

# SPECIAL FEATURE

## Defining excellence

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**Abstract:** Excellence in the pharmacy profession, particularly pharmacy management, is defined.

Several factors have a significant effect on the ability to reach a given level of excellence. The first is the economic and political climate in which pharmacists practice. Stricter controls, reduced resources, and the velocity of change all necessitate nurturing of values and a work ethic to maintain excellence.

Excellence must be measured by the services provided with regard to the resources available; thus, the ability to achieve excellence is a true test of leadership and innovation. Excellence is also time dependent, and today's innovation becomes tomorrow's standard. Programs that raise the level of patient care, not those that aggrandize the profession, are the most important. In addition, basic services must be practiced at

a level of excellence. Quality assessment is a way to improve care and bring medical treatment to a higher plane of excellence. For such assessment to be effective and not punitive, the philosophy of the program must be known, and the goal must be clear.

Excellence in practice is dependent on factors such as political and social norms, standards of practice, available resources, perceptions, time, the motivation to

progress to a higher level, and the continuous innovation required to reshape the profession to meet the needs of society.

**Index terms:** Administration; Economics; History; Nomenclature; Pharmaceutical care; Pharmacy; Politics; Quality assurance; Sociology  
**Am J Hosp Pharm.** 1993; 50:921-8

*The Gap, Inc., a brilliant supernova stock just six months ago, has dimmed to a white dwarf, its price down more than 40% since the beginning of the year.*

—*The New York Times*, August 21, 1992<sup>1</sup>

By definition, a person who might be called a supernova is a superstar, and I believe you will agree that a superstar is someone who excels in his or her chosen field of endeavor. Therefore, this quote from *The New York Times* leads us to ask the question, What, in fact, is excellence?

How do we define excellence in relation to our professional activities? Is it recognizable by perception or achievements? If by achievements, under what conditions does it flourish? Does excellence traverse time, or is it, without continual innovation, no more than a contemporary phenomenon? Does today's excellence forecast tomorrow's standard and next year's substandard? What are those factors that inhibit us from achieving excellence? Based on my experiences, I would like

to share some thoughts concerning the theme of the Webb Lecture, excellence in management.

### Economic and political climate

One factor that has a significant effect on our ability to reach a given level of excellence is the economic and political climate under which we practice. Some consider the continued growth of the nonprofit sector in the United States disturbing, because it does not create capital for economic growth and is generally less efficient than the private sector.<sup>2</sup> If we were to compare the efficiency of the economies of Japan and the United States with that of the controlled economies of the formerly Communist Eastern European regimes, it becomes clear that a free-market economy with limited controls is superior to a tightly controlled, centralized system.

As we in the health care system come under greater government and third-party control, we will have less

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Presented on October 26, 1992, in connection with Dr. Mehl's designation as the eighth John W. Webb Visiting Professor in Hospital Pharmacy by the College of Pharmacy and Allied Health

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The encouragement of Florence Mehl, the review and suggestions of Gary Seidman, and the assistance of Barbara Farajun are acknowledged.

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The John W. Webb Visiting Professorship in Hospital Pharmacy was established in 1985 at the College of Pharmacy and Allied Health Professions at Northeastern University, Boston, Massachusetts. Webb was Director of Pharmacy at Massachusetts General Hospital from 1959 until his retirement in 1983. After receiving Bachelor of Science and Master of Science degrees from the Massachusetts College of Pharmacy in 1949 and 1951, respectively, Webb was Director of Pharmacy at Hartford Hospital and worked at the University of Connecticut before returning to Massachusetts General Hospital in 1956 to become Assistant Director of Pharmacy. Webb also served as director of the graduate program in hospital pharmacy at Northeastern from its inception in 1964 until his retirement. He is the author of numerous contributions to the pharmacy literature.

A hospital pharmacy practitioner is appointed to the visiting professorship each year by the dean of the college in recognition of his or her commitment to hospital pharmacy management, experience as a practitioner and educator, and dedication to publishing management-related articles. The visiting professor presents a lecture on excellence in management to hospital pharmacy practitioners and students in the graduate program.

ability to practice entrepreneurship. If the process continues, thereby eroding our ability to function as a private-sector industry, our efficiency will suffer and the gap between mediocrity and excellence will widen. As we practice under stricter controls and reduced resources, we will have to overcome the obstacles of increased competition for dollars and the probability of program terminations. We witnessed these events when prospective pricing for diagnosis-related groups was incorporated into the Medicare system.<sup>3</sup> Block<sup>4</sup> summarized it well when he wrote "Organizations have limited resources, limited budgets, limited people, and a limited number of actions they can attempt. We want at least our fair share of those resources."

