Achieving excellence

ROBERT B. WILLIAMS

Abstract: The concept of achieving excellence in pharmacy through development of effective leadership is discussed.

The majority of hospital pharmacy directors have had very little education and training in management and effective leadership. Yet, excellent leadership skills will be needed to transform pharmacy more completely into a health profession. The management style most likely to be effective in this era of change is one that encompasses a high regard for both people and production through shared responsibility, high participation, involvement, and commitment.

The following recommendations are offered to help achieve excellence through effective leadership: (1) the ethic of self-development must be instilled in aspiring managers; (2) courses in human behavior, leadership, and management should be added to undergraduate pharmacy curricula; (3) pharmacy technicians should be educated in college-based programs that focus on drug distribution; (4) Master of Science programs in hospital pharmacy should be deleted or restructured to focus on leadership and management; (5) regional "centers for excellence" in leadership education should be developed; (6) general residency training should be incorporated in undergraduate education so that more advanced residencies can be offered to graduates; (7) high-level, self-study programs in management and leadership need to be developed, and (8) substantial research funds need to be dedicated to the study of hospital pharmacy management.

Index terms: Administration; Curriculum; Education, pharmaceutical; Health professions; Personnel, pharmacy; Pharmacy, institutional, hospital; Professionalism

Am J Hosp Pharm. 1986; 43:617-24

We talk about excellence in many endeavors—excellence in service, excellence in products, excellence in education, excellence in life. Not perfection, but excellence. The pursuit of perfection is frustrating, neurotic, and a terrible waste of time. The pursuit of excellence is gratifying, healthy, and productive. However we wish to describe it, we know excellence when we see it—the autumn color of New England's leaves; Leonardo da Vinci's *Mona Lisa*; the desert in bloom; health care's Mayo, Hopkins, and Massachusetts General; medicine's Fleming, Sabin, and De Bakey; hospital pharmacy's Whitney, Francke, and Brodie.

I want to talk about achieving excellence in pharmacy through effective leadership. I will be reviewing our past progress and the future directions for clinical practice in pharmacy as developed at the Hilton Head conference. I will summarize these directions as well as discuss some of the factors that were identified as barriers to achieving excellence in clinical practice. Even though numerous recommendations were made for overcoming these barriers, I will concentrate on those that relate to management and will focus on the barrier that I believe deserves our greatest attention—that of ineffective leadership. I know that some of what I will say will be provocative, but I say it with the intent of helping us to become insightful and visionary—to become more concerned with our future than with our past. I will draw on examples

ROBERT B. WILLIAMS, M.S., is Director of Pharmacy Services, Shands Hospital at the University of Florida, and Assistant Dean and Clinical Professor, College of Pharmacy, University of Florida, Box J-316, JHMHC, Gainesville, FL 32610.

Presented on October 1, 1985, in connection with Mr. Williams's designation as the first John W. Webb Visiting Professor in Hospital Pharmacy by the College of Pharmacy and Allied Health Professions, Northeastern University, Boston, Massachusetts.

from the business world, because concern for managerial effectiveness and leadership has received the most attention from the private sector, with its desire to maximize profits and minimize expenses. The private sector has significant influence in the health field. More similarities exist between our health-care industry and private sectors of the economy than many may care to acknowledge. Finally, I will make some recommendations that we can follow to achieve excellence through effective leadership.

Past Progress

Over the past 20 years, hospital pharmacy has continuously been striving for excellence—from floor stock to unit dose, from bulk manufacturing to sophisticated pharmacokinetics, from handwritten patient profiles to detailed computer printouts, from no i.v. admixtures to total drug administration responsibility. Have we achieved excellence? Some would say yes. Others would say that excellence is not achievable but is something toward which we all need to move. In the past, we have operated under the principle that more is better and better is best. Cost pass-throughs have helped us fund numerous pharmacy programs, increased revenues have bought us more personnel; increased drug charges have made us look good to our fiscal administrators. But that era is over. Will we be able to progress as much in the next 20 years as we have in the past 20? Will we even be able to hold onto the progress we have made, let alone strive toward excellence? I believe we will. We will because we are heirs of hospital pharmacy leaders who were visionary and realistic, sensitive yet demanding, innovative but practical, and they passed on these characteristics to us. We will progress toward excellence because many of us are diligently developing others to be our heirs.

