"I see many changes coming in our profession."

Milton W. Skolaut

(1979)

At the time he received this award, Milton W. Skolaut was the Director of Pharmacy at Duke Hospital, Durham, North Carolina, and Adjunct Professor at the School of Pharmacy, University of North Carolina, Chapel Hill.

Moving towards the 21st Century

I want to thank the Harvey A. K. Whitney Selection Committee of past recipients for the honor of selecting me to join their group. I also wish to thank the American Society of Hospital Pharmacists, the Southeastern Michigan Society of Hospital Pharmacists, and each of you for coming. Furthermore, I would not be here if it were not for the understanding, support, and encouragement of my best friend, my wife, Rheta.

Let us take a short trip back into history to review some events which may be of interest and then move forward to the year 2000, the beginning of the 21st century. Though many of you will agree with my forecasts because you happen to like what I say, while others will object because you disagree, none of us will really know the accuracy of these forecasts until the year 2000 arrives.

The first Harvey A. K. Whitney Lecture Award was given to Dr. W. Arthur Purdum, Chief Pharmacist of the Johns Hopkins Hospital in Baltimore, in 1950. I was associated with Arthur Purdum at the University of Maryland and later served as his assistant chief pharmacist at the Johns Hopkins Hospital from 1947 to 1949. Now, 29

years later, I am receiving this same award.

It is even more interesting to note that my predecessor at Duke University Medical Center also was formerly associated with the Johns Hopkins Hospital. I am speaking of I. Thomas Reamer, who worked at the Johns Hopkins Hospital for Mr. Robert S. Fuqua. In 1931, he departed Hopkins to become the chief pharmacist at the Duke University Hospital in Durham. In 1941, I arrived in Baltimore to work for Mr. Fuqua in a pharmacy internship, the forerunner of residency programs. While director at Duke, Tom Reamer received the Whitney Award in 1959. Twenty years later, I am being honored to join Tom. Hence, the Duke University Medical Center has had only two full-time directors of pharmacy, both of whom now have received the award. We are establishing quite a challenge for the next director.

I have devoted 38 years of my career to the practice of institutional pharmacy. It has been very rewarding to me, and institutional pharmacy practice is getting better, though considerably more complex. I also have served for 19 years as a member of the ASHP Executive Committee and the ASHP Board of Directors, including serving as president, vice president, and treasurer for 11 of those years. Based upon these experiences, I believe I can forecast some of our future trends, programs, and services.

Today's colleges of pharmacy are doing a better job of training students for the expanded roles now available in institutional practice. Many have developed innovative programs within the past five to seven years, and more programs are being developed or improved because of the endless, unselfish hard work of many of you. I foresee that graduate pharmacists will be able to go back to school part time or to participate in correspondence courses and complete a course with a final, short period of residence at a college of pharmacy. These programs will allow practicing pharmacists to upgrade themselves to stay competitive with new graduates, and such upgrading of practicing pharmacists can, in turn, provide stability and longevity in the professional work force.

The B.S. in Pharmacy Degree will be eliminated before the year 2000; by 1987, everyone coming out of school will have received a Pharm.D. degree. Because this degree will be the new standard, the push will be on in the early nineties to initiate another degree equivalent to the Ph.D. for a group of specialist pharmacists who will be educated to meet the needs of a total, clinically applied pharmacy practice. In the year 2000, the colleges will be graduating only 3000 new pharmacists per year, in response to both the changes in practice and the increased use of nonpharmacist assistants.

I see many changes coming in our profession—changes in responsibilities, departmental operations, and pharmacy practice. Some of these changes will be good and some will be upsetting, but one thing is certain—there will be changes.

Today, many institutional directors of pharmacy receive criticism that they hinder the new graduate intellectually and that they do not understand what is needed. In the eyes of the new graduate, some of these accusations are true, because the new graduate does not understand that the operation of a pharmacy in a hospital is extremely complicated. Budgeting and management are difficult and will become increasingly

demanding with the limited funds available under constant pressures to reduce costs. We have made more progress in our practice in the 1970s than we did over the previous 30–40 years, and we are just getting started. But we must bear in mind one fact—the institution does not and will not revolve around the pharmacy, nor was it built so the pharmacist could practice.

