



*“We have rededicated ourselves to a professionalism
which finds its fulfillment in serving.”*

=====**MARY JO REILLY**=====

(1984)

At the time she received this award, Mary Jo Reilly was Senior Vice President of the American Society of Hospital Pharmacists, Bethesda, Maryland.

Old Dreams, Young Hopes

Having celebrated my 20th anniversary as a member of the ASHP staff last March, I began several months ago a journey of retrospection that has helped me to formulate the thoughts I will share with you this evening. If I struggle to find the words and the proper voice to express those thoughts, it is not a dilemma of language but of emotion and persona. There are many in this audience and on this dais to whom I am grateful for having always tried to make the mountains seem low; the crooked, straight; and the rough places, smooth. Between us there is a depth of understanding that words need not reach, perhaps cannot. For me and for my family, thank you all for sharing this evening with us.

You honor this evening, in a break with the Harvey A. K. Whitney Lecture Award tradition, not an innovator but an implementor, a facilitator, an enabler. And in so honoring me, you honor all ASHP staff—past, present, and future. All our staff bear their white ribbons with pride and with few aspirations to anything but utility.

I have had on my desk for many years a quotation by William Blake, “He who

would do good must do it in minute particulars . . . For art and science cannot exist but in minutely organized particulars.”¹ I and many others of our staff have tried to serve our profession in minute, organized particulars.

I have been privileged to work side by side with six past recipients of this Whitney Award. I know personally and have worked in a variety of capacities with more than 20 others. These associations and those I have had with so many ASHP officers, Board members, leaders, and members have afforded me a unique perspective on the continuum that is ASHP and American hospital pharmacy.

The Society is 42 years old this August—middle aged. Middle age is a complicated thing. It means growing up; it means being at the heart of the matter; it means it is time to reexamine the past and replot the future. It can be a time for reorientation or for a last grand fling at the fading fantasies of youth.

There is a certain insistency in middle age. Time becomes quite different. The sense of “this is it” bullies us into a state of semiorganization. It is not enough to “plan” to stop smoking, get in shape, or get straight with the underwriters. We must do it now. We become more aware of the challenge of simple maintenance. The back must be bent with discipline or cease to bend at all. We begin to appreciate the long view. We begin to understand the meaning of phrases such as “it takes time” and “set in your ways” and “you have your whole life ahead of you.” I suppose the difference between middle age and the next, less agreeable, stage is the fact that in middle age we can still believe that next year will be better.

In the fifth decade of its age, ASHP is undergoing its expected midlife crisis. Crisis connoting not a catastrophe, but a turning point, a crucial period of increased vulnerability and heightened potential. Those who pioneered our professional Society and our practice of hospital pharmacy fashioned a society and a practice dedicated to certain values, and those values have always been the center of life at ASHP. One role of a mature ASHP is to maintain that abiding sense of the past—to be the custodian of the dreams. ASHP must hold the old values while we collect the new, young hopes. Dreams and hopes, old and new, must be matched to the possibilities for progress as we present a confident face to the future.

The challenge is to sort out the qualities we want to retain from our childhood models, to bind them with the qualities and capabilities that distinguish us now as a mature profession, and to fit all of this back together in broader form.

The original 1942 ASHP Statement of Purpose, which served us so well in our youth, was revamped into a new constitution and bylaws in our 21st year, 1963. For more than 20 years, the 1963 documents offered us, through our young adulthood, a certain stability and a set of commonly accepted professional and cultural values. But life is a continuum, not an accumulation, and “well enough” will rarely let itself be let alone.

For those of us who have grown up with the Society, our perception of ASHP does not change much as time passes. After all, we are always with ourselves, peering into the mirror most mornings and evenings, and changes come slowly, with subtlety. If we run across a photograph of ourselves—or a membership or budget report—of 10,

20, or 30 years ago, we are reminded of how much we have changed; but once the picture is out of sight, it is quickly out of mind.

