



“Converging paths have led to the profession’s transition to pharmaceutical care.”

=====**HAROLD N. GODWIN**=====

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At the time he received this award, Harold N. Godwin was the Director of Pharmacy at the University of Kansas Medical Center, Kansas City, and Associate Dean and Professor and Chairman of the Pharmacy Practice Department at the University of Kansas School of Pharmacy, Lawrence.

To a New Beginning from Converging Paths

I stand here in awe. Recognition by one’s peers is the greatest recognition of all.

I wish to express my love and thanks to my family—Judy, Jennifer, and Paula—who have provided the supportive environment for me to achieve my professional goals and for my attempts to influence the profession. My thanks to Sara White, my colleague and confidant, and to my colleagues at the University of Kansas Medical Center and School of Pharmacy who provide a stimulating practice base on which to grow professionally.

A special recognition goes to all of the residents associated with my career who provide challenges, stimulation, and rewards in the process of developing leaders for the profession reaching for excellence. I also want to thank all of you here tonight and

all who have sent notes and letters and made phone calls of congratulations. This experience is truly heart warming and humbling.

While I have had no direct link to the University of Michigan and Harvey A. K. Whitney, my preceptor and mentor, Clifton J. Latiolais, provided me with the influence and principles that are the legacy of the man we are honoring tonight. In preparing for this presentation, I read many of the previous addresses by Whitney Award winners. Indeed, the legacy lives! Previous Whitney addresses are thought provoking and provide a vision for the profession. Stephen Leacock once wrote, "It may be those who do the most, dream the most."

Napoleon said, "A leader is a dealer in hope." It is truly an honor to be associated with this collection of leaders and pathfinders.

The pharmacy profession is on the edge of a great new beginning. The near future will bring opportunities that, if recognized and seized, will change our health care system significantly. A new beginning! Wouldn't we all like to have a new beginning—knowing what we know now, retaining our insights, avoiding previous mistakes, and having the ability to do it right. So often we pass through time without the chance to start over—to reset the stage—or the ability to follow the correct path. Finding that path is the key, as Lewis Carroll knew:

One day Alice came to a fork in the road and saw a Cheshire cat in a tree. "Which road do I take?" she asked. His response was a question: "Where do you want to go?" "I don't know," Alice answered. "Then," said the cat, "it doesn't matter."

The pharmacy profession is facing a unique window of opportunity to meet a new societal obligation. Pursuit of this opportunity could represent a landmark akin to the differentiation of apothecaries from medical practitioners. As I reflect on our professional history and look at the signals in our profession today, I see evidence of a new horizon for pharmacy.

Historians tell us emphatically that we are leaving the industrial revolution and passing into an age dominated by science, technology, and knowledge. Never in history has knowledge been so central to the conduct of an entire society. The advent of the knowledge age and our rapidly changing environment will profoundly affect the profession of pharmacy.¹ The impact of the knowledge or information age on pharmacy has been recognized for years. In 1967, Donald C. Brodie, Whitney Award winner and pathfinder for the profession, used the term "drug use control" to describe a system of knowledge, skills, controls, and ethics that ensures optimal safety in the distribution and use of medications.² Drug use control became a central concept in the development of clinical pharmacy.

In 1972, the Millis Commission was created to examine the practice of pharmacy as an integral part of the health care system. Two years later, the Millis Commission reported that the main function of pharmacy centers on the discovery, interpretation, and dissemination of drug knowledge.

