Pharmacy's Golden Circle

Am J Health-Syst Pharm. 2024;81:1096-1102

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https://doi.org/10.1093/ajhp/zxae119

Editor's note: The following was adapted from Dr. Ginsburg's remarks in acceptance of the 2024 Harvey A.K. Whitney Lecture Award at the ASHP Pharmacy Futures 2024 meeting, held in June in Portland, OR.

Thank you for this honor. I am truly humbled by this recognition and thank past Whitney Lecture Award recipients and others for their support. Thanks to each of you for being here this evening and ASHP for hosting such a beautiful event. No one accomplishes anything without the support of others. At this time, I would like to acknowledge the many individuals and organizations that have sustained me throughout my career.

Thank you to the University of Pittsburgh School of Pharmacy. My education at Pitt and experience I gained as an intern at UPMC Presbyterian directed my interest in the pharmacy profession and the nonlinear journey I have traveled thus far in my career.

Thank you to the University of Houston College of Pharmacy and to Roland Patry, the late Toby Clark, and the late Darrell Newcomer for convincing me to pursue the MS/residency program and to take a chance and be the first resident at Methodist.

Thank you to the Texas Society of Health-System Pharmacists for your support. It is an honor to represent and be a part of Texas Pharmacy.

I am grateful and appreciative of the leadership and support from my colleagues and students at the University of Texas at Austin College of Pharmacy. I am fortunate to have some of my faculty colleagues with me tonight to share this recognition, including our dean, Sam Poloyac. A special thank you to Lynn Crismon. Lynn recruited me to UT Austin over 35 years ago, when pursuing a career in higher education was never in my imagination as a path to travel down. Lynn saw something in me I do not know if I would have seen as a young practitioner, and he has been who I have reported to, a mentor, and dear friend throughout my career. I would not have had the opportunities at UTCOP and for everything I have pursued without his encouragement and support.

My students are my source of energy and inspire me every day. They are the reason I do what I do. I am fortunate to have 4 of them here this evening. Please meet these young practitioners as they are rising stars in our profession.

To my ASHP family, you are my pharmacy home and have mentored, encouraged, and supported me to learn and serve this organization and profession. There are so many of you deserving of praise and recognition, but I cannot mention everyone individually. I hope you realize that your impact on me has been deeply felt and greatly appreciated.

To my friends and family, those by choice and marriage, thank you for your encouragement and support and for being here tonight to share this special moment.

Thanks to my late mother, Phyllis Ginsburg, who taught me the only limitations we have in this world are those we impose on ourselves. I do my best to honor her memory every day by what I do.

To my husband, Dr. Jeffrey Josephs. . . . If you ask Jeff, he may tell you the night he met me I said, "If you stick with me, it will never be a dull moment." Jeff, I think I have kept my word. You have supported me in everything I have done, understand my commitment to my profession in all facets. Most importantly, you have believed in me and loved me unconditionally. This is as much a recognition of you as it is of me.

I must admit that I experienced the imposter phenomenon when I was notified [of receiving the award] and as I have prepared for this evening. The Harvey A.K. Whitney Lecture Award is like the Academy Award in pharmacy. When I look at the list of prior recipients, it is hard to think of myself in the same arena as those individuals. These are my pharmacy heroes, mentors, and bigger-than-life pharmacists. I do what I do because it is my passion and calling. Perhaps prior recipients felt the same way.

Preparing for this evening, I did what many other recipients have done. I reviewed prior Whitney award lectures. The geek in me was fascinated to read their perspectives and projections for our profession and healthcare, issues they faced, their drive and commitment to pharmacy and patient care. Many of the issues prior recipients identified are still present today. I approached this honor through the lenses of my multiple roles in the profession—as a pharmacist, professor, dean, and patient. I believe with recognition comes responsibility. I was given this platform for a reason and reflected on the message to provide. Thank you for allowing me this evening to share my thoughts and call to the profession. The title of my lecture, "Pharmacy's Golden Circle," gets to the heart of what I want to talk about. Pharmacy's purpose, our identity, and a call for action.