A mature ASHP has earned the right to new sensations, emotions, and opinions. We do not have to bend with every political or cultural wind. We do not have to believe that the world was invented in the 1960s. We can allow others the fierceness of their opinions and the right to be inconsistent—just as we allow ourselves to be inconsistent. That tolerance is a function of maturity. We have more reference points now than were available to us 20 years ago. We have a better sense of what is temporal and what is enduring than we had 20 years ago.

In our 40th year, we began a revision of ASHP's governing documents. Throughout this project, we have embraced our original purposes and values and at the same time reexpressed our mission as a society in relation to contemporary needs. We have rededicated ourselves to a professionalism which finds its fulfillment in serving. We are committed to fostering rational drug use and pharmacy practice innovation in pursuit of quality patient care. Such a goal cannot be achieved by people who are afraid to pay the cost, feel the exertion, stretch, change, move, and accept the pain that may be involved. We must help each other respond to the demands and responsibilities of our success. We rely on the vigor of each member's contribution.

Perhaps it is my own middle age—my 20th anniversary with ASHP, planning for the 25th reunion weekend of my pharmacy school class—that has set me on this course of looking both backward and forward. I recently realized, too, that all my favorite young movie stars—Jane Fonda, Robert Redford, Dustin Hoffman, Mary Tyler Moore—are 46 years old. “Oh well,” said I, “1937 was a very good year.”

In hospital pharmacy, in 1937, Spease offered at Western Reserve University the first academic program combined with a residency. The first hospital pharmacy residency program, conducted by Harvey A. K. Whitney, was already 10 years old. Whitney, in 1937, had his residents attend clinical staff conferences, grand rounds, and autopsies—an unusual occurrence in a hospital in 1937 and a dream, perhaps, for the future of pharmacy by a man whose vision became his legacy.

The very first Whitney Lecture I ever attended was in 1960. Tom Foster was the recipient of the award, and the title of his lecture was “The Expanding Role of the Hospital Pharmacist as a Member of the Health Care Team.”² Mr. Foster envisioned participation in clinical research; leadership in disaster planning; involvement in the development of intelligent, practical, and economic prepaid health care plans; and leadership in confronting the socioeconomic challenges presented by geriatric and catastrophic disease problems. He saw in the future hospital pharmacists playing a vital part in formulating public and professional opinions and attitudes on health issues. His 24-year-old dream is reiterated in the hopes of today's practitioners.

For many of us, it is only the present that matters, the imposition of the dreams of others and the struggle to realize our own. But if we examine things more closely, I think we shall find that tradition and irony have their own system of circulation, their own sense of fulfillment and surprise. What we describe as change is really continuity. The answers of one generation become the questions of the next. Let me describe

what I mean by using as an example an area of practice close to my own heart—drug information services.

As the ASHP was founded in 1942, one of its stated objectives was “to disseminate knowledge by providing for interchange of information among hospital pharmacists and members of allied specialties and professions.” Information service of some description, then, was identified very early in our Society’s history as a basic value of our profession.

As early as 1945, the editor of the *Bulletin of the American Society of Hospital Pharmacists*, Don Francke, editorialized, “The pharmacist should be a consultant to the physician.”³ Until the early 1950s, though, emphasis in hospital pharmacy was on integration of pharmacy with administration and on providing services to nurses. In the 1950s, our literature began to reflect ways the pharmacist might function in programs of drug evaluation, thus providing more service to the medical staff. In the mid-1950s, the audit of pharmaceutical services in hospitals (*Mirror to Hospital Pharmacy*) first showed that drug information services were provided or that pharmacists would like to provide these services in a very high percentage of hospitals. The audit recommended:⁴

that hospital pharmacists more fully recognize the importance of their role as consultants on matters pertaining to drugs, that they commit themselves to the task of improving their ability to assume this role, and that they make efforts to assemble and organize the bibliographic resources to enable them to perform this function

By 1959, two important documents were under development, and between 1959 and 1964 these were adopted by ASHP in conjunction with other organizations including the American Hospital Association, American Medical Association, and American Pharmaceutical Association. The *Statement on the Pharmacy and Therapeutics Committee* and the *Statement of Guiding Principles on the Operation of the Hospital Formulary System* formally acknowledged agreement among the medical and pharmacy professions and hospitals that achievement of rational drug therapy requires an organized program, that drug information services are essential to the conduct of this organized program, and that the pharmacist has prime responsibility for these information services.