In 1985, ASHP held an invitational conference on directions for clinical practice

in pharmacy, the famous “Hilton Head Conference.” At Hilton Head, pharmacy leaders concluded that a commitment must be made to establish pharmacy as a true clinical profession.³

Since that time, there has been an evolution from Brodie’s idea of drug use control to the philosophy of practice espoused by Hepler and Strand: pharmaceutical care.^{4,6} Hepler first described pharmaceutical care at the Hilton Head Conference and later refined the concept in his paper entitled “Unresolved Issues in Pharmacy.”^{7, 8} Pharmaceutical care is described as “the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient’s quality of life. These outcomes are (1) cure of a disease, (2) elimination or reduction of a patient’s symptoms, (3) arresting or slowing of a disease process, or (4) preventing a disease or symptoms.”⁴

Pharmaceutical care is not practiced in isolation from other health professionals. Rather, it must be provided in collaboration with patients, physicians, nurses, and others. Pharmaceutical care should not be available only on the basis of patient need or when requested by the patient. Most importantly, the concept is not and must not be restricted to pharmacy practice in organized health care settings. Supporting the need for the provision of pharmaceutical care, Manasse^{9,10} demonstrated the critical need for a system to improve medication use in society and to avoid medication misadventures.

Great interest in the concept of pharmaceutical care was demonstrated at the Pharmacy in the 21st Century Conference, held in October 1989. A conclusion of this Conference was that pharmacy practice needed a mission statement, for public declaration, that fostered such a concept.

This movement towards pharmaceutical care has prompted the American Pharmaceutical Association (APhA) to approve a new mission statement for the pharmacy profession, which states: “The mission of pharmacy is to serve society as the profession responsible for the appropriate use of medications, devices, and services to achieve optimal therapeutic outcomes.” Further, a mission statement being drafted by the Joint Commission of Pharmacy Practitioners (JCPP) states that the “mission of pharmacy practice is to help people make the best use of medications.”¹¹

The specific elements of these mission statements are important. According to the APhA mission statement, “the mission of pharmacy is to serve society as *the* profession responsible for the appropriate use of medications. . . .” The stated aim, “to achieve optimal therapeutic outcomes,” dictates an important new responsibility and commitment by the profession. The mission statement suggests that pharmacy has a covenant with the patient to ensure the positive outcome of drug therapy. This applies to all of the pharmaceutical services (clinical and nonclinical) that are required and received by the patient to obtain the desired clinical outcomes of the use of drugs.

The provision of pharmaceutical care inherently means that the pharmacist is responsible for and is to be held accountable for a patient’s achieving the desired clinical outcomes of the use of drugs. I like to describe the pharmacist’s role as being a

drug therapy manager. The physician still makes the diagnosis and prescribes drug therapy in broad terms. The pharmacist is responsible for managing that drug therapy to achieve optimal patient outcomes.

The recent concurrence of events is unequalled. The profession's leaders and organizations have reached consensus on the definition of pharmacy practice and the mission of the profession. Practitioner organizations have come from converging paths to agree on our profession's societal purpose and our new beginning. It is time to stop debating the future and to implement pharmaceutical care.

A number of activities are occurring that will accelerate the implementation of pharmaceutical care.

In addition to adopting a new mission statement for pharmacy, APhA has embarked on revalidation of its Standards of Pharmacy Practice. Revision of the standards will be based on assessments of practice by 5000 pharmacists. This summer, the first examination for the certification of specialized practitioners in pharmacotherapy will be administered by the Board of Pharmaceutical Specialties. This examination will assess the level of clinical knowledge of pharmacists and help to establish baseline expectations.

The American Association of Colleges of Pharmacy (AACP) has formed the Commission to Implement Change in Pharmaceutical Education. As this Commission continues its work, it is publishing a series of position papers. The first paper, "Mission of Pharmaceutical Education,"^a states that pharmaceutical education is responsible for preparing students to enter into the practice of pharmacy and to function as professionals and informed citizens in a changing health care system. AACP is responsible for generating and disseminating new knowledge about drugs and about pharmaceutical care systems.

Pharmaceutical education promotes advances in pharmaceutical care by fostering postgraduate residencies and fellowships in clinical sciences and differentiated areas of pharmacy practice. Pharmaceutical education is also responsible to the profession and to society for generating new knowledge about drugs, drug products, drug therapy, and drug use through the conduct of basic and applied research. This position paper states that pharmacy practice is one means through which the profession delivers its knowledge and products to patients in society. Thus, the Commission stated its belief that the mission of pharmacy practice is to render pharmaceutical care.

