"The most important priority for organized pharmacy is to define what we mean by quality and become specific in our measurement of it."

John A. Gans

(1998)

At the time he received this award, John A. Gans was Executive Vice President and Chief Executive Officer of the American Pharmaceutical Association (APhA).

The Patient Is Waiting

As a profession we have reached consensus that patients—not drugs and not doctors—are our primary responsibility. I decided to call this speech "The Patient Is Waiting" because of what Iowa community pharmacist Greg Yaekel said to me in 1993 about tackling our responsibilities: "We aren't walking our talk, and it's your job, Gans, to make us do that."

Why are patients waiting? What are they waiting for? That is what I'll speak about tonight.

First, come with me on a short journey. Imagine you are sitting in the Hubert H. Humphrey Building, named for a famous pharmacist and home of the U.S. Department of Health and Human Services. On the dais are Vice President Gore, Secretary Shalala, the Surgeon General, and other key leaders responsible for the nation's health. Leaders from pharmacy, medicine, and nursing are there to witness a historic moment.

Mr. Gore steps up to the microphone and announces a new federal initiative called

"Safe Drug Use—A Focused Agenda." The goal is an 80% reduction in preventable drug-related morbidity and mortality in the United States. The Vice President cites Thomas J. Moore, Jr.,[1] senior fellow in health policy at George Washington University, who has estimated that 100,000 people die each year because of adverse events caused by drug use and that another million may be injured so severely they require hospitalization. Mr. Gore goes on to say that "as prescription drug use increases, we face the troubling prospect of even more pain and suffering. That is simply unacceptable." He commits to a massive $500 million campaign involving the public and private sectors and many public advocacy groups. This is what our patients have been waiting for! Now pharmacist-led pharmaceutical care will become a reality because the government will support it. There can be no excuses.

You might be surprised to learn that such an initiative was reported on the front page of most newspapers last April. You probably missed it, though, because there was a big difference between the actual announcement and what I have just described. The Vice President announced "Safer Skies—A Focused Agenda," a new federal initiative against air-traffic-accident deaths. The goal of this initiative is to bring about an 80% reduction in fatal aviation accidents, even though the airline industry already enjoys a remarkable safety record. The program aims to eliminate 140 of the 175 annual fatalities (based on 1995 statistics) from U.S. airline accidents. As a frequent flier, I applaud anything that makes it safer to fly. I was on an airplane when I read the newspaper report of Vice President Gore's announcement, and I thought it ironic that on the very day the world was reading about this new federal objective to decrease airline fatalities, it was reported (on the same page) that more than 100,000 lives are lost each year as a result of medication-related problems in our country's hospitals.[2] While Vice President Gore announced the commitment of $500 million to save 140 lives, President Clinton proposed just $1 million in federal support to address drug misadventuring and improve medication use. I contend that the patient is waiting because we in pharmacy have not taken responsibility for these medication-related issues. Nor have we forced the public to recognize and support our efforts.

Taking responsibility

Let's make this personal. All the drugs involved in these fatalities were dispensed by pharmacists. I assume that many of you, like me, have seen the dark side of pharmaceutical care as children of an aging parent or friends of someone who suffered a drug treatment failure. When I speak to consumer groups, I always ask the audience to raise their hands if they or someone they know has had a problem with drug therapy, and most people raise their hands. Take my own mother, for example. I receive calls from my family, all with essentially the same message: "Mom isn't doing very well. We've taken her back to the hospital." Poorly managed medications are always the cause, congestive heart failure the effect. Certainly she is one of many patients who are waiting for pharmaceutical care. Her experience tells me that we have much to do to ensure that preventable drug misadventures are eliminated. So, if we are going to walk our talk, what path do we take from here to there?

I received a clue in reading a letter that pharmacist Eugene White wrote to his

local newspaper in Berryville, Virginia, upon retiring after almost 50 years of providing pharmaceutical care to his patients. He acknowledged that from very early in his career he had radical ideas about how pharmacy should be practiced. His practice, which included offering his patients a professional office setting and patient-specific drug histories, was not even consistent with the profession's code of ethics, let alone the law. But he believed that such innovations allowed pharmacists to become directly involved in the care of their patients.