Our professional literature around the time these official policy statements were being developed suggested some specific types of drug information services—some dreams and hopes of the late 1950s and early 1960s—making ward rounds with physicians; evaluating manufacturers’ literature; assisting in double-blind, placebo-controlled studies; and consulting in pharmacologic problems and therapeutic problems such as therapeutic uses, therapeutic equivalents, and comparisons.

The study by Barker and McConnell at the University of Florida in 1961,^{5,6} confirmed by studies of Heller and Barker at Arkansas⁷⁻¹² and Tester, Black, and colleagues at Iowa,¹³⁻¹⁵ showed that the incidence of medication errors in hospitals was much higher than anyone had realized. These studies also suggested the value of having pharmacists working more closely with physicians and nurses and knowing

more about how and why drugs were being prescribed and how they were handled on nursing units. These studies led to the advent of unit dose drug distribution systems, which freed the pharmacist to associate with physicians and nurses—to leave the pharmacy and follow the drug, to investigate what went on in nursing units and patient care areas. Hand-in-hand with unit dose systems were development of pharmacy-based IV additive programs, receipt of physicians' original orders by the pharmacy, and development of patient profiles.

A group of practitioners examining and improving the distributive aspects of institutional practice intersected with the group interested in drug information services, each making a unique and necessary contribution to modern pharmacy practice. Practitioners who shared basic values were pulling together in the same direction.

Pharmacists were now out of the pharmacy because of improvements in distribution systems. Realizing the improvements in patient care that would result if drugs were used more intelligently and armed with the official sanction of involvement in therapeutics, the pharmacist as drug information expert came into his own. The clinical need for drug information was identified and characterized, and practical techniques and services were developed to provide support of rational therapeutics. The early drug information pharmacists helped us gain access to the total drug use process and therapeutic decision-making.

One of the primary characteristics of the health practitioner's need for drug information is the random manner in which it occurs. Usually, physicians, nurses, and pharmacists need information in relation to a specific problem in a specific patient. This need for information is best accommodated by data, not by documents. Ideally, drug information should be available in time to be used in making decisions about treatment of the patient.¹⁶

Any response to the drug information needs I've just described must involve several components. Considerable effort must be exerted in developing an information store. Some method must be developed to retrieve bits of data about drugs in a short period of time and, similarly, specific patient data must be available to the decision maker. A specialist is needed to organize and centralize existing drug information and to assist in selection, coordination, and dissemination of information.

By the mid-1960s, there was a cadre of pharmacists who considered themselves drug information specialists. In 1964, the ASHP held a Special Conference on Drug Information Services in conjunction with ASHP's Committee on Drug Information Services. This Conference and subsequent committee meetings signified the early recognition of a clinical role for the hospital pharmacist and the changing character of drug information needs that accompanied the pharmacist's increased involvement in direct patient care.

This contribution by drug information pharmacists set the course for a generation of practitioners and offered us hope for a new kind of pharmacy practice. It suggested new ASHP products and services, new guidelines, statements, and standards of practice.

It has been said there are three ways to get something done: do it yourself, hire someone, or forbid your kids to do it. Our profession's "kids" in the late 1960s and

early 1970s would not be denied. With determination, our kids aspired to use their drug knowledge to contribute to quality patient care and to become respected members of the health care team. And they did. It has been a decade since the fever of pharmacy's youth culture burnt for itself and for our profession a unique and permanent place in American health care. While there is no antidote for that special enthusiasm of youth, many doors had to be opened by those in the practice establishment, who recalled their own dreams for our profession. Your professional Society developed standards of practice that incorporated principles that were once dreams, then hopes, and, finally, realities. At that important crossroad, we all saw a path to a new beginning—an opportunity to make ourselves more.

