"My enthusiasm for hospital pharmacy has been all pervasive."

Sister Mary Florentine

(1975)

At the time she received this award, Sister Mary Florentine, C.S.C., was the Chief Pharmacist of the Infirmary at St. Mary's Convent, Notre Dame, Indiana.

Enthusiasms

The mountain climber who, after the long, arduous, sometimes dangerous climb, rests exultant on the peak surveys the twisting path behind him with exhilaration, a sense of pride tempered by humility. He has been carried over obstacles along the way by enthusiasm for the climb, as well as the attainment of the pinnacle. As I stand here tonight upon what must surely be the pinnacle of a long professional climb, my feelings can best be expressed in these few lines, written many years ago by a friend of mine:

Now for a little hour let me stand
Here where the Past meets Future, face to face,
Let me lay one reluctant hand
Upon the years I see the Past embrace,
The while the other reaches valiantly
Out to unveil the Future's mystery.

Monday, January 13, 1975, began much like many other Mondays, with the excep-

tion of that "just before an examination feeling" that something dire was about to happen which has presaged many great events, both good and bad, in my life. The Irish call it "fey," I believe, so perhaps it is traceable to my maternal Irish heritage. In any case, the feeling persisted until late afternoon when the phone rang and Joe Oddis announced that I had been voted this year's recipient of the Whitney Award! Quickly bringing me back to earth was the dictum that the title of my address be forthcoming within the next couple of days! After much soul searching and brain wracking, I selected "Enthusiasms," the hallmark of hospital pharmacy, as my title and theme. Over the years, I've enjoyed a few pet enthusiastic projects which have finally come to universal adoption. This evening I would like to recount a few of these enthusiasms and then start what I hope will be a great ground swell for my most recent interest.

First, there was the enthusiasm for pharmacy engendered by accompanying my father who, on his day off, went to visit another pharmacy. It was further nurtured by a stubborn desire to become a pharmacist in face of equally obstinate opposition from that same father. Since first taking over as a very inexperienced hospital pharmacist, my enthusiasm for hospital pharmacy has been all pervasive; subsequent interests have been just by-products. That enthusiasm has encompassed even the day-to-day performance of merely routine professional functions. When performed for the love of the neighbor seen in outpatient clinics, even these can be soul satisfying indeed. Someone once said there were no small tasks, merely small persons doing them. Yet even small persons can make of these multiple small actions a mighty force for good. The phenomenal growth of hospital pharmacy and its impact on the entire field are evident proof of this.

This enthusiasm for pharmacy focused on hospital practice after my being literally plunged into it by stepping into a hospital position vacated by the death of the incumbent. Not the blunders, the long hours, nor the hard work interfered with the convictions, soon arrived at, that this was truly pharmacy and that pharmacy is service. In those early days, hospital pharmacists had only a section at the annual meetings of the American Pharmaceutical Association and of hospital associations in which to discuss their special problems and exchange ideas. The enthusiasm of the pioneer leaders was spread by state groups, the first institutes, and the generous sharing of ideas that characterized the beginnings of the Society. Few of us who sat with our feet in wet sawdust at the Princeton Inn that hot July in 1948 went away unmoved by Dr. Carl Walters' description of the "green seawater" technique of preparing hypodermic injections! For me, it was the beginning of a continuing enthusiasm for the preparation of sterile products—injections and ophthalmics as well.

Evolution is a slow process, and the progress from hypodermic tablets to disposable cartridges has taken several decades. Equally gradual has been the passage from the one-or-more ounce bottle of ophthalmic drops to today's sterile units. Yet a chance conversation with one of our ophthalmologists about preparing a "chain of sausages," each containing but a few drops, sparked in me an enthusiasm that could not be dampened by machines that failed to seal, tubes that spouted their contents unexpectedly or dried out because of water seepage through the walls! Bill Heller, remem-

bering a disastrous demonstration at the Institute in Chicago I'm sure, suggested that I bring to this assembly a little tube which he remembered as the first unit dose eye drop. Enthusiasm and persistence have finally paid off, and today industry furnishes tubes that really work.

There have been other related enthusiasms as well, but why try to enumerate? Once, after I showed the director of trade relations for one of the large pharmaceutical companies through our department, he remarked: "You're very keen on your job, aren't you?" At the moment I was pleased that it seemed so obvious. As time passed and I reflected more deeply on his remark, I wondered whether I might have been too keen on the immediate job to see clearly the wider potential of service. The emphasis today, however, on clinical pharmacy as service has had unprecedented acceptance. A field of practice spawned in the hospital, the concept has spread to other branches of pharmacy.