Industry's Example

The United States airline industry was created by a small group of visionaries—William Patterson at United, C. R. Smith at American, Eddie Rickenbacker at Eastern, and C. E. Woolman at Delta. Each of these individuals established airline companies that were successful and profitable. Only one of these visionaries, however, passed on his skills, his philosophies, and his drive toward achieving excellence to his successors. Though each of these people was successful at building a strong company, only C. E. Woolman put together a group of managers capable of carrying on the skills that had brought early success to Delta. Woolman's competitors held onto their power and neglected to develop successors; the result was corporate reorganization, directional shifts, and disastrous profit problems. Delta's excellence, however, was sustained because Woolman very consciously and methodically shifted the responsibilities of management within Delta to a group of coworkers who were also committed to his credo and his philosophies. When Woolman died in 1966, those executives to whom he had left the corporation were able to make a smooth transition and take over the reins. Delta today is the most profitable airline in the world. Its cumulative net earnings have been twice those of any other airline over the past 10 years.

Hickman and Silva, authors of *Creating Excellence*, put it this way: "Individuals, not organizations, create excellence. With their unique skills they lead others along the pathway to excellence; carefully cultivating those who will later assume the controls. To groom future leaders successfully, the mentor makes sure he passes on both his gift for strategy and his flair for building a strong corporate culture." [1] As today's hospital pharmacy leaders, we must know more than our predecessors did in order to establish and maintain excellence. We need to build on past foundations, but we also need new management skills in order to be the type of leaders needed to thrust pharmacy into the next century. We need to be visionary and, at the same time, quite pragmatic as we train and develop others who will be tomorrow's leaders in hospital pharmacy.

Directions for Pharmacy

In February 1985, 150 pharmacy practitioners and educators attended an invitational conference conducted by the American Society of Hospital Pharmacists Research and Education Foundation on Hilton Head Island. The conference was entitled "Directions for Clinical Practice in Pharmacy." [2] It went beyond clinical practice and turned out to be an assessment of pharmacy itself. The participants concluded that the value system created by the clinical movement needs to be assimilated by all pharmacists so that our profession will become more fully professionalized in the future.[3]

Hickman and Silva assert that there are six skills that will be absolutely necessary for transcending the past with the future.[4] Two of these skills are vision and insight. I saw both vision and insight displayed at the Hilton Head conference. The clearest message I heard was that pharmacy is fundamentally a health-care profession.

A number of specific consensus statements came out of the Hilton Head conference regarding pharmacy as a clinical profession. I believe these statements reflect the vision and insight of today's pharmacy leaders and provide a heading toward which we must move in our search for excellence. Seven of these statements, in my opinion, summarize the direction that will lead us toward the achievement of excellence.

I would paraphrase these seven consensus statements as follows: The health-care profession most

concerned with drugs and their clinical application is pharmacy. Our purpose is to serve as a societal force for the safe and appropriate use of drugs. Our fundamental goal is to promote health. We can do this by promoting the optimal use of drugs, by providing leadership among other health-care professions, and by advocating rational drug therapy directly and prospectively in the drug selection and prescribing process rather than by just reacting to treatment decisions made by others. Pharmacists should continue to be ultimately responsible for drug distribution and control, but these functions should be delegated to technicians, thereby allowing a major portion of pharmacists' time to be focused on clinical services and patient-care outcomes.[2]

Barriers to Achieving Excellence

One of the conference objectives was to establish a blueprint for practitioners to use in developing and strengthening clinical pharmacy services. Although no such blueprint was explicitly developed, a number of barriers were identified that the conferees thought were standing in the way of developing and strengthening clinical practice. Seven of these barriers concentrated on management.[2] Based on the cross section of practitioners and educators attending the conference and the consensus on these barriers, I am comfortable in accepting their list of important barriers:

1. Many pharmacy directors are unable to provide effective leadership to their staffs.
2. There is inadequate substantiation of the value (cost-effectiveness) of clinical pharmacy services.
3. Priorities in the provision of clinical pharmacy services are ill-defined.
4. There is a lack of an effective management support system in many pharmacy departments.
5. There is a political naiveté among pharmacists—that is, a lack of sophistication concerning how to bring about change through the political process.
6. There is an inadequate system of rewards in pharmacy.
7. There is inadequate training in management.