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She completed a bachelor of science degree in pharmacy at the University of Pittsburgh School of Pharmacy, a master of science degree in pharmacy at the University of Houston College of Pharmacy, and a 2-year ASHP-accredited residency in hospital pharmacy administration at The Methodist Hospital in Houston, TX. She received her doctor of philosophy degree in higher education administration and leadership in the College of Education at the University of Texas at Austin.

A sought-after expert in pharmacy law, practice transformation, healthcare reform, ethics, leadership, and pharmacy education, Ginsburg has delivered nearly 600 presentations, including approximately 350 lectures to national and international audiences. She is a pharmacist consultant on drug diversion to the Department of Justice and the Drug Enforcement Administration (DEA). She is an adjunct instructor at the DEA Training Academy, where she trains attorneys, investigators, and field officers to analyze pharmacy data for drug diversion. She has worked with several state governments and jurisdictions on the Multi-District Opioid Litigation, which has resulted in multimillion-dollar settlements. She is a consultant member of the Food and Drug Administration Nonprescription Drugs Advisory Committee.

Ginsburg has served ASHP in several capacities, including president, a member of the Board of Directors, chair of the Council on Educational Affairs, member of the *AJHP* Editorial Advisory Board, Texas delegate to the ASHP House of Delegates, and co-coordinator of the National Clinical Skills Competition. She is the editor of *PharmPrep: ASHP's NAPLEX Review*, coeditor of *Infectious Disease Pharmacotherapy Self-Assessment,* and an author and coeditor of ASHP's *Preceptor's Handbook for Pharmacists*. She was inducted as a Fellow of ASHP in 1998. She also served as chair of the ASHP Foundation Board of Directors.

She has held several leadership positions with other pharmacy organizations, including the American Association of Colleges of Pharmacy, the Academy of Managed Care Pharmacy, and the American Society of Pharmacy Law. She was recently appointed to the Accreditation Council of Pharmacy Education board of directors. She is a past president of the Texas Society of Health-System Pharmacists (TSHP) and the TSHP Research & Education Foundation. Ginsburg is a founding member of the International Pharmaceutical Federation (FIP) World Hospital Pharmacy Research Consortium and a frequent presenter during FIP World Congress sessions.

She has received several honors and awards, including the University of Pittsburgh School of Pharmacy Distinguished Alumnus Award (2005), Texas Ex Students Association Texas Ten Award, which recognizes the 10 most talented and inspiring professors at the University of Texas at Austin (2016), and the University of Houston College of Pharmacy Roger Anderson Leadership Award (2022).

The Golden Circle. The Golden Circle is a classic concept by Simon Sinek[1,2] that helps organizations as well as teams and individuals reach their full potential. The Golden Circle is a powerful model to explain how leaders inspire action. According to Sinek, we must start with our "Why" and work from the inside out. Inside the circle is the "Why". This is the core belief of the business or individual. It's why the business exists. It's not about making money; that is a result. It's the purpose, cause, or belief. It's the very reason the organization or individual exists. The "How" is the things that make you unique, the practices or values that set you apart from others. It's how the organization or individual does what they do. As for the "What": Every organization knows what they do; this is the products you sell or services you offer.

Sinek's main argument is that most companies communicate from the outside of the circle by starting with the What, but the most inspiring leaders and organizations communicate from the inside out, starting with the Why. This approach resonates more deeply with people, leading to greater loyalty and a stronger ability to inspire. Sinek's Golden Circle theory inspires action and drives leadership success. Sinek provides an example from Apple Computer. If Apple were like everyone else, a marketing message from them might go as follows[1,2]: "We make great computers [the What]. They are beautifully designed, simple to use, and user-friendly [the How]. Wanna buy one?" The message is not very inspiring. Then Sinek recounts how Apple actually communicated in one ad campaign[1,2]: "Everything we do, we believe in challenging the status quo, we believe in thinking differently [the Why]. The way we challenge the status quo is by making our products beautifully designed, simple to use, and user-friendly [the How]. We just happen to make great computers. Wanna buy one? [the What]."

