



“I believe that pharmacy will be at health care’s center stage in the next century, and that there will be a standing ovation and rave reviews.”

===== **WILLIAM A. GOUVEIA** =====

(1999)

At the time he received this award, William A. Gouveia was Director of Pharmacy, New England Medical Center, Boston, Massachusetts.

At Center Stage: Pharmacy in the Next Century

In the next century, I believe that we will have the opportunity to bring our profession to the center stage of health care. While some have thought of us as stagehands, in the new century we will have the opportunity to become key players in managing patients’ drug therapy. Pharmacotherapy has become more complex than ever before, with patients being given more and more drugs to manage their acute and chronic diseases. In addition, patients routinely consume nonprescription drugs, herbal remedies, and dietary supplements. Access to information

about drugs has increased enormously, and online pharmacies are beginning to have an impact on the provision of services.

I will explore some of the actions we might take to bring ourselves to center stage of health care, who the key actors will be, and who might author the drama. Will the playwright be a patient, a physician, a pharmacist, another health care professional, or corporate America? Will we as a profession step forward to write the pharmacotherapy play? We have both the skill and the public trust to craft a spellbinder of a play in which we also have a starring role.

The medicated society

Samuel Proger, former physician-in-chief of the New England Medical Center, edited a book titled “The Medicated Society” in which concern was expressed about the enormous quantities of prescription and nonprescription drugs in use in the 1960s.¹ The consumption of medications in the years since Proger’s book has not only not abated, it has escalated. In fact, new prescription drugs are being introduced at such a bewildering rate that prescribers cannot possibly command a full knowledge of the available medications. Consumers—our patients—hear about new drugs each day through the news media. Seeking quick relief from their ailments, they come to us with a request for a new drug before we can develop a knowledge base on it. The marketplace for prescription drugs is increasingly competitive, and the available therapies carry greater rewards and risks than ever before.

The story does not end with prescription drugs. Advertising has increased demand for nonprescription drugs, herbal drugs, nutritional therapies, even homeopathy. Use of tobacco, alcohol, and illicit drugs is still widespread in the United States. Who knows what combinations of agents our patients are using? And who knows what the consequences are?

We do know that drug therapy is costly, and that costs are rising faster than in any other segment of health care. In 1998, Americans spent about \$94 billion on prescription drugs²; in 1997 they spent \$16.6 billion on nonprescription drugs³ and an estimated \$27 billion on alternative and complementary medicines,⁴ for a total of \$137.6 billion. Calculations of the cost of drug therapy should include the cost of negative consequences, which may equal what the drugs themselves cost.⁵ Further, drug costs have been increasing at the rate of 15–20% per year in the United States, fueling increases in the cost of prescription drug benefit plans. Some have predicted that, early in the next century, drug costs will exceed hospital inpatient costs for many health insurers.

Not only has the amount of drug information increased, but access to that information has grown explosively. Today ordinary people have only to power up their personal computers to learn about the latest therapy. The Internet is available to health care consumers, licensed health care professionals—and modern snake-oil salesmen as well. Without regulation of the Internet as a drug information provider, sources vary widely in accuracy, completeness, and independence from promotion.

Some \$1.3 billion is now spent on direct-to-consumer advertising of prescription drugs.⁶ We know that such advertising can have the effect of turning magazine read-

ers and television watchers into “diagnosticians” seeking treatment for ailments they did not even know they had. Direct-to-consumer advertising might or might not represent medical need, good therapy, or effective use of scarce health care dollars.

Drugs are now available from a greater variety of sources than ever before. Community, chain, and mail-order pharmacies; food stores; department stores; large discounters; herbalists; nutrition stores; and new online pharmacies all sell drugs to consumers. We have increased the number of sources of medications and at the same time increased the distance between the consumer and the pharmacist. The days of the friendly corner drugstore are over, yet consumers continue to declare us their most trusted professionals. Is this image of the corner druggist what the public still has in mind when it refers to pharmacists as trusted professionals?

If drugs are the props, and health care professionals are the actors, who might be the playwright of this pharmacotherapy play? My concern is that the play might be written by large corporations and not by health professionals. The pharmaceutical industry has become globalized and is represented by fewer, larger companies. Similarly, the consolidation of chain pharmacies in the United States has resulted in only a handful of retailing giants. One of them recently diversified into the pharmacy benefit management business in an attempt to increase its impact on the prescription drug market. In many areas of the country, successful independent pharmacies are hard to find. Some drug wholesalers have expanded into health care conglomerates. Providers have also consolidated, so that in most health care markets there are but two or three integrated health systems. There are only a small number of health insurers in most regions as well.