In addition to identifying these barriers, a number of recommendations were made that, it was thought, would serve to help remove the barriers. Among the recommendations was the need for strengthening undergraduate curricula by including courses on managing resources, people, time, and information and courses that encompass goal setting, planning, setting priorities, cost-effectiveness analysis, change, problem solving, and decision making. Additional recommendations involved the need for certificate programs in management that could be developed for mid-career pharmacists, directors, and aspiring directors. In addition, it was recommended that leadership conferences be conducted for pharmacy directors and that more pharmacy graduates be encouraged to take management-oriented residencies.

A few years ago, as part of ASHP's National Institute Program, I coordinated and conducted management training programs. It became very evident to me from pharmacists attending these programs that there was an unfulfilled need for management information and training that was directly applicable and relevant to hospital pharmacy. This need is even greater today. Unfortunately, there has been no organized and active effort to meet it.

As hospital pharmacy managers, we came to our jobs with a value system different from that of typical managers. We tended to emphasize loyalty to our profession and our ability to practice pharmacy. This loyalty was ingrained in us by the pharmacy world, since many of our professors and peers had similar loyalties. We were generally not oriented toward or prepared for the goals of the business world and, therefore, sought careers in the hospital, a setting that many pharmacists consider as nonbusiness. But how wrong we are if we continue to consider our hospitals to be nonbusiness oriented. We need to look only as far as today's health-care reimbursement systems to be convinced that we are, indeed, in a business environment. We must, therefore, begin using new management skills in this environment in order for us to continue our progress toward excellence. We must learn from today's successful businesses, be they in health care or private industry; we must draw upon the characteristics of leaders in management in order for *us* to provide leadership in moving toward a more fully professionalized practice of pharmacy.

Need for Management and Leadership Training

Published data on the education and training credentials of those in hospital pharmacy management are sparse. However, in June 1984, Oakley et al.[5] published the results of their survey regarding the education and experience of pharmacy directors in hospitals of 300 beds and larger. I've taken the liberty of extracting a few pieces of information from their study which may, in part, help to explain why so many of the barriers identified at the Hilton Head conference dealt explicitly with management and leadership. Oakley and coworkers found that 7% of pharmacy directors in their study population had M.B.A. degrees, whereas 25% had M.S. degrees. In other words, only 32% of the pharmacy directors had formal educations that one would speculate included some degree of management training. Directors with postgraduate Pharm.D. and entry-level degrees constituted, as a group, 68% of all directors. We all know that the courses in post-Pharm.D. and entry-level degree curricula do not address the management and lead-

ership issues that arise in today's hospital pharmacies. Furthermore, I submit that there is very little education in M.S. and M.B.A. programs that is made relevant to clinical pharmacy practice. For years we have had the good fortune of having many hospital pharmacy practitioners trained in residency programs. However, Oakley et al. found that fewer than 50% of pharmacy directors having M.B.A. and M.S. degrees had completed ASHP-accredited residencies. We also know that general ASHP-accredited residency programs are not designed to focus on high-level training in management and leadership. The bottom line seems to say that if we take the liberty of extrapolating the data from the survey of Oakley et al., the majority of today's pharmacy directors have had very little education and training in management and effective leadership; and, yet, the practice of hospital pharmacy has advanced more professionally in the past 10 to 15 years than perhaps any other profession within the hospital. Some might say, Why change anything; don't fix it if it's not broken! To that I would ask, What are we doing today so that our heirs will be prepared for tomorrow's health-care environment?