Sinek's philosophy is simple: "People do not buy what you do, they buy why you do it." When we say what we do, how we are better or different and then expect some behavior associated with this and wonder why we do not achieve the outcome or results we expect, this is due in many ways to

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an uninspiring message. If you don't know why you do what you do, how will others? How can you lead if you can't articulate your purpose?

The Golden Circle and pharmacy. The Golden Circle is my philosophy and the "why" behind everything I do. We need to ask the question: Why does our profession exist and why should anyone care? Has pharmacy lost its purpose? We are so fixated on the "what" that we have lost the "why" behind it. We need to get back our "why we are pharmacists" versus "what we do as pharmacists." How often do we take time to reflect on our purpose and effectively communicate it to others? We are at a critical time in healthcare when people are questioning motives and intentions behind everything we do. I do not remember a time when there has been so much question, doubt, and suspicion behind medicine and modalities to improve patients' lives. If there was ever a time to be clear on our purpose, the time is now.

"Clinical" pharmacy. Let's discuss "Clinical Phamacy and our Purpose." Although some clinical pharmacy services were implemented in the 1960's, it was the mid- to late 1970s when the AACP Millis Commission recommended pharmacy was a "clinical" profession and that pharmacists should be trained to provide direct patient care services.[3] Harvey A.K. Whitney published a very compelling editorial stating, "The highest priority must be given to implementing clinical pharmacy programs if we are convinced that the maturing of our profession is dependent on clinical pharmacy becoming the future model for practice."[4] And the unanimous consensus of pharmacy leaders participating in the Hilton Head Conference was "the need for a definition of clinical pharmacy or, alternatively, for a modernized definition of pharmacy." Participants were asked to address the question "What is pharmacy's societal purpose and the place of clinical pharmacy practice within that purpose?" All participants

Harvey A.K. Whitney Lecture Award

PAST RECIPIENTS

Year	Recipient	Year	Recipient
2023	Milap C. Nahata	1986	John W. Webb
2022	Patricia C. Kienle	1985	Fred M. Eckel
2021	William A. Miller	1984	Mary Jo Reilly
2019	Bruce E. Scott	1983	Warren E. McConnell
2018	Rebecca S. Finley	1982	William E. Smith
2017	Max L. (Mick) Hunt Jr.	1981	Kenneth N. Barker
2016	Sister Mary Louise Degenhart, A.S.C.	1980	Donald C. Brodie
		1979	Milton W. Skolaut
2015	Sharon Murphy Enright	1978	Allen J. Brands
2014	John E. Murphy	1977	Herbert S. Carlin
2013	Jannet M. Carmichael	1976	R. David Anderson
2012	Rita R. Shane	1975	Sister Mary Florentine, C.S.C.
2011	Daniel M. Ashby	1974	Louis P. Jeffrey
2010	Charles D. Hepler	1973	George L. Phillips
2009	Paul W. Abramowitz	1972	William M. Heller
2008	Philip J. Schneider	1971	Sister M. Gonzales, R.S.M.
2007	Henri R. Manasse Jr.	1970	Joseph A. Oddis
2006	Sara J. White	1969	Leo F. Godley
2005	Thomas S. Thielke	1968	Clifton J. Latiolais
2004	Billy W. Woodward	1967	Paul F. Parker
2003	James C. McAllister III	1966	Robert P. Fischelis
2002	Michael R. Cohen	1965	Sister Mary Berenice, S.S.M.
2001	Bernard Mehl	1964	Albert P. Lauve
2000	Neil M. Davis	1963	Vernon O. Trygstad
1999	William A. Gouveia	1962	Grover C. Bowles
1998	John A. Gans	1961	Herbert L. Flack
1997	Max D. Ray	1960	Thomas A. Foster
1996	William A. Zellmer	1959	I. Thomas Reamer
1995	Paul G. Pierpaoli	1958	Walter M. Frazier
1994	Kurt Kleinmann	1957	Sister Mary John, R.S.M.
1993	Marianne F. Ivey	1956	George F. Archambault
1992	Roger W. Anderson	1955	Gloria N. Francke
1991	Harold N. Godwin	1954	Evlyn Gray Scott
1990	David A. Zilz	1953	Donald E. Francke
1989	Wendell T. Hill Jr.	1952	Edward Spease
1988	Joe E. Smith	1951	Hans T. S. Hansen
1987	John J. Zugich	1950	W. Arthur Purdum

