

Management diplomacy: Myths and methods

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Abstract: The importance of a manager's ability to tolerate and overcome ambiguity is discussed in relation to achieving excellence in hospital pharmacy management.

Health-care programming and policy in the 1980s are shaped largely by financing and increased corporate control; in this environment, hospital pharmacy managers face new definitions of excellence in management. Today's director of pharmacy must be "bilingual" in a sense, since he or she must effectively relate to the hospital's corporate administration on the one hand and the professional staff and patients on the other. The hallmark of excellence in a modern director of pharmacy is the ability to tolerate and overcome ambiguity that arises from both of these sources. Ambiguity may be rooted in issues external to the pharmacy department, including (1) structural or organizational barriers that distort power

and authority, (2) the gap between professional values and bureaucratic expectations of behavioral norms, (3) the potential for encroachment on professional boundaries, and (4) the difficulties associated with establishing the effectiveness of clinical pharmaceutical services. Intra-departmental ambiguity may be rooted in structural flaws in departmental organization coupled with inappropriate management styles.

If the pharmacy profession is to cope effectively with mounting ambiguity, a theory of clinical systems and practice management will have to be developed. This will require the knowledge, skills, and leadership of "bilingual" directors of pharmacy.

Index terms: Administration; Administrators; Hospitals; Personnel, pharmacy; Pharmacy, institutional, hospital
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Each honest calling, each walk of life, has its own elite, its own aristocracy based on excellence of performance.

James Bryant Conant

The notion of excellence has been an integral part of the ascent of man. "Excellence" is a curiously powerful word that evokes deep and different opinions, feelings, and aspirations. In his classic work on excellence, Gardner¹ aptly described how the concept of excellence can take on different meanings at different times in different societies. Gardner described the range and varieties of excellences: from intellectual activity—which leads to new theory development—to art, music, craftsmanship, human relations, leadership, parental responsibilities, etc. He also reminded us that inas-

much as people have different definitions of excellence, they often view excellence from different vantage points.

The theme of the Webb lecture is achieving excellence in hospital pharmacy management. Accordingly, the perspective I have of excellence is that of a director of pharmacy. Personal experience, some study, and much observation have led me to believe that one of the most critical determinants of achieving excellence in hospital pharmacy management is the manager's capacity to tolerate and ability to transcend ambiguity. Indeed, this might well characterize much, if not all, of the core of what constitutes effective leadership by any manager.

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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. Webb also served as director of the graduate program in hospital pharmacy at Northeastern from its inception in 1964 until his retirement, and he is the author of numerous contributions to the pharmaceutical literature.

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

Like the concept of excellence, the nature of the challenges facing hospital pharmacy managers in dealing with ambiguity have taken on different meanings at different times. Tolerating and surmounting ambiguity in the formative years of the profession's growth (1940-60) had a different meaning from tolerating and surmounting ambiguity in the current management climate of the health-care and hospital industries. Moreover, the 1990s and the dawn of the 21st century have the portent for an even more complex management scenario for pharmacy managers.

During this lecture, I will attempt to explore the range, context, and contrast of ambiguities with which hospital pharmacy managers have had to deal to date and, to the extent possible, I will attempt to provide some insight into the future. I also will attempt to define and characterize the role of the director of pharmacy as a program manager and discuss some of the structural and functional factors that contribute to ambiguity in this vein. Finally, I will attempt to provide some insight into the concept of management diplomacy, address its importance in dealing with ambiguity, and offer some broad recommendations for students of hospital pharmacy management.

The Evolution of Values Systems in Health Care

Any discussion of the values system of a profession must be cast in broader social, political, economic, and technological contexts. Since Flexner's comparative study of medical education was published in 1925,² health care in the United States has been shaped by public-policy as well as economic, social, and technological responses to three major crises—the quality crisis, which lasted from the turn of the century to World War II; the access

crisis, which lasted from the post-World War II era to the late 1960s; and the cost crisis, which has lasted from the early 1970s to the present. Each of these periods of crisis has been responsible for major changes in the landscape of American medicine, the hospital industry, the roles of the government and the private sector in the financing of health care, the regulation of health care, the education of health professionals, the concentration of power and authority in the health-care system, and the public's perceptions and expectations of health care.

