"I would like to see practitioners who have been taught by other practitioners."

Leo F. Godley

(1969)

At the time he received this award, Leo F. Godley was the Director of the Department of Pharmacy and Central Sterile Supply at Harris Hospital, Fort Worth, Texas.

Form and Substance

At the outset, I would like to declare myself a part of the establishment. I am a product of it. I helped to build it. I function in it, to some degree, on almost every level: I count, I pour, I teach, I consult, I study, I edit, I administer, I assay, I research, I inform, I gripe a lot, I praise a little, but, most of all, I administer.

And since I am a member, a product, and an architect of the establishment, I have the right to criticize and to suggest—and I criticize and suggest with pride because I love the establishment. I sometimes annoy myself and wish I were more like my administrator who always warns us that we should do something nice for somebody every day, even if it means leaving them alone. Consequently, I feel compelled tonight to comment on some areas of the establishment that concern me a great deal. How could I have deserved such an audience? Surely, from this pinnacle on which I tremble tonight, exquisitely conscious that I share it with those who have touched the "Golden Fleece" of accomplishment and possessed of this heady euphoria and this pounding heart that seem to be all mine, I am sensitive to these things because they are your concerns also.

Every now and again, I read that a colleague speaks of the "over-education" that the pharmacist must buy in the five-year curriculum; and the general trend of the reasoning usually concludes that to put the profession back on an even keel, we need to return to the four-year plan.

Now, this may be all right, but the arguments that I have heard don't appeal to me. I think we need some serious and honest thinking on education. And I am not certain that my idea of how the pharmacist should be educated is possible, at least not without some heroic shifting of long-established concepts and values.

Very simply, I would like to see practitioners who have been taught by other practitioners wherever possible; and further, I would like to see this practitioner in a working environment where his associates on the same staff are, generally, his equal in education and outlook.

I get so depressed at seeing the graduate with the fine mind—top man in the class, or very nearly—who loses the interest, initiative, and ability to apply the service of professional politeness to the dispensed product. I guess the product itself, or the volume of it, has loomed so big and bewildering that the "priceless ingredient" is dwarfed, consciously at first, because it is hard to come by. Then, as hundreds of product dispensings go through the practitioner's hands, the necessity to know no more than a token of information about it becomes easy to accept. This elusive "priceless ingredient"—now called "clinical involvement" because it embraces, as it should, the whole transaction: the pharmacist, the product, and the patient—becomes lost in a miasma of social graces and pseudoprofessional scramble.

This kind of outcome is unfortunate; and if that's the way it has to be, I guess it doesn't matter if we have only a four-year curriculum. But the five- or six-year man has a little more maturity and, hopefully, his decline into professional ugliness would become more painful.

So what does all of this mean? Does the pharmacist decline in professional integrity because he has too much to do, or because the job is not professionally interesting, or because he wasn't educated in the most effective way, with the most effective curriculum, by the most effective instructors?

The truth of the matter is that it's probably a combination of all of these forces. Let's consider some of these things and superimpose them on the so-called "changing image" of the pharmacist. I suppose I need to speak primarily of the institutional pharmacist because that's what I am and that, also, is what Mr. Whitney was.

So we have a new image—or we hope we have in this strange, wonderful trivalent combination of pharmacist-product-patient. Image is important if it's good. It makes us happier and healthier; and if we're happier and healthier, we should be wealthier; and if we're wealthier, we can buy a new image. So what will it be next? Are we going to be physicians? I don't quite know, but I do have some ideas about what we need now.

Benjamin Franklin said, "By failing to prepare we are preparing to fail." And a few weeks ago the president of my alma mater said: "We never learn anything from people who agree with us. It is in the act of conflict-of-ideas that learning takes place, and this we must not forget."

If we apply these philosophies to education and get the curriculum really cleaned up, I think we will have achieved a giant step. It needed cleaning up in 1939, and now, 30 years later, it still needs cleaning, and of many of the same things. Cannot educators and clinicians and industrialists get together? Shouldn't clinicians be involved in education in a meaningful way? If the clinician isn't qualified to educate, neither is the educator for very obvious kettle and pot reasons. I say that in the direct application of the professional curriculum, the educator and the clinician must often be one and the same. As long as the clinician remains a "cut below" the instructor, neither can support, in deed and word, the mandate of the profession. Ironically, the educator cannot advance himself until the practitioner is advanced.

There is still the old duplication in chemistry, and calculations, and pharmacognosy, and operations, in the professional school and in the school of arts and sciences. We must have the preclinical sciences at least as advanced as the physician, and these must include human anatomy, human physiology, human pathology, and therapeutics. These disciplines must be a part of the professional degree—not graduate study.

These are the curriculum changes the practitioner needs for responsibility and respectability today, not tomorrow. I have thought about it a great deal—so much, in fact, that I might call myself an authority on curriculum "thinking."

I cannot appreciate the graduate programs in hospital pharmacy where this preclinical background hasn't been satisfied and such ancillary niceties as data processing and personnel management and the like are piled on top of this inadequacy.

The clinician can "pick up" these ancillary disciplines "on the job." It's not quite so easy to study anatomy and pathology on the job when he needs them to perform in a clinical climate.

I know that this kind of curriculum treatment is coming out of some few colleges even now; but there are many areas yet that have not reacted to the demonstrated need of the practitioner with clinical responsibility.

Also of great importance to the practitioner is the ability to use and appreciate the periodical literature. I am appalled at the inexperience in this area of most graduates who come through my practice. It should be a graduation requirement that at least two subjects be researched, in-depth, in the library, with reports properly prepared and presented; and every professional course should require regular periodical literature assignments. It is unfortunate when this skill has to be acquired after graduation, for this is very difficult, especially if the graduate skips a residency and goes directly into professional practice. Often it's a thing that the practitioner never has time to acquire mainly, I think, because he hasn't been schooled to appreciate this need in his practice.