The corporatization of health care is not all bad. However, as these companies grow, the distance between their corporate leadership and the consumer widens, and their tendency to influence health care decisions formerly made by health care professionals, including pharmacists, becomes more pronounced.

Drug discovery is the principal research mission of pharmaceutical companies. They fund clinical trials conducted by contract research organizations. Many such studies are conducted in hospitals, which profit from them. Pharmaceutical manufacturers seek medical and pharmacy thought leaders to conduct studies of new drugs, and they hire our best clinicians to serve as medical science representatives to assist decision-makers in their formulary and patient-specific decisions. The pharmaceutical industry is now a major provider of drug information that goes well beyond what the “detail man” of the past provided. This is not all bad either, but I believe that patients and prescribers should be fully informed of the economic influences, if any, on sources of drug information they may consider using. Similarly, patients and prescribers should not rely on the company-provided information alone. The various information sources must be balanced so that consumers and providers get the complete picture, both positive and negative.

Getting to center stage

Given the scene I have described, how is pharmacy going to get to center stage? We cannot develop the props or write the whole script, but we can be skillful, knowledgeable players who have our patients’ best interest in mind, and whose value will therefore be impossible to deny.

A set of interrelated challenges face us. In the remainder of this address I will, first, describe what it will take to maintain the public's trust at high levels. Next, I will discuss how we might develop systems of care that ensure a high quality of drug therapy. Then, I will propose a means of involving not only clinicians but managers in drug therapy and patient care. I will conclude with a charge to pharmacy to put pharmacists at the center of the health care stage.

Keeping the public trust

Since we do not understand precisely why we have been held in the public trust year after year, we must work harder than ever to keep that trust. We must place our highest priority on increasing the amount of time we spend with and on our patients. I define such time as time spent face-to-face with patients, time spent solving patients' problems with drug therapy, time spent teaching groups of patients about their drug therapy, and time spent with other professionals addressing patient care issues. I include in the definition electronic communication, such as responding to patients' inquiries via e-mail and voice mail and guiding patients in using the Internet, telemedicine, and telepharmacy to full advantage. We must help patients in their quest for timely and accurate information about drug therapy. We should consider e-mailing information to groups of patients with specific diseases on a routine basis. We might also evaluate Internet sources for patients and suggest which are credible and which are not. If a good source of information is not available, we should take the lead in developing one. It is worth asking whether nutritionists and alternative therapists, for example, are not seeking to fill voids our profession and medicine have created. Managed care has increased the number of patients each physician must see per day. Chain and even hospital outpatient pharmacies have increased their prescription volume, turning the pharmacist into an automaton, not a clinician. The distance between pharmacist and patient has grown greater than ever before, and if it continues to grow, we are likely to lose patients' trust.

We exhaust the public trust when we primarily involve ourselves in reducing drug costs. That is not to say we should not try to ensure that health care dollars are spent intelligently and responsibly. Rather, such efforts should not be the principal duty of pharmacists. The drug cost issue is indeed a complex one, and we are well suited to help patients, prescribers, and insurers gain maximum value from dollars spent on drugs. This activity is best performed by pharmacists who have full knowledge of a patient's drug therapy and not by those whose goal is to reduce the cost of a single prescription.

More and more medications are highly priced. Some are highly prized in terms of their benefit to individual patients. We must work with prescribers to determine when there is true value and when "highly priced" and "highly prized" are in synchrony. When we do not believe that to be the case, we must make our opinion known. Our goal must be to help patients balance the effectiveness of a drug against its cost. We must be the profession that seeks the rational use of drugs, not rationalization of the high cost of drugs.

We must carefully review the sources of our education about new drugs. More than

half of our continuing education should come from programs that are not sponsored by the drug industry. Some programs meet FDA guidelines through educational grants to third parties, but the source of the funds is still the industry. While this may be a challenge for us, the search for truth in the patient's best interest requires that we seek out the most reliable, unbiased sources of information. Continuing education must be comprehensive and unencumbered, not simply convenient.