In addition, as a nation we face an obstacle that has had a continual and substantial impact on our ability to reach excellence. That obstacle is the velocity of change, which continues to increase. In 1979 Flaherty<sup>5</sup> wrote that the velocity of change was the main cause of crisis in government and politics, as well as in the knowledge explosion, the feminist movement, the decay of the environment, the loss of the work ethic, and the "vacuum in values." These changes are still with us, and as a nation we cannot continue to exist as a productive, cohesive society unless we are able to control the many factors that are pressuring our daily lives. As a profession we cannot continue to assume greater responsibilities and perform at a level that can be defined as excellence unless we recapture and nurture two of the most important traits of any profession and society: values and a work ethic. No amount of management

direction can replace these traits, but leadership and role models can direct our path to them, and thus to a level of excellence. However, we must be able to adapt to the velocity of change and use change for our benefit to reach the excellence we seek.

### Innovation

The excellence of the innovations of Barker and Heller,<sup>6</sup> which led to the introduction of the unit dose concept, is now a standard for pharmaceutical services.<sup>7</sup> Yet there are hospitals that have not met this standard of practice.<sup>8</sup> Are they substandard? Perhaps, but I submit to you that some of these services have done the best they can, given their resources. They have attained their own level of excellence. The adage about walking in another's shoes is appropriate when attempting to define excellence. Thus I suggest that excellence itself must be defined to include flexibility, or the ability to adapt to differing situations, a particular moment in time, and the resources available. In addition, such a definition focuses on the innovative ability of the leader and the leadership qualities needed to use to the fullest extent the available resources to reach a given level of excellence. There are those who argue that excellence in pharmaceutical services can be defined only by the service rendered being at the highest level of practice at a given moment in time. I disagree. I would argue that excellence is measured by the services provided with regard to the resources available. It thus becomes a true test of leadership and innovation.

A pharmacy located in a Third-World country may excel by innovation, using the resources at hand. It would be inappropriate to compare this pharmacy with the pharmacy in a major teaching hospital in the United States that has relatively unlimited resources. This would be like comparing a 100-m track star in the Olympics to a 100-m track star in the Special Olympics.

To further support my position, I point to an article that appeared in the *Wall Street Journal* on August 17, 1992.<sup>9</sup> Wang Laboratories, a \$3 billion company and a major innovator in the field of computers beginning in the late 1950s, filed for protection under Chapter 11 of the U.S. Bankruptcy Code. The lead-in to the article stated, "Large size customer base couldn't compensate for lack of innovation." Imagine that. A \$3 billion company with major resources may be out of business because it could not maintain its ability to be innovative! Regardless of the size of the organization or the amount of resources available, without innovation, excellence cannot survive.

### Perception

It is also worth noting that Peters and Austin<sup>10</sup> point to various studies indicating that most inventions come from the "wrong" person in the "wrong" place in the "wrong" industry at the "wrong" time by the "wrong" user. They indicate that cimetidine (Tagamet, Smith

line & French) was discovered by the "wrong" scientist, and its market value was totally underestimated by the company. Most people would agree that the drug was, in fact, an innovation. If it was discovered by the "wrong" person, does that mean it was simply an accident and there was no innovation involved? On the contrary. It took innovation, which must be a part of excellence, to recognize that the drug was important to the field of therapeutics.

Perhaps the problem concerning the scientist was one of perception. The Disney Corporation has created a certain perception by stating that it has guests, not customers. It has created another perception, cleanliness, by the fact that guests do not find gum on the floors or seats of the Disney parks. One way Disney accomplishes this is by not selling chewing gum. Similarly, pharmacists have been perceived as honest, ethical practitioners. If you believe as I do, that perception has a direct effect on one's determination as to whether excellence exists, then as pharmacists we start with a very positive image. On the other hand, the "wrong" cimetidine scientist was obviously not the wrong scientist; rather, the perception of the world around him was that he did not have the innovation, or the ability to excel, to discover the drug. Therefore, I submit that perception is another factor required to reach the goal of excellence, and that without it, excellence may not be recognized.

