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## Pharmacy as a clinical profession

CHARLES D. HEPLER

Everyone, it seems, wants to be a "professional." Real estate agents want to be professionals. Automobile repairmen want to be professionals. In a recent television commercial, a service manager, wearing a clean white shirt, reassures a bride-to-be that the groom will arrive at the church on time. That's a lot of concern to show a mere customer. There are many senses of the word professional, some invested with quite different connotations. There is the world's oldest profession, the professional athlete, the professional soldier, the "real pro," and the health professional.

In the early days, sociologists identified a need to clarify the senses of the word, and they produced definitions that would discriminate between occupations usually thought to be professions and those thought not to be. A good example, one that appeared eventually in the *American Journal of Pharmaceutical Education*, was in Thorner's 1942 essay on pharmacy.<sup>1</sup> His essay included the following list of characteristics defining a profession:

- A specific and socially necessary function, the performance of which requires
- A special technique that rests upon
- A body of knowledge, mastery of which requires theoretic study; and
- A traditional and generally accepted ethic subordinating immediate private interests to the most effective performance of the function; and
- A formal association fostering the ethic.

Many other definitions of profession have been proposed by sociologists and others over the past 50-100 years. In my opinion, most agree reasonably well in their general outline, although they have different emphases and details. Today, the question of whether an occupation is a profession or not is viewed as meaningless. Everett Hughes<sup>2</sup> pointed out some years ago that an occupational group, especially a clearly defined group, is a reality that can be observed with the senses, while the concept of a profession is just that—a concept. A concept of a profession, therefore, is useful only as an ideal or standard.

Let me use an engineering example to illustrate this point. If we happened to be interested in making ball bearings, the mathematical equation defining a sphere might be quite helpful, despite our

expecting never to find a perfect sphere in nature. As we tried to make ball bearings, the concept would help us communicate the idea of a sphere precisely to others and to decide whether our efforts were taking us in the desired direction.

These are likewise the uses of a well-developed definition of a profession. Rather than speaking of profession as a static concept, most sociologists prefer to speak of professionalization or deprofessionalization, meaning occupational movement over time. Some pharmacists, however, want to know whether pharmacy is a profession or not. If they read the sociological literature, they usually find a catalog of pharmacy's shortcomings. The feelings of disappointment this engenders result in part from unfamiliarity with the methods and objectives of sociology and are to that extent unwarranted. I suggest that we should be more concerned with those elements of pharmacy that can move it toward or away from the ideal rather than how close it already is or whether it will ever become perfect.

Most pharmacists already have conceptions of what a profession is or ideally should be, and in this paper I wish to clarify, to make explicit, and to build upon those concepts rather than try to change them. I will use concepts and models of professions that are reasonably well accepted,<sup>3</sup> and I think these will each contribute to our overall understanding of pharmacy as a clinical profession.

In this paper, I will first explore the social purpose of professions in a historical context, clarifying why professions were created. Then I will examine a profession's relationship to society—its manner of providing services. Third, I will discuss the concept of professional authority and examine the need for professional consensus to obtain authority. Finally, I will identify characteristics of clinical pharmacy's client, paying particular attention to the possible industrialization of health-care services. Some of this material is the result of empirical research, but some is at the level of plausible but untested hypotheses.

### Social Role of Clinical Pharmacy

According to Larsen,<sup>4</sup> modern professions in England and the United States developed about the same time as the industrial revolution. In response to social upheavals, such as widespread migration to the cities, many people were faced with problems of buying and selling services. Industrialization, despite its intrusion into all aspects of society, was built around changes in the production of goods, not services. When people moved from the rural villages in which their families had lived for generations to cities so that they could find jobs making cloth or steam engines or whatever, they left behind midwives, herbalists, bone-

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setters, and other service providers they knew and trusted. When the new city dwellers needed those services, they had to find a stranger to provide them. Larsen says in effect that services with three characteristics became the objects of the developing professional service market:

- They were closely linked to major human values (e.g., health or property);
- They required a degree of knowledge, skill, and understanding beyond those possessed by ordinary people of the day and beyond a layman's ability to evaluate (e.g., the accuracy of a diagnosis or the purity of a prescription); and
- They were inherently personal or individualized in nature, meaning that they could not be readily standardized or mass-produced.