Harvey A. K. Whitney (1894–1957) received his Ph.C. degree from the University of Michigan College of Pharmacy in 1923. He was appointed to the pharmacy staff of University Hospital in Ann Arbor in 1925 and was named Chief Pharmacist there in 1927. He served in that position for almost 20 years. He is credited with establishing the first hospital pharmacy internship program—now known as a residency program—at the University of Michigan in 1927. Harvey A. K. Whitney was an editor, author, educator, practitioner, and hospital pharmacy leader. He was instrumental in developing a small group of hospital pharmacists into a subsection of the American Pharmaceutical Association and finally, in 1942, into the American Society of Hospital Pharmacists. He was the first ASHP President and cofounder, in 1943, of the *Bulletin of the ASHP*, which in 1958 became the *American Journal of Hospital Pharmacy* (now the *American Journal of Health-System Pharmacy*). The Harvey A.K. Whitney Lecture Award was established in 1950 by the Michigan Society of Hospital Pharmacists (now the Southeastern Michigan Society of Health-System Pharmacists). Responsibility for administration of the award was accepted by ASHP in 1963; since that time, the award has been presented annually to honor outstanding contributions to the practice of hospital (now health-system) pharmacy. The Harvey A.K. Whitney Lecture Award is known as "health-system pharmacy's highest honor."

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agreed that "A fundamental purpose of the profession of pharmacy is to serve as a force in society for the safe and appropriate use of drugs."[5]

Clinical pharmacy's inflection point. Importantly, using our knowledge to take care of patients should not be setting dependent. Are we not clinical regardless of setting? When I ask students what they want to do when they are P1s [pharmacy students in their first professional year], they usually tell me (for the most part), "I want to be clinical." I ask them to define what this means. I get interesting answers. "Practice in an outpatient clinic"—which shows students entering our profession have some understanding of the myriad of practice settings for pharmacists. "Do a residency"—not an unusual comment, as many of our students entering Pharm.D. programs understand the need for postgraduate training. One of my favorites, which I also hear from prospective students, is "Use my knowledge to take care of patients." Using our knowledge to take care of patients . . . is this really setting dependent? Are we not clinical regardless of setting? My dear friend, colleague, and mentor Deb Devereaux recently sold her company. She and her team conducted audits regarding how medications were used. She wasn't in a brick-and-mortar pharmacy, yet she was using her knowledge—her knowledge as a *pharmacist*—in her role. I asked her to describe what her company does, and this is what she shared: "Helping health plans be compliant with government regulations designed to ensure member access to care and medications. We begin with the data and previous treatment samples and critique process and decisions before CMS [the Centers for Medicare and Medicaid Services] arrives. After the audit we support corrective actions and continuous quality improvement." Her practice was all about the patients and improving their care. . . . Isn't that clinical?

Some of my colleagues who serve in chief pharmacy officer or director of pharmacy roles within their institutions described their budgets to me. I was not surprised to hear that for some large institutions, medications encompassed 80% to 85% of their budgets. Personnel and equipment were small in comparison. One colleague shared his drug budget was over $1.5 billion. When administration asked him to cut 10% of his budget, he asked, "What drugs and therapies should we cut?" Although he was not providing direct care to patients daily, the multimillion-dollar decisions were all about patient care—clinical decisions.