Clearly, Eugene White is an icon of American pharmacy, but that is not my point. I learned two important lessons from Eugene White's role in history. First, he acted on his conviction that practice had to change if patient care was to be improved, despite what law, conventional wisdom, or reimbursement might dictate. Second, once this pharmacist stepped across that boundary, his patients supported his practice. Unlike most Americans, pharmacist White's patients were no longer waiting for quality pharmaceutical care.

Andrew Jackson said, "One man with courage makes a majority." As a group, I do not think we are quite as brave as Eugene White, Paul Parker, Clifton Latiolais, and Harvey Whitney himself were when they accepted responsibility for fixing the errors caused by the floor-stock medication system and i.v. compounding at nursing stations.

Are we as willing to accept responsibility for society's drug therapy problems as our past leaders were willing to accept responsibility for the issues of their day? These problems are real. How many exposés in *U.S. News and World Report, Dateline,* and *Prime Time Live* will we endure before we realize that, if we do not accept responsibility for solving these problems, the public will find someone who will? We are the drug experts. We are the most trusted and accessible health care professionals. But the patient is still waiting for much more from pharmacists.

The patient's need for a therapeutic counselor and medication caregiver will grow rapidly because an explosion in therapeutic technology is on the way. In describing the launch of a new genetic research program, Novartis Chief Executive Officer Wayne Yetter noted that new therapeutic horizons were about to multiply beyond our wildest imagination. Current disease models have isolated just 417 targets of action for therapeutic agents. The human genome project may provide more than 80,000 new targets for science and therapeutics. Our patients are waiting anxiously for these therapeutic tools. Some of their lives are literally hanging in the balance. Will we be poised and ready to serve these patients?

I have highlighted two challenges for our profession. *The first is the challenge to take responsibility for creating a system in which the pharmacist is always there to manage drug therapy. The second is the coming explosion of an entirely new arsenal of complex therapeutic agents*. I believe that our progress on the first of these challenges will secure our role in managing the second. Some of you may think the tone of my remarks thus far is too negative in terms of pharmacists' current contribution, but I believe we must be pragmatic and face today's reality to realize tomorrow's promise. That is what Don Francke, Herb Flack, Herb Carlin, Grover Bowles, Sister Gonzales, and Joe Oddis did, and we should demand nothing less from ourselves. I am highly optimistic about

pharmacists' future role in patient care. That is why I left the Philadelphia College of Pharmacy and Science nine years ago. I believed that I needed to shift from my 25-year focus on clinical pharmacy education to the implementation of what we had learned and that the American Pharmaceutical Association (APhA) could become a force, along with ASHP, for making the profession accept this new responsibility or, in the words of pharmacist Yaekel, "walk our talk."

Pharmacists making a difference

The lipid management demonstration APhA calls "Project ImPACT: Hyperlipidemia" lends credence to my optimism about pharmacists' role in patient care. Through this project, 29 pharmacists in 15 states are managing 700 patients in close collaboration with physicians. Let me tell you what a patient and a physician had to say about the program, in their own words.

"When my cholesterol hit 304 I realized I had to make some changes," says a hospice nurse in Indiana. Hyperlipidemia runs in her family and not long ago cut short the life of a cousin. "It's hard to change eating patterns when you're descended from farmers who raised you on an egg every day and butter on your toast. And I hate to exercise." She sought assistance from pharmacist Stacy-Marie Norman. "Stacy helps motivate me to stick with a low-fat diet and developed an easy-to-follow medication regimen. This program works," says the nurse. "I think about my cousin and wonder, what would have happened to me if I'd kept living that way?"

"Many of my patients find it inconvenient to schedule a visit to the clinic to recheck their cholesterol," notes James Lee, M.D., a family practitioner in Minnesota. He feels comfortable having patients monitored at a nearby pharmacy. "Pharmacist Steve Simenson is informed about how to lower cholesterol and is familiar with all the dietary measures. He is able to sit down with patients, talk to them, and compare their current cholesterol levels with prior values, which motivates them to make the changes they need. When patients need medication readjustments, Steve refers them back to me, but many times we can save them an office visit," Lee says. "Steve certainly has my respect—he does an excellent job and is an information source I can rely on."