Through ASHP you have recently revised the 20-year-old statements on the formulary system and the Pharmacy and Therapeutics Committee to make them more contemporary. We no longer have a separate statement on the hospital pharmacist and drug information services—that concept has been incorporated into all of our standards of practice. Indeed, the Report of the Study Commission on Pharmacy in 1975 concluded that pharmacy should be conceived basically as a knowledge system and suggested that the greatest potential for our profession is in developing, organizing, and distributing knowledge and information about drugs.¹⁷

It is quite an amalgam of old dreams and young hopes that together sum up the complicated experience of middle age. As a society and as a profession, we are finding that middle age has some advantages, or at least some consolations. There is a perspective that age alone affords. While vigor may wane somewhat, so do the foolish purposes in which it was sometimes employed. The presumed slights that were once so affronting in adolescence and young adulthood are suffered more tolerantly in the middle years. Conclusions are not reached in haste. The generation that so hotly contested the issues of the sixties and seventies is now given to long looks and sober consideration.

Middle age is a period of transition. It can be a period of reevaluation, a period of new hopes, or a time of early despair. It represents an opportunity for reflection on our dreams and hopes, for gauging our further course in life.

One of the major challenges of our middle age is the computer and related technology and the transition it is causing in all our lives. Continuing with my drug information service example, computers and related technology have changed substantially the way we now approach information-handling needs. Fresh tracks must be laid, novel approaches taken to enable us to work the available technology we know is at our disposal. Beginning with large-scale computational and business applications, the use of computers has spread to information retrieval and database management. At ASHP, we have developed a host of drug information resources and conducted instructional programs to help advance a practice in transition. We have recently announced the availability of our new generation of drug information resource—Drug Information Fulltext—an on-line database service geared to management of an impressive store of drug information and to rapid retrieval of data of a random nature. The experts tell us that in the future we will see a proliferation of knowledge-based

systems such as Drug Information Fulltext, the “expert systems” that are intelligent computer programs using knowledge and inference procedures to solve problems difficult enough to require substantial human expertise.

Pharmacy will be one of the professions regularly using computers. We are confident that a computer is just another tool to help us do our jobs. Such diverse professionals as lawyers, engineers, librarians, and medical practitioners all use the computer with equal facility, not because computer science is part of their academic training but because their basic communications skills are well developed. In an information-oriented age, we must be able to communicate ideas, problems, descriptions, and solutions. We must be able to speak and to write concisely, to express ourselves clearly. As an editor, it seems I’ve been making that same plea for years and years. If we are to remain respected health professionals, we must be able to communicate effectively. It is a basic challenge of our times to improve our education system in many areas, but none so important as linguistic and logical skills.

One final comment.

We hear so much today about containing health care costs. Every day we hear, “Health care stands out as the single most inflationary factor in the American economy today,” and “\$321 billion annual cost of health care delivery—10% of the gross national product—is too much.” How are we to decide how much is too much to spend on health care?

The successes of the medical system are being dealt with in the political system. Everyone agrees our resources are not unlimited. The problem of increasing costs will only worsen as research labs, pharmaceutical companies, and makers of diagnostic equipment continue to turn out new methods and new products. These innovations can help save lives that are now doomed, but they will make tomorrow’s health care costs even higher than today’s.

Today’s care is complex, sophisticated, and effective. Our system of health care offers achievements, capabilities, and hope once deemed unobtainable. As John Alexander McMahon of the American Hospital Association has pointed out, we have set a high and visible standard and created an expectation of quality from which we cannot now retreat.¹⁸

What we must strive to achieve is the same and better quality for less money. Our ability to do that will depend on all professions, and indeed all individuals throughout the system, altering their behavior and targeting, refining a bit more sharply, their role in the system. We must trim the excess without cutting into the essence. We must above all maintain a caring environment in the face of technological assault. Any endeavor of the healing professions is valued because of its ability to affirm the dignity of the human person and life and to build a human community by its respect for the sanctity of human relationships. There must be a heightened sensitivity among all health professionals to the dignity of patients and their families.