Another important point on education that bothers me a great deal is that, to my knowledge, the professional curriculum of most schools does not provide instruction in the dispensing of sterile prescriptions. We were taught how to count and pour, but the preparation of prescriptions for our sickest patients must be learned on the job or taught by the nurse. Most pharmacists are ashamed, and appropriately so, to tell the nurse that they don't know how to compound an injectable prescription.

I would like to mention a disturbing kind of situation that we seem to perpetuate

among hospital pharmacists—the relegation of the staff practitioner to some kind of second-rate status. The real glory boys in our ranks are the administrators, the drug information pharmacists, the educators, and even the purchasers. I know that we stress the status symbol of being a chief too much, for it seems that the holder of a residency certificate considers himself something of a failure if he isn't able to find a director's job at graduation time.

Yesterday's staff pharmacists must be today's clinical pharmacists. The specialty activities generated by specialty pharmacists on a pharmacy staff should, in my opinion, be directed through the staff practitioner to the patient, the nurse, and the physician. These staff pharmacists must represent the best blood in the profession—not men who couldn't quite make it in administration, or the assay laboratory, or the library—but practitioners who are specialists in clinical practice!

I must not forget that I cannot dignify my own office until I dignify the practitioners on my staff as clinical specialists. These practitioners must be competent in the library and the clinical laboratory; they must school their personalities into a compatible and acceptable pattern, for the ability to relate to other people and the possession of professional competency are equal criteria for patient care.

I would like to talk now about some ideas and impressions that I have on clinical experience. As I discuss with my colleagues over the country the evolving concept of clinical practice, I note the great awareness of the excitingly gratifying experiences of administering pharmacy services on the patient areas. It is very obvious that the pharmacist's "in vitro" knowledge has become functional in its "in vivo" fulfillment.

Pharmacists in clinical areas are applying their services now, on a consultative basis, in regular visits to patients with the physician or the nurse, to discuss and suggest in matters relating to the drug therapy programming. Pharmacists answer emergency calls to the bedside along with other professionals. Pharmacists are performing patient interviews for drug history information, as well as correlating the biochemistry of the patient's therapeutic program with laboratory and other diagnostic procedures that the physician has ordered for the patient. And while these relatively new thoughts and ideas and procedures are emanating more frequently from teaching medical centers, they very surely and certainly are being studied and practiced in community and government institutions as pharmacy clinicians learn to extend the humanness of their art.

As I mentioned earlier, in talking about these trends with other practitioners in other hospitals as well as in my own beginning experiences, I notice that the pharmacist very quickly relates his disadvantage in the doctor-nurse confrontation on the nursing areas to his bedside inexperience. I think we have demonstrated that this experience cannot be effectively achieved by "observing and visiting." Comfort at the bedside appears to come gracefully to those who have been deliberately taught patient care responsibility.

We are thinking very seriously of introducing an exercise into our residency program in which the pharmacist will be taught this patient care responsibility. Our thinking now is that the pharmacist will be assigned to a specially selected nurse. This

nurse must be in sympathetic agreement with the pharmacist's educational need; and the pharmacist will work with this clinical nursing practitioner during her shift of duty—40 hours a week—caring for her assignment of patients.

The plan is that the pharmacist will give medications, including injections and suppositories. He will apply the treatments and administer the tender love and care under the direction of this clinical preceptor. This patient assignment will include 10 or 12 patients, and the pharmacist will be concerned with this same group of patients from admission to dismissal. During his experience of administering treatments and medicines and care, he will also be observing patient responses to drugs and how these responses are affected in a variety of physiological systems by a myriad of pathological, psychological, and environmental parameters.

The pharmacist will be required to carry out the patient care procedures alone when his instructor considers him competent, and he will have ample opportunity to discuss his patients with the nurse and the attending physician. As each of his patients is dismissed, the pharmacist will be required to document his experience with the patient, the nurse, and the physician. This documentation will include a detailed discussion and rationalization of the therapeutic and treatment programming. We think these exercises will demonstrate the value of this experience to the pharmacist in his clinical function.

At our hospital, nursing care is administered on the "total care" plan. Each staff nurse is given a patient assignment, and she manages the entire spectrum of care of the patients assigned to her. We feel this approach to patient management is especially compatible with the educational need of the pharmacist.

We think that six weeks of this concentrated experience in exploring the mystery of patient care will give our pharmacy residents the kind of maturity that they need to function effectively as pharmacists on patient areas in the hospital. We have no interest or desire to create a nurse-pharmacist. We simply feel that it is our responsibility to give the pharmacist an experience base for his comfortable and effective function with the nurse and the physician at the bedside. If we can increase the pharmacist's usefulness and confidence in an association in which he belongs, we will have achieved our need. We have not effectively satisfied this need in the past by putting the pharmacist through patient area observation exercises.

When I look at the prospectus of this program and realize what I project into it, it seems unforgivable that we have overlooked this approach to establishing clinical sensitivity in our practitioners.

If our clinical image is important for our productive professional future, an integrated compulsory performance at the bedside will give maturity and substance to an image that often, now, has only shadow or form.

Surely then, with an appropriate curriculum administered wherever possible by practitioners, with an effective residency strengthened with clinical experience, and with an adequate laboratory in which to serve mankind, we can feel the stir in the "womb of time" of a progeny of practitioners with purpose, compassion, and humility. And I say to you that the greatest of these things are purpose, compassion, and humility.

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

www.ashpfoundation.org