The connotation of "clinical" has a certain detachment and sterility of approach that made my initial enthusiasm for clinical pharmacy something less than wholehearted. Nor was this apathetic view stimulated when senior pharmacy students, after a semester's exposure, declared themselves "clinical pharmacists." Further reflection produced evidence to convince me that this was just a new label on a time-honored method of practice in hospitals. For, after all, patient-oriented service had always been the goal; now it could be achieved on a wider scale. So much so, in fact, that warnings are being issued that we are training too many clinical pharmacists.

Today, in the leading medical centers and hospitals across the country, clinical pharmacy is the accepted standard of practice. Here, this one-to-one, patient-oriented service gives patients the advantage of rational drug therapy. Patients entering these hospitals (as well as any hospital which has a clinical service) have pharmacists taking the patient's drug history, which can be used by the physician as well as the nurse to improve patient care. Possible drug interactions, known sensitivities, favorite home remedies are pointed out. A pharmacist counsels the patient on the proper use of his medications. The patient improves, is discharged, and this service is abruptly terminated. And what of the more than 22 million of the population who are over 65 and are not hospitalized? In an editorial in the October 1973 *American Journal of Hospital Pharmacy*, George Provost spoke of the "advancement of rational, patient-oriented drug therapy," which would be provided in organized health care settings rather than hospitals.

By whatever term we choose to call it, we are moving inexorably in the direction of more government interest in, and control of, the delivery of health care and the regulation of hospital pharmacy along with the other health professions. We have read articles and heard leaders warn that change was inevitable. What direction that change takes can be influenced by the profession itself if we all turn our enthusiasm and innovative thinking towards a more subjective approach to our service. The February 1975 issue of *Pharmacy Times* quotes Julius E. Stolfi, M.D., associate editor of the *New York State Medical Journal*, who defines humane, humanism, and ethics and then asks, "Join us, please, in our prayerful hope for a return of humanism in all phases of the

practice of medicine in the New Year." Our toastmaster, Grover Bowles, commented in his Remington address that students are not being adequately prepared in the humanities. To reinforce further the need for the trend towards wider scope for our clinical approach, one of our enthusiastic young leaders, Dr. Tom Mattei, asks:

What could we possibly accomplish if we freed ourselves from our frozen concept of pharmacy practice? The common denominator of our involvement must be the chronically ill patients' need for medication and their need to know how to use these medications properly.

This "need to know," the continuing thirst for knowledge that is man's inheritance from his first parents, takes many guises. It is present equally in the clinic mother who doesn't know whether she should remove the tinfoil from her child's suppository and the senior citizen who wonders how, when a number of pills of various sizes and colors are swallowed, each knows which part of the body to go to. The answer in each situation seems so obvious as to border on the ridiculous; yet it is of serious import to the questioner. So, for the moment, we become teachers and sharpen our communication skills to assure patient compliance. But even more, we must have concern for these questioners. Clinical pharmacy then will be enriched with an added dimension of communication and concern. Instead of being completely objective, it becomes more subjective and we become listeners instead of preachers. Speaking of U Thant's abilities as a listener, Robert Mueller said that "man can learn so much by simply opening himself to others, by lowering the barriers of his self-sufficiency and infallibility."

Concern, then, must be our watchword for the future. Concern is something more than routine and mechanical procedure. It is a gift of service, a gift of ourselves. Such service will be a natural outgrowth of present outpatient services flowing into neighborhood health centers, and there will be innovative preventive care as well as newer educational efforts. Currently, a large percentage of persons over 65 who are confined to nursing homes, extended care facilities, and long-term facilities are receiving pharmaceutical services from community practitioners. Here problems of overuse, underuse, and interactions of drugs are under surveillance. But what of the remaining 95% of this population? They, more often than not, live out their days in loneliness in apartments or rooms. They, too, are the patients on long-term drug therapy to whom the multiplicity of drugs is confusing. Time plays strange tricks with the memory. Was that dosage taken—and when it should have been? We know from studies performed that noncompliance with dosage schedules is widespread among patients attending our outpatient clinics. I do not recall seeing any compilation of statistics on the ages of the nonperformers, but I can venture a guess. So this is my latest enthusiasm, a greater concern for the older, sometimes confused, and often lonely segment of our population.