The crisis in health-care costs that was first enunciated by President Richard Nixon in 1970 has continued unabated despite the interventions made by the principal parties.³ This crisis was preceded by the halcyon decades of the 1950s and 1960s, when financial pressures were largely unknown. During those years, the health-care industry was dominated largely by a nonprofit ethic, and the values of most health-care managers and professionals were rooted in considerations of equity in, quality of, and access to the health-care delivery system.

Since the early 1970s and the dawn of the cost-containment era, enormous shifts in institutional power and influence and professional authority have occurred, with the resultant emergence of a "business" and "bottom-line health care" value setting.⁴ Key articles and books in the medical literature that deal with subjects such as managing the new medical-industrial complex, the monetarization of medical care, megacorporate health care, and the social transformation of medicine bear powerful witness to a rapidly changing culture in the health-care industry in the 1980s.⁵⁻¹⁰

In the view of at least one prominent spokesman, the pursuit of cost containment that began in the pre-Medicare era and was heightened by major health-care policy reform in the 1970s and 1980s has caused the destabilization or undermining of the existing structure of the U.S. health-care system. Ginzberg¹¹ cited the following factors: (1) the general trend away from private medical practitioners to physician employees of nonprofit hospitals or corporate enterprises; (2) the shift in ownership and control of hospitals from nonprofit to profit, and the accompanying threat to freestanding community hospitals; (3) the increasing segmentation of the broad risk pool that enabled persons in poor health to acquire health insurance at a reasonable cost as large employers have moved to self-insurance; and (4) the evaporation of cross-subsidization in the face of heightened price competition, with adverse consequences for the poor and near-poor.

The Business of Health Care

Health-care programming and policy in the 1980s appear to be driven and shaped largely by

financing. Business people are now considered to be the chief architects of the redesign of the health-care system—the new “fourth party.”^{12,13} American health-care organizations are experiencing fundamental changes in their goals, forms of authority, core technologies, and marketing strategies, and the pursuit of excellence in such organizations has taken on totally new dimensions.

Shortell¹⁴ poignantly described a new management milieu for the future that will be characterized by continued cost-containment pressure, ethical dilemmas raised by new technology, changing consumer expectations, professional conflicts, and increased competition. He has developed a new management paradigm for the high-performing health-care organization that will clearly outdistance its counterparts in the future. Shortell's 10 characteristics of high-performing health-care organizations can be summarized as follows:

1. *They have an overarching commitment to the extraordinary.* These organizations stretch themselves and have a commitment to the extraordinary; they are driven to set and achieve high standards. They are not concerned with industry norms or just meeting voluntary accreditation standards. There is an emphasis on the manager as a “developer” rather than as a “master technician.” The focus is on leadership through the development of one's subordinates.
2. *They maximize learning.* These organizations maximize learning by undertaking new ventures and developing strong management and clinical information systems in support of organizational learning. They also push information down to the lowest level and emphasize effectiveness over efficiency. The maximization of learning is accomplished through both proactive (ahead) and reactive (behind) methods. Parties of
3. *They exhibit transforming leadership.* As people-intensive organizations, high-performing health-care organizations have the ability to “lift people into their better selves” by giving meaning to employees' lives on a daily basis. They effectively integrate the personal values and goals of the employees with those of the organization.
4. *They have a bias for action.* This bias for action is evident at both a macro and a micro level. These organizations do not view their environment in a passive fashion; they act on the environment to create new markets and service lines and develop strong hospital and physician relationships. Problems are handled promptly through everyone pitching in to get the job done, their positions in the organization notwithstanding.
5. *They have the ability to create “chemistry” among managers.* These organizations provide a milieu in

which skills and orientations are balanced. Managers appreciate each other's abilities and complement, rather than compete against, each other. Managers in high-performing health-care organizations recognize their true abilities and the advantages they have relative to the talents of others.