I have taught over 4,000 students during my tenure at UTCOP. My roots are in hospital pharmacy, and frequently, when I talk to a student, they are almost embarrassed to tell me they want to go into community practice. They see community pharmacy as a lesser facet of our profession. Listen to their terminology—they do not use the term "practitioner" or "patient care" to describe what they do. I am *not* naïve to what is happening in chain pharmacy and the current practice model. Are these pharmacists not using their clinical knowledge in their assessment and care of patients? Yes, they are dealing with many things, but they are the clinicians taking care of those patients.

You must ask, "Does chain pharmacy value their pharmacists or see them as a means to an end?" (they must have pharmacists to operate in the current regulatory climate). Pharmacists are necessary for their stores to operate; however, I ask myself if statutes and rules changed, would these companies proceed without pharmacists as part of their workforce? We need great community practitioners/clinicians. The current practice model does not allow these highly educated and trained clinicians to fulfill their purpose and role as healthcare providers.

Think about our role, the role of pharmacists, in the pandemic. I used to be so proud when daily I would return home after being at our vaccination clinic on campus and hear Wolf Blitzer and Sanjay Gupta talk positively about pharmacists and our role in providing patient care. For once they didn't show us with the Abbott counting tray and spatula. When I see pharmacists shown on TV portrayed that way, I always hope they at least had a good manicure as they are more like hand models then clinicians.

There were many positives with the pandemic—and I am not talking about testing positive. Pharmacists were no longer the "Horton Hears a Who" of healthcare! We were seen, accessible, and critical to our getting to the other side of the pandemic. I remember [ASHP Past President] John Murphy breaking the videotape with the "Invisible Ingredient" during his inaugural presidential address to demonstrate and advocate that we can no longer be invisible participants in patient care if we were to fully capitalize on the value pharmacists bring to patients' lives. In his 2014 Whitney address, "The Visible Ingredient," he asked, "Do pharmacists make a difference in the lives of patients? If so, do patients know? What is our reason for existence as a profession as we move toward the future?" In many places we are visible, but in many places we are still the "Pharmacist Whos from Whoville"—not visible and perhaps not seen as necessary to patient care and safety. I know all of you would agree this needs to change.

I was blown away at the Opening General Session at this past ASHP Midyear Conference when ASHP launched the new campaign titled "We're the pharmacists." The message was enormous, shining a bright light on the exceptional contributions pharmacy professionals provide across the full spectrum of patient care. I was so pleased to see there were not a ton of adjectives and labels. I am optimistic this will be successful in educating the public about what we do.

Nomenclature and credentials. When I think of our purpose, I also reflect on the nomenclature and words we use in our profession. The titles we use—do people outside of our profession understand what

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they mean? There was a time when we needed to use terms to demonstrate pharmacy is a clinical profession. Have we gone too far? In his 2015 article entitled "Personal reflections 30 years after the Hilton Head Conference," Max Ray stated, "The central (and perhaps the most enduring) message was that pharmacy is an inherently clinical profession and that future planning for pharmacy practice should be predicated on this assumption. . . . Clinical pharmacy is now woven into the fabric of pharmacy practice to the extent that most of us might agree that the adjective 'clinical' is redundant."[6]

These adjectives and labels. . . . Physicians, dentists, podiatrists, optometrists, physician assistants, nurse practitioners—they do not use the label "clinical" before saying their profession. Why do we do this in pharmacy? Pharmacy is a clinical profession! We have a common denominator—we are all pharmacists. *Pharmacists* who practice in our respective settings. I understand why some in our profession choose to use these terms to label themselves. But the labels describe "What" they do, not "Why" they do it. How can we communicate outside of our profession to get the message across as to what pharmacists do and why we are an essential and critical part of patient care if we do not have agreement within the profession? We frequently label what we do by who pays us.