Such services require "trust between strangers," an idea I will develop later in this paper. Certainly medicine, surgery, and law met these criteria in those days. The services of the apothecaries of that day apparently met them also. The point is that professions developed in response to social needs. It is also interesting that those social needs resulted from rapid socioeconomic change such as our society is experiencing now.

**Role of Pharmacy in General.** With that brief background, let me turn to the analysis of modern pharmacy that it suggests. First, consider the criterion that the service must closely relate to basic human values. Of course, health is a major value, perhaps the most important value. Similarly, most people tend to recognize, perhaps even to overestimate, the importance of drugs in preserving or restoring health. I think the issue for pharmacy here is society's perception of pharmacy's role in drug therapy. I will return to this point later.

The second criterion concerns complexity, knowledge, and skill beyond a layman's understanding. For convenience, we can call this the "complexity" criterion, although it refers as much to the competence needed to provide the service. People are able to evaluate many services that once were beyond their capacities because of higher educational levels and access to information once considered esoteric. This increased sophistication of the population may explain in part the diminishing prestige of all professions, but it seems to have affected pharmacy more than others. Many people are not aware of any pharmaceutical services beyond the basic services that one would expect from any merchant, and they usually feel qualified to evaluate those. I can symbolize this problem with the cliché, "Why does it take so long to take my pills out of a big bottle and put them in a little one?" According to this analysis, pharmacy can professionalize in the eyes of the patient by increasing or more effectively communicating the complexity of pharmaceutical services and the knowledge and skill required to provide them.

Larsen's third criterion distinguishes profes-

sional services from the world of mass-produced materials or standardized services. Her point is that the professions were not needed for readily standardized services or goods that could be mass-produced and resold in normal mercantile channels of distribution.

Early pharmacy practice involved the compounding of highly individualized prescriptions. We are all too familiar with the standardization that accompanied the industrialization of drug products and the perhaps not coincidental rise of large, bureaucratic pharmaceutical service corporations, such as chain drugstores. I believe that bureaucratic pharmacy attempts to standardize pharmaceutical services just as the manufacturing industry has attempted to standardize pharmaceutical products. Such bureaucracies tend to ignore services that cannot be standardized. I am struck by chain pharmacy's apparent avoidance of drug interaction and allergy-checking services until they became available as computerized, that is to say standardized, products. Unfortunately, many pharmaceutical services that are most closely related to health and that involve the most knowledge, skill, and complexity also are the hardest to standardize. Such services tend to be ignored by bureaucratic pharmacy corporations. This seems an important source of deprofessionalization to the extent that patients believe that pharmacy is represented by chain drugstores and other bureaucracies (including, of course, some bureaucratically organized institutional pharmacies).

The obvious competitive strategy of nonbureaucratic ("independent") pharmacists would be to provide highly personalized service, but this seems to have been unsuccessful. Many advisory services were discouraged or prohibited by the APhA Code of Ethics until 1969.<sup>5</sup> Perhaps chains were able to shift the basis of competition to price because independent pharmacies were unable or unwilling to publicly offer such services. It is possible, albeit tragic, that some independent pharmacists thought of themselves as merchants and accepted price as a basis of competition, unfavorable a basis as it may have been.

Many hospital pharmacists have escaped this source of deprofessionalization, but some have not. It is useful to recognize that many hospital pharmacy departments are bureaucratic to a greater or lesser degree. Bureaucratic departments may tend to discourage pharmaceutical services that cannot be made routine outputs of a production process, such as services requiring judgment in using patient-specific information. Such services are extremely difficult to supervise by usual bureaucratic methods. A dilemma results because some hospital pharmacy managers claim a right, perhaps even a duty, to supervise all of the work in their departments, but think only of bureaucratic methods of supervision. This problem has retarded or even

reversed professionalization in some pharmacy departments.

**Distinguishing Roles of Clinical and Distributive Pharmacy?** This same kind of analysis can be applied to the important issue of "clinical" services vis-à-vis the distribution of drug products in hospitals. This issue expresses the central question of clinical pharmacy's social purpose.

Some pharmacists argue for the separation of so-called distributive functions from clinical functions, while others argue for their integration. In the framework of Larsen's analysis, distributive functions appear as the highly standardized, mass-produced services that were left outside the professional system. In contrast, primarily informative and advisory functions, like therapeutic monitoring and pharmacokinetic analyses, appear as the highly personalized nontransferable services for which the professional system was developed.

