

# Professional policy as a catalyst to pharmacy's transformation

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The selection committee for this new lecture series may often bring to this platform speakers whose perspective is that of an “outsider looking in”—individuals whose broad knowledge and experience in health policy produce an important message for the creators of American Society of Health-System Pharmacists (ASHP) policy. I am writing from a different perspective, that of a former insider who has had time to reflect on the many facets of professional policy.

## Context for the policy process

The work of participants in ASHP's Policy Week occurs within several contexts; examples of these contexts include the U.S. economy, the nation's health care delivery system, the structure of the hospital industry, and our country's method of developing, approving, and marketing medicines. The better one understands all the relevant contexts, the more effective one will be as a participant in the policy process.

When I refer to the ASHP policy process, I mean both the *development*

of professional policy (i.e., positions and practice standards) and the *implementation* of policy. Implementation includes ASHP's work with quality-improvement organizations, liaison with health professional and related organizations, and activities involving public relations and government affairs.

Three particularly important contexts of the policy process have become somewhat underappreciated: pharmacy's ongoing transformation, society's quest for rational use of medicines, and professional and ethical challenges in pharmacy. Renewed attention to these contexts could enhance the already significant effectiveness of ASHP in the national health policy arena.

## Transformation of pharmacy

It is instructive to reflect on the purpose of ASHP's Policy Week, an annual event that involves intense preparation by ASHP staff and by the members of the five councils<sup>a</sup> and the ASHP Commission on Affiliate Relations. Why do so many ASHP members eagerly volunteer to participate in Policy Week, which is a

very time-consuming commitment? Is it because they feel an obligation to help solve all the knotty issues on their group's agenda? Is it to network with their friends and colleagues? Is it to foster their personal development as leaders in the field? Those are all good reasons, but they miss the fundamental purpose of the policy process, which is to nurture the transformation of the profession of pharmacy.

All recent participants in Policy Week probably have accepted the premise that dispensing and order fulfillment will not sustain our profession. Health-system pharmacy leaders have reached a tipping point in accepting this reality. The extent to which this belief is accepted more broadly in health-system pharmacy and in pharmacy as a whole varies across the country.

We still have work to do in building consensus on what will sustain our profession into the future, and health-system pharmacy will continue to play an important role in the transformation process for the profession as a whole. That role relates to the distinctive character-

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Dedicated to the many pharmacy practitioners, educators, and students who voluntarily devote their time, energy, and intellect to the American Society of Health-System Pharmacists (ASHP) policy process.

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## Willam A. Zellmer Lecture

The William A. Zellmer Lecture was established in 2010 by ASHP in collaboration with the ASHP Research and Education Foundation's Center for Health-System Pharmacy Leadership to honor Zellmer's numerous contributions to pharmacy practice in the United States and abroad. The lecture will be given annually during ASHP's Policy Week by a distinguished individual who has demonstrated exceptional leadership in advancing health-care-related public policy that has improved the safety and effectiveness of medication use.

istics of health-system pharmacy, such as

- Practice within a culture of health care (not a culture of retail sales),
- Practice in close proximity with physicians and other health professionals,
- Substantial work with high-risk medicines,
- Strong commitment to compliance with evidence-based standards of care,
- Focus on continuous improvement in the quality of medication-related care, and
- Leadership in creating and implementing drug-use policy.

These environmental features allow health-system pharmacists to be pioneers and innovators, and their innovations are often adopted or adapted in other practice settings. Historic examples of this "innovation transfer" from health-system pharmacy to other segments of pharmacy include (1) formulary systems, which used to be very controversial, (2) population-based drug-use review, (3) delegation of meaningful tasks to pharmacy technicians, (4) collaborative drug therapy management, and (5) clinical services in ambulatory care clinics.

As physicians and others discover for themselves the value of health-

system pharmacists in patient care, they may become receptive to pharmacists in the community providing similar value. A recent commentary by the chairman of the board of the American Medical Association expressed comfort with the concept of pharmacist-physician collaboration in the "controlled" environment of the hospital while explicitly stating that it is a challenge for physicians to develop similar comfort with such arrangements in ambulatory care.<sup>1</sup>

ASHP's policy process also plays a role in the profession's overall transformation. In general, there is a strong relationship between the perceived relevance of pharmacists and the perceived relevance of the collective voice of pharmacists as expressed by ASHP and other pharmacist associations. When ASHP policies are communicated effectively to the public, people's expectations of pharmacists may be elevated. ASHP policies also affect pharmacists' understanding of what is expected of them, and this helps advance practice.