The Commission's second paper, "Entry Level, Curricular Outcomes, Curricular Content, and Educational Process," states that "to enter practice is to render pharmaceutical care."^b Students prepared at the entry level must be capable of coordinating and rendering pharmaceutical care. The Commission recommends that AACP member schools and faculty immediately commit themselves to curricular change that (1) engenders competencies and outcomes essential to pharmaceutical care and (2) strengthens the effectiveness of the process of pharmaceutical education. The stage is set for the colleges of pharmacy to meet the challenges of preparing the entry-level student to practice pharmaceutical care.

Another significant development in education is occurring. In 1989, the American

Council on Pharmaceutical Education (ACPE) announced its intent to begin a 10-year review process to establish, as part of its periodic review of accreditation standards, revised standards that will reflect and respond to the mission set forth for pharmacy practitioners. This process is another sign that the profession is embracing the provision of pharmaceutical care.

ACPE also has said that it foresees the time when the accreditation standards will focus on a Doctor of Pharmacy program as the only professional degree program evaluated and accredited. Current standards consider both the B.S. and the Pharm.D. as entry-level degrees for pharmacist licensure. Standards that are consistent with the entry-level practitioner's ability to provide pharmaceutical care may become reality as soon as the year 2000.^{c, d}

The first few years of the 10-year revision of standards will be devoted primarily to determining what competencies and curricular content are necessary for a generalist practitioner. The revision process provides for open hearings and for the submission of written comments on drafted or proposed revised standards. Unfortunately for the profession, at least one pharmacy trade association representing corporations that employ pharmacists, the National Association of Chain Drug Stores, is initially focusing efforts in opposition to this process based on the degree designation and the length of programs leading to the entry-level degree—elements of the standards that are to be determined after the establishment of competencies required for entry into the profession to practice pharmaceutical care.

The revised accreditation standards will represent competencies required for the entry-level generalist practitioner. While many Doctor of Pharmacy graduates up to now have practiced in specialized areas, the standards for the future will set entry-level competencies for practice. The standards will acknowledge the new mission of the profession and will focus on the provision of pharmaceutical care for all practice sites, including community practice.

Significantly, ACPE is also calling for opinions and recommendations about appropriate educational development for baccalaureate-degreed pharmacists already in practice (i.e., nontraditional educational approaches). It is equally important to develop and train existing practitioners to provide pharmaceutical care at all practice sites.

ASHP has a rich tradition of promoting pharmacy as a clinical profession through its *Statement on Long-Range Pharmacy Manpower Needs and Residency Training*, its residency accreditation standards, and the Hilton Head Conference and its state and local followup conferences. Continuing this philosophy, the ASHP House of Delegates has unanimously endorsed the concept of pharmaceutical care, reaffirmed support for the Doctor of Pharmacy as the single entry-level degree for practice, and endorsed the proposal for a clinical skills development program. Thus, ASHP continues to position itself well to help practitioners in organized health care settings to practice pharmaceutical care.

Thus, converging paths have led to the profession's transition to pharmaceutical care. What of the future? Einstein once said, "I never think of the future. It comes

soon enough.” We have a great future ahead of us because of what is behind us. H. G. Wells wrote, “The past is but the beginning of a beginning.” We must move rapidly from the frontiers of the past to the new frontiers of the future.

With all of the signs and signals pointing to the correct path, we can no longer afford to debate the future; we must implement pharmaceutical care. Our challenge is not concept, not philosophy, not agreement with the mission statement for the profession; rather, it is implementation. The implementation of pharmaceutical care is the most important challenge the profession has faced in this century. Pharmacy is committed to this end. Implementation must occur at all levels of pharmacy practice—hospitals, HMOs, nursing homes, community practice sites of independent pharmacies, professional pharmacies, and chain pharmacies.

There is an urgency for implementation of pharmaceutical care. Joseph Califano, former Secretary of Health, Education, and Welfare, recently stated that pharmacists’ monopoly over dispensing should be eliminated. His comments reinforced the uninformed perception that pharmacy services are rooted in self-interest rather than in consumer protection.