It seems to me that we have two burning questions before us. First, are we content to risk our future professional progress on yesterday's management techniques even though many would argue that we have done quite well so far? Second, are we really committed to achieving excellence in clinical practice? The way we answer these questions depends to a great extent on our attitudes. Business consultants tell us that deeply ingrained attitudes often prevent us from having insight and vision. These consultants have found that "most American executives suffer today from short-term orientation, shallow thinking, and quick-fix expectations." [6] I can honestly say that I don't believe that hospital pharmacy, thus far, has suffered from these same three attitude problems. However, I am concerned that because hospital pharmacy is professionally so young and has had so much success over the past few years, we may become lulled into complacency and may soon suffer from these problems.

Today's business schools have curricula that teach the fundamental managerial skills of setting goals and establishing policies; organizing, motivating, and controlling people; formulating strategic plans; responding to change; and producing respectable returns on investments. These skills are supposed to provide to managers success in today's business world. Some believe, however, that these skills will not work in the future. I agree. We need only look around us at the decline of productivity and profitability of many American companies. We need only look around at the decline and demise of many of our country's hospitals. Hospitals that will survive and flourish in the upcoming years are those that refuse to continue doing things the way they have done them in the past. Successful hospitals are refusing to base tomorrow's decisions on yesterday's successes. Those hospitals that focus solely on cutting costs, cutting people, and cutting programs in order to keep their profit-and-loss statements balanced will fail. Those hospitals that realize they are no longer in the hospital business but rather the health-care business, looking outside of their hospital walls and beginning to diversify, will flourish and achieve excellence. I believe that the same phenomenon must occur with hospital pharmacy. But it will require a new attitude with a new outlook on tomorrow.

Qualities for Effective Leadership

Of all the management barriers that were cited at the Hilton Head conference, the one that rises to the top is that "many pharmacy directors are unable to provide effective leadership to their staff." [2] Some feel there is a mystery about leadership; they cite the fact that two people may attend the same school, study the same subjects, and pass the same tests, but one will be effective at leadership whereas the other will be ineffective. There really is no mystery. Effective leaders have the same knowledge as others, but they have, in addition, the ability to assimilate, integrate, evaluate, and apply all of the data to questions and problems and to come up with the right answers. In order to achieve excellence in clinical practice, we must achieve excellence in leadership. "Excellence doesn't happen miraculously, but springs from pace-setting levels of personal effectiveness and efficiency." [7] Excellence springs from effective leadership.

In preparing this lecture, I had the good fortune of obtaining a document that was written in June 1982. It describes the leadership characteristics of an individual who was committed to achieving excellence. I would like to share parts of this document with you. "The spirit and excellence of our institution is exemplified by this leader. He is an original and creative thinker. His administrative style appeals most to those who enjoy freedom *and* responsibility. He sets high standards, but treats his staff as equals. He expects excellence, but gives much freedom in developing one's individual talents. He never lets his staff forget why they are here—the patient. He supports creative ideas, contributes to their implementation, and gives recognition to the originator. He is people-conscious and his employees find him approachable. He is an attentive, compassionate, and thoughtful listener, willing to give support. His staff admires his even temper, diplomacy, and tact and the fact that he never takes out his frustrations and pressures on them. They also appreciate his wit and humor." To show the warmth and affection his employees felt

for him, the document goes on to say, they gave a surprise party in his honor to mark his 20 years as their leader. This material does not come from one of the more recent publications on excellence or leadership. Rather, it is a description that was written about the person after which this visiting professorship in hospital pharmacy is named, John Webb.

I believe that pharmacy managers have little chance of success in tomorrow's hospital environment if they do not develop and use sound leadership qualities. Many people think they understand what leaders do, how they act, and what it takes to be a good leader. Others feel that leadership traits and skills cannot be delineated and are not well understood. Regardless of which camp we are in, all of us have known pharmacy managers who are not leaders. We have seen their disruptive effects on groups, their inability to function in the tense situations found in hospitals, and their uncanny ability to become part of the problem rather than the solution.