The influence of professional policy on pharmacy's evolution imposes important obligations on how the policy process is conducted. Here are four of these obligations, expressed as guidelines for the process:

1. *Devote some energy to big issues whose importance is self-evident to the public.* A good example of putting this guideline into practice is ASHP's position opposing nontherapeutic use of antimicrobials in farm animals; public health leaders and citizens at large are concerned about developing resistance to the world's reservoir of antimicrobial agents.
2. *Do not get bogged down in too many little (introspective) issues.* This expresses the reverse of point 1.
3. *Advocate big-issue policies assertively, in collaboration with others.* There is far more value in authentically working to implement a policy than simply having the policy on the books. Big public-interest policies will not be

achieved by ASHP alone, hence the need for collaboration.

4. *Consistently and regularly inform the public about pharmacists' contributions to patient care.* The most effective approach is telling compelling stories about patients who were helped by pharmacists. This is especially important in meetings with elected government officials. ASHP's enhancement of its public relations program some years ago has helped make the news media "ready" to discover their own stories about the modern role of pharmacists, as reflected recently in the journalism of *The New York Times*<sup>2</sup> and by an op-ed piece in the *Wall Street Journal*.<sup>3</sup>

### The quest for rational use of medicines

An important historic event in drug safety was marked in September 2010 when the Food and Drug Administration (FDA) bestowed its first Kelsey Award on the person in whose honor the distinction is named, Dr. Frances Kelsey.<sup>4</sup> Fifty years ago, Kelsey, an FDA reviewer of new drug applications, refused to sign off on the marketing of thalidomide, which was promoted in other countries as a remedy for insomnia and morning sickness. Kelsey was not persuaded that the manufacturer's claims for the medicine were valid. As the birth defects caused by thalidomide became widely known, Kelsey's courage in resisting the manufacturer's pressure on the agency took on well-deserved heroic status.

Our nation has a history of progressively tightening oversight of drug products after tragedies are associated with their use. A number of drug law reforms followed the thalidomide case, including the empowerment of FDA to ensure both the effectiveness and safety of new medicines. More recently, we witnessed the passage of the Food and Drug Administration Amendment Act of 2007, and surely we are not done yet with new laws govern-

ing medicines. But statutory and regulatory approaches will take us only so far toward the rational use of medicines. To achieve that goal, we need medicine-use experts not only at FDA headquarters in White Oak, Maryland, but also on patient care teams wherever medicines are used.

In his book, *Powerful Medicines: The Benefits, Risks, and Costs of Prescription Drugs*, Harvard University Physician Jerry Avorn offered some of the best writing regarding the challenges to the responsible use of medicines. Here are two powerful passages from Avorn's book:

Medication decisions . . . are still heavily influenced by the triumph of hype and hope over data, of the politics of self-interest over coherent science-based policy. Many physicians and patients are seduced by the latest medication fashions, gorge on expensive clinical junk food and empty pharmacologic calories, haven't a clue as to what it's all going to cost, and don't feel like it's their problem.<sup>5</sup>

[From a medical educator's perspective], it makes more sense to teach students about the basic molecular mechanisms of drug effects [than to teach them how to use currently available medicines which may be obsolete by the time students are finished with their training]. The idea is that knowledge about how to prescribe actual drugs to sick people can then be "picked up along the way" as the students begin their internships and residencies, and later on in practice.<sup>6</sup>

Has any physician ever written a better manifesto for the pharmacist as a collaborator in patient care? However, Avorn made no mention of this role of pharmacists. Although this may upset us, let us admit that most physicians, health policymakers, and patients would not find anything amiss in Avorn's omission. Here, then, is an immense problem for us—a

problem of perception and image—and an immense opportunity.

If we were to make a list of the unique competencies—the core strengths—that pharmacists bring to health care, that list would include the capacity to understand, interpret, and communicate drug information and apply it in patient care. The expertise of pharmacists in this area exceeds that of any other health care professional.

The extent to which pharmacists actually use this capacity is another matter. Society has invested heavily in the education and training of pharmacists, yet pharmacists as a group allow themselves to be underutilized in applying their drug information expertise.

This situation has profound implications for the ASHP policy process. The creation of the Council on Therapeutics (known by various names over the years) was stimulated in part by a desire to elevate public awareness of pharmacy's role in rational therapeutics. When the Council was formed, it was noted that whenever new controversies about the use of medicines made the news, the media often turned to physician organizations for interpretation. Never did the media show interest in what a pharmacist organization had to say. The thinking was that if ASHP had a council devoted to the rational use of medicines, if that group established a track record of intelligent and timely assessment of complex issues in therapeutics, and if ASHP publicized this work appropriately, the gap in public understanding about the expertise of pharmacists would gradually be closed.

It takes time, of course, to achieve an ambitious goal of this nature, but we may not have always pursued the goal with the vigor it deserves. It may be time to reassess if this goal for the Council on Therapeutics is realistic. If the goal is realistic, then it would be good to move to a faster track for achieving it.

One of the core strengths of ASHP is its assessment and dissemination of drug information through a self-sustaining service, *AHFS Drug Information*. An unmet challenge is how to effectively integrate the expertise of AHFS with the ASHP policy process, including the work of the Council on Therapeutics and the regular advocacy efforts of ASHP.