What must be done to accomplish our goals on a timely basis? Each professional organization must make pharmaceutical care a priority, not merely rhetoric.

The JCPP must move beyond adopting the philosophy of pharmaceutical care; it must commit to implementing pharmaceutical care. The value of the mission statement drafted by JCPP is that it is aimed at society rather than the profession: “The mission of pharmacy practice is to help people make the best use of medications.” JCPP could best serve the profession by aggressively marketing this mission—or patient expectation concept—to the public. We need a unified national campaign depicting the value-added pharmaceutical services that we call pharmaceutical care.

APhA must continue to focus on its newly adopted mission statement. It must not only revalidate the Standards of Pharmacy Practice but continue to measure the levels of practice to determine the current contributions of pharmacy practitioners, their potential, and their limitations in providing pharmaceutical care. We need a continuing analysis of the services provided by our nation’s pharmacists, parallel to ASHP’s national survey of hospital pharmaceutical services.

Probably most important, APhA needs to promote postgraduate residency training programs aimed at developing and providing pharmaceutical care to patients in all settings. We must expand model practices that depict value-added pharmaceutical services, the drug knowledge component of pharmaceutical care. The concept of the office-based family pharmacist, pioneered by Eugene White, must be adopted. APhA must grasp the opportunity to establish the pharmaceutical care concept in relation to the Omnibus Budget Reconciliation Act of 1990 mandate for patient counseling and drug use review by 1993.

ACPE must continue to seek input from the profession and practitioners as it receives, analyzes, and produces the competency requirements for entry-level practice of providing pharmaceutical care. The focus for the first few years of the 10-year revision process must be on the competency requirements and not the title of the degree or the length of the program. ACPE should seek input and formulate sound

and efficient educational pathways for current practitioners who need to develop their practice competencies to meet the goal of providing pharmaceutical care to all patients.

AACP must receive, debate, and act on the recommendations of the Commission to Implement Change in Pharmaceutical Education to ensure that the academic process is consistent in meeting the needs of the graduate entering the practice of pharmaceutical care.

ASHP has been a leader in promoting the concept of clinical practice for the profession. Through its strategic planning process, it has identified in advance many of the changes in the health care arena. The Hilton Head Conference nurtured the early development of the concept of pharmaceutical care. Now, ASHP must take a leadership role in the implementation of pharmaceutical care. Attention must shift from the ASHP strategic planning process to an expedited process for strategic implementation.

ASHP should convene a follow-up national conference on the issues of implementing pharmaceutical care in organized health care settings. Such a forum would be appropriate during ASHP's 50th anniversary celebration in 1992. As we recognize ASHP's half century of progress, we should chart a course for the implementation of pharmaceutical care by the turn of the century. This would give our members an opportunity for a renewed commitment to reaching higher practice goals.

After such a national conference, I recommend that ASHP create a commission to implement pharmaceutical care in organized health care settings. This commission should have the highest priority for professional development and programming. Timetables would be set and an action plan would be carried out. This commission should identify methods for implementing pharmaceutical care at all practice sites, develop educational mechanisms to ensure that all current practitioners are capable of providing pharmaceutical care, assist colleges of pharmacy with electronically mediated educational methods for developing clinical practice skills and clinical practice experiences, develop strategies to remove the barriers to pharmaceutical care, and foster research programs that demonstrate the cost-effectiveness of pharmaceutical care.

Why create a commission rather than just follow the regular policy implementation process of the ASHP councils and Board of Directors? A commission would be better able to focus continually on the mission of implementation, respond to the urgency for implementation of pharmaceutical care, and commit to reaching closure on this vital task. Creation of a commission would also signal to the profession and the public that ASHP is dedicated to this cause. This concept of creating a commission could be reviewed and debated at the proposed 1992 national conference for implementing pharmaceutical care.

What issues confront us in the implementation of pharmaceutical care? First, there is a need for commitment by the individual practitioner and the management of each department to support this cause. The concept will have to be marketed not only to our patients but to other health care professionals as well.