Extensive research has been performed to help identify effective leadership. Efforts in this area have produced beneficial information that can help us become better leaders. The 1950s saw studies performed at the University of Michigan and Ohio State University examining two major areas: achievement orientation and employee satisfaction orientation.[8-12] These studies found that achievement-oriented leaders emphasized the organization and employees' roles in performance. Employee-oriented leaders stressed a friendly and supportive environment and were predominantly concerned with the welfare of all employees in the work group. Achievement-oriented leaders achieved high productivity and were rated highly by their superiors. The hidden costs of this dimension, however, were high turnover, absenteeism, and low morale. On the other hand, employee-oriented leaders usually achieved both high productivity and high job satisfaction among employees. There did not seem to be a way for leaders to be rated highly from both aspects; they were one or the other.

Principles of Leadership

I believe that the most productive and satisfying form of leadership for both the leader and the group is one described by Blake and Mouton.[13] They call it "One Best Style." This style encompasses a high regard for people *and* for production. It stresses being both highly task oriented and people oriented versus being one or the other. After extensive research, Blake and Mouton concluded that this type of leadership achieves high production through a high degree of shaped responsibility, coupled with high participation, involvement, and commitment. Their research has resulted in the identification of 10 principles of human behavior critical to effective leadership. Let's examine these leadership principles and their relevance to clinical practice.

1. *Participation.* Effective leaders don't get things done by themselves. When they try to, their accomplishments are often limited to their own talents and energies. Furthermore, the failure to stress participation can result in the formation of divisions within the pharmacy—divisions between the clinical, distributive, and technical staffs. On the other hand, when leaders encourage interaction at all levels within the pharmacy, a climate for teamwork is established that results in much higher productivity and satisfaction.
2. *Candor.* Effective leaders are open and frank with all departmental members. Inability to shoot straight, to be honest and open, will create a lack of the third principle which is trust and respect.
3. *Trust and Respect.* I have seen too many instances in which there is a lack of trust and respect between the clinical staff and clinical faculty and the pharmacists who do not possess high-level clinical skills. In my opinion, those clinical pharmacists who fall into this trap are lacking in leadership skills. Gaining trust and respect is a two-way street. We must have confidence and faith in, and a regard for, each other's worth if we are to participate in the future clinical goals of our profession. As was identified at the Hilton Head conference, pharmacists must continue to have responsibility for drug distribution and drug control activities even though these activities need to be carried out by technicians. The pharmacy leader who candidly sets this direction in a clear, open, and frank way will gain the trust and respect of staff members. This doesn't mean that everyone will agree with that direction, but everyone will know what the direction is.
4. *Involvement and Commitment.* By applying the principles of participation, candor, trust, and respect, all members of the pharmacy are more likely to become involved in and committed to the goals. If we have participated in identifying where we need to move clinically, there will be more ownership from everyone. This will lead to a higher motivation toward learning, problem solving, and production. It will also serve in helping those within the department who lack the commitment to come to grips with deciding if they want to remain members of the team or to seek employment in another environment more in keeping with their personal goals.
5. *Conflict Resolution.* Conflict that is managed through honest and open confrontation is healthy. Conflict that goes unmanaged becomes destructive and destroys teamwork. To become effective leaders, we must learn how to deal with conflict rather than avoiding it. We must learn how to negotiate with hospital administration, the medical staff, and the nursing staff in order to achieve the fully professionalized position that clinical practice can attain. We must *not* place our pharmacy staff in the position of choosing between drug distribution and clinical practice.

Rather than setting priorities between the two, we must learn how to integrate both responsibilities. I personally believe that having one group of pharmacists responsible for distribution and another group responsible for clinical services will set up unresolvable conflict. On the other hand, by not developing technical expertise in supportive personnel and delegating technical functions to them, we will continue to sap the clinical strengths of our pharmacists and cause even greater conflict.