### **Fringe versus group**

As we progress in our professional and daily lives, we must consciously make or avoid making decisions. One of the major choices we make is whether we wish to be "on the fringe" and go it alone or join the group and go along with the crowd. Can we reach excellence with an either/or choice? The answer is yes, but we must define the group and the fringe and determine the objectives of both before we can know if success has been achieved.

I recently heard about a study that determined that the objective of a gaggle of geese is to reach a given destination. The study found that those geese that fly within the group arrive faster than those who fly alone. The conclusion reached was that the group can accomplish the task better than the fringe.

That conclusion is probably appropriate, because the entire gaggle had the same objective, and those on the fringe were not innovative enough to find a better, faster route. In the mid 1960s our pharmacy department had an objective: To have the pharmacist practice on the patient unit alongside other health care providers. Our publications at the time pointed to the success that can be achieved with such an approach to pharmaceutical services, but those of us in the department were the fringe. The hospital was the group; at the time, it could not fully understand the value of our innovation. To complicate the problem, we practiced throughout the years under an umbrella of cost containment that

slowed or prevented our implementation of new programs. However, we never lost sight of our objective. Today we are a decentralized pharmacy service only because we believed in our objective and because we, as a department, were willing to be the fringe to reach the level of excellence that we were seeking.

The moral of these stories is that the fringe or the group can succeed, depending on how each is defined, its objectives, and its willingness to seek a given level of excellence. To quote Peter Drucker, "Management by objective works if you know the objectives. Ninety percent of the time you don't."<sup>11</sup> We knew what our objective was.

### **Management and leadership**

It is clear that excellence is composed of many different processes. Two processes often perceived as one and the same are management and leadership. Differentiating between the functions becomes difficult if we do not start out with an adequate definition.

Kotter<sup>12</sup> uses the term leadership to refer to the process of setting a direction and mobilizing people and their ideas. He defines managing as a planning function. However, he also cautions against confusing leadership with being in a leadership position. The two are not necessarily the same. The major differences between leadership and management functions are shown in Table 1.

Based on this differentiation, management and leadership can be seen as separate and distinct activities. Can either one or both of these functions reach a point of excellence? The conclusion must be that excellence can be reached in both activities, because they may be distinct processes. However, it should also be clear that although the processes may be different, this does not preclude a director of pharmacy from being required to practice and excel as both manager and leader. The need to develop excellence in both functions is required of most who practice in the field of pharmacy. In reality, I question whether the processes of leadership and management can be separated as clearly as Kotter has separated them.

### **Time dependency**

As I mentioned earlier, I believe that excellence is time dependent, or defined at a moment in time. If we

Table 1.  
**Differences between Leadership and Management**

Leadership	Management
Establishing direction	Planning and budgeting
Aligning people	Organizing and staffing
Motivating and inspiring staff	Controlling and problem solving
Produces change	Produces a degree of predictability and order

look around us, we recognize those factors that make for an outstanding performance at the present time. An example of this is the current concern regarding medication errors. Why now? We first began to hear about the problems of medication errors during the early 1960s, and at the time we determined that our medication error fighters, the innovators of new systems, were leading us to a new level of excellence. Then it all disappeared. The problem became yesterday's standard.

Now, 30 years later, the topic of medication errors is back in vogue. We have new innovators, leaders taking us to higher planes of excellence with their opinions, recommendations, and actions. But why did we not recognize this as an important continuing problem for the past 30 years, and why have these same leaders, who have been working among us during this time, not been recognized before now?

This phenomenon points to the ebb and flow of practice, in which today's "hot topic" is tomorrow's forgotten thought. This is the point at which the excellent leader and manager begins to stand out. The leader who recognizes the importance of medication errors never loses sight of the need for innovative programs to prevent errors from occurring. It does not matter whether medication errors are the hot topic of the day, but it does matter that the reduction of medication errors continues to remain the objective of the pharmacy department. The superior leader recognizes the need for those programs that benefit patients and raise the level of care. He or she recognizes that programs that raise the level of patient care, not those that aggrandize the profession, are the most important ones, and in the long run they bring pharmacy to a higher plane of excellence.

