



*“Hospital pharmacists have manifested
a dedication to the career concept.”*

=====**R. DAVID ANDERSON**=====

(1976)

At the time he received this award, R. David Anderson was the Director of Pharmacy Services at Waynesboro Community Hospital, Waynesboro, Virginia.

The Peril of Deprofessionalization

The following thesis has a twofold purpose. First, I will repeat the often ignored warning that American pharmacy is in great peril of being deprofessionalized, that forces both external and internal, deliberate and unknowing, are intent upon reducing pharmacy to a technical vocation. Second, it is my belief that hospital pharmacy practice offers the best hope we have of reversing this trend and creating an environment in which pharmacy will be able to restore the respect which the public and other health professionals once had for this honored profession.

I fully realize that the breast beating, cynicism, and self-criticism which are to follow will be strongly offensive to some and that I will be taken severely to task for my disloyalty to the profession. However, few people can claim greater love for his chosen career than I have for pharmacy. My presence here tonight offers some evidence that I have worked diligently for the advancement of pharmacy. That is a path which

I expect to follow for the rest of my life, and this is but the first step into tomorrow rather than the last labored step of today or yesterday. My effort here is to direct attention to some concerns that I feel must be dealt with if we are to achieve our destiny.

Five of the distinguishing attributes of a profession are: (1) a systematic body of knowledge or theory, (2) authority recognized by clients, (3) broad community sanction of this authority, (4) a regulative code of ethics, and (5) a professional culture sustained by professional associations.¹

Many believe that pharmacy does possess these characteristics. Practitioners, educators, pharmaceutical scientists, and those who author the literature that sustains the body of knowledge upon which our work is based use the term freely. Some social scientists, however, consider our use of the “professional” designation as inaccurate. They point out that pharmacy fails to meet the criteria established for the ideal type profession. Indeed, we see references to pharmacy as a “marginal profession,” a “limited profession,” a “semiprofession,” a “quasiprofession,” a “peripheral profession,” and an “incomplete profession.”

Many of the intellectuals in pharmacy are strained to acknowledge professional status for the pharmacist. Numerous studies and commentaries depict the pharmacist as being in a class closer to technician than professional. Knapp² and his colleagues have studied the pharmacist’s performance, and they have concluded that professional ability eludes the pharmacist. As drug advisors to physicians and the public, we fail to demonstrate good communication and consultation skills. Knapp’s devastating evaluation, which I am grieved to accept, lumps me together with all those “who utterly failed the tasks presented to them—failed to the point of exposing their patients to the unnecessary risk of possible death . . . because of the overwhelming nature of the incorrect responses and the severity of the consequences of the pharmacist’s actions.”

George Provost³ has observed that pharmacy is promising more professionalism than it is able to provide, while Robert Fischelis⁴ noted that the public has lost faith in pharmacists as guardians of the public health and that pharmacists themselves are not sufficiently interested to perform functions they were trained and licensed to do. More recently, the Chief Justice of the U.S. Supreme Court proclaimed in a formal opinion that the pharmacist, when dispensing a prescription, is no more professional than the “clerk who sells law books.”⁵

The public ranks pharmacists low on the scale of professionalism. The Dichter report⁶ stated that pharmacists have lost contact with their patients. Forty-one percent of their respondents indicated that they never consult a pharmacist on medical or drug questions. Drug advice was obtained most frequently from friends and neighbors. Pharmacists were mentioned last, after physicians and the media, as sources of health information. The public is unable to identify the pharmacist as a professional.