Many pharmacists have devoted years of education and practice to performing informative functions. The term *clinical* became attached to *pharmacy* to distinguish these functions and these pharmacists from other pharmacists who had not developed in this way. It is common for clinically oriented pharmacists to avoid performing standardized, mass-produced services like drug distribution.

By emphasizing personal service, informative functions meet Larsen's third criterion. Because informative services usually are complex and require substantial competence, they meet the second criterion as well. We must, however, address concerns about the first criterion, the one that involves a service's closeness to primary human values. What services should constitute the core of clinical pharmacy? Two dimensions of this issue are (1) whether clinical pharmacy should be defined in terms of functions or in terms of responsibilities, and (2) whether these functions or responsibilities should include both drug products and information about the use of drugs or just the information.

My general impression as a pharmacy educator is that most people refer only to informative functions when they use the term *clinical pharmacy*. A good example of such use occurs in the "ASHP Statement on Clinical Functions in Institutional Pharmacy Practice."<sup>6</sup> The statement virtually defines clinical pharmacy in terms of informative functions, except that it does include control of drug distribution and administration as one of 10 clinical functions. (Controlling drug distribution and administration involves managerial functions which some practitioners may not wish to perform nor be capable of performing well, so this item is as confusing as it is helpful.)

In the context of Larsen's criteria for professional services, such a definition of clinical pharmaceutical services does not convey clinical pharmacy's maximum value to society. Professions exist to meet social needs, not to perform isolated func-

tions. Performing informative functions alone seems less valuable to society—to have less apparent impact on health—than acceptance of responsibility for the appropriate use of drugs in patients, including providing the drug products themselves.

Defining clinical pharmacy in terms of responsibilities instead of functions is clear and unequivocal. It clearly suggests the social value of clinical pharmaceutical services. It also allows clinical pharmacists to accept responsibility for certain technical functions without having to imply that they personally should perform them. This is Brodie's concept of drug-use control expressed as a responsibility.<sup>7</sup> As he pointed out, technique alone will not make us professionals. It is a good thing for clinical pharmacists to claim authority over drug use—to claim that they are drug experts. It is a much better thing, however, to accept a share of responsibility for drug use.

This is certainly not a finished idea, for as it stands it has some serious problems. For one thing, I think that we have a dilemma because this definition is really a definition of the role of pharmacy practice itself. It excludes many more pharmacists than it includes, so perhaps it is a goal rather than a definition. On the other hand, I doubt that further definitions in terms of functions will advance the professionalization of clinical pharmacy. I leave this dilemma to conference participants to resolve.

The second problem with defining clinical pharmacy in terms of responsibility for drug-use control is that pharmacists do not currently have legal responsibility for drug use in patients. This does not prevent clinical pharmacy from offering to take such responsibility, but the reality is that today we could have at most only shared responsibility for drug use.

This analysis of the reason for the existence of professions suggests that we define clinical pharmacy in terms of responsibilities rather than functions and in terms of a complete set of drug-use goods and services.

#### Manner of Providing Professional Service

I now wish to extend this examination of professional services a bit further. Obviously, if you needed to purchase a service that was of vital importance to you and that was unique and beyond your ability to evaluate, you would want the provider to be trustworthy. You would be at a terrible disadvantage; you simply could not protect your interests as you would in a normal business dealing. The professions' response to this need is sometimes called professional altruism, but this term is often quite misleading. I prefer to explain that society entered into a covenant with the professions to protect itself in these circumstances.<sup>8</sup>

The word covenant is unfamiliar to many peo-

ple. It seems to have only two common uses today. One refers to real estate or partnership agreements and has nothing whatever to do with my use of the word. The other use is religious. Both Jews and Christians describe their relationship to God as covenantal. God offered Abraham, and later Moses, to make the people of Israel His chosen people and to take care of them. In return, He asked the people of Israel to love Him and obey His commandments. Christians believe that Jesus renewed that covenant.

Regardless of one's religious beliefs or disbeliefs, that relationship between God and His people is a good metaphor for the covenant that I believe exists between society and a profession. (My use of this metaphor is not intended to suggest that religious motives are necessary for professionalization.) Society asks a profession to obey certain rules in providing very valuable, complex, and personalized services. The effect of these rules is to ensure that the profession will serve society.

For example, every profession accepts a duty to protect the long-term interest of its clients and never to take advantage of a client's dependency or weakness. Each profession promises to maintain its members in number, knowledge, skill, and attitude. In return, society promises to give the profession authority. This occurs through a long process of exchange in which the would-be profession demonstrates its value and commitment while society grants a bit of authority.