6. *They have the ability to manage uncertainty and ambiguity.* These organizations thrive on uncertainty and create, rather than react to, change. They are flexible in organizational design and staffing and are very close to their clients. They are like a football team that comes out of the huddle in a basic formation but, after reading the defense, changes to another formation. They frequently use ad hoc task forces, quality circles, self-managed work groups, parallel organizations, and overlapping committees. Fluidity and flexibility are the hallmarks of how they meet changing demands.
7. *They exhibit a loose coherence.* They allow members considerable autonomy while coordinating individual contributions. High-performance health-care organizations simultaneously exhibit tight and loose properties. They are quite tight at times in terms of employees' agreement with the overall goals and mission of the organization; however, this allows them to be loose in allowing employees considerable autonomy to be experimental and innovative.
8. *They have a strong culture.* They are able to create an organizational culture that is characterized by a shared system of beliefs, values, and norms. This culture guides behavior and standards on a daily basis in various ways.
9. *They possess a unique “spirituality.”* There is an overriding sense of self-awareness—a wholeness—in these organizations. High-performing health-care organizations know who they are in terms of strengths and weaknesses and know what they want to become. They have the ability to give meaning and purpose to people's lives and to create products and services that provide meaning to people.

In its broadest sense, the term “culture” is used to describe the quality and value setting of a particular stage of advancement of a civilization. Recently the term has found its way into the management literature as well. We speak of corporate cultures, professional cultures, etc. There is little doubt that the culture of the health-care industry as well as the perceptions of excellence in health-care management have changed remarkably since the advent of the cost-containment era in the early 1970s. There is a heightened concern about the preoccupation with business in health care.

In an essay in the *Wall Street Journal*, Schwartz¹⁵ described a phenomenon associated with the increased corporatization and emphasis on the business dimensions of health care. He described a possible unacknowledged change in the basic physician-patient relationship in the United States that he termed the “veterinarian ethic.” According to Schwartz, the veterinarian owes his primary ob-

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ligation not to the animal he is treating, but to the animal's owner who is paying the bill. Heretofore, the physician's allegiance has been to the patient's welfare; however, the emerging larger group of physician employees may have total allegiance not to their patients' welfare but to the patients' employers and third-party payers.

A contemporary hospital executive recently admonished his colleagues in health-care administration to focus on outcome of patient care rather than process. Rindler¹⁶ described his experiences with hospital managers who measured their respective performances not by patient-care outcomes or institutional improvements that contributed to improved patient care, but by the size of their budgets, the sophistication of their computer hardware, and the number of personnel reporting to them. In his view, "they were process-oriented and saw their departments as ends in themselves, rather than means to service the needs of patients in their institutions." Rindler described the essence of hospital management as the production of positive outcomes for patients, and he reminded hospital executives that in their zeal for better corporate structures, more advanced systems, and more technology, they should not forget that the basic mission of hospitals is to care for sick people.

Expanding corporate control may well be the dominant force in American health care today. How will this affect hospital pharmacy managers? Zellmer¹⁷ has raised several concerns about the ability of hospital pharmacy to control its destiny in the new health-care culture. The consensus development conference on "Directions for Clinical Practice in Pharmacy" that was held on Hilton Head Island, South Carolina, in February 1985 reaffirmed hospital pharmacy's commitment to being a true clinical profession and yielded strategies for achieving complete professionalization in this vein.¹⁸ In his exploration of pharmacy as a clinical profession, Hepler¹⁹ described how the new culture of the health-care industry may well provide clinical pharmacy with an opportunity to demonstrate and document the cost-effectiveness of its services. However, Hepler continued, this heightened authority may not necessarily professionalize pharmacy further, particularly if it occurs at the expense of pharmacy's commitment to patient welfare.

The "Bilingual" Pharmacy Director

It is clear that in the 1980s and beyond, hospital pharmacy managers face new definitions of excellence in management. Inasmuch as they are responsible for the line management of a professional support service component of the organization and are still relatively autonomous professionals, hospital pharmacy managers are key program

managers. As program managers, they are expected to be advocates for hospital administration in terms of resource allocation, personnel management, fiscal control, and patient-care operations supervision of the department as a "production unit" of the hospital.