There are other compelling examples of pharmacists' success in providing patient care in areas such as anticoagulation, mental health, asthma, and diabetes. The fact is, many pharmacists *are* delivering pharmaceutical care, and it works. Patients love it, physicians support it, and increasingly payers are willing to pay for it. Now we must make it readily and consistently available. When I think about APhA's vision statement of "making the provision of pharmaceutical care the standard of pharmacy practice by the year 2002, a standard of practice that is accepted by the citizenry and for which pharmacists are paid," I feel overwhelmed at times. Sometimes it is like trying to turn a battleship in a bathtub, but in reality it must be approached much more simply—one pharmacist and one patient at a time. Paul Pierpaoli[3] said it best: "The ultimate determinant of our progress is the strength and persistence of will of each individual practitioner." I believe it is the role of ASHP, APhA, and their state affiliates to assist each pharmacist who wants to make this transition.

Planning for success

I want to finish by offering my thoughts on several concrete things we can do, as individuals and as leaders of our organizations, to make a difference in advancing our shared agenda.

I believe the most important priority for organized pharmacy is to define what we mean by quality and become specific in our measurements of it. We need to do this because it is essential that the pharmacist and the people who pay for care know when they are delivering quality care and when patients are receiving it. *I believe it is essential that we move away from staking our future entirely on the quest to save dollars for the health system.* The winning proposition will involve quality improvement and patient satisfaction. That may sound odd in health care environments that equate quality with cost reduction. But I believe history will support APhA past president Gary Kadlec's contention that quality drug use must become job one for pharmacy.

We need to agree on a specific set of quality measures that are positively changed by pharmaceutical services. We do not have to create them from scratch but simply to adapt them to incorporate the unique and powerful contributions made by our profession. A quick look at the measures adopted by the Health Care Financing Administration's Diabetes Quality Improvement Project reveals many ways in which pharmacists contribute to quality patient care. A diabetic patient from Spokane, Washington, says this about pharmaceutical care: "Last year I was dying with diabetes. This year, I'm living with it." This patient was overwhelmed by the demands of being a diabetic new to insulin therapy when she noticed a brochure in her pharmacy offering glycosylated hemoglobin monitoring and diabetes management. "I jumped on it and it was one of the best decisions of my life," she says. Pharmacist Linda Garrelts began counseling her and taught her to monitor her blood glucose levels. Working with the patient's physician, Garrelts developed a dosage regimen for her patient and helped her learn to use the new tools to manage her disease. "Linda Garrelts changed my life," says the patient. "She gave me back the control that diabetes had taken."

We need to study these practices and create user-friendly quality indicators that will allow practitioners to benchmark their progress. I am now going to offer six "what if?" questions about things that we can accomplish before next year's Whitney address that would reduce our patients' waiting time.

1. *What if we standardized models for collaborative care so physicians knew what to expect from pharmacists when they wrote orders for pharmacist anticoagulation management?* Wouldn't physicians write prescriptions for these services more often? Select pharmacists across America have achieved such understanding one physician at a time, but our patients are waiting for a more rapid diffusion of these innovations. State and national organizations must help facilitate this diffusion.
2. *What if we developed credentialing programs to fill the gap between licensure and specialty recognition?* Surely this would give more payers the confidence to pay credentialed pharmacists to provide the sophisti-

cated new services needed to make drug therapy work, services that payers want to buy? Such programs must assume a higher priority for organized pharmacy. We need a critical mass of recognizable, identifiable, advanced-practice pharmacists who will implement the drug therapy plans of our specialists and guarantee the best patient outcomes.

3. *What if we identified teams of physicians, pharmacists, and patients whose collaboration is already working to improve the quality of patient care and held these collaborative teams up as examples to physicians, pharmacists, and the media?* Surely that would defuse the criticisms of naysayers and offer models and hope to other patients, pharmacists, and physicians who are aspiring to do the same thing? This approach is critical to pharmacy's long-term success in lobbying legislators and regulators, as well as private payers, as we learned at pharmacy's California Summit of Health Care Payers and Providers in April.

4. *What if we developed and actively marketed a minimum data set for pharmaceutical care and made sure, as my past presidential colleague Jim McAllister suggested, that every patient discharged from a hospital received a pharmacy discharge summary to give to his or her community-based pharmacist and other caregivers?* Would that improve the continuity of care? Would it empower community pharmacists by giving them the information they need to become pharmaceutical caregivers? I think so.