It can also work the other way, as a disillusioned society gradually withdraws authority from a profession. For example, pharmacy, medicine, and law have lost substantial amounts of authority over the past few years. Prominent examples are loss of the internal control made possible by prohibitions of advertising and partial loss of control of professional school admissions. This process may continue at a relatively rapid rate for medicine as the market for health-care services is restructured and industrialized.

Now we have an answer to the question, "What does a professional profess?" Every professional primarily professes his side of the covenant: a commitment to the welfare of a client. In addition, a professional professes competence and a belief that his techniques are safe and effective. But professionals are expected to show such competence and effectiveness objectively, not merely to profess them. As outlined in the next section, the ability to show effectiveness is an important prerequisite for professional authority.

### **Professional Authority**

In return for its commitment, society gives the profession authority—legitimate power to influence behavior. At first, that may not sound like much, but it multiplies rapidly and lasts as long as

the covenant with society, just as Abraham's descendants multiplied and endured.

A profession can use authority to gain wealth, and many do just that. The professional covenant, even as a lofty ideal, in no way asks the professional to live in poverty. This is, however, a common misunderstanding of the concept of professions, probably a result of using the word altruism to describe this idea. In his book, *The Social Transformation of American Medicine*, Starr<sup>9</sup> explains,

The historical success of a profession rests fundamentally on the growth of its . . . authority. Acknowledged skills and cultural authority are to the professional classes what land and capital are to the propertied. They are the means of securing income and power.

Starr emphasizes that a professional's knowledge and competence must have been validated by a community of peers.<sup>10</sup> This implies, of course, that the peer group is collegiately organized, hence the need for a professional association. Note, however, the emphasis on an organization that actively validates competence, not one that merely accumulates members. We in pharmacy desire consensus, but seldom achieve it. Our organizations may sometimes confuse membership numbers with organizational strength. Starr seems to be suggesting that a professional's authority could be increased by membership in an organization that is generally recognized as being selective on the basis of consensually valid and professionally relevant competence criteria. Such an organization might have its own continuing competence criteria as does, for example, the American Academy of Family Physicians.

Starr's second point regarding authority is that the profession's consensually validated knowledge and competence must rest on rational scientific grounds.<sup>10</sup> To gain professional authority we must have research into the bases and methods of clinical pharmaceutical services. It is often difficult (although by no means impossible) to find support from the sources that support most health-services research. The money available from the ASHP Research and Education Foundation and other sources is helpful, although the amounts available do not support enough research. The shortage of money is aggravated from the profession's viewpoint because the money is seldom directed into areas that the profession has agreed will help it or the public.

I believe that money funneled through the Foundation would do more good for the professionalization of clinical pharmacy if it were targeted on selected problems, perhaps as a part of the ongoing ASHP strategic planning process. I also think that the recognition awards of the Foundation could encourage research in targeted areas by recognizing the best projects on a selected topic. This might achieve the greatest effect for the fewest dollars, given most people's thirst for peer rec-

ognition. Finally, I want to stress that the valid studies of the effectiveness of clinical pharmacy do exist but seem to get little attention. I will mention studies led by Smith,<sup>11</sup> Herfindal,<sup>12</sup> Helling,<sup>13</sup> Bootman,<sup>14</sup> and Avorn<sup>15</sup> as examples. These and other studies lend support to clinical pharmacy's claim to authority over the drug-use process.

Starr distinguishes two types of authority.<sup>16</sup> The first and most familiar type is social authority, the probability that someone will obey a command or follow a suggestion, for example. Cultural authority is the legitimate power to interpret facts, to define what is real, and to impose values. Medical diagnosis is a good example of cultural authority. A syndrome becomes labeled and eventually becomes a disease through the cultural authority of medicine. Legionnaires' disease is a recent example. Many more examples are available in psychiatry.

A clinical pharmacist uses cultural authority when he defines a set of symptoms as an adverse drug reaction. To a large degree, this assertion is true only because he says it is true: It would rarely if ever be empirically tested in the clinical setting. If his authority were accepted, the drug would be discontinued and treatment would continue without it. The more adverse drug reactions, inappropriate therapies, and so forth, there are, the more important pharmacists are to society. Once an occupation gains social and cultural authority, then, it is allowed to define the client's need for its services and is on its way to control of its own market. This is why authority is much more valuable than money. It confers professional autonomy, fruitfulness, and virtual immortality, but only as long as the profession's covenant with society lasts.