Fortunately, in the l990s and beyond, the young graduate will have two choices in the larger institutions—practice in a limited, specialized area or practice within the total area of pharmacy responsibility. The total service practitioners will be providing services in distribution, drug information, clinical rounding, teaching, and consultation. They also will be the ones who will clear paths for and who will assist those practicing as specialists. I believe we need to stress the practice of total pharmacy service in all institutions, but we need to assist in the further education of specialists in teaching hospitals as well. With the necessary experience and training, some of these specialists will practice within hospitals and some will move to ambulatory group practice settings.

The common criticism of medical practice is that everybody is specialized and no one looks at the whole patient. As a result, programs in which the physician is interested in the total patient are being developed (i.e., family practice). Pharmacy is moving in much the same way. Many new practitioners want to be highly specialized and actually care to know very little about the total pharmacy practice in the hospital. Yet, the hospital and the patient will be demanding total service which, in addition to excellent patient services, includes good management, reasonable costs, and liaison with the entire hospital. To meet these demands will require practitioners who can maintain good working relationships with the hospital administration and the Pharmacy and Therapeutics Committee, and who can provide careful attention to infection control, sterilization quality control, drug distribution quality control and safety, drug use review, educational programs, service and performance within prescribed standards, and productivity.

Some practitioners will want to specialize in cardiology, infectious diseases, neurology, emergency medicine, or the like, and I encourage this where conditions permit and where there is a need. Since this will be possible in only a limited number of large teaching institutions, residency and other hospital training programs will be obliged to train well-rounded pharmacists who can assume responsibility for total patient-oriented services in smaller institutions.

As patients become more familiar with health care programs and continue to demand excellence while keeping costs down, we will be expected to account for our services, our productivity, and our value to the institution and the patient. Many of us now practicing will find that our new, innovative programs will change present duties. While I do not think that pharmacists will be eliminated from institutions, other than through attrition, we will have fewer practitioners in the future than we do now. The clinical movement, or total patient service, will proceed at a quickening pace, and I see many of the specialists working with physicians in group practices. I see the pharmacist specialist as a primary drug and dose prescriber, or advisor, in the routine care of patients. As the individual pharmacist working with a group of physicians

shows his credibility, he will become an indispensable member of the team.

There will continue to be individual frustration within institutions where the pharmacist practices as part of the pharmacy department. No position in any institution can be ideal in every respect. All positions have good and bad functions, because specific tasks must be performed for the patient's total care. As cost containment gathers force, hospitals will be forced to cut programs to reduce expenditures. Obviously, as most physicians will tell you, we cannot cut in the nursing department. Dietary will be fairly secure because we will not stop feeding patients. Radiology and laboratories will not be cut, because physicians feel they cannot diagnose without these services.

This leaves pharmacy, physical therapy, environmental services, operating rooms, and maintenance most vulnerable to cost-reduction efforts. Pharmacy will have to manage its operation very carefully. Pharmacists will need to know how to manage and how to budget, and they will have to justify existing services and positions as well as new programs and services.

There will be a number of large departments of pharmacy where the directorship will be split. A professional director will supervise and direct professional services only, and a nonprofessional director will handle other management functions, such as procurement, charges, inventories, and personnel management in nonprofessional matters. This nonpharmacist director will have a specialized education, such as an M.B.A. degree, and will exhibit skills in these types of responsibility.

I believe that a pharmacist, regardless of his degree or where he practices, is still a pharmacist; it can be no other way. Many pharmacy leaders have concurred and believe that we should have only one, big organization. This has not been and, without modifications, will not be the solution. We must realize that any one organization cannot be responsive to the different needs of this multifaceted profession.