It is my contention that hospital pharmacy managers, more specifically directors of pharmacy, must be "bilingual" in a sense. Directors of pharmacy must effectively relate to two major (and at times competing) organizational constituencies within the hospital: the hospital's corporate administration (for day-to-day management) and the medical staff and patients (for issues related to drug-use control). In the latter area, it is generally held that pharmacy practitioners now have a duty to influence prescribing. Moreover, the clinical concept of practice emphasizes that it is the pharmacist's duty to provide patient-specific drug information to prescribers both before and after the act of prescribing and to monitor drug use. This concept has evolved incrementally over a period of three or four decades; it has been a stabilizing influence rather than an abrupt change in emphasis.²⁰

Hall²¹ has concluded that bureaucratic entities, such as large organizations that house professional departments, must maintain a state of equilibrium between the ideologies of the professional workers and the bureaucrats to avoid conflict. In citing Hall's work, Hepler¹⁸ acknowledged the potential for conflict and even for the deprofessionalization of the hospital pharmacist if bureaucratization continues under the threat of financial pressure. He concluded with a very important strategic point for hospital pharmacy managers: that "... professionalization can occur in a bureaucratic organization if the professionals are organized in a separate professional department headed by a person who is able and willing to insulate the professionals from the bureaucracy." I see this as a phenomenon that already exists in the more well-managed and highly professionalized pharmacy departments in this country; it represents one form of the excellence that separates outstanding hospital pharmacy directors from their more mediocre counterparts. This genre of excellence is one of the characteristics of the "bilingual" director of pharmacy who can span the boundaries of professional ideology and bureaucracy by using the most creative and diplomatic styles of management.

Achieving excellence in hospital pharmacy management, then, may well be the most formidable and elusive of goals for managers, particularly in the late 1980s and beyond. The achievement of excellence will be complicated by management structures and behavioral dynamics that will still be somewhat bureaucratic on the one hand, yet quite fluid and flexible on the other, as described by Shortell.¹⁴

The Director of Pharmacy as Middle Manager

Directors of pharmacy are professional-support-service managers. In an operations sense, they can be viewed as general managers who are responsible for a particular administrative unit at the intermediate level of a hospital's corporate hierarchy. Uyterhoeven²² has described the role of the middle-level general manager as being much more difficult in many respects than that of the top-level general manager. The middle manager, according to Uyterhoeven, accomplishes his goals by managing relationships in three dimensions—those of subordinate, equal, and superior. He relates to his superiors as a subordinate: he takes orders. He relates to his team as a superior: he directs. He often relates to his peers in the organization as an equal: he may have to solicit assistance or cooperation. In contrast, the top-level manager acts primarily as a superior and facilitator.

Uyterhoeven likens the demanding role of the middle manager to that of a baseball player who must excel simultaneously in hitting, fielding, and pitching. Risk and opportunity often go hand in hand. In addition to managing all three relationships, the middle manager must shift quickly and frequently from one role to another. Effective completion of one set of relationships may often compete with effective completion of another.

Middle managers have a dual role: they usually receive abstract guidance from superiors in the form of goals, and they ultimately are expected to translate those goals into concrete actions and results. The middle manager often has to be more of a strategist than he realizes. Moreover, it is not unusual for a middle manager to have full responsibility for results in spite of holding limited authority. He must define the political environment in which he has to survive from a position of limited power and great vulnerability.

In short, the middle manager or program manager is a dynamic "line" executive—a linchpin to the achievement of the organization's goals and results. Uyterhoeven's construct of the role and characteristics of the general middle manager effectively characterizes the role of today's director of pharmacy in hospitals and organized health-care settings.

As to what such managers really do, the concepts of planning, organizing, coordinating, and controlling are quite vague. Mintzberg²³ described the manager's job in terms of various roles, or organized sets of behavior—interpersonal roles, informational roles, and decisional roles. Effectiveness as a manager, according to Mintzberg, is predicated on the manager's recognition of what his job really is and his subsequent use of resources at hand to support rather than hamper his own nature. Katz²⁴ further described the requisite personal skills for effective management as technical, human, and

conceptual skills. Katz defined these skills in light of their relative importance at various levels of management responsibility within the organization. The director of pharmacy must have sufficient professional knowledge and skill to discharge the professional and technical duties of his organizational unit, the department of pharmacy. In addition, he must have sufficient human skill in working with others as an effective group member to build cooperative effort within the team. He must have conceptual skills to recognize the complexity of the various factors within the hospital's management environment that ultimately will lead to finite actions likely to achieve the maximum good for the total organization.