Physicians and other health professionals have shown an alarming indifference to pharmacy. We are seldom called upon for more than simple advice concerning cost, available dosage forms, and brainless comparisons. In spite of frantic efforts by both

community and hospital pharmacists to become useful sources of drug information, the services that have evolved are utilized infrequently and are of questionable usefulness in many instances. In those cases where pharmacists have gained a reputation as drug information specialists, they are rarely compensated for this knowledge, and there is little incentive to develop these abilities. A bound collection of official package inserts, supported by the pharmaceutical industry, and the detailman continue to serve as the physician's primary sources of drug information. The Study Commission on Pharmacy observed, "The least frequently used source of information (for the physician) is consultation with a pharmacist."⁷

The government and others who control our health care system demonstrate a remarkable disdain for the relevance of the pharmacist in all areas where drugs are being used. We are seldom called upon for advice, and we find ourselves cast in the role of storekeeper-conveyor-assessor of drugs rather than an authority on the use of drugs. We are more frequently considered extravagant, unessential purveyors of drugs who are overpaid and overtrained for the work we are required to do. Much of our time is spent in idle, nonproductive tasks requiring a low order of technical skill, which could be more economically provided by supportive personnel.

Pharmacists appear to have lost faith in themselves and have become resigned to a second-class role in the health care scene, knowing little and producing less that is absolutely essential to the safe, effective use of drugs. Regrettably, surveys have shown that some students in our colleges of pharmacy also appear to view their chosen career more as a business than a science or profession.⁸ They look forward to years of frustration and lack of fulfillment for they know that their productive years will offer few opportunities to effectively use the training they have obtained. They cringe at the bleak outlook of prostituting themselves to the "commercialized jungles" where their extensive knowledge gained in a rigorous college education is soon adulterated by concerns for wine, auto parts, garden tools, and building supplies. They find little encouragement in the independent pharmacies which attempt to compete with the giant chains on their own terms only to vanish into that ever deepening vortex of merchandising and business conflict.

Those who select a career in pharmacy as an outlet for charitable service to fellow man soon find the path blocked and pockmarked by the practical economics of business and the moneymaking ethic. We are paid not for our knowledge and service but for the products we dispense. In short, we find that high ideals of professionalism are soon diluted by managers who thumb their noses at standards of excellence, acknowledge no sense of community responsibility, and resist application of special intellectual techniques and abilities which are unprofitable.

The above and many other citations can be provided which indicate that pharmacy is in great peril of being deprofessionalized in the eyes of those it serves as well as those who practice it. In the community, it is indulged by longstanding legal protection. It suffers from a decreasing emphasis on knowledge. It has foresaken much of its service orientation and sense of obligation to the sick and injured of society. In some settings, its status has deteriorated badly.

The true profession identifies early in its existence a sense of mission. It recognizes

that it and it alone has the opportunity to develop and deliver those essential services on which the community depends for its very existence. In the case of pharmacy, it should rest in a devotion to patients and the acquisition of the knowledge, skills, and judgments that will assure optimum use and safety of drugs that are required in the treatment of illness. In my view, pharmacy is losing its sense of mission and thereby courts deprofessionalization.

Regrettably, most of those who use pharmacy to advance their own aims and many pharmacists have as their mission the accumulation of wealth. Once taken up, that goal obscures every value the professional holds dear: standards of excellence are eased to accommodate profit potentials, the sense of responsibility to community and profession is undermined, rules of conduct are relaxed, efforts by management to ease entry into its educational system become apparent, and its social standing begins to deteriorate.

Greenwood¹ has stated that the chief difference between a professional and a non-professional occupation lies in the element of superior skill which is supported by an organized, internally consistent body of knowledge. As we have already pointed out, the responses of pharmacists to the most elementary drug-related questions have soiled the name and reputation of pharmacy. Many of us are incapable of communicating in simple medical terminology. We demonstrate no superior skill, and the knowledge we attempt to manifest can be found largely between the covers of a pricing catalog.

The professional commits himself to a lifelong effort of study and contemplation. He requires no outside pressure to force him to study and develop an insight into the use of drugs. But pharmacy is struggling with the question of mandatory continuing education to coerce so-called professionals to become professionals. The typical pharmacist does little to elevate his level of competence. Very few commit themselves to serious study. Few pharmacists develop their own personal professional libraries. Those which are visible in most drugstores consist of the legally mandated USP and NF and a few free magazines that feature a small amount of pharmaceutical information sandwiched between advice on the latest deals in kitchenware and pantyhose. A few outdated textbooks on galenical pharmacy and inorganic pharmaceutical chemistry and, occasionally, a journal published by one of the state or national associations make up the bulk of the literature that is readily available. Little, if any, is permanently bound to provide quick access to needed information. Many hospital pharmacists, however, have recognized the need for comprehensive drug information services and have developed programs which meet the needs of a diverse clientele.