The Society has conceived, nurtured, and brought to fulfillment so many innovative methods in the past. It has such a wealth of eager, enthusiastic, and imaginative talent that a multitude of plans could be operable in short order. Perhaps a presenta-

tion of two simple, yet workable, schemes may stimulate many here this evening to think along similar lines.

The first plan involved a hospital where physicians maintained their offices and where the physicians' answering service was also hospital based. Here the hospital administrator became involved after noting the frequency with which recently discharged geriatric patients were readmitted in a badly deteriorated condition. Consultation with patients and physicians confirmed the fact that needed medications had been omitted or overdosed, primarily because these patients just could not remember whether or not they had followed the prescribed dosage regime. "How silly," we are inclined to say. Yet how often have the best of you forgotten whether or not you had taken a routine drug dosage? And you are young, knowledgeable, alert. What then of the old, confused, debilitated?

In this hospital, the administrator arranged with the answering service of physicians caring for these patients to call each patient daily to check on them and remind them to take their medicine. A patient load of six to 10 patients for each operator was maintained from a card file listing medications and times, as well as a neighbor's phone number. This latter information proved useful in one particular case where no answer was received and the neighbor's timely intervention was instrumental in obtaining prompt emergency assistance. Not only was the system helpful to the patients, by acting as a surrogate person who cared, but it also relieved the physician of many nuisance calls and acted as a liaison between patient and doctor. Think how much our services could expand by the use of volunteers to reach out to these patients who are waiting to hear a friendly voice, to know someone cares.

Your program tells you that I am a gadgeteer. With this in mind, the next plan is for a gadget, or a method, or any convenient way of reminding the patient to take medicine at appointed times. It would also serve as a check to assure that indeed they have been taken as ordered. Which one of us has not, in the middle of engrossing duties, paused to wonder whether or not he has really taken an appointed dose?

My interest in, and enthusiasm for, this phase of patient compliance was stimulated when visiting a really spry octagenarian, seemingly alert and responsible, who complained about inability to follow a rather complicated multiple medication regimen. The solution came in the form of a plastic container with days of the week listed across the top and a series of pockets below with times under each one. On the side opposite the designated times were the names of the drugs. All that had to be done, then, was fill the pockets once a week. An interested friend, neighbor, or relative could perform this service from well-marked prescription containers. A glance at the full and empty pockets will reveal at once compliance or noncompliance. Cards such as those designed to be filled and used as hypnotic records might easily be converted for use in such cases. In any event, I am sure there are many ingenious minds here that could devise a much better system. Think of the potential!

Finally, I would like to enlist you all in efforts to promote research into the pharmacological effects of drugs in older patients. As clinical pharmacists practicing in hospitals where great numbers of the patients seen in the outpatient services are in the over-65 group, you are the ones to see the drug-induced toxicity caused by dimin-

ished renal capacity, slower metabolism, or the lessened response caused by failure to take the drug. Where multiple-drug therapy is an additional factor, the potential for interactions and toxicities increases sharply. Or add to this conglomeration the doses of the leading products for the world's ills pushed on television. Is there any wonder that this potential for drug interactions runs so high? Pharmacy at large has begun a response to the needs of the patient in long-term-care facilities. But what of the enormous population, mentioned previously, living out their lives in one room, lonely, often unwanted, who need a concerned, generous gift of our very special service. George Griffenhagen, in his editorial in the January 1975 *Journal of the American Pharmaceutical Association*, states:

Yes, we have come a long way in providing pharmaceutical service to patients in long-term-care facilities but the results cited in recent studies lead to the unavoidable conclusion that we still have a considerable distance to travel.

Let us be on the road at once.

It would be inappropriate for me to close without thanking all those friends that I have met along the road who have helped me over the rough spots and have made this heady moment possible. So I thank God for the accident of having been born, as I've so often phrased it, "in a drugstore." My thanks are due to those farsighted teachers who insisted, while I was gobbling every science course possible, that I not become "one-sided" and who fostered in me an abiding interest in the arts and literature. My deep gratitude, as well, must be tendered to the many great practitioners who have been an inspiration to me as well as faithful friends over the years. Nor should I neglect the scores of students who spent time in our department and always kept me "on my toes." I would be remiss indeed to neglect all those of the Society's headquarters staff without whose painstaking efforts this evening would not have been the perfect reunion and enrichment that have delighted us. Finally, let me thank all of you who have shared this glorious evening with me and close with these lines from the friend quoted earlier:

Ah soft the grey veiled Past now turns away;
Down darkening paths that greet her victory
She carries even this exultant day
Off to tear-misted hills of memory.

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

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