### **Back to basics?**

If we attempted to dissect superior leadership, there would be no doubt that the underlying principle practiced must be one not of "back to basics" but of maintaining an ongoing, excellent level of basic services. I firmly believe that if you cannot perform on a basic level when required, the perception will be that you cannot effectively perform on a clinical, interdisciplinary level, nor can you have credibility with others.

As a profession we must be able to practice our basic services at a certain level of excellence in order to be accepted in new roles by other health professions. We cannot lose sight of the fact that service is everything. If you cannot satisfy the needs of your customer—the physician, the nurse, the administrator, the patient, and now the third-party payers—you cannot succeed. The services to all of the parties differ: The physician may require drug information; the nurse, the patient's drug; the administrator, financial information; the patient, consultation; and third-party payers, assistance in managed-care programs. The needs themselves may differ, but service becomes the binding factor for success.

It has been said that pharmacists need not themselves practice the distribution functions of the medication cycle.<sup>13</sup> It has been suggested that these activities be delegated to technicians, with the pharmacist remaining the responsible professional. Although I agree in principle, I cannot fully agree in concept. Although my opinion may now be representative of a minority of pharmacists, I am concerned about nonlicensed staff and errors that can be attributed to their actions. I am fully aware that errors occur as a result of the actions of both the pharmacist and the technician, but there are restraints that, according to state regulations or the lack thereof, place a legal burden on the pharmacist that cannot be avoided. Therefore, it is necessary to carefully review those functions that place undue legal responsibility on the pharmacist, and until our legal system and state practice regulations fully recognize the actions of a technician, care must be taken in assigning responsibilities and supervision. Unfortunately, excellence quickly fades if an illegal action by a department staff member is allowed. This in no way suggests that the use of nonlicensed staff is inappropriate. On the contrary, what it does suggest is that staff must be properly assigned, supervised, and protected to allow the pharmacist to assume responsibilities other than those of distribution. It also suggests that we must continue to upgrade the status of nonlicensed people, through both education and regulation, to allow for increased pharmacist interaction with other health care professionals and with patients.

Williams,<sup>14</sup> in a previous Webb Lecture, alluded to basic services by stating that we require a competitive advantage and that our advantage does not lie in drug distribution, but in drug information. I fully agree. The physician, other prescribers, the nurse, lay individuals, and patients look to the pharmacist for drug information. However, I will argue once again that if the pharmacy department does not perform its basic functions well, the department may not be called on to perform other professional responsibilities such as providing drug information. I do believe that the drug distribution function will continue to decline in importance, but we still must excel in all areas of practice. To do this we must sustain excellence in basic services on a daily basis.

### **Economic responsibility: Clinical economics**

Pierpaoli,<sup>15</sup> in another Webb Lecture, stated that the pharmacy manager must be bilingual, or able to speak the language of both the clinician and the manager. Gouveia<sup>16</sup> took this a step further, stating the clinician must not only become bilingual, but as a manager should develop programs that reduce costs and improve quality. He also indicated that pharmacy clinicians should be champions of quality drug therapy. Gouveia went on to cite an article written by Gold-

stein,<sup>17</sup> who stated that there is a negative correlation between quality and cost and that, by avoiding high technology, we may be able to provide better patient care at less cost. Rucker<sup>18</sup> supported this same position when he said, in a critique concerning economic and patient outcomes, "If pharmacists are to become effective participants in this process, they must not only master the technical complexities of therapeutics but find the time to handle these new administrative obligations (economic outcomes) as well." I wish to take this thinking further and focus on the cost issue, specifically the cost of drugs for patient treatment.

We have reached a point in health care in which cost has become a, if not the, major factor in preventing a continued progression to better care. It is estimated that the United States will spend 16.4%, or \$1.6 trillion, of its gross national product (GNP) on health care by the year 2000, compared with 9.2%, or \$250.1 billion, of the GNP in 1980.<sup>19</sup>

Until recently the medical care recipient had little reason to be cost conscious, and the provider had few incentives to control costs. Individuals are often unable to evaluate the credentials and effectiveness of providers, and there are so many private and public players in health care that no one player is strong enough, large enough, or willing enough to control costs. All of this leads to shifts of costs between players, which continues to escalate national expenditures. We are all acutely aware that the upward spiral of health care costs cannot continue unabated, and we can anticipate major changes in the health care system in the near future.