Those pharmacists who are not in constant face-to-face contact with physicians, nurses, and, particularly, patients where they are being treated and who are unable to see exactly how drugs work, what they do to people, and how they affect particular organ systems are destined to know little more than a myriad of unorganized details. No matter how vast the details known about drug products, the pharmacist who is unable to organize that knowledge into abstract principles, combine it with information gained from observation of the patient, and then interpret the relationships which exist between drug and patient will find that the element of skill which permits ap-

proval as a professional is missing.

We are destitute of experts in pharmacy. The plaintive cry is often heard that the pharmacist is the expert on drugs. Who can identify them? Where are they? We devote our lives to dealing with drugs, but we are satisfied to know so little about so many drugs. Few of us can claim to be expert in a single drug. Our failure to master the available information on drugs leads the public and other health professionals to reject us as advisors and colleagues.

A basic need of every profession is to control the manner in which its practitioners are recruited, nurtured, and secured to the ideals and mission of the profession. Pharmacy's practice component is losing its control over the breeding of pharmacists; unfortunately, hospital pharmacy has never exerted any effective control at the undergraduate level. Entry into the profession is largely regulated by the colleges of pharmacy, though they frequently plead for assistance from alumni and practitioners. Students are selected primarily on the basis of grades and the ability to meet demanding curriculum requirements. Little, if any, attention is given to identifying and rejecting those who would violate professional ideals and morality.

An insidious bureaucracy seeks to influence admissions and regulate the number of students. Capitation grants are dangled like a carrot before a dumb ass to increase the number of students, qualified or no. Research funds may suddenly dry up or the availability of other subsidies may be placed in jeopardy if the school refuses to lower its standards to a level of uniform mediocrity. A monolithic community pharmacy orientation continues to dominate the curricula of many of our schools. Faced with demands from every segment of the profession to increase curricular offerings to match the needs of special interest groups, the colleges frequently spawn a potpourri of courses which utterly fail to equip the student for a life of professional accountability.

Greenwood¹ declared that one of the distinguishing characteristics of a profession is the professional culture sustained by formal professional associations. Pharmacy has few peers when it comes to the number and variety of associations which vie for precious time, talent, and money. At every level of our society, city, county, state, and national organizations plead for allegiances, exhort us to get on the bandwagon, fight and bleed for dear old pharmacy. While many are of questionable usefulness, they offer common interests and goals around which some pharmacists will rally. They prevent isolation and loneliness by making available a forum for the expression of ideas, exchange of experiences, fellowship and contact with others having similar needs and views.

We hear constant calls for occupational and organizational unity. The premise is advanced that the ASHP has become too strong and powerful, that it duplicates the work of others, that the energies of its members are being wasted by devoting themselves to patients rather than the weightier matters of politics and the maintenance of a viable economic base for the independent practitioner of pharmacy.

Our leaders are criticized for harboring parochial attitudes. We are condemned for our failure to cleanse ourselves of provincial feelings and for speaking out on issues of common concern to our members. Hostile criticism is heaped upon us for our continued thrust towards improved standards for the profession. When we come together

in free association to discuss common problems and attempt to define new areas of practice in which we can serve our patients more effectively, we are accused of developing pompous attitudes.

Strauss⁹ points out that professionalism:

. . . complicates the task of developing teamwork between occupations. Each profession tends to develop a parochial, specialized point of view. As a result, jurisdictional disputes become more common, and the overall organization starts to break down into a number of semiautonomous departments.

American hospital pharmacy has followed this predictable course and has rapidly developed an autonomous relationship with other segments of the profession. While exhibiting an earnest desire to cooperate in solving mutual problems, the Society and its members have rejected restrictions on our thought, activity, and political agitation.