**The Professional versus the Businessman.** Pharmacists seem perpetually confused about their so-called dual roles as professionals and businessmen.

Business does not rely on a covenant but rather uses a more concrete, legally enforceable agreement, the contract. There is a contract within every professional covenant, and, when a covenant is washed away by breaches of faith, what remains is a businessman's contract. Society gives cultural authority to business only reluctantly and gives social authority only over an employee. That is, business has no basis to tell customers what products to buy. Correspondingly, business makes no promise to guard the interests of the customer. Its doctrine is *caveat emptor*: Let the buyer beware.

In my view, a business relationship is a limited, special case of a professional relationship, not a separate and distinctly different type of relationship. Mixing business with a professional relationship, therefore, narrows and limits the professional relationship. A businessman's aspiration to become professional to gain cultural authority over the client is not so much immoral as it is misguided. Society grants authority slowly and only in propor-

tion to demonstrated social value and commitment to the interests of clients. Society is not stupid. A professional covenant with society leads to professional authority, while a business relationship does not. These rather philosophical lines of demarcation can be made quite concrete by putting them in terms of an occupation's acceptance of responsibility, its standards of conduct, its recognition of exemplary practitioners, and its rejection of the unfit.

A practical example of the difference between a business and a professional concerns the issue of whether we should charge separately for clinical services, what I have been calling informative services. To address this question, it seems that we need to know whether the pharmacist accepts responsibility for the clinical use of drugs and claims at least shared authority to decide what services are to be provided to a patient. If one adopts the position that informative services are separable from the drug products involved and especially if the services are considered optional extras that the patient or his physician may select, then it seems logical to charge for them separately. However, it is not logical to separately bill for goods and services if the pharmacist decides what is needed.

Sometimes this question is asked in an entirely different context, such as, "Why should pharmacists give away their services?" I think this question is insidiously misleading, and people who take it seriously should know better. This question can only be asked in a business environment, and it forces a businesslike answer. A businessman has a right to request payment for everything he sells to his customer, unless he chooses to give it away for goodwill. In contrast, a professional takes responsibility for a package of goods and services. His services should be distinctive and valuable enough so that he can set his fees to compensate for the occasional client who costs more than the fee covers. It seems unnecessary to tack on charges for the routine elements that are needed to meet those responsibilities. You may have heard the joke about the patient who tried to get a discount on a vasectomy by only having one side done. Pricing is always a game, and I do not want to appear dogmatic about this. My point is that there is a difference between a businessman's price and a professional's fee. The professional takes care of his client and the businessman takes care of his business.

**Professionalization as a Social Project.** I began this paper with a discussion of society's needs during the industrial revolution, as England and America converted from agriculture to industry. Now, for a moment, we should turn our attention to the service provider in the rapidly growing cities during this period. The midwife, bonesetter, herbalist, or apothecary: Each would have a very tenuous hold on the market for his or her services. The industrial city would be flooded with people

offering services. Many would be charlatans. The problem of the would-be profession was, in essence, to create a basis for the sale of services to strangers in a climate of extreme competitiveness. According to Larsen,<sup>4</sup> this required the would-be professions to organize themselves along the following lines:

- To develop exclusive education, training, and standards so that the services provided by the would-be professionals were distinct and recognizable by the public;
- To persuade recruits to forgo income long enough to complete their training, so that a sufficient number of providers were available to meet the claims of the professions; and
- To seek governmental license to eliminate competing occupations.

These three elements depend upon and influence each other.

This was a somewhat tightly constrained project for a large group of free people. They had to define and agree on apparently distinctive services that met the criteria of value, complexity, and specificity, and they had to recruit and train new disciples. Starr<sup>17</sup> emphasizes the importance of consensus in the development of a professional market. If the members of the would-be profession cannot agree at least on the education and training required to enter the occupation and cannot agree on the basic nature and content of their services, the other steps may well be impossible to complete.

I wonder if any parallels to clinical pharmacy in the 1980s are occurring to you. The objectives of this conference on clinical pharmacy sound remarkably like the problem, just described, that pharmacy solved during the industrial revolution. The parallel is even more striking—and disturbing—if you agree with Toffler<sup>18</sup> that we are entering a post-industrial “Third Wave” or information era. If we are, the conference organizers are right on target. On the one hand, we are here to reach consensus on the same types of issues that Larsen said all professions had to address years ago. We should be encouraged by the possibility that the occupation of pharmacy is somewhat better organized than it was then. On the other hand, I need not dwell on pharmacy’s chronic problem during our lifetimes of seldom finding consensus on important issues.