We should take the lead in measuring patient outcomes with standardized instruments. Questionnaires are available that ask patients to evaluate their satisfaction with care and their ability to function given their disease state. These tools have been widely studied, and now we must champion their use in evaluating the effectiveness of drug therapy. Such tools provide an excellent vehicle for us to discuss with patients their expectations of drug therapy and to determine whether patients are receiving true value from drugs on the basis of how well the desired outcomes have been achieved.

To keep the public trust, we must speak out when public policy discussions about drugs are taking place. We must seize as our issues such matters as antimicrobial overuse and resistance, Medicare coverage of outpatient prescription drugs, and the use of funds from tobacco company settlements for public health programs.

We should actively seek the right to prescribe medications in collaboration with physicians. In doing so, we may invoke the wrath of organized medicine, but my experience has been that individual physicians often prefer our help in prescribing. In many instances, pharmacists are the professionals most qualified to prescribe drugs, yet several other nonphysician groups have gained legal authority to prescribe while we wait patiently for this right. We need to study carefully the circumstances in which we are prescribing under protocol and collaboratively with physicians. There are many areas where we can be involved in prescribing, monitoring, and adjusting medication regimens.

I recommend that each pharmacist calculate his or her own "patient trust quotient." Does our documentation of care indicate that priority has been given to spending time with patients? Is this a priority in residency training? Ultimately, we will be richly rewarded for the time we spend with patients. Patients are less concerned with how we refer to what we do—as clinical pharmacy, disease management, pharmaceutical care, and so on—and more concerned with how we use our energies on their behalf. They are the best judges of how well we commit ourselves to them.

Systems of care that ensure quality

A good cast must be able to act day after day in a consistent, high-quality fashion. What systems do we have in health care that ensure a high quality of care? What investments have we made, and should we be making, to develop fail-safe systems of drug management? Should our patients expect any less? Would you?

Health-system pharmacists must assume leadership in setting the quality-of-care agenda. We have spent a great deal of effort and money on developing comprehensive health systems. The reality is, however, that with few exceptions we are still caring for patients in the way we always have. Development of the agenda on quality must reflect answers to some key questions.

Have we developed information systems for managing medication therapy across the continuum of care? Many health “systems” are little more than collections of disparate organizational units. They need to give attention to proper medication management, since drug therapy is central to each segment of care from primary to tertiary. We must improve therapy in each segment of care and in the transition from one site of care to another. There are few health care problems that are not addressed today in whole or in part by drug therapy. In most cases, drug therapy is the thread that holds together the fabric of health care. We urgently need information systems that will help us manage all of a patient’s drug therapy.

Can our systems of care obtain information on virtually all the drugs our patients are taking? There are effective electronic means of maintaining a complete medication profile on each of our patients. Privacy and confidentiality of health information are of paramount importance, and patients alone should dictate who has access to information about their health. There are a wide variety of sources of information on drug therapy, including hospitals, community pharmacies, pharmacy benefit management companies, and online pharmacies. Patients often switch providers, health systems, insurers, and pharmacies; to properly manage their drug therapy, we must convince them that we need a single, comprehensive database on the drugs they take. Patients trust financial advisers to ensure their long-term fiscal health. We must be the ones responsible for their pharmacotherapy “portfolio.”

Do our health systems take a patient-focused view of the provision of care, and are initiatives to improve the quality of care high on our agenda? The pharmacist is best equipped to make a drug therapy decision at the level of the individual patient. Vertical integration of health systems is important, but an understanding of what it takes to prescribe, dispense, administer, and monitor drug therapy in all settings of care is crucial. Do our health systems balance pharmaceutical care resources, drugs, and pharmacists? Have we analyzed patient medication-related needs to be sure that we have the right balance of resources in each segment of care? We traditionally have had more resources in the acute care segment than in the non-acute care segment. Do we have quality measures to support that use of resources?

Pharmacy managers and patient care

Hospital downsizing and health-system integration and reorganization have taken their toll on pharmacy managers. The rapidity of change has left some managers feeling disenfranchised, dispirited, and separated from patient care and hence their profession. Well-defined pharmacy career ladders exist in few organizations these days, and many practitioners no longer aspire to management positions.