Patient care, patient safety, and the public welfare have been our first considerations. If we demonstrate solidarity and single mindedness of purpose, it is because we share a common interest with many in a unique responsibility. This posture has created relationships with other pharmaceutical organizations that, at present, are free of serious conflict but characterized more by accommodation, avoidance, and competition.

We work under different circumstances. We work with a different type of people in different relationships in an attempt to meet the different requirements of a different patient or client. We work under a different form of bureaucratic management composed almost entirely of nonpharmacist administrators under the control of housewives, bankers, and farmers who sit on hospital boards of directors committed to altruistic service to the community. Regulatory authority imposed upon us by local, state, and national governments is vastly different from that which affects our compatriots in community practice.

We accept the description of the Millis Commission⁷ as differentiated brethren, but we reject being categorized (by those who refuse to recognize these distinctions) as separated brethren to be shunned, avoided, and ignored. We will not go away; our organization will not go away. We will not be deprofessionalized by those who wish to recast us in a common mold whose shape is already flawed.

The prestige and dignity of a profession are largely determined by the trust and reliance placed in it by the public it serves. This confidence must be gained by strict adherence to a code of conduct; it is not willingly conferred by a constituency which is cheated, duped, and deceived. Failure to adhere to codes of ethics and conduct spawn laws, regulations, and interference by government—the people. Most pharmacists are law-abiding, ethical individuals, but we must recognize that pharmacy is one of the most rigidly controlled professions, which suggests that ethical imperatives are not as uniformly observed as we would like. There is ample historical evidence of gouging, rank substitution of inferior drugs, kickbacks, solicitation of premiums, fraud, and dishonesty to explain the necessity for many of the laws and regulations under which we function.

Marshall¹⁰ defined a profession as an occupation in which *caveat emptor* cannot be allowed to prevail. Yet, we find in the recent scandalous revelations of the Senate Medicaid investigations that some pharmacists abused their clients and perverted their profession. Perhaps this disclosure will provide some relief from the stricken conscience we in hospital pharmacy experienced after similar practices were documented in some California hospitals. Who has brought charges against them? Have boards of pharmacy revoked or suspended licenses? Have local, state, and national associations censured them in any way or revoked their membership for such conduct? Indeed, have any of them called their ethics committees into session to investigate cases of misconduct against the public and professional standards? Are there, in fact, ethics committees to summon?

Hospital pharmacy, with a few exceptions, has generally escaped the slander associated with such dishonesty. But each of us can point to the acts of some who have violated the canons of human decency to take advantage of their fellow man. We have no code of ethics in hospital pharmacy. The Code of Ethics of the American Pharmaceutical Association is a document to which each of us should subscribe. Few of us could recite a single phrase in it; many of us have probably never seen it. It expresses some noble ideals, but the different nature of our practice locations demands that we create a code that reflects our relationships with all of the different people and conditions under which we practice. We have no means by which we can call delinquent members to account or to penalize them for deviation from accepted standards of conduct. There is great danger that a few derelicts in our midst will reflect poorly upon our good name and contribute further to the deprofessionalization of pharmacy. We have no way to weed them out, expose them to our scorn, and insure that they are obstructed from future practice.

Hospital pharmacists, by and large, have demonstrated a personal and collective "sense of mission" which is essential to a professional psyche. Hospital pharmacists recognize that we require (and often possess) talents and abilities which no other professional can provide. The pattern most idealized of a professional pharmacist would be one who has a close association with patients; has a comprehensive awareness of their previous medication habits; knows their allergies, sensitivities, and idiosyncrasies to drugs; extracts information about them from charts and contact with laboratory, x-ray, and other data; has access to a sophisticated source of drug-oriented information; is able to correlate that information with knowledge about the patient's physiology and disease; and recommends to physicians, nurses, and others the proper course to follow where drugs are indicated. He emphasizes and insures safety and effectiveness of drugs. The hypothetical professional pharmacist would serve as a counselor, advisor, teacher, monitor, and patient care team member who is also capable of managing traditional duties related to drug procurement and distribution. The model which comes closest to conformance with this professional ideal is the clinical pharmacist. While the need for his services exists in community practice, storefront clinics, and sophisticated HMOs, he functions almost exclusively today within the institutional setting.