It may help to recognize that ASHP’s membership is more homogeneous than pharmacy taken as an entire occupation. Institutional pharmacists may be more able to professionalize because they practice in more organized settings where decisions of role and responsibility are made more explicitly and claims to social value can be made more effectively. To put it another way, few institutional practitioners depend on other professions, especially medicine, to the extent of most community pharmacists.

Attempts to increase the professionalization of clinical pharmacy will certainly meet with resistance from outside the profession. We must have consensus within to progress. ASHP and its membership may have to continue breaking new ground in the professionalization of pharmacy. Birenbaum,<sup>19</sup> in his article, “Reprofessionalization in Pharmacy,” specifically nominated hospital pharmacists as agents of change. ASHP should continue to seek support from pharmacy educators and members of state boards of pharmacy, for the roles of these individuals as recruiters, teachers, and gatekeepers are crucial to the continued professionalization of clinical pharmacy.

### Clients for Clinical Pharmacy

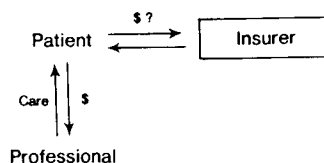
The last topic of this paper deals with the client—the recipient of a professional’s services.

Most models of professional service explicitly or implicitly define the professional’s client as one who both consumes and pays for the professional’s services. Most envisage a simple professional-client relationship like that shown in Figure 1.

Some occupations, such as airline pilots and many disciplines in engineering, meet many criteria of professionalization but do not provide services directly to individual consumers in exchange for a fee; these occupations are viewed as exceptions. In Larsen’s typology of services, work in these exception occupations is valuable and complex, but mass-produced or transferable. The services are performed either for a third party (engineers) or for large groups (airline pilots).

Starr<sup>20</sup> describes in considerable detail the efforts of American medicine to remain free of corporate domination and influence. Assignment of insurance benefits (Figure 2) is as close as most of American medicine has come to dependency on a third party. American medicine, although it could not prevent the employment of physicians by non-

**Figure 1.** Fee-for-service relationship.



**Figure 2.** Assignment of insurance benefits.

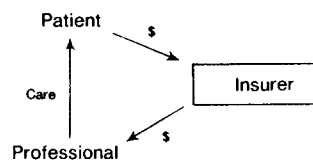
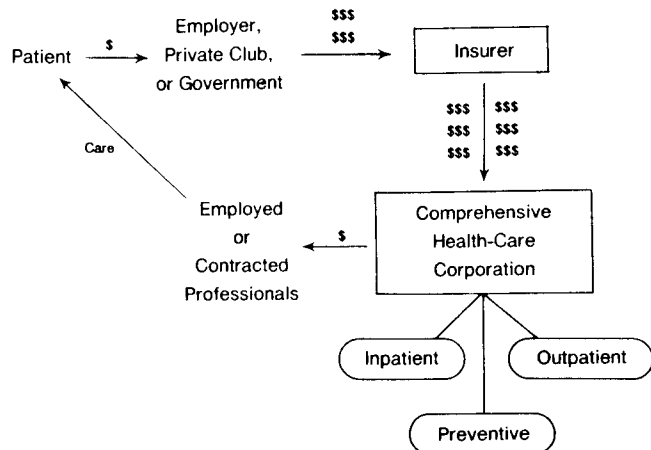


Figure 3. A possible restructured medical-care market.



physicians, severely limited competition from what it called "the corporate practice of medicine." There are, of course, very real concerns behind this resistance as exemplified by engineers, who have in many cases lost control over the uses of their work. An automotive, aeronautical, or nuclear engineer, for example, may find that his designs have been distorted before they are actually produced or that they are sold for uses with which he disagrees. Putting this in terms I use in this paper, the employer may usurp the engineer's authority. Quoting Starr's analysis of American medicine,<sup>20</sup>

One reason that the profession could develop market power . . . was that it sold its services primarily to individual patients rather than organizations. . . . In the early . . . twentieth century, doctors were able to use their growing market power to escape the threat of bureaucratic control and to preserve their own autonomy.