The Life Cycle of a Hospital

The role of the director of pharmacy as a general middle-level manager is complicated even further by considerable ambiguity when one considers the "duality" of the hospital manager—professional department head span of responsibility in production-unit operations and clinical and professional matters. A depth and breadth of capacity to tolerate and overcome ambiguity in both of these spheres is the hallmark of excellence in a director of pharmacy. From my own personal experience, the level of ambiguity often is exacerbated by the hospital's stage in its life cycle as an organization.

The phenomenon of life cycles in organizations has been discussed extensively; Dimock²⁵ and Greiner²⁶ both have described the cyclical gyrations of organizations as they respond to external and internal forces over time. Each life-cycle phase is characterized by a specific management style and influenced by a previous developmental crisis. The first phase is characterized by entrepreneurship and energetic, charismatic leadership. It is followed by a second administrative phase in which top managers are as orderly as their predecessors were temperamental. This second phase is often the peak stage in an enterprise, because the organization still enjoys the energy of innovation while being at an orderly and logical point of equilibrium. In the third phase, systemization and bureaucratization have been carried to excess. The organization's goals are obscured and subordinated to a concentration on means as ends in themselves. Technique triumphs over purpose, morale deteriorates, innovativeness grinds to a halt, and the organization often is outpaced by its competitors. The final stage is renewal—there is a deliberate effort of will and infusion of entrepreneurship, usually accompanied by the firing of the top managers of the old leadership. Through newly formed leadership, the organization attempts to regain the energetic personality that it lost.

As organizational entities, hospitals are constantly faced with such changes. Directors of phar-

macy may well find themselves on either side of each of these phases; it is an inevitable fact of hospital organizational life for any program manager. The "bilingual" director of pharmacy, through a combination of tact, diplomacy, vision, creative skill in practice management, and high threshold of tolerance for uncertainty and ambiguity, is able to establish and maintain a milieu in which professional and clinical purposes are not made subordinate to corporate business or pure operational interests. In my view, these managers are consciously able to identify and successfully deal with the "ambiguity axis" in their respective hospitals. This allows them to develop and execute appropriate strategies to bring about desirable organizational and behavioral changes and outcomes in ways that are mutually satisfactory to the hospital organization at large, the pharmacy staffs, and the directors themselves.

Ambiguity and the Director of Pharmacy

I now want to focus on the nature of ambiguity in the world of the director of pharmacy. I will discuss some of the organizational, systems, and interpersonal factors that contribute to ambiguity and suggest some methods for dealing with them.

The effective director of pharmacy functions as a program manager who must modulate between two distinct frequencies: one as a corporate unit manager (which can be likened to a production manager) and the other as a relatively autonomous professional. Both frequencies, of course, serve different constituencies within the organization and may well represent competing interests depending on the issues and the politics of power at any given time. These frequencies apply to two distinct categories of ambiguity: those that are rooted in issues and matters that are external to the pharmacy department, and those that are focused internally within the department.

Extradepartmental Ambiguity. I view four areas as important potential sources of extradepartmental ambiguity for the director of pharmacy: (1) structural or organizational barriers that distort power and authority, (2) the gap between professional values and bureaucratic expectations of behavioral norms, (3) the potential for encroachment on professional boundaries, and (4) the difficulties associated with establishing the effectiveness of clinical pharmaceutical services.

Structural or Organizational Barriers That Distort Power and Authority. Power and authority in hospitals often are not vested in the same individuals and are seldom reflected in the hospital's organizational chart.²⁷ Those of us who have practiced in hospitals are also aware that the individuals with the real power (that is, the ability to make or influence decisions) vary from hospital to hospital. In this vein, the formal administrative reporting line

for a director of pharmacy may be well insulated from the top managers who have a greater degree of commensurate authority and power. It is not unusual for a director of pharmacy to report through a third level of the hospital's vertical hierarchy. Moreover, in some hospital organizational structures, the reporting line for a director of pharmacy may include logistical and managerial support-service units, such as materials management, purchasing, and central supply, rather than professional support-service units or clinical-care departments with patient-oriented missions.