6. *Consensus.* Until we are able to provide effective leadership, consensus will never be developed within our departments. If we trust and respect each other, we will find it easier to reach consensus. We will allow for differences but will also allow for participation that leads to consensus.
7. *Centered Creativity.* The most creative happening in pharmacy was the point where we stopped thinking about products only and started thinking about patients. Pharmacists are intelligent, have critical minds, and with effective leadership can be stimulated to think creatively. Creativity does *not* mean doing things the way they have always been done. An effective leader says, "There ought to be a better way to do it." A loser says, "That's the way it's always been done." We must challenge others to look at new and unique ways to function within the health-care environment. For example, to achieve excellence in clinical practice, I believe we must be creative in finding ways to delegate drug distribution activities to technicians who have been formally trained through educational systems in colleges of pharmacy to assume that responsibility. This will also require creativity on our part in dealing with state boards of pharmacy and other organizations that don't see it that way. Without the opportunity to function clinically most of the time, tomorrow's pharmacist will be replaced by lesser-paid, nonpharmacy personnel or by technological machinery.
8. *Goals and Objectives.* Departmental cohesiveness will occur when there is a sense of direction—when outcomes have been identified and strategies developed to reach them. Walk into any pharmacy department and you will see a lot of activities going on, but these activities are not goals. Leaders think in terms of what the activity will achieve rather than focusing on the activity itself. For example, we can become so engrossed in keeping drugs off the formulary and using detailed forms for the nonformulary process that we lose sight of the overall goal of the formulary system, namely, cost-effective rational therapy. Those at the Hilton Head conference stated that the "fundamental goal of the profession is to promote health" and that in order to pursue this goal we need to "provide leadership to other health-care professions"; this means that we must "be involved in a very positive way in advocating rational drug therapy rather than just reacting to treatment decisions made by others. Pharmacy should be thought of more in terms of a responsibility for patient-care outcomes than in terms of specific functions."
9. *Mutual Support.* The psychologist Ernest Becker contends that people are driven by a "dualism"; that is, we need to be part of something and at the same time to be unique.[14] We need to be a member of a winning team but, also, the star of the team—a paradox to say the least. By applying these first eight principles, we will create a team that will win and, at the same time, allow for stars to be recognized. Throughout the world, winning teams have stars, but through effective leadership those stars learn that it takes mutual support from other team members to make them look good.
10. *Changing People.* The former president of Columbia University Nicholas Murray Butler says there are three groups of people: "The small group who make things happen; a little larger group who watch things happen; and the overwhelming majority who haven't the slightest idea what is happening."[15] It has been suggested that if we are doing great, it's time to consider changing to ensure our future, for if we wait until we're in trouble, it may be too late. Through open and honest interaction and feedback, effective leaders will guide the way to changes in the behavior and actions of others. Change cannot be left to chance. We must plan for it, get everyone to participate in it, and make it happen. The majority of us do not want to risk our future professional progress on yesterday's management and leadership techniques, but this will require significant change.

Michael Macoby, author of *The Leader*, stresses the need for a new attitude in leadership. He says, "A new model of leadership that expresses an ethic of self-development is needed, not just at the top, but at all levels of large business, government, union, and non-profit organizations."[16] He further suggests that we need this new leadership now; that we don't have time to educate the next generation. This means that we must immediately develop new skills and abilities, not by memorizing lists of principles and characteristics but by being committed to a new attitude toward leadership, to new skills.

In their book *Creating Excellence*, Hickman and Silva discuss six skills that must be learned if we are to achieve excellence.[17] These skills are creative insight, sensitivity, vision, versatility, focus, and patience. To use these skills, the authors stress that we must first establish a strong foundation of strategic thinking and culture building.

Professional Culture

Much is being written and talked about regarding corporate culture. What is culture? We have been inundated by books, articles, and television documentaries on the culture found in Japanese companies. American companies such as IBM, McDonald's, and Hewlett Packard are frequently praised for their widely admired corporate culture. Like excellence, we can recognize a healthy culture when it's present. But sometimes it helps to look at what a concept is *not* rather than what it is. One of