It is stunning that in 2023 the American Medical Association (AMA) does not recognize the depths of our clinical education and training and is threatened by our role in patient care. They state that "education matters more than convenience."[7] I realize only 15% of physicians belong to AMA, but it is a very influential body. Although many physicians are members of interprofessional teams, there is still this very vocal group spreading the falsehood that pharmacists do not have the education and training to provide clinical services to patients. They cite the current practice situation in community pharmacy as an excuse, stating that even if pharmacists were qualified, we do not have time to provide these services. They are more concerned with "scope creep" versus their purpose: providing the best care possible for their patients. Fortunately, today medical education is team based, and medical students and residents are being educated and trained with other health professionals. We need to work closely with these new practitioners, while they are early in their practice, so they understand the clinical expertise pharmacists bring to the team and care of patients.

There are times I wonder if we are doing as Einstein said, "Doing the same thing repeatedly and expecting different results." We continue to do things the same way and expect things to be different. We go one step forward and frequently 2 steps backwards, fighting the same battles we have fought for years. Reading prior Whitney addresses was incredibly insightful, interesting, but in some regards discouraging because we are fighting the same battles. Hasn't the time come to develop a different strategy?

We must be aggressive with talking to decision makers, eg, payers. We are good at talking to ourselves within the profession (maybe not all the time), but our target must be on those who make decisions and those who have influence over the legislative and regulatory process—and not just legislators. We must be working with payers because they have the power and position to drive legislative changes. We have done the studies demonstrating the value of pharmacists, cost savings, impact on patient outcomes; more studies are not needed. The data is there. And we have seen success in some states where provider status for pharmacists has been achieved. I do believe we are working at all levels and know the millions of dollars in resources that have been directed to achieve provider status, but we must be working aggressively with payers. It is all about dollars and cents to them. I don't think I am naïve when I say they could be the "pharmacy *Field of Dreams*," as we have the data that proves our value. If you build it, they will pay—they will come. When you show a corporation how it can effectively save money and do so while providing high-level patient care, it is a no-brainer—it is good business to include those professionals that have a positive and major impact on their bottom line. I would dare say it is part of their purpose.

Traditional versus nontraditional. We continue to use the terms "traditional" and "nontraditional." The term "nontraditional" infers that pharmacists in other settings are like unicorns. Look, there is a pharmacist over there. . . . One could ask, why do we need one? Pharmacy practice is where pharmacists practice. Let me say that again: *Pharmacy practice is where pharmacists practice!* In the dark ages when I graduated from pharmacy school, the usage of the terms "traditional" and "nontraditional" were appropriate. Pharmacy graduates practiced in community pharmacy or in a hospital. I may have been looked upon as a unicorn moving away from where I grew up to practice in another state . . . and I know Texas was considered the "Wild West"—very different from the Commonwealth of Pennsylvania. My plan at the time to start law school and pursue patent law was certainly considered nontraditional. You did not see many pharmacists combining their pharmacy degree with law. Maybe graduate education, but even residency training was not something that I saw or was discussed.

Today, I ask why we are still using the term "nontraditional?" When we use this nomenclature, we as a profession are telling others that if a pharmacist is practicing in a particular setting that we do not consider traditional, then where they practice is not valued and the pharmacist could be the "token" member of the team and not seen as a necessity. There are those who recognize the need for pharmacists and mandate their involvement. Those who practice in solid organ transplantation know they

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must have a pharmacist on the team. The United Network for Organ Sharing (UNOS) and the Centers for Medicare & Medicaid Services, respectively, require transplantation centers document the participation of a pharmacist specialized in solid organ transplant or a pharmacology expert on multidisciplinary transplantation teams to meet accreditation standards. These regulations make transplant pharmacy the only pharmacy specialty practice in the United States to have such a requirement. Why isn't this required for all practice areas?

Credentials. When I think of my husband and most physicians, to practice in their respective areas they are required to complete additional training and be credentialed. I am confident my husband would not have wanted to start treating psychiatric patients full-time without his 4 years of residency and board certification. As pharmacists, would we consider practicing in different areas without the necessary training and credentials to provide care to our patients?