Another aspect is even easier to understand. Again quoting Starr,<sup>21</sup> "In effect, medicine's authority puts at its disposal the purchasing power of its patients."

Pharmacists employed by one type of corporation—the hospital or medical center—seem to have professionalized faster than other segments of pharmacy and to have professionalized while other segments began a slow, persistent deprofessionalization. I lack reliable data to support this assertion, but it is a common view. Certainly few hospital pharmacists appear to have been deprofessionalized by their status as employees. The same can be said for physicians employed by hospitals. Hospitals have, heretofore, been devoted to the goals of health care and have interfered little in the practice of medicine. There has been some interference with the practice of pharmacy because most hospital pharmacy departments have been kept financially dependent on hospital management, despite the millions of dollars that pass through hospital pharmacies every year.

During the period of rapid rises in costs following passage of Medicare in 1965, hospital pharmacy continued to flourish. Those were the years in which unit dose drug distribution systems and clinical pharmacy were established. From today's perspective, those seem like years of plenty, although we should recall that they did not seem so at the time. It now appears that hospital pharmacy benefited from "cost plus" reimbursement, and that hospitals at least broke even on the cost of expanded pharmaceutical services, despite dark warnings to the contrary.

It may not be safe, however, to predict the next 20 years by extrapolating from the past 20. Hospitals today appear to be changing very rapidly in almost hysterical reaction to changes in one segment of the market for health-care services. Two major changes appear likely to occur in the health-care market over the next decade or two. First, competitive pressure on third-party payers will mount, mainly as a result of the formation of large insurance purchasers, such as employers, labor unions, and private organizations. The insurer may then either directly provide services or may contract with a health-care provider corporation. To remain competitive, insurers will attempt to negotiate flat-rate contracts with provider corporations (Figure 3). Because of a surplus of health-care facilities resulting from years of Hill-Burton and other federal programs, the competition for those contracts may be keen. This would force providers into large aggregates; hospitals will become health-maintenance organizations (HMOs), and many small providers will be forced to combine because the direct market will be shrinking rapidly. It will also result in a steady expansion of prospective or flat-rate payment programs for health care, which will in turn force down costs of producing health-care services.

One possible consequence, apparent already in some hospitals, is the ascendancy of the financial officer in a hospital's decision-making system. Hospitals have traditionally been institutions for the provision of professional services, but now they seem ready to reduce their role to that of a low-bid contractor or at best a broker of health-care functions. The financial forces acting on hospitals may be irresistible, but we must ask ourselves if hospital pharmacy, which has flourished under corporate influence over the past 40 years, may yet suffer the fate of pharmacy in the chain drugstore.

The tendency of hospitals to become more businesslike may deprofessionalize pharmacy by two major avenues. The first I explained fully in the examination of the difference between professional and business relationships. There are no covenants with a low-bid contractor.

Second, businesses as large as even a small hospital tend to be organized bureaucratically. The concept of a bureaucracy is blurry in its everyday uses,



but it can be made quite clear. According to Hall,<sup>22,23</sup> an organization is said to be bureaucratic to the extent it meets six criteria. First, it has a hierarchy of authority. This means that the organization predetermines who will make certain decisions. Second, it uses division of labor, specialization that is determined by the organization and not the worker. Third and fourth, it uses rules and procedures to provide for organizational control over individual actions and methods of work. Fifth, a bureaucracy is impersonal; it treats people without regard to individual qualities. Finally, a bureaucracy relies on standards of technical competence for selection and promotion.

In his study of professionals employed by bureaucracies, Hall defined professionalism as a set of personal beliefs and values. He said that a person has professional beliefs and values to the extent that the person does the following:

- Uses formal and informal associations with others as a source of new ideas and standards for his work,
- Believes that his services are valuable to the client and that they should be performed in the client's interest,
- Believes that he should be evaluated only by another member of his profession and tends to ignore evaluations by people who he does not accept as professional peers,
- Feels called to his work, and
- Believes that he must have final authority to decide what should be done for the client.

In the study, involving 328 subjects employed by 27 organizations ranging from advertising agencies to hospitals, Hall found many negative correlations between degree of professionalization and degree of bureaucratization of the employing organization. He concluded that professional ideology and bureaucracies are alternative means of controlling workers' behavior and that these two segments will conflict with one another unless they are allowed to exist in equilibrium. This finding is important to the topic of this conference because hospital pharmacists may experience conflict and eventual deprofessionalization if hospitals bureaucratize in response to financial pressure.