Boston's oldest educational publishers, Allyn and Bacon, was started in 1865 by two gentlemen deeply dedicated to education. Over the years, Allyn and Bacon received respect from teachers and school administrators as a reliable supplier of textbooks. But 115 years later, in 1980, the $30 million firm was in financial trouble. Top management blamed their problems on all the obvious reasons—competition, the economy, and high production costs. But they failed to recognize a more serious problem. Allyn and Bacon's old culture, which had gained respect over the years, had died. It had been replaced by people who lacked the love of books. The new management brought in managers from competitors, creating a massive bureaucracy, which resulted in a staff that worked half-heartedly and jumped ship for better positions elsewhere. Line employees were not part of the team, they were glossed over, and they had to account for every pencil and paper clip. Disgruntled employees unionized and the organization was torn apart. Recently, Esquire took over Allyn and Bacon. But it's going to be a long road back overcoming what one former employee calls "culture shock." [18] In contrast, there's a grocery chain down my way in the southeastern United States called Piggly Wiggly. A few years ago, this chain turned down a buyout offer. So gratified were its employees that they bought their company a $40,000 refrigerated tractor trailer to say thanks. As one mechanic with 10 years of service put it, "When you work for a company as good to you as this one, you just feel like doing good for them." [19]

To achieve excellence in clinical practice, we must develop a professional culture within each of our departments. We must have a commitment to a common purpose, be competent to deliver superior performance, and we must be consistent in perpetuating that commitment and competence. Building a good culture takes time, but as in any other sound investment, the payoffs are great. However, before we can use these new skills, we must also build a strong foundation of strategic thinking.

Strategic Thinking

Long-distance runners get their minds and bodies ready for the race by visualizing the goal they want to attain. Then they work on the skills needed to get there. If we intend to reach our goals of excellence in clinical practice, we need to visualize those goals by becoming strategic thinkers. We won't lack the clinical expertise to get there, but we must be sure we have the leadership expertise.

Wherever there is competition—football, tennis, business, or health care—victory usually belongs to those who outthink, outplan, and outplay the competition. In the business world, locating, attracting, and holding customers is the purpose of strategic thinking. Health care is not so dissimilar.

There are three components in every successful strategy: customers, competitors, and the company. Consider what happens when a company fails to give attention to all three of these components. Not too long ago, the airline industry was deregulated. When that happened, Braniff Airways immediately extended its long-haul routes to many cites it had never served in the past. Braniff made this decision because it wanted to become the number one long-haul carrier. Unfortunately, it failed to realize that long-haul routes would be much less profitable as airlines now waged price-cutting wars. Braniff found itself struggling with routes far from its home base. Not long thereafter, bankruptcy hit the company. What went wrong? First, Braniff lacked vision. It saw the future to be the same as the past. In the past, long-haul routes had always opened the doors to success. Under deregulation, that was not the case. Second, it ignored its own hub of operations in Dallas and did not capitalize on that strength. And third, it failed to consider the fact that deregulation would spur overall airline expansion and thus negatively affect profitability. Weak strategic thinking resulted in Braniff's failure.[20]

How can we learn from such business experiences? First, we need to satisfy customer needs. Who are our customers? Granted, our professionalism always focuses on the patient, but we do have other customers. These include physicians, nurses, administrators, third-party payers, and numerous other organized purchasers of health care. We must move out of our traditional patterns of thinking and identify the different needs that each of these customers has. If we continue to think that all of them need the same product we have been supplying over the past 20 years, we could end up the way the Detroit automobile industry did in thinking that bigger was better.

Second, we must gain a competitive advantage. Our major competitors are nursing and medicine. What is our competitive advantage regarding the products and services we have to offer? I believe that our advantage does *not* lie in drug distribution; rather, I believe it is in drug information. If our fundamental goal is to promote health, then we must strategically think about how we can do that through our drug knowledge base. We must develop expertise that surpasses that of our competitors regarding the safe and appropriate use of drugs. It cannot be a knowledge base equal to that of the physician if we expect to compete in the medical arena. Perhaps our greatest competitive edge will come from coupling our knowledge of drug information with that of drug cost, giving us an edge with respect to cost-effective therapy.