In reference to drugs and drug therapy, whereas the consumer price index increased 21% from 1985 to 1991, prescription drug prices jumped 66%.<sup>20</sup> In addition, it has been estimated that the percentage of a hospital's budget allocated for drugs will increase from the current 3-5% to 25-30% by the year 2000.<sup>21</sup> This is not a totally negative projection. On the contrary, we are all aware that drug therapy is replacing surgery and other treatment modalities as new, innovative agents are discovered to prevent, treat, and cure disease. Under these conditions, drug costs can be expected to increase, replacing the cost of other therapies. However, pharmacists, whether managers or clinicians, cannot cast a blind eye on the cost aspect of drug therapy. If we do, we will experience the same problems that physicians are experiencing because there was no concerted effort to control medical costs in the past.

Pharmacists' expanded role in drug therapy provides us with the opportunity to excel, but the clinical role of the pharmacist must include, along with appropriate drug selection, knowledge of the cost benefit or cost-effectiveness of the drugs prescribed. Neither the clinician nor the manager can shirk the responsibilities of assisting in the elimination of expensive pharmaceuticals with limited therapeutic advantages and influencing the behavioral factors affecting drug selection.

The need for more economical outcomes for drug interventions has become an important factor in the decision making concerning therapeutic choices, and the field of pharmacoeconomics is helping to give us a better understanding of the economic realities of drug therapy. The use of cost-benefit, cost-effectiveness, and cost-minimization analyses are important. The application of these and similar analyses will become more critical as the cost of therapy increases and as decisions by pharmacist managers and clinicians are based not only on therapeutic appropriateness but also on ethical and cost considerations.

We are now at the point where, in determining treatment, less costly, more effective drug alternatives must be considered. A more costly but more effective drug must be justified, and a more expensive but equally or less effective therapeutic agent must be avoided. These types of decisions are difficult, because we are usually dealing at an individual level of treatment. A specific drug that offers a cost benefit for society may not in fact be the best therapeutic choice for a given patient.

Are we as a profession willing to accept this type of decision making? Are the patients we serve and the prescribers we work with willing to allow us to influence their decisions, and are we willing to make the ethical choices required to come to appropriate determinations of treatment modalities?

I submit to you that the choices may be limited. Managed care has become the watchword of the day, and government intervention in health care will continue to grow. As a profession dedicated to drug therapy, we must face ethical and therapeutic dilemmas, and we must have our position made known. We must also use the powerful tools available to us to increase our ability to become better decision makers. We must seize the opportunities of the moment to allow us to excel in the field of pharmacoeconomics—perhaps a more inclusive term would be clinical economics—where difficult, ethical decisions concerning patient treatment will have to be made. If we fail to seize these opportunities, we will surely find others willing to fill the void that will exist because of the serious nature of the problem. If there is one issue today that stands above the others, it is the need for forceful leadership in binding the clinical field of pharmacy with the economic necessity for appropriateness in the therapeutic use of pharmaceutical agents. If we wish to ascend to a higher plane of excellence, we cannot allow ourselves the luxury of avoiding the coming conflicts related to the economics of drug therapy.

### **Quality assessment**

Quality assessment is another concept that has been identified as a way to improve care and bring medical treatment to a higher level of performance. What is new is that this concept has been formalized and structured

into a process that is currently a requirement for accreditation of health care organizations. Perhaps here we again see the concept of yesterday's innovation becoming today's standard of practice, but in this situation there are also driving forces. These forces are third-party payers and patients who are not leading but driving us toward outcome assessment in medical care. The cost of medical care, third-party intervention, better educated patients, and questionable medical practice are other driving forces.

Regarding the practice of pharmacy in the institutional setting, quality assurance can be separated into two distinct areas: first, drug-use evaluation and second, quality assurance programs that are intended to identify, correct, and improve the performance of the pharmacy department per se.

