



“. . .our practice must be based on the basic belief that pharmacy is ultimately not about technology, computers, budgets, or even drugs but about the people we serve and our genuine love, respect, and concern for them.”

== **Billy W. Woodward** ==

(2004)

At the time he received this award, Billy W. Woodward was President, Renaissance Pharmacy Services.

The Discontent of Professionalism: A Call in the Night

I want to thank the Southeastern Michigan Society of Health-System Pharmacists, ASHP, and the Harvey A. K. Whitney Lecture Award committee for this distinct honor. I am so very grateful but also humbled. I am humbled by the very thought of being considered among the list of recipients, all of whom I have respected and admired for what they have done for the profession and our patients. I am also humbled by the realization of how many others deserve such recognition, and I accept this award on their behalf as well.

After learning that I was chosen to receive this award, I reflected on the many colleagues and friends in pharmacy and ASHP who have contributed in so many ways to whatever success I have enjoyed. The list of people to recognize is too long, and I would regret leaving out even one person, so I just say “thanks” and hope to thank each of you personally in the near future. I must thank my colleagues in the Texas Society of Health-System Pharmacists and at the University of Texas for allowing me to serve many years ago.

As all of you know, when someone pursues a professional passion, there is always a price to be paid, in time, attention, and days spent away from home. I thank my staff at Methodist Hospital and Scott and White Health System, who for many years joined me in a wonderful journey based on a shared vision for patient care. We did some good and had fun, too. I must thank my mom, who taught me to never quit, and my dad, who taught me to treat others as I want to be treated.

Finally, I want to thank God for protecting our patients over many years from serious error and for allowing me to find my real passion while on the way to medical school. I want to thank my three children, Natalie, Billy, and John, for their love and support; they are my proudest achievement. Most of all, I want to thank my counselor, biggest fan, and best friend: my wife, Camellia.

A call in the night

It is the season for the annual budget battle, and this year seems even tougher, with more pressure to reduce drug costs and cut staff and vital programs critical to patient care. I am restless and tired but finally fall into a deep sleep, only to be awakened by a startling sound. It is the telephone, and Gladys, the night nurse supervisor, says, “Oh Bill, I’m glad I could reach you. We have had a serious medication error on the pediatric unit, and you need to come to the hospital right away!”

Minutes later I am in the truck, heading toward the hospital. Between prayers that the patient will be OK, my mind is flooded with a confessional litany of factors that could have contributed to such a serious error, the little concessions regarding hours of service, staffing levels, salaries inadequate to keep the most competent staff, daily checks and balances that somehow erode ever so slightly with the incessant budget pressures. I am also thinking of the advanced programs, like bar coding and expanded clinical coverage, that can prevent such errors yet are postponed each year as millions of dollars are reserved for bricks and mortar, as well as the latest diagnostic technologies and endless information technology projects. Suddenly I am feeling anger.

After arriving at the hospital, I quickly dash up the back stairs to the pediatric unit where I see nurses wheeling the patient out of the room toward the intensive care unit. It is a little girl, with a portable respirator seeming to overpower her small body. I get a horrible sick feeling, as she appears to be the age of my youngest granddaughter, Madison. I see her parents beside her, themselves looking very young and frightened. I then recognize that she is a cystic fibrosis patient named Amy McFarland. All of our staff has come to love and respect her as she struggles with chronic respiratory problems. We should be making life better for her, not worse.

The attending physician greets me by first name and then introduces me to the

parents before we briefly discuss Amy's condition. It seems that the parents and physician are looking to me, silently asking, "How could this happen?" They are kind enough not to say it, but they did not have to. They just want Amy to be OK and go home with them.

The physician and I then head to a conference room where a critical-response team has gathered to conduct a preliminary review. More than anytime I can recall, I feel very fearful, sad, and alone. It is clear that everyone is devastated by this event. The chief financial officer—the administrator on call tonight and the person who has hassled me constantly in recent weeks to cut staff—now seems very docile and genuinely concerned but makes no eye contact with me. The attending physician is a longtime colleague who has been an advocate for pharmacy with the exception of one conflict over some of our expanded clinical functions. Our eyes meet, and that issue now seems far, far away. The director of nursing and Gladys both show genuine concern, our occasional "turf battles" seeming unimportant now. The nurse caring for Amy can barely lift her head to discuss the details. My pharmacy staff members appear beaten and distraught while trying to be professional. As we begin our discussion, all eyes turn toward me. It becomes clear that the patient received the wrong intravenous antibiotic and had a severe allergic reaction. Because the pediatric satellite pharmacy was closed and the central pharmacy is understaffed at night, Amy's nurse elected to prepare the first dose, so the usual checks were circumvented. I have nothing much to say, because what happened could have been prevented had we only done the things we know we should have done.

