“The future of pharmacy practice is bright if we center our activities around the patient.”

HERBERT S. CARLIN (1977)

At the time he received this award, Herbert S. Carlin was the Apothecary-in-Chief of The Society of the New York Hospital in New York City.

Patient Accountability—Pharmacists’ Future

Thank you for making it possible for me to receive the 1977 Harvey A. K. Whitney Lecture Award. I am indebted to my professional colleagues as well as to my mother; my wife, Ruth; my preceptor and mentor, Herbert Flack; my many professors, Drs. Brillhart, Tice, Avis, and Webster; members of the various pharmacy staffs with whom I have been associated; and my students and residents for this high honor.

I accept the award not only with a feeling of humility but with the realization that it is a symbol of achievement and progress for all of pharmacy and for its many thousands of practitioners everywhere. It is truly an honor to be shared with you this evening and forevermore.

To me, one of the most meaningful stories in the Great Book concerns the Good
Samaritan. St. Luke’s Gospel ends this parable with our Lord stating, “Go and do thou likewise.” This statement not only provides meaning for our personal and professional lives, but it happens to be inscribed on the official seal of The New York Hospital, the institution with which I have been privileged to be associated in recent years. In reflecting on this parable, I realized that “go and do thou likewise” fits well with the theme of my message on this occasion: “patient accountability—pharmacists’ future.”

The satisfaction derived from service to mankind is one of the greatest rewards an individual can attain in his life. The practice of pharmacy, as a profession, should be that kind of rewarding experience. As pharmacists, our rewards are derived from our commitment to patients for whom we are responsible. The service we provide to our patients is safe and effective drug therapy.

Our expertise in drug therapy incorporates selection of drug products; recommendations about appropriate drug use; drug information; education of physicians, nurses, pharmacists, and patients; patient interviewing; patient monitoring; and the control of the system that provides for the delivery of the product to the patient.

Pharmacists must use their talents to their maximum in order to provide the comprehensive pharmaceutical services to which our patients are entitled. By doing so, the hospital pharmacist is adding the patient to the group to whom he is traditionally accountable—the hospital administration and physicians on our medical staff.

Pharmacists have always been indirectly accountable to patients when they have dispensed physicians’ prescriptions with the right drug to the right patient at the right time. Over the years, we have become more involved in the total therapeutic system.

The epitome of a hospital pharmacy service 40 years ago was one that manufactured the products the physician needed for his patient. As the pharmaceutical industry developed, our attention was directed to the packaging of commercially available products which were issued to patient care areas as standard floor stock, free floor stock, or charge floor stock.

When a physician’s order was sent to the pharmacy for dispensing to a hospitalized patient, it was transcribed by a nurse or a clerk and contained limited information—usually the number of dosage forms deemed necessary by the clerk. It did not include dosage information or route of administration.

We provided drug information—when asked. Rarely did we emerge from our four-walled pharmacy to determine if our services were meeting the needs of our patients. When we did appear on the patient care unit, it was to fulfill a JCAH requirement.

As we entered the sixties, things began to happen—drug information services came of age; drug interactions; then clinically significant drug interactions; parenteral incompatibilities; unit dose dispensing, centralized and decentralized; parenteral admixture programs; direct copies of physicians’ orders; total parenteral nutrition; and so on. All these activities drew us closer to the rest of the health care team and, yes, to the patient.

Hospital pharmacy practice in the seventies varies from floor stock orientation to the most sophisticated of clinical care. At present, some pharmacists practice in such
a manner as to constitute an under-utilized health care resource. Knowing they have become stagnant and knowing they are not providing quality, comprehensive pharmacy services create a high degree of frustration within the individual practitioner. Frustration may lead to an attitude which causes loss of credibility among other health care providers. Ultimately, the loser is the patient—whose confidence and support are so essential to pharmacists’ successful provision of safe and effective drug therapy.

The traditional “isolation practice,” the Dutch door subterranean storeroom, has been another roadblock in our attempt to be full partners on the health care team. In recent years, however, more pharmacy services, especially in our large teaching hospitals, have been divided into smaller functional units, located strategically throughout the institution. In decentralized service, with each unit dealing with smaller patient populations, we have increased our visibility in a more personalized way to other health care practitioners, while at the same time increasing our services to patients. Suddenly they find that the pharmacist is a real person. Stripped of the veil of traditional anonymity, he now makes his personal contribution to health care.