Although these structural elements may pose problems for directors of pharmacy, they are not the sole sources of uncertainty and ambiguity in the director's management milieu. Under the best of circumstances (at least in a structural sense), the director of pharmacy must be an effective spanner of boundaries, because the support of the medical staff and hospital administrators usually is required to make substantial changes in drug-use policy or to develop innovative pharmacy services. Power and influence are in a constant state of flux between these two important constituencies; furthermore, dangerous political crosscurrents characterize these waters. Directors of pharmacy or, for that matter, any nonphysician program managers must be extremely diplomatic and adroit in negotiating change in hospitals. It is not unusual for the inexperienced or overly zealous program manager to choose sides in an attempt to gain support for program changes. However, the resultant long-term effects of such political alliances can be disastrous, particularly if they have not been carefully thought out. Diplomacy is the pharmacy manager's key to dealing successfully with these two constituencies.

This type of ambiguity is exacerbated for directors of pharmacy who view the formal administrative reporting line in literal terms that may unconsciously contribute to a classical subordinate-superior relationship. As the cartoon philosopher Pogo said upon exiting the forest from a reconnaissance mission: "I have seen the enemy and it is us." The director of pharmacy does not have line accountability to the hospital administrator for execution of his duties and responsibilities as a clinical professional. Accountability in this area is to the patients, as is the case with other clinical professionals in the hospital.

Interpersonal role conflict and ambiguity can also exist between directors of pharmacy and relatively inexperienced and unseasoned third-tier hospital administrators. Such administrators may not have been exposed to highly professionalized and assertive directors of pharmacy who rightfully guard their autonomy as professionals. Because these administrators may have limited experience with and understanding of line-unit management within the hospital, they may exhibit management

styles that are either (1) highly autocratic and based on a literal interpretation of the hospital's lines of authority, or (2) overly sensitive to the political ramifications of decisions, to the extent that the administrators may erode true team relationships with the department heads. The latter is particularly true for younger hospital administrators, who often are ascending to higher "power" posts in the hospital. Perhaps Shortell's¹⁴ mandates for high-performing health-care organizations will provide the impetus for a new breed of hospital administrators who will rise through the ranks from line-unit management positions.

The Gap between Professional Values and Bureaucratic Expectations of Behavioral Norms. Organizations such as hospitals, universities, and accounting firms are said to favor considerable professional autonomy and decentralization of power, since they rely on trained professionals to execute their operating tasks and missions. However, they are highly bureaucratic in terms of their daily behavior. Key middle managers (such as directors of pharmacy) routinely have to integrate hospital policies and procedures into their respective unit operations. At times this creates competing interests in matters of basic personnel management; these include barriers to creative job enrichment as well as scheduling phenomena or specifications for automated information systems that breach measures for safe and effective drug use in the interest of greater hospitalwide efficiencies. Integrating the personal goals and objectives of highly professionalized and motivated staff members with those of the hospital can almost be described as an art, given the bureaucratic nature of some hospital organizations.

Ambiguity and conflict can stem from the superimposition on pharmacy clinical practice systems of rigid rules and regulations of professional- and hospital-licensing bodies or standards mandated by voluntary accrediting agencies. Similar stresses can stem from the emphasis on increased productivity and efficiency, especially if the pharmacy manager is viewed as a production manager rather than as a professional. In short, how does the director of pharmacy ensure that his program is considered a viable contributor to hospital clinical-care outcomes, rather than just a part of "organizational overhead?"