As a mature profession, we have an obligation to arrive at and take responsibility for those difficult, uncomfortable decisions that must be made as we take a hard look at the complex of problems associated with cost versus quality.

ASHP's new governing documents state that ASHP was formed "to foster rational drug use in society such as through advocating appropriate public policies toward that end."¹⁹ As one of the sobering responsibilities of middle age, ASHP has an obligation to take this more active role in the public policy debate. You, as individual members of a mature profession, must do the same.

Patient protection in all drug-related areas will be a continuing need. "High-tech" drugs providing specialized therapy tailored to individual patient needs will be highly beneficial but very expensive. Pharmacists will need to take a proactive role in drug use policy development, analysis, and enforcement. Important issues are going to be determined by someone: why not by those of us who are best qualified to present a balanced and patient-centered perspective? Middle age is the time of maximum influence—of necessary thinking by knowledgeable people. Now it is time that we claim the authority we have earned.

We must see to it that our public policy decisions are based on wisdom and morality, not expediency. We must provide that deeper and more comprehensive perspective that goes beyond pure science and technology.

Whatever our decisions, they must be made in a caring atmosphere. That is the health professional's contribution to the decision process.

And what if we continue to be successful in saving and prolonging more lives at an acceptable financial cost? Finding the solution to a problem changes the nature of the problem. The next challenge will be in evaluating handicapped or impaired persons—those with transplants or with implantable pumps, those with serious illnesses who are undergoing successful long-term treatment—and restoring them as functioning members of society. What are the medical requirements for handling these workers, and what physical adjustments to the workplace are necessary? We need more creative approaches to employment of the handicapped and a review of public policy issues and the responsibilities of employers and employees.

It's a dilemma. No matter how much we do, we will never do enough. And what we don't do is always more important than what we do.

One of the real hazards of middle age is having to view the world through bifocals. Near and far vision are quite clear, but the midrange is blurred, the image jumps. There is that distance between close up and far away that bifocals don't correct for at all: speedometers, prices on supermarket shelves, papers across a desk.

Exactly how we approach the tough issues of the next decade may be a little blurred right now, a jumpy image. One thing is certain: our leaders must call forth the creativity from us all. They must listen with an understanding ear, speak with simplicity and directness, and give value to the presence and contributions of all. As a society, we must reaffirm the goodness that we have been, we are, and are becoming.

Above all, we must refuse to be victimized by apathy and discouragement. We must avoid a climate of undue seriousness and apprehension, even though we live in an anxious age. There must be room for joy and celebration and laughter and good fun as we go about the serious tasks we have undertaken.

For life is about getting better. Ideally, we have learned from our past. We keep

moving forward, seeking out new ways of doing things, new things to do. We have learned that willpower and intellect alone do not overcome all obstacles. We have some experience now with many techniques for facing challenges and change; we have modified many of the assumptions and illusions of youth. We are willing to make a few mistakes and to learn from them. We cannot deny what experience has taught us. The best we can do in life is to discover what we are good at and then build on our strengths. We come to approve of ourselves quite independently of other people's standards and agenda. We have given each other the courage to experiment with our lives and have arrived at a point of dignity worth defending—we have achieved a measure of integrity. Mind and heart can at last be united in judgment, and it is this improvement in the exercise of judgment that is one of the most reassuring aspects of middle age.

Many have contributed to our profession and to our professional Society to bring us to a secure and stable middle age. Hubert Humphrey once said, "before the reality lies the dream," and how obvious that is as we view our own rich heritage as a profession. There are still needs unanswered, unresolved, unextinguished. It is for the future to fulfill those hopes.

(For the complete list of references cited, please see page 1535 of the *American Journal of Hospital Pharmacy*, Aug. 1984.)

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

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