Yet, we will find that we have to unite. Pharmacists must establish a successful umbrella organization comprised of a group of more specialized organizations that do not compete with one another and that can work together without requiring membership in several organizations. Whatever the names of these organizations may be, their objectives will be the welfare of *pharmacy* and the assistance of *pharmacists* in serving the public, regardless of the ways in which they provide such services.

The actual role of the institutional pharmacist has yet to be recognized by the public. By 1984, the Society will embark on an extensive program of educating patients about the pharmacist's contributions to their health care in the institutional setting.

Let us review the Society's membership and future trends. The current membership is over 18,000. Of this number, approximately half are active members and the rest are first-, second-, third-, and fourth-year pledges, students, and others. With the ASHP programs and services now being provided, I predict that the total membership will level out at 21,000. However, if the Society is successful in broadening its role through extending institutional practice into home health care, I then predict that by 1987 our total membership will be 25,000 and by the year 2000 it will be

40,000. There will be an amazing shift of membership categories by this time. A large number of the members will be technicians and technologists, representing individuals with two levels of training and legal recognition.

The technologists will be legally recognized as associate pharmacists. A number of schools will be offering programs for two-year technologists or associate pharmacists by 1986. By 1995, there will be at least 42 states licensing these individuals. Technicians, however, will continue to be trained in institution-based or noncollege programs and will have certification recognition by many state boards of pharmacy.

The ASHP must continually review its responsiveness to the practitioner's needs. As the ASHP gets bigger, members may perceive that the Society has become more remote. Even with our efforts through deliberations of the Councils, SIGs, and the House of Delegates, we must continually reexamine our organizational structure to determine if it truly is responsive to the interests of the majority of practitioners.

The Society has to become even more active in the legislative field, but the state societies will have the greatest opportunity and need for legislative involvement. The ASHP can only continue to stress and assist in sensitizing members to the importance of local and state involvement. The members themselves must actively encourage state chapters to increase awareness and participation in legislative and agency regulatory matters.

As a reminder of the Society's growth over the last 25 years, let me cite several treasurer's reports. In 1955, when I was vice president, Treasurer Sister Mary Rebecca reported an income of $11,250 and expenses of $13,515 with a savings account of $1,020. In 1963, when I was president, Treasurer Sister Mary Berenice reported the income as $303,432 and expenses of $317,325. In 1968, my first year as treasurer, I reported an income of $883,985 and expenses of $874,023, while the 1979 income and expenses will exceed $4,080,000. The treasurer's report in the year 2000 will report an income and expenses of over $20 million or, possibly, as high as $25 million. With the many new membership-directed programs, ASHP dues will be $215 per year by the year 2000.

Hospitals will embark on communication programs directed to the public that are based upon sound marketing principles. Hospitals will be forced to listen to patients, their families and friends, and consumer groups and then to respond by providing imaginative, appropriate, and useful health programs. Many hospitals will establish regional and local advisory groups, as well as being required to respond to citizen awareness groups.

I believe that the 7000 hospitals existing in 1979 will decrease to 5600 by 1990 and to 5100 by 2000. Hospitals will not be necessary in every small town, but those hospitals that do remain will expand and prosper by referrals from the ambulatory health centers that will be operating in the small towns.

Consumers will continue to demand improved regulatory protection as drugs and services provided by the pharmacist are more closely scrutinized. The pharmacist will become more responsible for drug product selection, less concerned about trade names, and more knowledgeable about bioavailability and quality consistency, and

will improve patient compliance by proper counseling, recommend appropriate drug therapy, and control the delivery of that product to the patient.

The successful institutional pharmacy practitioner of the future will benefit from:

1. Improved education, including individualized residency programs,
2. Commitment to a total pharmacy service, including specialized services,
3. Commitment to membership support of the ASHP in return for broader organizational support and services to the members, and
4. Changes in expectations of practice from physicians, colleagues, and the public that will open entirely new roles and opportunities for our pharmacists.

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

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