Once Amy is stable, I reluctantly return home after leaving instructions to page me if her condition changes. After falling into an uneasy sleep, I hear a loud noise and reach for the pager on the nightstand, only to realize that it is the alarm clock. I shut off the alarm, sit on the edge of the bed in a cold sweat, and realize that it was only a dream. I quickly dress and settle into my favorite chair, breathe a deep sigh of relief, and start to think.

I think about the pediatric satellite pharmacy that was not open to check the patient profile and mix the first dose. I think about the bar-code syringe system that would have caught the error but was never funded and about the override procedure, which should never have been allowed, that gave the nurse access to the vial. This mistake would be recorded as a nursing error, but in our hearts we know that pharmacy has set the nurse up by the things we have failed to do.

I chose to share this because such dreams were common for me and the patients and issues were always real. I wanted us to feel the experience of a serious error and be reminded of how easily one can occur, even in our best health systems. Three messages are clear in this dream. First, when we put faces on our patients, we realize just how serious this business of pharmacy really is, with the potential for good or bad things to happen to patients on the basis of what we do or fail to do in our daily practice. Second, when we look around that conference table, it is apparent that nobody, not even those who seem to care more about bottom lines and egos, wants bad things to happen to patients. And third, it is brutally clear that the ultimate responsibility for drug therapy outcomes rests with the pharmacist. No one in that conference

room had the slightest interest that night in turf battles, clinical control, budget cuts, or contesting the pharmacist for final responsibility. So I want for us to consider that final responsibility, how we are doing as a profession in that respect, and what we must do to avoid a real call in the night.

Pharmacy's quality chasms

An Institute of Medicine (IOM) report in 2001 used the term “quality chasm” to describe the gap in quality practices in health care.¹ Pharmacy has its own version of such chasms, including the striking disparity between the sophisticated technology and clinical services in some hospitals and the lack of basic services in others, particularly in small, rural, and urban charity institutions. Another disparity lies within our advanced hospitals between the clinical care and quality checks available during certain shifts and for patients in some areas, such as intensive care, and the lack of basics in other areas like pediatrics, the nursery, and outpatient pharmacy. Our clinical services are often what I call hydromorphic in that, like water, we simply allow them to go wherever there is the least resistance rather than the most proven need. Our acceptance of these common gaps in care demonstrates a contradiction between our actions and words regarding what we consider to be the essential core of pharmacy practice. One of my greatest disappointments has been our failure, after more than 30 years, to clearly define and imbed an undeniable core of clinical practice that protects the patient in every pharmacy setting. We have educated ourselves to the point of being almost overprepared for what we are not yet doing—providing clinical services for all patients all of the time. We are paid better than ever for tasks, many of which we should probably stop doing so that we can do what we truly believe will benefit our patients.

Some good news

Despite these chasms, there is some very good news to report. Never in the history of our profession have we been in a better position to ensure that our patients receive safe and appropriate drug therapy. I believe we now have the technology and information systems that can remove 90% of the error potential that lies in the distributive process. We also have over 25 years of proven clinical practices that, if applied consistently on behalf of all patients, have the ability to prevent over 90% of preventable adverse drug events. Thanks to the IOM reports^{1,2} and the excellent work of the Institute for Safe Medication Practices, we have finally focused the attention of the health care community and the public on medication safety. Pharmacy must capitalize on this momentum before the fickle public moves on.

My greatest concern is that, despite this wonderful opportunity, 5 or 10 years from now another pharmacist will be here describing identical or similar pharmacy chasms that continue to put our patients at significant risk. The most recent ASHP national survey revealed that only 1.5% of U.S. health systems use bar-code technology, which can eliminate the errors of administering the wrong drug or a drug to the wrong patient.³ Such proven technology should be as basic as radar in the airline industry. Can you imagine if only 1.5% of the airlines used radar? You and I know that there

are many reasons for this lack of implementation but I doubt Amy's parents would understand. Surely our job as professionals is to be discontented with anything less than the best possible care we can provide. Patients and families do not know what that care is, other health care professionals and administrators do not know, and, fortunately, most lawyers do not know, but competent and conscientious pharmacists do. It is our duty, both in our institutions and at the public policy level, to define quality care and lead the effort to mandate the core standards of pharmacy practice. Our patients, the health care team, and the public expect nothing less.