The Potential for Encroachment on Professional Boundaries. In their quest to achieve a greater level of professionalization, hospital pharmacists have expanded their roles as patient advocates in drug therapy to the point that fundamental goals of the profession are "... to serve as a force in society for safe and appropriate use of drugs" and "... to promote health... by working to promote optimal use of drugs."¹⁸ Zellmer²³ has proposed that the concept of clinical pharmacy be "thought of less in terms of discrete functions by discrete pharmacists

and more and more in terms of responsibilities of a pharmaceutical services department." However, assumption of this responsibility inevitably entails the expansion of the professional role of the pharmacist into areas typically occupied by other professionals, such as physicians and nurses. The potential for such professional boundary encroachment may range from nil to substantial, depending on a host of factors including hospital government and the power and influence of each professional group. These factors may also represent an area of significant ambiguity and uncertainty for the director of pharmacy, and only the highest levels of diplomacy, tact, and creativity will assist the director of pharmacy in attaining goals of clinical role expansion.

Difficulties Associated with Establishing the Effectiveness of Clinical Pharmaceutical Services. Since the inception of clinical pharmacy as a concept of practice in the early 1960s, the pharmacy profession has been preoccupied with the documentation, evaluation, and measurement of the effectiveness of pharmacy intervention in or control of all aspects of drug use in the hospital setting. Demonstrating clear and unequivocal improvements in terms of either quality or cost effectiveness of drug therapy has proven to be difficult. This may well be related to the scarcity of effective methods for conducting such assessments. Also, it is unrealistic to expect that one major study or even a handful of such studies will present overwhelming evidence to tilt the balance of proof in favor of clinical pharmacy.

Realistically, broad acceptance by the health-care industry and the public of the benefits of clinical pharmaceutical services has occurred incrementally over 25 years or more. Such acceptance more than likely will accelerate as a result of improved methods (e.g., the method-development study recently commissioned by the ASHP Research and Education Foundation), as well as increasing demands for cost-effective health care in the broadest sense.

In attempting to garner more staff and resources for expanding clinical pharmaceutical services, a director of pharmacy may be faced with considerable ambiguity, particularly considering today's cost-containment environment. On the other hand, the most resourceful and successful pharmacy program managers have used the concept of clinical pharmacy as a means to achieve mandated hospital cost-containment goals while furthering the professional goals of their staffs and departments.

Intradepartmental Ambiguity. Internally focused uncertainty and ambiguity are equally perplexing and challenging to the hospital pharmacy program manager. For instance, structural flaws in departmental organization, coupled with inappropriate management styles and systems configurations that try to conform totally to the hospital

bureaucracy's expectations of behavioral norms, may lead to substantial role conflict and ambiguity among the following groups:

1. Clinical specialists and other pharmacists who perform more logistical or purely dispensing roles without opportunities for upward professional mobility or fulfillment; and
2. Technicians and other members of the support and professional staffs whose missions and roles have not been effectively identified or integrated into a holistic approach to total drug-use control.

Role conflict and ambiguity will be heightened when such personnel have disparate values and attitudes. In some hospitals, intradepartmental ambiguity has grown as a result of the ever-increasing flow of young, highly motivated, and clinically trained pharmacists (who seek role expansion and fulfillment) into hospitals that are downsizing and emphasizing greater productivity and efficiency.

Conclusion

I have touched on what I consider to be some of the major sources of ambiguity and uncertainty in management for directors of pharmacy. There is a range of such dilemmas for pharmacy managers depending on institutional variables as well as forces within the health-care industry and the profession itself. A rapidly changing corporate culture for the health-care industry further heightens such uncertainty in hospital pharmacy management today and will continue to do so in the future. To achieve excellence in hospital pharmacy management, as in any other realm of management, the manager must have an inordinately high tolerance for ambiguity, coupled with the vision and personal commitment to surmount uncertainty to achieve desired professional and management goals. However, tolerating and surmounting uncertainty and ambiguity need not be an inevitable personal rite of passage for the pharmacy manager; at least part of it can be mitigated by the application of theory. This may well be the rate-limiting step in the complete adoption of clinical pharmaceutical services.

For the profession at large to effectively cope with mounting ambiguity, a theory of clinical systems and practice management must be developed. This will require the knowledge, skills, and leadership of the "bilingual" director of pharmacy—the boundary-spanner who can effectively speak the language of the production manager while creating an optimal professional environment in which his staff can achieve meaningful, agreed-upon

clinical and operational outcomes on behalf of both the patients and the hospital.

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