Hall also distinguishes different forms of organizations. Although his findings in this area are less clear, it appears that the least tenable organizational structure for professionals employed in a bureaucracy is one in which they are thinly spread throughout the organization and are unable to take collective action. Therefore, a clinical pharmacist's flight from the hospital pharmacy department to a medical department to avoid bureaucratic management may instead isolate the pharmacist from his colleagues and result in deprofessionalization. The most compatible form of organization, on the other hand, is the autonomous professional organization in which the company is owned by and operated for the benefit of the professionals it employs. I

predict that physicians will form such corporations as alternatives to becoming employed by hospitals. Hospital pharmacists also may experiment with this through pharmacist-owned pharmaceutical service corporations.

According to Hall's results, 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. This suggests a seldom-recognized dimension of hospital pharmacy management that could have great strategic importance in the future.

One final aspect of the restructuring of the health-care market is the possibility that it will increase the pharmacist's corporate authority relative to the physician. If hospitals become subject to extreme competitive pressure and negotiated flat-rate reimbursement contracts, it will become crucial that they control prescribing. Starr's aphorism regarding the power of medicine over insurance companies will apply to hospitals and HMOs: "The power to prescribe is the power to destroy."<sup>24</sup> Clinical pharmacy's claim to increasing the cost-effectiveness of drug therapy will be tested, and, if hospital managers find clinical pharmacy useful, pharmacists' authority will be much greater than ever before.

Furthermore, since hospitals' responsibility for quality of care probably will increase, some people are predicting "corporate licensure" of professionals. The concept would allow an HMO to decide what functions its employees may perform since the HMO must take responsibility for the care it provides. On one hand, this is merely a hospital credentials program in a new light; looked at in another way, the concept proposes that health-care corporations authorize employees to perform procedures beyond those allowed by the state, provided that the corporation accepts full responsibility for the employees' actions. This may shock some people, but in pharmacy's case, it is a modest extension of prescribing by protocol. According to McGhan, Stimmel, and other researchers,<sup>25-27</sup> prescribing by protocol has been successful in California.

Over the past 40 years, hospital pharmacists have developed ways of serving patients through hospital committees and other structures. We are accustomed to medicine's dominance and to management's essentially beneficent attitude toward patient care. An increase in the pharmacist's authority relative to the physician's could easily seem like substantial gains in professionalization. Pharmacists must, however, remain vigilant. It is possible that an expanding effort to manage hospital finance will project business relationships and bureaucratic decision making into areas in which the patient's interest is not served. To put this bluntly, pharmacists must take care that their pro-

Professional integrity is not compromised in exchange for corporate authority.

### Conclusion

In a free society, the people ultimately will have their way. They created the health professions and were served well, except from a fiscal viewpoint. Now society will try a mixture of corporate, professional, and market mechanisms to serve its needs. Pharmacy will prosper most by serving the needs of society best.

<sup>a</sup> For background information regarding these concepts and models, see Reference 3.

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## Panel discussion on realities of contemporary practice

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TERESA VOLPONE MCMAHON,  
STEVEN L. SMITH, AND DENNIS K. HELLING

*Helling:* The purpose of this panel discussion on "Realities of Contemporary Practice" is to set the stage for this afternoon's workshops, which will address the issue, "Removing Barriers to Effective Clinical Practice in Pharmacy."

It is a pleasure for me as moderator of this session to introduce the four clinical practitioners on the panel. Robert P. Fudge is a 1971 graduate from The Ohio State University; he has an undergraduate degree in pharmacy. For the last 12 years, Bob has practiced clinical pharmacy on the hematology-oncology service at The Ohio State University Hospitals. He currently holds an academic appointment as Assistant Clinical Professor in the College of Pharmacy at The Ohio State University.

Next, I welcome Teresa Volpone McMahon. Teresa in 1975 received an undergraduate degree in pharmacy from the University of Washington and in 1977 a Pharm.D. degree from the State University of New York at Buffalo. For the last eight years Teresa has been involved in clinical practice. The first five years were at Thomas Jefferson University Hospital in Philadelphia, where she worked in decentralized services in the cardiopulmonary area. For the last three years, she has been at the University of Washington Hospitals in Seattle where she works in the outpatient division of the

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This panel discussion was presented in a plenary session preceding session II workshops. See page 1332 for the discussion topics and consensus report relating to session II.