Finally, we need to capitalize on our company's strengths, those that are inherent in ourselves, our fellow team members, and our departments. We need to inventory these strengths and build on

them. We also need to inventory our weaknesses, identify those that would keep us from achieving excellence, and use strategic thinking to strengthen those deficiencies.

Conclusion

This presentation would be incomplete without my sharing some of my personal recommendations with you—recommendations that, I believe, will help us achieve excellence through effective leadership.

Self-development. We must instill the ethic of self-development in pharmacists who are in managerial positions or who aspire toward management and leadership. We cannot wait for organized pharmacy to do it for us.

Education. Colleges of pharmacy need to incorporate courses in human behavior and leadership in their undergraduate curricula rather than adding classical management courses. Further, they need to develop educational programs for training technicians capable of handling drug distribution activities. For every pharmacist educated in clinical practice, there needs to be a pharmacy technician educated in drug distribution.

Master of Science programs in hospital pharmacy need to be deleted unless we are willing to restructure them so that they focus on the leadership and management skills needed in today's health-care environment. We need regional "centers for excellence" that would be responsible for offering education and training programs in leadership and management. These centers could be associated with colleges of pharmacy in each region of the country.

Residency Training. The objectives of general residency training should be incorporated in the clerkship component of undergraduate programs. By so doing, residencies could then be dedicated to clinical practice or administration.

Pharmacy departments with the resources to offer an ASHP advanced residency in hospital pharmacy administration need to give that priority over general residencies.

Organization. ASHP needs to develop high-level self-study management and leadership programs that have true relevance to clinical practice. Further, it needs to work with the American Hospital Association to establish and publish minimum standards for pharmacy directors relating to education, training, and experience.

Research. A major study needs to be funded through the ASHP Education and Research Foundation that would determine the existing status of hospital pharmacy management and develop an education and training model to meet the leadership needs of our profession. Further, the Foundation needs to solicit financial support to develop a $1 million trust that would focus on leadership and management education and research. Finally, sufficient funding must be found to provide research in the areas of cost-effective drug therapy, clinical practice, and leadership. The findings from this research must be incorporated in the education and training programs offered by the centers for excellence.

I believe that excellence in clinical practice can be achieved through effective leadership, but we must be committed to developing new approaches and acquiring new skills. In the words of Hickman and Silva, "In order to establish and maintain excellence, a huge investment in time and effort" will be required. "But down that long road lie not only financial and life style rewards, but the pure joy of a job well done." [21]

References

1. Hickman CR, Silva MA. Creating excellence. New York: New American Library; 1984:25.
2. Directions for clinical practice in pharmacy. *Am J Hosp Pharm.* 1985; 42:1287–1342.
3. Zellmer WA. Achieving pharmacy's full potential. *Am J Hosp Pharm.* 1985; 42:1285. Editorial.
4. Hickman, op. cit. 31.
5. Oakley RS, Bradham DD, McCormick WC. Education and experience of pharmacy directors in large hospitals. *Am J Hosp Pharm.* 1984; 41:1146–9.
6. Hickman, op. cit. 35.
7. Ibid. 23.
8. Likert R. New patterns of management. New York: McGraw-Hill; 1961.
9. Likert R. The human organization. New York: McGraw-Hill; 1967.
10. Fleishman E. The description of supervisor behavior. *J Appl Psychol.* 1953; 38:1–6.
11. Fleishman E. Leadership, climate, human relations training and supervisory behavior. *Pers Psychol.* 1955; 6:205–222.
12. Fleishman E, Harris E. Patterns of leadership behavior related to employee grievance and turnover. *Pers Psychol.* 1962; 15:43–56.
13. Blake RR, Mouton JR. How to choose a leadership style. *Train Dev J.* 1982; 36:38–47.
14. Peters RJ, Waterman RH. In search of excellence. New York: Warner Books; 1982:xx–xxi.
15. Odiorne GS. The change resistors. Englewood Cliffs, NJ: Prentice-Hall; 1981:29.
16. Hickman, op. cit. 296.
17. Ibid. 99–245.
18. Ibid. 61.
19. Ibid. 61–2.
20. Ibid. 49.
21. Ibid. xv.