But are we prepared to make this type of change?
Perhaps not. In some, a frustration of professional inadequacy may exist. Several options exist for us all. The way in which we exercise these options demonstrates our true commitment to the service of others. We may, of course, continue the way we always have—in isolation, even within the new environment—or we can meet the challenge by offering a personal contribution to safe and effective drug therapy.

Let’s look at some of the ways we can commit ourselves to such service.

To practice “clinically”—is it merely the laying on of hands, being excellent clinical librarians, making recommendations to physicians or others that they may or may not accept? This describes much of the clinical practice within our hospitals today. For example, many clinical educators who bring their students into our hospitals have no idea or interest in the total workings of the pharmacy department. They come into the hospital, make recommendations, and leave. The physician responds to these recommendations or tries to follow up on the situation. The clinical education is long gone. The pharmacist who is accountable to the physician and to the patient for the provision of the drug product is the one with responsibility. The best interests of the patient have certainly not been met in this case. Tension develops between the physician and the pharmacy department. Future suggestions of the clinical educator may not be readily accepted, and a conflict may arise between the clinical educator and the hospital pharmacist. The question of accountability is crucial to the provision of comprehensive pharmaceutical service and to the survival of pharmacy as a profession making a full contribution to health care.

Comprehensive pharmaceutical services should not, and cannot, be episodic. If our pharmaceutical services are to be of value, and I believe they are—in fact, I believe they are essential to patient care—then the services should be available continuously and whenever they are needed. Consistency builds reliability, an essential component of acceptance. The ability to follow up is necessary because it leads to credibility and allows us to assess for ourselves our personal contributions to the care of the patient.
How can we attain this goal? We must consider two aspects—the environment in which we practice and ourselves as individuals.

There are many factors that influence the environment in which we practice—not the least of which are the awareness and support of the concept of comprehensive pharmaceutical services by the institution’s administration and medical staff. Their initial support may not be enthusiastic or based on total commitment to the program, but they must show enough faith to allow a truly comprehensive program to develop and grow and eventually demonstrate its value.

Another contribution of the environment is the assemblage of a critical mass of pharmacists who are willing to give of themselves and form a team. This team concept must engender a mutual respect among all its members as they individually and collectively go about fulfilling their roles. Some will be administrators, some deal with distributive functions, and others with clinical activities. But all make an equal contribution to the comprehensive service. Each must be equally committed and equally accountable. Without team members who have mutual respect for one another, the objective will never be obtained.

A third aspect of the environment is an interdisciplinary team on which the pharmacist is able and willing to work as a team member. An effective interdisciplinary team is more difficult to accomplish than an effective pharmacy team. More than a decade ago, I had the opportunity to participate on an interdisciplinary team consisting of a physician, a nurse, a dentist, a physical therapist, and a pharmacist. The objective of our task force was to determine the feasibility of interdisciplinary continuing education programs. It became apparent after many weeks of dialogue, centered mainly upon each individual profession’s rationalization of its importance to patient care, that our project was in danger of failure. We termed these barriers to effective team work the “negativism of professionalism.” Not until we focused on the needs of the patient whom we all served did we begin to work as a team and to respect each member profession’s unique contributions to the overall effort of patient care.1,2 This experience demonstrated effectively to me that patients must be the central focus of all our endeavors. To succeed as professionals, pharmacists must be mature and realistic enough to accept a patient-centered interdisciplinary approach as the most effective and efficient method of providing patient care.

Patient education is one good example of an instance in which an interdisciplinary approach may be most appropriate. At one time, pharmacists felt they were not giving complete services to the patient unless they personally provided the drug counseling. While we know patients are more compliant if they receive some instruction relating to their medication regimen, aren’t we being provincial and unrealistic when we think only the pharmacist can provide that instruction?

A mechanism for patient education is probably already in place in the hospital. Rather than developing a parallel effort for the pharmacist’s direct counseling of patients, isn’t it more logical to assist the professionals already doing the job to incorporate drug education?