Failure of traditional strategies

For decades, pharmacists and pharmacy leaders could be relatively successful just by being conscientious, working hard, avoiding conflict, quietly dispensing drugs and related information, and doing a little "clinical" if any time was leftover. Many believed that if we did a good job, our bosses would recognize the value of pharmacy and intercede on our behalf in matters of budget and resources. However, competition for resources in today's hospitals is the ultimate zero-sum game, indicating that this reticent professional strategy is no longer working very well. Today's highly competitive economic and political world requires leadership and communication skills far beyond anything demonstrated in our past. Failure to adjust to this harsh reality ensures that pharmacy receives minimal support and gets only the budget leftovers in most systems. Thus, many services are gradually deteriorating into a survival mode called mediocrity, working hard but barely holding on. Yet, a 50% increase in a typical pharmacy staff budget would increase hospital costs by only about 1% (based on average pharmacy costs equaling about 10% of overall hospital costs, with pharmacy salaries plus benefits equaling about 20% of those pharmacy costs). Making this case may be the most important thing we can do in pharmacy. Surely patients like Amy warrant such an investment.

A new direction

According to a Chinese proverb, "Unless we change our direction, we are likely to end up where we are headed." Since Hepler and Strand⁴ introduced the concept of pharmaceutical care in 1990, we have been far more effective in using the terminology than at practicing it. Many believe scarce resources and the lack of payment for clinical services have been our greatest barriers. I believe the greater barrier resides within the psyche of our profession. Such clinical care requires a transformation even more fundamental than many of us realized, not just in our practice duties but in our professional self-concept and approach to pharmacy practice. We can no longer go behind closed doors and make such a change within our traditional sphere of influence. The very nature of clinical practice requires a whole new level of self-confidence, communication, and interpersonal skills. This change must occur not only in directors, although it certainly starts there, but in all pharmacists. With today's decentralized operations and clinical services, the focal point for practice has permanently moved beyond the walls of pharmacy. As a result, pharmacy middle managers, staff, and clinicians have much the same professional demands and autonomy as yester-

day's pharmacy directors. Few directors today can manage in a top-down fashion because most pharmacy staff members are not physically accessible for such a management style to work. It is now a "wind them up and turn them loose" game, with pharmacists needing diverse abilities, such as clinical and financial expertise and skill in human relationships.

Expectations of today's successful pharmacist

With our practice focal point having moved outside of pharmacy, pharmacy staff and leadership must now meet a dramatic new expectation—to develop a clear vision and demonstrate the resulting core practices, both clinical and distributive, in the trenches of patient care. Meeting this expectation requires the building of a coalition of support, first within our own staff and then with other members of the health care team.

Working with over 500 physicians for many years, I learned that clinical credibility is achieved by demonstrating that we (1) truly care about the patient, (2) are unquestionably competent to perform our professional duties, and (3) are absolutely committed to fulfilling our professional responsibilities. Pharmacy leaders must carry the same message to the chief administrators, medical staff, the board of directors, and the public. All too often, health-system administrators believe that good pharmacy service simply means passing inspections by the Joint Commission on Accreditation of Healthcare Organizations, keeping reported complaints and errors to a minimum, and holding costs below the 25th percentile of some arbitrary benchmark level. Without an equally clear standard for quality, how can we simply use low cost as our sole criteria? Yet, we do. However, make no mistake about it, to be successful pharmacy directors today, we must be as good at managing the finances of pharmacy as providing clinical services. Failure to deliver financially will virtually eliminate the opportunity to deliver the clinical care we envision. In addition to the obvious requirement of clinical competence, pharmacists must fulfill a myriad of expectations, including being (1) effective communicators, able to build consensus for quality practices, (2) strategists, tacticians, and skilled negotiators (sometimes even politicians), (3) innovators, risk takers, and entrepreneurs, and (4) motivators, marketers, and salespersons to generate enthusiasm for change. None of these expectations are part of the traditional pharmacist's psyche. Successful pharmacists project a professional attitude and appearance that is self-confident but humble, assertive but not aggressive, always articulating a clear message that defines quality and the requirements for delivering it.

The moral

Before we become too concerned that pharmacy, as a result of this "sea change" in thinking, will be overrun by slick salespeople and activists—in my opinion, the snail darter and redwood tree have more active support than medication safety—it is important that this more assertive professional style be grounded with a critical set of character traits.

"If you always do right," wrote Mark Twain, "this will delight some and astonish the rest." Pharmacists must have character and courage, both more essential than

ever because the financial stakes and corporate influences in pharmacy have escalated, and require an unquestionable moral compass. The necessary traits include

- ▶ A solid foundation of principles, including honesty, integrity, genuine concern, love, respect for others, a sound work ethic, a proper view of material things, and commitment to family, friends, and country,
- ▶ An enduring passion for the profession, including a commitment to something bigger than self, a paycheck, or a 7-hour, 59-minute workday,
- ▶ An unwavering commitment to lifelong learning and the willingness to change,
- ▶ An ability to stay the course, which in today's world requires the courage to (1) say yes when something is the right thing to do, even though it may be unpopular, difficult, or have a significant risk of failure, (2) say no to financial or corporate pressures if patient care or the profession could be compromised, (3) confront a physician, administrator, or peer when a patient's best interest is at risk, (4) let go of traditional duties that no longer are necessary, (5) persevere and stay at the health system for the good of the team and patient care when times are difficult and challenging, and (6) leave the institution when basic principles of practice, safety, and patient care are threatened and differences cannot be reconciled,
- ▶ The wisdom to take professional duties seriously while never taking oneself too seriously. This means having fun along the way, enjoying the moment and people, taking time to tell others "thank you" and "I care," always giving more than required, and leaving the things we cannot control to divine providence, and
- ▶ The ability to make the right call during our professional "accountability moments" by taking a second look at a problem, spending extra time speaking with a patient or mentoring a colleague, listening to a suggestion, or fighting harder to ensure that the right thing is done for the patient.