Hospital pharmacists have manifested a dedication to the career concept. They

have accepted a calling which has placed them in a close association with other professionals intent upon serving their patients. They recognize in their career a calling, a life devoted to good work, and they receive intense emotional and intellectual satisfaction from the rewards which are visible in renewed vigor and health of patients.

Self-centered motives cannot exist in the heart of the dedicated hospital pharmacist for he cannot profit from the accumulation of funds that might be charged for the services he provides. He escapes the slurs so often cast upon others who are accused of plundering the family fortune by unreasonable charges for drugs. Hospitals, faced with meeting ever increasing costs, are frequently singled out by the public and the government for pillaging public and personal resources, but the pharmacist engaged there in his professional work should do everything in his power to serve the interest of his patient rather than succumb to demands for more and more profits from pharmacy operations. His interest should be in the maximal use of his knowledge and in the needs of his patients rather than the self-centered needs of the practitioner.

This is not to imply that the professional person refrains from seeking adequate and just compensation for his work and his knowledge. The professional and his professional association must work constantly to secure the rights and privileges that will insure his prosperity and achieve a lifestyle that is consistent with his importance and responsibility to the community.

We in hospital pharmacy have enjoyed a very special relationship with our national, state, and local associations. The ASHP, with its network of state affiliates, regional advisory panels, and local associations, has achieved general recognition as one of the most effective, responsive, and productive professional organizations in American pharmacy. It is a concentrated, cohesive group with an exceptional interest in serving its membership as well as society. It has provided a sense of identity that is unmatched by other pharmaceutical organizations and their members. It has been extremely successful in developing standards of practice to which its members aspire. Its educational programs have been uniformly hailed as the most intense, fruitful continuing education programs available. Its publications have demonstrated a commitment to the elevation of the professional knowledge of hospital pharmacy practitioners. The *American Hospital Formulary Service*, the *American Journal of Hospital Pharmacy*, and *International Pharmaceutical Abstracts* give evidence of its dedication to excellence in drug information and knowledge. That we are dedicated to the development and sharing of knowledge is evidenced by the success of the 1976 Midyear Clinical Meeting of the ASHP where the largest group of hospital pharmacists ever assembled has come together to freely disseminate the information we possess.

The ASHP has subscribed to a policy of advancing basic knowledge concerning the use of drugs in hospitals. It has assumed responsibility for developing training standards and for certifying training centers for hospital pharmacists through development of residency programs. The time has now arrived when the Society must address the basic educational component of the professional hospital pharmacist, the undergraduate curriculum. Donald Francke¹¹ has advanced the idea of an American School of Hospital Pharmacy. If we are to train and educate practitioners who will be required for future hospital practice in the skills, knowledge, and understanding of

unique problems of rational drug use in hospitalized patients, the Society and its members must advance the development of a curriculum that emphasizes those needed qualities. No college or university currently offers a dedicated curriculum in hospital pharmacy practice. The net effect is indistinct directions for the student, confusion and bewilderment for the faculty, and a poorly prepared practitioner.

The Society and its members can wait no longer to seek the development of an institution of higher learning that will be capable of conferring both undergraduate and graduate degrees in hospital pharmacy. As the fountainhead from which new ideas, research, development, and application of the hospital pharmacist's unique talents will spring, the university should become the central forge on which all legal, ethical, moral, and educational facets of the hospital pharmacy profession are molded. Bringing together a faculty and student body dedicated to the one principle of good health for patients, especially those dependent on institutional care, would insure the essential direction and purposeful efforts that are lacking in today's pharmaceutical education.