Given the centrality of drug information in the education of pharmacists and given ASHP's experience in producing an authoritative drug information reference service, what is the most effective way to create a strong ASHP voice on issues of drug safety and effectiveness—a voice that people associate with the expertise of the pharmacist? This question merits deeper consideration than it has received to date.

### Professional and ethical challenges in pharmacy

Most pharmacists today do not have control over their practice environment. These pharmacists are employees; they must balance allegiance to the patient with allegiance to their employer, and their professional autonomy is often compromised in the process.

Erosion of the individual pharmacist's autonomy poses two important risks. The first risk is to the patient, who may not receive the full benefit of the pharmacist's expertise because of a weak or absent relationship with the pharmacist. Another risk is to the stature of the pharmacy profession, which is diminished if pharmacists do not act consistently in the best interest of the patient.

In health-system pharmacy, some practitioners seem far more aligned with their institution's "don't-rock-the-boat" values than with the ethics and values of their profession. Consider the examples of pharmacy teams that

- Stick with a drug distribution focus for the primary thrust of their work,



- Do not challenge prescribing that is clearly inappropriate,
- Do not exert housewide leadership in medicine-use safety, and
- Ignore the need for a systematic plan for improving medicine use in the institution.

Parker Palmer,<sup>7</sup> a writer, teacher, and cofounder of the Center for Courage and Renewal ([www.courage-renewal.org](http://www.courage-renewal.org)), has asserted that many people today work for businesses, institutions, and organizations to which they subordinate their personal sense of what is right; in his words, they lead “divided lives.” He believes that there is a tragic gap in modern life between the way things are and the way we know they could be. People evade this gap through denial, equivocation, fear, cowardice, and avarice (which Palmer calls the rewards for stifling the soul).

Palmer advocated that professional persons should be taught how not to subsume their knowledge and ethics to the needs of the corporation or institution that employs them. He has appealed to universities to prepare a “new professional,” which he defined as “a person who is not only competent in his or her discipline but [also] has the skill and the will to deal with the institutional pathologies that threaten the profession’s highest standards.”<sup>8</sup> In Palmer’s<sup>8</sup> words, “We need professionals . . . whose allegiance to the core values of their fields makes them resist the institutional diminishment of those values.”

These ideas, when translated to our profession, mean that in order to save pharmacy as a valuable health profession, we must ensure that individual pharmacists lead undivided lives—that they are authentically concerned about the welfare of the people they serve and that they have the courage to conduct their professional lives accordingly.

Palmer’s advice is, in effect, an agenda for pharmacist associations,

schools of pharmacy, and the teams of pharmacists at all practice sites. Here are some of his prescriptions for treating the problem of divided lives among professionals:

1. *Help students and practitioners understand that institutions are not external to us; institutions are us.* In the words of Palmer,<sup>8</sup> “If we are even partly responsible for creating institutional dynamics, we also possess the power to alter them.”
2. *Take students’ and practitioners’ emotions as seriously as their intellects; reverse the notion that we must suppress our emotions to achieve technical competence.*<sup>8</sup> This point should resonate strongly with us as we reflect on how “technical” pharmacy education is today.
3. *Teach students and practitioners how to cultivate communities of discernment and support.* Palmer<sup>8</sup> said, “Every serious effort at social change requires organized groups of people who can support each other when the demands of being a change agent threaten to overwhelm them.”

From my perspective, here are the top implications of this topic for ASHP, expressed as guidelines for the policy process:

1. When identifying emerging policy issues, be alert for challenges to professionalism experienced by health-system pharmacists.
2. Pay more attention to ethical issues in health-system pharmacy. (Ethics is explicitly within the purview of the ASHP Council on Pharmacy Practice.)
3. Continue to seriously examine conflict-of-interest issues that are currently receiving well-deserved attention in health care. (We have much to lose if pharmacy ever becomes perceived as a mere extension of the marketing of the products and technologies we handle.)

### Summary and conclusion

As ASHP continues to refine the

policy process in the coming years, it should reflect on (1) the importance of understanding context in the policy process, (2) the role of professional policy as a catalyst in transforming pharmacy practice, (3) the opportunity to capitalize on pharmacy’s and ASHP’s strengths in drug information, and (4) the urgency of nurturing the ethical awareness and professionalism of pharmacists. Practitioners engaged in the ASHP policy process should be reflective and expansive, build on natural strengths, and buttress the moral foundation of pharmacy. If participants in the policy process are sensitive to these points, they will hasten the day when it is commonplace for patients across the land to say, “My health improved because the team that cared for me included a pharmacist.”

<sup>a</sup>The domains of the five ASHP councils are education and work-force development, pharmacy management, pharmacy practice, public policy, and therapeutics.

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