Let's consider the terms "standard of care" and "top of our license." Standard of care (SOC) is an essential concept in determining whether a person was negligent and potentially liable for a tort. If a person breaches the standard that applies to them and their actions cause harm to another person, they will be liable for negligence. The standard of care usually revolves around the concept of the reasonable person standard: whether someone acted with care as the average person would have in those circumstances. The SOC is determined by the individual circumstances that present in practice rather than specific requirements codified in law.

I admire the State of Idaho for changing the laws and rules for pharmacy practice to a SOC model. For individuals who want to provide additional services and/or specialized care/practice, they are required to acquire additional credentials. Is there an issue with this in pharmacy? Would you want a surgeon operating on you without 4 years of residency (and probably more?) This certainly is a concept some state boards are considering to decrease regulations and allow for flexibility in practice.

Although this term is well defined in healthcare and law, to those outside of our profession, and the public, this could be perceived as healthcare providers not meeting the SOC when caring for patients. Is there ever a day when we would not be providing the best care possible? The SOC is the standard, yet we persist in differentiating our practices by using this nomenclature.

Working "at the top of your license" as a medical professional means you are utilizing your full scope of practice and skills to provide the highest level of care that you are trained and authorized to offer. Although we may not do everything we are licensed to do, does this mean we are operating at the bottom of our license? What does this say to those outside of healthcare?

Call for action. My call to action for the profession is as follows:

1. **We must *change the narrative!*** Words matter! It is time we used a common language in pharmacy. This is not only for the public but also for our understanding.
2. **Live, eat, and breath our purpose.** I look at our purpose—our Why—as our true north, the magnetic force that bring us back to our Why. If we do not do so, we will drift farther away and run the risk of our profession becoming obsolete. At a time when colleges and schools of pharmacy are having problems filling their classes, I can't help but wonder, are we truly articulating our purpose, our Why? I know what they see in community practice may deter this, but this is not where all graduates are going. As I look at our employment data for the past 5 years, the percentage of our students going into chain pharmacy practice continues to decrease as the percentages going into residencies and institutional practice continue to increase. If we are going to keep blaming the current chain pharmacy practice model for decreased enrollments, then we must do something to change it. Again, let students know that *pharmacy practice is where pharmacists practice!*
3. **Work together as a profession.** Let's stop fighting amongst ourselves and truly work together to get the recognition for our expertise and role we play in patient care. No more lip service, with months and years passing by while we have the same conversations at the JCPP [Joint Commission of Pharmacy Practitioners] table. To hear this is like listening to a Peanuts cartoon when the teacher goes "waw wa wa wa." It is time for the "A" organizations and the "N" organizations to put our labels aside and agree on a common goal—achieving what is good for pharmacy. If we do that, we will accomplish our purpose: using our knowledge and expertise to help our patients.

Conclusion

I always tell people it does not matter how many letters I have after my name; I am a *pharmacist* first and foremost. I may not provide direct patient care, but my profession is part of my identity. I tell them I am a pharmacist who practices in an academic setting and then about the stuff I teach and serve as a dean over (if I even go that far). More importantly, I tell them *why* I am a pharmacist.

I always think of a quote from Billy Woodward's 2004 Whitney address. He said, "Being a pharmacist is a privilege and a blessing bestowed by society on a relative few. With such privilege comes responsibility—a sacred professional duty—to continually define quality by our actions and never, never be content with anything less." What a beautiful way to express to all our purpose—our Why.

So, when you are boarding your flight home [from this meeting], you might walk onboard the plane with your earbuds or noise cancellation headphones on and utter to yourself,

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"Rats! I didn't charge these before I left the hotel." The person next to you may say something to you. It starts out very innocently: "Hi, what is your name? Where are you from, what do you do?" How will you answer? Will you start with the What or the Why? I am hopeful that after tonight, you will start with your Why and proudly say, "I am a *pharmacist*."

Thank you.

Disclosures

Dr. Ginsburg has declared no potential conflicts of interest.

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