Our contribution in this instance would be in developing the instructional materials and supporting the other health care personnel in the educational effort. At our
hospital, Dr. John Romankiewicz recently developed a patient education program through the work of two interdisciplinary committees: The New York Hospital Medical Patient Care Committee and The New York Hospital Formulary and Therapeutics Committee.

Actually, the pharmacists provided the major thrust in designing and implementing the program, but the success of the program is the result of the work of not only the pharmacists but also of the physicians, nurses, and administrators. The pharmacists provide the necessary information and train the nurses in drug education. The physicians, within their respective specialties, review the data as they relate to patients, the disease state, and the effect on the physicians’ therapeutic plans. The nurses then become primary patient educators for the inpatients, while the pharmacists serve this role for ambulatory care patients.³⁵

To make the program work, the support of administration and the cooperation of the various members of the pharmacy department and the interdisciplinary medical patient care and formulary and therapeutics committees were all required—they established the proper environment.

The second critical factor in achieving full participation in patient care, including accountability, is related to us as individuals. We must ask ourselves at least the following questions:

- Why do I want to perform this role?
- How adequate is my knowledge?
- Am I capable of being fully accountable?
- If not, how can I increase my competence?
- Am I willing to make the personal commitment of time and energy necessary to not only gain but to maintain competency?

Our motivation to perform must be based on service to the patient. There is no place for professional ego in patient care. A patient-oriented attitude, stressing service, is an essential ingredient in our prescription for personal success. And this attitude is needed by all pharmacy personnel, not just by those who have direct clinical responsibilities.

Drug and disease knowledge is, of course, essential. We must honestly assess this ingredient as we make the commitment to patient responsibility. Any area of knowledge or skill needing reinforcement should be attended to. I believe that the best method of this reinforcement is self-learning. The best impetus to self-learning is the continual challenge provided by the demands of a comprehensive daily practice. When our practice demands us to broaden our knowledge, I personally do not believe that we need laws “mandating” continuing education. The quest for knowledge and the enthusiasm I have seen this past week within the throngs of professionals—here at this largest and most comprehensive pharmacy educational program in the world—demonstrate that our pharmacy practitioners have the commitment to patient orientation and a desire for learning.
During the past 20 years or so, services that seemed to be good for patient care often were easily implemented and readily received support from administration. At present, we are constantly faced with cost justification of programs of proven patient benefit.

The entire health care system is, and will continue to be, subject to the scrutiny of the government and the public. Thus, it becomes essential for institutional practitioners to find methods to assess the quality of our contributions, not only in terms of patient care but in terms of economic cost. Without such assessment, it is unlikely there will be any expansion of comprehensive services.

Assessment of the quality of patient care is, at best, difficult. In addition, pharmacists must initiate more programs aimed at the economic justification of the numerous advances in practice that we have already nurtured and advocated. I believe this activity must be a major goal of organized pharmacy—including the American Society of Hospital Pharmacists—so that pharmacists and the profession will be able to promote and innovate practices we know to be beneficial to patients.

One serious situation which must also receive some attention is related to the rapidly decreasing availability of employment opportunities for our young pharmacists—pharmacists with excellent educational credentials and expectations for professional satisfaction.

This situation is arising because of the lack of new hospital construction, the reduction of beds within our hospitals, the reduced number of positions in schools of pharmacy, and the economic ceilings that are being placed on hospitals and which increase the competition for available funds and new programs. This brings us back to the realization that pharmacy as a profession cannot be on the periphery of patient care. To flourish in the future, the patient must be our central focus. We as pharmacists must be accountable to that patient.

Being an optimist, I know that the future of pharmacy practice is bright if we center our activities around the patient and if we make the pharmacist accountable for patient services. I see patient accountability as the primary way to satisfy pharmacists’ professional needs, to increase pharmacists’ utilization, and to improve pharmaceutical and therapeutic aspects of patient care while effectively reducing our frustration stemming from a lack of use of our knowledge and skills.

(For the complete list of references cited, please see page 267 of the American Journal of Hospital Pharmacy, Mar. 1978.)