5. *What would happen if pharmacists decided that counting pills was no longer the primary focus of their practice—period?* Would that force our profession to accelerate up the curve of technology in order to bring automation into the reach of the typical practice and to bring unit-of-use packaging to the United States, as has happened in virtually every other developed nation? Would this offer frontline practitioners the time to deliver direct patient care? I think it would.

6. *And what if we agreed to focus on the most vulnerable and most rapidly growing population—the elderly?* As many as 23% of admissions to nursing homes are the result of these patients not being able to manage their drug therapy.[4] It is ironic that floor-stock quantities of medications sit unused in the homes of far too many older adults yet, as soon as these patients enter a nursing home where nurses oversee their care, the same drugs are dispensed in unit dose packages designed to help these licensed health care professionals "get it right." *We should develop special drug packaging and training for elderly patients so they can remain at home.* Serving the needs of an elderly patient wins the hearts and minds of two key publics—the elderly and their families. I believe the impact on pharmacy could be enormous, particularly given the tidal wave of older citizens reach-

ing an age at which medications are key to health and independence. Doesn't this seem like a logical priority for the delivery of individualized patient care by pharmacists?

Conclusion

Our patients are waiting, and soon we, too, will be waiting with them—as patients. As I look around this room, I can see that many of us are at the front end of the baby-boom population ourselves. We come from a generation that hates to wait. And, while it may sound self-serving, I want to know that when I am my mother's age I will have access to a personal care pharmacist and to pharmaceutical care. And for those of you who know me well, I *don't* want to be kept waiting.

Acknowledgments

It is with a deep sense of gratitude that I accept this distinguished award. I am humbled to be placed among those who have gone before and who have been a light and an inspiration to me. At times like this, the thoughts of Alex Haley come to mind: He said he often felt "like a turtle on a fence post" because, if you see a turtle on a fence post, you know it did not get there by itself—someone had to put it there. I am as honored by the love and the effort of those who nominated me and worked so diligently for this wonderful moment as I am by the award itself. I wish to thank Gerry Meyer, Terry Schwinghammer, and all my colleagues at the Pennsylvania Society of Health-System Pharmacists. When I learned that I would be the 1998 Harvey A. K. Whitney Lecture Award recipient, I reacted in ways that I suspect mirror the reactions of previous recipients. First I was shocked, but that quickly gave way to delight, and then, almost immediately, I began reminiscing about all the people I have known during my 35-year association with the profession of pharmacy and who have had some part in my being here tonight. My list of mentors includes almost every pharmacist, educator, scientist, and patient I have known. So there is simply no way that I could begin this presentation without acknowledging all those who have contributed to whatever it is that has earned me the Whitney Award. I hope therefore that everyone from whom I have learned will forgive me for simply saying "thank you." I could not have done it without you.

But I do want to recognize the people in the organizations that have had the greatest impact on my professional career: my colleagues from the Pennsylvania Society of Health-System Pharmacists and the Philadelphia College of Pharmacy and Science and my associates from the American Society of Health-System Pharmacists and the American Pharmaceutical Association.

Phil Schneider told me that he hopes one day he is introduced only as the father of each of his children. The same goes for me. Allison, John, and Charlie, being your dad gives me more pride than any award, any accomplishment, and anything I do. Many people ask me, "How do you get such great children?" Well, the answer is easy. The real rudder and enabler of our family is my wife, Eileen. Eileen is the essence of giving and sharing with others. I have insufficient words and time to express my appreciation. She has worked and dreamed with me and encouraged all of us every

step of the way, through thick and thin, and has turned all the opportunities that evolved for me into successes for our family. She has straightened me out when I needed to be straightened out and supported me when I needed support. Thank you, Eileen.

My parents raised their sons to give something back and make the world a better place—to commit to a profession, work for it, and make it better. Excellence in practice is very different today than it was in 1950 when this award was established, and so it will be in the future. But I pray that it will always be about making lives better for *our patients* through extended hands-on care, concern, and competence.

(For a complete list of references cited, please see page 1679 of the *American Journal of Health-System Pharmacy*, Aug. 1998.)

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

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