The concept of drug-use evaluation dates back to the Task Force on Prescription Drugs, which was established in 1967 by the Secretary of the Department of Health, Education and Welfare (now known as the Department of Health and Human Services).<sup>22</sup> The purpose of the group was to study the cost of prescription drugs to determine whether Medicare should cover such cost; but the task force also recommended that research be undertaken to determine methods of conducting drug reviews. This was one of the first innovations in the field of drug-use evaluation. Interestingly, 20 years later a new report, "Medicare Drug Utilization Program," was issued.<sup>23</sup> This report by the Inspector General of the United States was intended to encourage an effective drug-use system for Medicare recipients, but the discussion still continues on how to introduce a Medicare prescription drug program.

Fortunately, although the federal government has taken more than 20 years to come to the conclusion that the problem must still be studied, there were innovators in the field who understood the value of drug-use review and published their work and thoughts on how to proceed, how to move in a direction that brings us to a higher level of excellence.

In 1974, Knapp and his colleagues<sup>24</sup> published a definition of drug-use review, saying that it was a method of assuring quality and economy in the use of drugs. In 1976, Brodie and Smith<sup>25</sup> described a conceptual model for drug use in hospital settings. We thus see the innovation of pharmacists who were able to understand the value of a concept, to further define that concept, and to adapt it to practice.

The concept of drug-use review has progressed and is currently defined as drug-use evaluation. It has become an integral part of the standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).<sup>26</sup> Revisions to the standards, having started with JCAHO's Agenda for Change,<sup>27</sup> have given pharmacists practicing in health care organizations an important, powerful tool to assist and guide prescribers and others to more effective drug therapy. By defini-

tion, the JCAHO requires that drug-use evaluation be performed with the aim of improving the processes and outcomes involved in prescribing, preparing, dispensing, administering, and monitoring medications within the institution. The regulations state that "if the practitioner is unable or unwilling to improve his or her practices, the hospital acts to limit the ability of the practitioner to use medications for patient care in the hospital (for example, through modification of clinical privileges)."<sup>26</sup>

Many articles have been written describing the process and concept of and the pharmacist's role in drug-use review, drug-use evaluation, and outcome assessment. Little has been said concerning the pharmacist's responsibility to health care providers, the patient, and the health care institution. I would like to address this area of practice as well.

The JCAHO requires institutional action to correct problems found in the medication cycle and requires that a disciplinary procedure be in place if difficulties are found. It should also be pointed out that the JCAHO identifies staff who may be involved as "practitioners" and as "health professionals." It is therefore safe to conclude that the terminology refers not only to prescribers but also to pharmacists, nurses, and others who prescribe, prepare, dispense, administer, or monitor drug therapy. The burden for determining fault in the drug-use evaluation process has become the responsibility of the pharmacist, and any action taken thereafter would be dependent on the decision of the pharmacist. If excellence in practice is required, this is an area where sensitivity must also be demonstrated.

As we assume responsibility for others, we take on a heavy burden. The JCAHO requirements for drug-use evaluation place new and difficult responsibilities on the pharmacist. They require ethical consideration, professional decision making, and discretion; while avoiding harm to the patient we must be wary of affecting a practitioner's standing in the community or causing financial loss to health care providers. The responsibility of drug-use evaluation cannot be taken lightly. To be successful, quality assessment must be performed in such a way that both the patient and the health care provider are protected.

Almost by definition the drug-use evaluation process and other performance measures can be interpreted as a threat to practitioners. The JCAHO intent statement tends to reinforce the conclusion that assessment is punitive in nature. However, this is not the intent or the goal of the JCAHO or the departments of pharmacy that initiate programs of quality assessment. In fact, within the preamble of the Quality Assessment and Improvement section of the *Accreditation Manual for Hospitals*, the JCAHO states, "Consequently, without shirking its responsibility to address serious problems involving deficits in knowledge and skills, the hospital's principal goal should be to help ever-ne

improve the processes in which he/she is involved."<sup>28</sup>

How do you assure staff that the goal is not finding fault, but improving practice and performance? A pharmacy manager with sensitivity knows that pharmacists and other health care workers are concerned about reporting drug errors, adverse reactions, or other medication problems. The fear is disciplinary action, termination, or, worse, loss of licensure.

Although the intent is not to find fault, the situation will undoubtedly arise in which a staff member cannot perform at the same level of practice as other pharmacists. The abilities and performance of the pharmacist may be such that even after counseling and retraining, he or she will still not be at the same level of practice as other staff members. In such instances, the manager may not have any choice professionally, ethically, or legally but to ask for the pharmacist's resignation. The difficulty the manager faces is one of determining when that point has been reached and being sure that all that could be done has been done.