Reversing the deprofessionalization of pharmacy can only be accomplished if each of us recognizes the fundamental role of knowledge of drugs and its dissemination to those who have need of it. I firmly believe that the pharmacist should know more about drugs than anyone. Our education certainly should prepare us to fulfill this expectation. Our entire educational experience revolves around drugs. Deplorably, few of us manifest expert knowledge in a single drug. We quickly lose the bulk of knowledge gained during our college years. Unless we are representative of the highly idealized group of clinical pharmacy practitioners, we have contact with patients only over the prescription counter. We seldom are able to see how drugs work. We cannot experiment with, evaluate, and understand the actions of drugs in sick people. We respond to the physician's efforts in these areas and are reduced to the count-and-pour status that characterizes so many of us. Our shame is that we are so satisfied with this role. We do so little to escape from it. Too many of us are satisfied to allow the process of deprofessionalization to proceed unabated.

Every day I become more convinced that every pharmacist should become a recognized expert on something. Every hospital with 10 or more pharmacists on its staff could have the world's greatest accumulation of drug experts if each of the pharmacists there was expected and required to become expert in a single category of drugs. Visualize the impact upon the status of pharmacy in the institution and the quality of its service if the directors of 50 of our largest hospital pharmacies called their staff together tomorrow and presented this speech:

You guys just can't hack it in this work. You don't know enough about drugs. There is a need for in-depth understanding of drugs by our medical and nursing staffs which they can't obtain on their own, and you sure aren't giving it to them. Generally, you measure up well to the majority of drug information requests, but the reason we are not called upon more often is that you just don't have it when it comes to expert advice. But from now on you're going to be experts and the best in the country. There are too many young kids out there looking for your jobs, and

you can be damn sure that you won't have one long if you don't become the experts we expect of you. Your advancement will depend on how well you perform as the experts in your field. You will be expected to develop your own personal libraries and study like you've never studied before in your specialized field. And you will also be expected to maintain your proficiency in all other aspects of pharmaceutical service and information. We expect you to be good within six months and expert within one year.

Beginning today we are making the following assignments: You, Smith, are to become the antibiotic pharmacist. Jones you will be the cardiovascular pharmacist; Perry's field will be in fluid and electrolyte therapy. Antineoplastic pharmacy will become your specialty, Owens. Brown will establish himself as the expert in central nervous system drugs, while Cohen will devote himself to gastrointestinal drugs. . .

We may not be able to answer every question that arises with masterful skill, but in these fields we are going to have the most expert pharmacists in the country, and you can count on it. When our drug information center receives a question dealing with your special field of interest, you are going to be expected to respond. When there are lectures to be given or classes to be taught about your specialty, you will be the principal resource person. When our poison treatment center is faced with a problem of overdosage with one of your drugs, you will receive the call for assistance. When our ambulatory patients need expert advice in the proper management or understanding of their therapeutic programs, you will see that they obtain it.

In you we are going to witness the beginning of a new age in which the pharmacist is to assume responsibilities for patient management never before available to him. We are going to witness the rebirth of professionalism in pharmacy.

The foundation of any true profession is based on its essential social value; it will not endure if it fails to sustain public faith and confidence. Pharmacy's social value is overwhelmingly dependent on the effective use and distribution of drug knowledge. There is no evidence to suggest that economic concerns and the sale of products unrelated to drug therapy will alter the public's current low assessment of pharmacy or enhance its professionalism. The institutional practice of pharmacy offers the greatest hope the profession has for the renewal and maintenance of a viable professional base. But we must take the initiative to develop a corps of experts whose knowledge, rather than techniques, effectively serves the vital needs of man.

We have the ability. We have the knowledge, if we will only use it. We have the sense of mission and an association that provides the group identity so essential to the support of a career concept. We must achieve greater control over practitioner education and recognize the basic underlying value of a regulative code of ethics or conduct. It is essential that we establish greater bonds of commitment and respect between practitioners and patients.

If we fail to utilize effectively the knowledge we have and reject the tasks before us, pharmacy will succumb to the peril of deprofessionalization.

(For the complete list of references cited, please see page 139 of the *American Journal of Hospital Pharmacy*, Feb. 1977.)

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

© 2006, ASHP Research and Education Foundation. All rights reserved.

No part of this publication may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying, microfilming, and recording, or by any information storage and retrieval system, without written permission from the American Society of Health-System Pharmacists Research and Education Foundation.

www.ashpfoundation.org