One way to respond to the growing isolation of pharmacy managers from patient care, and to help meet the goal of comprehensive, high-quality, individualized care, would be to start pharmacist patient rounds. Such rounds would bring together pharmacy clinicians and pharmacy managers to discuss cases. The patient, too, might be involved, if this is feasible. By including both clinicians and managers in these rounds, there would be a mechanism for bringing all available pharmacy expertise to bear on a patient’s needs. For example, by including managers, discussions could be broad-

ened to include economics, health insurance, continuity of care, and quality of care. Managers would become more grounded in the patient care process and would, in turn, achieve more useful roles as institutional leaders.

Pierpaoli⁷ spoke of pharmacy's "bilingual" nature—of the profession's unique combination of clinical and business skills. Managers who regularly participated in pharmacist patient rounds would be more effective on pharmacy and therapeutics committees and would better represent the health system in negotiations with HMOs.

By also involving pharmacy residents and students in such broad discussions, we could widen their perspective on drug therapy beyond the often myopic framework of drug therapy decisions. We need to instill in our bright young leaders of the future the aspiration to care for the whole patient and to take on both clinical and financial issues.

By focusing pharmacist patient rounds on the specific patient populations served by our health systems, we could constructively address the special health needs of those groups. An example of such a population with special needs is the elderly. No group of patients benefits more from drug therapy than the elderly; conversely, no group is more dependent on medications. The elderly are also highly vulnerable to economic pressures related to drug therapy. The lack of Medicare coverage of outpatient drugs is a serious problem for most elderly citizens, who are often reduced to choosing between drugs and food or other necessities. Pharmacists have much to contribute to the care of the elderly and to the science of geriatric pharmacotherapy. When might an antidepressant affect compliance? When might poly-pharmacy affect renal or hepatic function? When might economically driven rationing of drugs detract from therapeutic gains? When might substitution of a less expensive drug not be in the best interest of a confused patient, who capitulates to this decision without benefit of having a knowledgeable advocate?

Our audience

The audience of our pharmacotherapy play is a large and broad one. It includes the following groups, all of which we must keep interested in our play:

- ▶ Patients and families who have experienced an adverse drug event, and who know that drugs can have significant risks as well as benefits.
- ▶ The elderly, for many of whom drugs are an essential element of daily life.
- ▶ Members of Congress debating Medicare coverage of prescription drugs—one of the most important political issues of the day.
- ▶ Health-system and HMO administrators, who realize that the management of drug costs is vital to their organizations' financial stability.
- ▶ Physicians, who know the importance of drug therapy and of pre-

scribing the right drug for their patients.

- ▶ The public at large, which increasingly is exposed to media-provided information and advertisements on drug “discoveries” and nontraditional “therapies.”
- ▶ The pharmaceutical industry, which must continue to develop and market drugs in an increasingly competitive global marketplace.
- ▶ Pharmacy educators, who must provide good scientific and clinical training to students and who must teach new professionals to care for and about patients.

Conclusion

By tradition, pharmacists are a shy, reticent group. We are not accustomed to participating in tryouts for a leading role in a major play. We are uncomfortable seeing our names brightly lit on a marquee. We talk often about being members of a health care team, less often about being leaders of that team. We have been content with supporting roles in a health care play written by others.

Can we bring every ounce of our skill and knowledge—clinical, administrative, even political—to bear on this confluence of heightened interest in drug therapy? Can the superb training of our young pharmacists be brought to bear on the issues and problems of drug therapy? The clinical pharmacy and pharmaceutical care movements have stressed the importance of patient care to our profession. Can we translate this into reality in terms of the time we spend with patients?

Pharmacy is a true health care profession by virtue of its history, traditions, and contributions. Pharmacists know a great deal about how to manage pharmacotherapy and its costs. We must take advantage of our training and write our own script, assume starring roles, and drive home our message to audiences. The next century will bring great challenges to health care, and we are well equipped to respond to those challenges and continue to improve patient care. More than ever, we must believe in our profession and what it can do for patients. We must be passionate about our patients and their care, and not be bashful about expressing that passion to them and to providers, students, politicians—all the many people in our audience.

I believe that pharmacy will be at health care’s center stage in the next century, and that there will be a standing ovation and rave reviews.

Acknowledgments

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(For a complete list of references cited, please see page 1618 of the *American Journal of Health-System Pharmacy*, Aug. 15, 1999.)

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