At that time, it is imperative that other members of the staff be made aware of the problems and the reason disciplinary action was required. If this does not occur, the opportunity to have a successful assessment program may be lost. Staff must be convinced that assessment is not faultfinding, but practice improvement. The dilemma the manager faces can be defined by a slight alteration of an old saying: "If your error rate is 1 in 1 million, what do you tell the one patient?"<sup>10</sup>

In reference to other health care providers, especially prescribers, most drug-use evaluation programs are unintentionally punitive in nature. Most programs review the use of a drug and find practice discrepancies, the prescriber is then informed, and negative practice statements are placed in his or her file. The result is that the prescriber is punished, he or she feels abused, and animosity and friction occur between services.

To correct the existing situation, the philosophy of the program must be known and the goal must be clear. Assessment must not be punitive, but it must be effective enough to change practice if necessary, to educate practitioners, and, unfortunately, to retrain or restrain incompetent practitioners.

To have an effective, useful program, there must also be a change in the manner in which drug-use evaluation is performed. Current thinking is that outcome is of paramount importance in assessment. I agree, but process cannot be totally overlooked because it obviously leads to outcome. It also stands to reason that if outcome is what we are seeking, drug-use evaluation should be directed toward treatment of the disease, not the outcome that results from the administration of a single agent. What we are seeking is not to compile statistics for statistics' sake, but to determine difficulties that may arise within the medication cycle, how important they are, and how we can prevent them. How we prevent problems from occurring is the major concern,

and this can be determined only by identifying why medication difficulties occur. To accomplish this, we must be assured that the standards we use are acceptable and appropriate to allow us to reach our goal.

The reasons medication problems arise are many. Some are complex, others simple; some are a result of process, others of structure. But the most difficult problems relate to questionable professional practice. If there is a breach of practice standards, the seriousness of the problem must be defined. If a minor event occurred but there was no harm to the patient, an educational approach to the prescriber, without further action, is appropriate. However, if acceptable medical practice was not adhered to and the patient was harmed, an explanation from the prescriber is required, with further action taken if necessary.

A differentiation must be made among those incidents that indicate a lack of concern, an unacceptable knowledge base, or an unnecessary or dangerous act and those acts that are not intentional or dangerous or are easily correctable by an educational process. If there were a consensus definition of such acts, we could avoid the appearance that the intent of assessment is punitive. The pharmacist is the logical practitioner to accomplish this task. This would further elevate pharmacy's standing within the health care community and advance the profession to another level. Thus, the opportunity for the profession to excel in the area of quality assessment is here; innovation and leadership are required to have in place more effective programs.

### **Pharmaceutical care**

Thus far, I have presented my thoughts and outlook concerning pharmacy practice. I have not, however, discussed pharmaceutical care.

I have not mentioned pharmaceutical care, nor have I tried to place it within the scope of excellence as I define it, because I believe it has been overshadowed by a more important event. I believe that the introduction of the concept has accomplished more for the profession than the concept itself. It has caused our profession to examine itself to determine its strengths. The pharmaceutical care concept appears to have caused pharmacists to marshal their resources and practice innovations to give new direction to the field.

It is not even important whether the concept is the right one. What is exciting is that pharmacists have taken a renewed interest in the profession. Whatever the future outcome, we will have been brought to what may be a new level of excellence.

### **Conclusion**

I began by raising questions as to what constitutes excellence in professional practice. I conclude with the statement that excellence in practice is dependent on factors such as political and social norms, standards of practice, resources, perceptions, innovation, time, and,

most importantly, the motivation required to progress to the next level.

If we are to excel, we must continue to reshape the profession to meet the needs of the society we serve. We must forecast and develop visions of practice in the future. But there must also be continuous innovation in practice, or we will become like Wang and The Gap. There cannot be a status quo for the profession. We must understand and react to the forces that drive health care, and we must continue to attract bright, innovative people to replace those who have provided a strong foundation from which to build.

I will close by quoting J. P. Kotter:

We choose between maintenance and greatness. We choose between caution and courage. We choose between dependency and autonomy. These choices define the tightrope we walk.<sup>12</sup>

The direction we take on the tightrope must be toward excellence.

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