move up, to serve, and to move on to function in an advisory capacity, making way for the arriving generation of leaders. This is as it should and must be. When the day arrives that the young and the middle-aged leaders do not cast a critical, auditing eye on the oldsters, when they do not review and weigh that which is being done by the national Society, its publication, and the local branches, then on that day hospital pharmacy has lost an important self-examining element and may well pay the fearful price—the lessening and then the loss of professional status.

Of other specific Society responsibilities, may I point out that a moral responsibility rests upon ASHP leaders and those in local chapters to carefully guard the conditions of membership into the group, as well as the general requirements for good standing, and to see to it that these standards are adhered to. Further, it is their duty and ours to develop proper cooperative relationships between other professional hospital groups such as the American Hospital Association, the Catholic Hospital Association, the Joint Commission on the Accreditation of Hospitals, and the American College of Hospital Administrators, as well as to continue to foster the development of an exacting professional consciousness among our membership.

Our Society already reveals itself as one standing for a high concept of professional ethics. It must also indicate its awareness of any existing malpractices and take action for the correction of these conditions. In my opinion, the Society should even now be turning towards the development of an adequate, self-disciplining program as a means of enforcing, at local and state levels, the as yet unwritten but known standards of conduct of hospital pharmacists. The recently announced self-disciplining point-rating plan of the Bergen County Pharmaceutical Association of New Jersey might well be the ideal starting point for such a study.

I repeat, unless we assert the necessary modicum of self-government, we cannot claim to be a profession. Our national Society and our local branches must be vigilant to ferret out and curb unethical practices in hospital pharmacy. The status of any profession is never static. “Nothing is permanent except change,” and so it is with a profession. It has its ups and downs, as its members swing from the spiritual to the materialistic and back. Adherence to principles cannot be taken for granted; there will always be those few who are willing to sacrifice principles for self-gain and self-prestige. This occurs most often when the leadership fails to truly lead or when it lacks the courage to punish those who seek to break from that which is right and proper. For a truly inspirational example of outstanding leadership in this area by a national society, I cite the November 1955 report of the American Medical Association’s Judicial Council to its House of Delegates. Here is the American Medical Association’s answer to a move to change the principles of American medicine to the

extent that it would not be unethical for a physician to own a drugstore or sell drugs and appliances. The Council spoke to its membership by first quoting from its Code of Ethics: "The prime object of the medical profession is to render service to humanity;. . ." Then the Council asked, "Is this outmoded, empty phrasing, or is it our birthright?" Another part of the code was then quoted: "Reward or financial gain is a subordinate consideration." The Council again asked: "Is this poppycock or principle, a slogan or integral part of our real security?" The Council then reiterated that, "Principles do not change; rules of conduct and laws may change, but principles do not." Proud indeed must be the true physicians of America as they see their association take this stand.

What of some of the other moral responsibilities of our Society? Let me name but a few of the more important. You, the leaders of hospital pharmacy, know how well the Society, the Division, and the local groups are functioning in these areas and whether any action is necessary or desirable.

I raise the question of fellowships in the Society, the placing of its stamp of approval on proven, capable hospital pharmacists in a manner similar to the board specialties of the medical profession.

I raise the important issue of *enforceable* standards for internships and graduate programs, standards that will give us true internships and not programs that beg the name of internship by demanding a large number of hours of repetitious labor in bulk compounding or manufacturing of sterile and nonsterile preparations, routine tasks that have little teaching value in relationship to the number of hours invested. Instead, let us seek true standards for real teaching programs, programs taught with the aid and cooperation of the medical staff and others of the hospital team. Programs that, in addition to the training given within the four walls of the hospital pharmacy, rotate the intern through the other departments of the hospital such as internal medicine, dermatology, surgery, pathology, radiology, and the various phases of hospital administration such as finance and personnel. Are we properly discharging this, one of the greatest of our moral responsibilities, through the present proposed standards, or is hospital pharmacy merely establishing standards to fit some of the intern programs now in existence? Is this to be our goal?

I raise the issues of sufficient intern programs for pharmacists interested in hospital careers and the promotion of proper research activities for hospital pharmacy. Should we have guidance programs through special institutes for pharmaceutical educators, programs of a nature that will focus on what needs to be better taught and the proper perspective by educators towards intern programs and graduate hospital pharmacy programs?

Some of our educators, we know, have not yet thought to compare postgraduate hospital pharmacy intern training with medical, dental, dietetic, and other hospital intern programs wherein the experienced hospital team serves as preceptors for that needed experience sought by all young, inexperienced members of the health professions. If this group of educators is correct in their assumption that formal graduate programs are needed and necessary for hospital pharmacists and that the so-called

“nonacademic internship” is undesirable, then we must ask what is wrong with our undergraduate pharmacy courses. Are they sufficiently good to allow for the community practice of pharmacy and not good enough for hospital pharmacy practice? And again we must ask: “Is the internship plan as advocated for graduate physicians, dentists, dietitians, and others not proper for pharmacists?” There are 11,048 medical internships in 850 teaching hospitals today, all approved by the American Medical Association; 319 dental internships in 137 hospitals, all approved by the American Dental Association; 662 dietetic internships in 59 hospitals, all approved by the American Dietetic Association; and but 34 pharmacy internships.

We need more hospital pharmacy internships; we need the cooperation of the pharmaceutical educators in this regard. What finer way is there for the profession of pharmacy to advance with its five- and eventually its six-year programs than to move forward with hospital intern programs in many of the 850 teaching hospitals of the nation? These are programs designed to have the pharmacy intern rub shoulders with his medical, dental, dietetic, and other intern brothers and sisters; programs designed to have the young of pharmacy see patients ill in bed, on the operating table, in the recovery room; to witness drugs being prescribed and used and to witness their dramatic action. What better way is there to conclude one’s formal pharmacy education? This must be one of hospital pharmacy’s long-range responsibilities. We must carry this message to Garcia, to the pharmaceutical educators not yet alerted to this teaching potential.

Lastly, in this area of Society responsibility, let us be reminded that some 200 bills directed towards health care are introduced at each session of Congress. We have an obligation to the public to create soon a legislative section in our Society that will study each bill introduced and its implication on our specialty and on patient care.

So, I ask: “Where to now, hospital pharmacists?” Max Reinhardt once said: “Always act the part—and you can become whatever you wish to become.” It is an accepted truism that each member of a profession represents that profession to his community.

In the final analysis, the value each of us as individuals places on our profession will determine the place of the hospital pharmacist in American society. If we wear our professional cloak with pride and with dignity, if we behave professionally and realize the valuable and fundamental contribution our specialty has made in the improvement of patient care since the “renaissance of the twenties,” we shall continue to establish in the minds of the American people our rightful place as one of the true health professions.

My only purpose in speaking tonight on this subject is to start us, all of us, thinking seriously in this area of our rights, our duties, and our responsibilities. I hope what I have said will stimulate ethical discussions back home at the local branch meetings and that from the “grass roots” that has made hospital pharmacy the fine professional specialty that it is today will come ideas and ideals in the form of better hospital pharmacy practices and resolutions to the House of Delegates of the ASHP. I ask: “Are we proud of the ethical practices of hospital pharmacy as they are?” Can we

make our *mores* better and, if so, how? How about our young, and the young in the years to come? Hospital pharmacy and hospital care await our answer. What you, and you, and I, as individuals and as a group, think and do about our specialty of hospital pharmacy, about our responsibilities, our duties, our rights, and an enforceable code of conduct in the years ahead will decide whether hospital pharmacy remains a profession or becomes a mere job of work, a combination of technician-tradesman.

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