I have learned from the best in our profession, many of whom are in this room, that character can easily be described in words but can be taught only by action and example. This was best stated by St. Francis of Assisi centuries ago when he said, "It is no use walking anywhere to preach unless our walking is our preaching."

A clear plan of action

Although it is our professional responsibility to be discontented with substandard care, there is an inherent danger that we will become disillusioned, even cynical, as

we struggle with each day's realities. The answer is to always associate with winners, learn from them, and develop a clear and positive plan of action. Such a plan has many components.

- ▶ We must use our experience and seasoned voices to make students, residents, colleagues, and educators aware of the conflict between our professional ideals and the economic imperatives of the world in which we practice.
- ▶ We must encourage, through our own actions and words, tomorrow's practitioners and leaders to attack this conflict with action and a passion driven by the "face of the patient." We should approach this campaign with the same unrelenting commitment as the late President Reagan, who, against popular opinion, declared that communism in Eastern Europe and the cold war were no longer acceptable. He followed with focused action, and a few years later the Berlin Wall fell and the cold war ended. Focused, positive actions by pharmacists can close our quality chasms in an equally profound fashion.
- ▶ We must adopt an undeniable set of core clinical practices and quality pharmacy services that should be provided to every patient.
- ▶ We must—from the patient care unit to the chief administrators' offices to the budget table—proactively and clearly define the problems, outline the necessary core practices, and confidently request support and resources. No more reticent budget strategies, no more waiting for validation, no more waiting for endless analyses and studies or for someone else to act.
- ▶ We must see that our mother ship, ASHP, expresses the voice of the proactive professional, a voice that commits pharmacy to the core practices that every patient has the right to expect. ASHP's 2015 Initiative and Leadership Agenda are exciting first steps, and the ASHP Foundation's efforts in research and education will be the catalysts for change.
- ▶ We must urge ASHP to work aggressively to educate health-system executives about pharmacy's vital role and the critical importance of positioning the professional properly within the system structure. Even the most effective pharmacist trapped under a weak structure will find this essential progress difficult, if not impossible. We must encourage the development of a position of chief pharmacy officer or equivalent, structured appropriately and responsible for the entire medication-use process. This professional must be held to the highest standards of competence and ethical values.

- ▶ We must cultivate the mind of this professional by exploring and teaching (1) new ways of thinking, decision-making, and creative problem solving, (2) techniques for communicating and dealing with controversy and conflict, and (3) innovative skills and techniques proven in other industries, such as quality management, process redesign, and human relationships.
- ▶ We must continue to strengthen the unique professional network, our band of brothers and sisters, that has served us so well for decades, using ASHP as the time-tested conduit to share our fears and dreams, successes and failures, and, most of all, our shared beliefs for improving patient care. This network is our greatest asset in institutional pharmacy. Tomorrow's pharmacists will need it even more.

When historians look back on this era, I hope they will record the following:

As technology, clinical practice, and public awareness converged, pharmacists made a conscious decision to permanently move beyond the limits of practice centered on products to one centered on people and patients. They took charge of their destiny and assumed full responsibility for the medication-use process and drug therapy outcomes. They learned to work with and through people, and the quality chasms of the past were virtually eliminated. Patient outcomes improved dramatically, and the profession grew in wisdom and stature.

Conclusion

When the telephone rings in the middle of the night, it is most important that we can answer that call with a calm confidence. That confidence comes only when we know in our hearts that we have done everything possible to take care of our patients, never failing to take a stand, confront an issue, or lead a battle to ensure that quality care is delivered. To sustain that approach, our practice must be based on the basic belief that pharmacy is ultimately not about technology, computers, budgets, or even drugs but about the people we serve and our genuine love, respect, and concern for them. It is about Amy and her parents, our pharmacy team, the nurses and physicians we work with every day, and society and our duty to mankind. Being a pharmacist is a privilege and a blessing bestowed by society on a relative few. With such privilege also comes a responsibility—a sacred professional duty—to continually define quality by our actions and never, never be content with anything less.

(For the complete list of references cited, please see page XXXX of the *American Journal of Health-System Pharmacy*, Sept. 1, 2004.)

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