To meet the challenges of being responsible for optimal therapy outcomes, our

practitioners are going to need more training and confidence in patient-assessment techniques. Programs for training in primary care skills and patient monitoring, such as the ASHP Foundation's anticoagulant clinic traineeship program, should be expanded.

Patient medication compliance is also critical for achieving desired therapeutic outcomes. Efforts should be made to mandate pharmaceutical manufacturers to provide unit-of-use packaging and packaging that encourages patient compliance.

We need to press on for standardized education and recognition of technicians, and we must expand automation in our pharmacy systems so that much of the current pharmacist labor force can be redeployed into providing pharmaceutical care.

Electronic patient medication databases must be developed to provide information for both acute and ambulatory care. Mechanisms must be developed so that patients' medical data can be shared by all providers of pharmaceutical care.

These are but a few of the issues that will need to be addressed by the commission.

Back to ASHP initiatives. ASHP must ensure that pharmacy practice in organized health care settings is meeting the accepted standard of practice for patient care, including both clinical and nonclinical practices. I refer to data suggesting that intravenous admixture programs and drug distribution services still do not meet the standards of practice in many of our nation's hospitals. Pharmaceutical services meeting the standards of practice in all areas are mandatory as we move into providing pharmaceutical care for all patients.

ASHP states that it represents pharmacists in organized health care settings, encouraging them to provide high-quality pharmaceutical services that foster the efficacy, safety, and cost-effectiveness of drug use. However, most of ASHP's efforts and services have been aimed at practitioners in acute care hospitals. ASHP must give the same priority to the establishment of pharmaceutical care in all organized health care settings such as managed care organizations, nursing homes, ambulatory care pharmacies, and home health care pharmacies. ASHP must accelerate the previously recommended "name identity change" from the American Society of Hospital Pharmacists to ASHP.¹² A revised mission statement should proclaim that ASHP represents pharmacists providing pharmaceutical care in organized health care settings.

ASHP must examine its current organizational structure to validate that it is providing appropriate services and representation for all practitioners in organized health care facilities. Membership programs should promote the provision of pharmaceutical care at multiple levels and all sites of activity. The current organizational structure, which attempts to meet the needs of generalists, members who identify themselves by practice interest, and members of specialty practice groups, should be reevaluated to ensure that the depth and breadth of membership needs of all differentiated practitioners are recognized and met.

ASHP has been the preeminent professional organization providing educational services to its members and the profession. Given the importance of the implementation of pharmaceutical care, ASHP should prioritize and accelerate the clinical skills development project. In fact, using its expertise, ASHP should develop curricular

resources via electronic media to meet the needs of the practitioner to practice pharmaceutical care. Likewise, ASHP should use its resources and extensive experience in residency training to develop a cadre of practitioner educators to provide experiential opportunities through which practitioners can improve their clinical skills.

During the implementation of pharmaceutical care, the different pharmacy degrees and different levels of pharmacy practice will be a problem. Current practitioners are legitimately concerned about their professional status and value. We must recognize that pharmacy is in a transitional mode, and we must not dwell on such differentiating issues. I urge ASHP to encourage employers recruiting practitioners to not use the term “clinical pharmacist only” or “Pharm.D. only,” but rather to indicate that the qualifications for employment include the ability and expertise to practice pharmaceutical care. The profession must quickly adapt to the educational requirements for entry-level practice. But in this transitional time, we must recognize the important contributions of those pharmacists who have achieved distinction as clinical practitioners the “old-fashioned way,” by self-development.

We know the direction we must follow. Mark Twain said, “Even though you are on the right track, you get run over unless you can move down that track.” Implementation of pharmaceutical care is imperative. It is the profession’s destiny. William Jennings Bryan once wrote, “Destiny is not a matter of chance, it is a matter of choice, it is not a thing to be waited for, it is a thing to be achieved.” The profession as a whole is positioned to achieve our destiny. To a new beginning!

(For the complete list of references cited, please see page 1703 of the *American Journal of Hospital Pharmacy*, Aug. 1991.)

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

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