

2003
Remington
Lecture

Between the 'No Longer' and the 'Not Yet'

Leaders, risking popularity and safety, gamble their lives to help create a better world.

Mary Louise Tigie Andersen



Delivered by Mary Louise Tigie Andersen, recipient of the Remington Honor Medal, at APhA2003, the American Pharmaceutical (now Pharmacists) Association Annual Meeting and Exposition, March 30.

I look at tonight as an opportunity to have a conversation with the most important and influential persons in pharmacy and America's health scene in our society today. But first let me introduce you to the most important people in my life. Roger and I will have been married 50 years this summer. May you all be as lucky as I have been to have a spouse who is loving, loyal, and always there for you, as Roger has been for me. We also have some outputs from this union—Karen, Kenneth, Keith, Eric, Joan, Jane, and Kathleen. I am incredibly proud of each of them and want to say publicly that they are good people and good parents to our 13 grandchildren, with big hearts, who are wonderful to their mother and dad.

Making the Future Happen

Leaders are called to stand in that lonely place between the "no longer" and the "not yet." We are not called to be popular. We are not called to be safe. And, we are not called to follow. We are the ones called to change attitudes—to risk displeasures. We are the ones called to gamble our lives for a better world.

I wrote those words in April 1970 when I was Speaker of the APhA House of Delegates. The Policy Committee had made the recommendation that "the Association work for the repeal of the ant substitution laws in America." This was going to be one hell of a House meeting. The interests were many and passionate. The pharmaceutical industry had built its marketing strategy on the branding of drug products. Pharmacy associations, both national and state, depended on the financial support of industry. Community pharmacy's prescription reimbursement was based on a percentage of the cost of the drug product dispensed. Everyone felt threatened. The reference committee hearings were packed.

The lobbying was continuous and pressing.

I knew how to count votes and went into that House meeting with some trepidation. The vote on this issue, which had never before been considered by the House, would determine the independence of pharmacy as a profession for decades to come. You all know the outcome. Pharmacy began that stay in the lonely place between the *no longer* and the *not yet*.

Do I believe that the results have been worth it? You bet I do. Bill Apple's driving goal was the "emancipation of the profession of pharmacy," and Donald Brodie defined the profession as a "knowledge system" in a critical study completed about the same time. It was the courage to take these visions and turn them into policy decisions that led to the stature of the profession today.

I have seen the *not yet* become the everyday reality of today. Some of that reality is in my own family. Our daughter Karen and her husband John are decision-making pharmacists at Walter Reed Army Hospital and the federal Food and Drug Administration. They are partners with dispensing pharmacists, pharmacists in industry, prescribers, and researchers across the broad spans of the profession. They work in a knowledge system and are emancipated! So are all the new professionals who fill this meeting. Their

About the Remington Honor Medal

The Remington Honor Medal, which is the pharmacy profession's most prestigious award, was established in 1918 to recognize distinguished service on behalf of American pharmacy during the preceding years, culminating in the past year, or during a long period of outstanding activity or fruitful achievement. It was created by the then APhA New York Chapter in honor of Joseph P. Remington (1847–1918), eminent community pharmacist, manufacturer, and educator.

future is no accident. It happened because there were people with a vision who put a stake in the ground and made their future happen.

Genes, Environment, and Ethics

We are all products of genes and environment. I am one lucky lady! I had a handsome, charming pharmacist father who saw himself and the profession as exemplified in the painting, *The Pharmacist*. I still have it. Framed prints were distributed by Owens Bottling Company a long time ago. It shows the family of a very sick child at home at night, while another child waits at the pharmacy as the pharmacist prepares the medicine that the sick child needs. What do I think Daddy saw in that picture? He saw a professional whose first commitment was to his patient and responsibility was to assist whenever needed. My dad also was emancipated. He did business as Paul C. Tigue, Pharmacist.

My mother was smart and wise. She knew that education was the personal and societal basis for all excellence. She hosted seven foreign exchange students because she believed that long-term peace in the world would come from knowing one another. She recognized that the Social Security System, enacted during her lifetime, would free my generation and make it the first one in history that would not have to care for its parents financially. She taught me that there is an important ethic in how a nation spends its money. She taught me that voting is a privilege and one that I should never miss.

That's the genes—but the environment is also special. My personal life and professional life have been intertwined from birth. Roger and I met in college; Linwood Tice was my dean; David Krigstein was first my teacher and then my lifelong friend; Bill Apple was a special mentor and teacher; and then there are my friends from service to APhA. Mother always said, "Show me your friends, and I will tell you what you are." Well, they are Bowles, Parks, Gloria Francke, Weaver, Oddis, Griffenhagen, Goyan, Johnson, Eggleston, and Penna. These are winners and

keepers. They had visions and passion, and I thank each for the gifts that they have shared with me.

Does this recall have a purpose other than an old lady's memories? My purpose is to challenge all of us to the next *no longer* and *not yet* that we are to face.

For the last 30 years, I have worked with developing health services programs that were targeted because of vulnerable and underserved populations—whether the result of geography or social standing. These programs focused on the basic needs of primary care in communities that lacked them.

I have spent a good amount of time in Appalachia, on Indian reservations, and in some inner-city neighborhoods, settings that are all different yet all the same. The people living in these places share one tragic common thread: they are sicker and die younger than do the rest of us. Their primary diseases are diabetes, hypertension, heart disease, cancer, and asthma.

Every one of these chronic diseases is treatable with drug therapy. We can provide all the physicians in the world to these communities, but "without comprehensive pharmacy services, there is no comprehensive primary care." Jimmy Mitchell in HRSA's Office of Pharmacy Affairs has made this truth a mantra in the agency. The demand for prescription drug coverage for Medicare beneficiaries proves that our nation understands that fact.

Access to pharmacy services was mostly a problem of the poor and geographically isolated. Many of the rest of the country had some form of third-party reimbursement with small co-payments for their prescription drugs. This is *no longer* true. Our health system in the United States is built on employer-provided health benefits. It is collapsing rapidly. You and your families may soon be uninsured or underinsured based on the corporate decisions of the next few years. Very high co-payments and deductibles may leave many of us effectively uninsured or underinsured. And this country does *not yet* have any system to take its place.

Mary Louise Tigue Andersen

Mary Louise Tigue Andersen has had a long and distinguished career as a pharmacist, both as a practitioner and as a public servant. She has played a critical role in defining, declaring, and advancing the understanding that pharmacists have the education, training, and experience to select the appropriate drug product to meet a patient's needs.



Tigue Andersen

During Andersen's 1970–1971 term as Speaker of the APhA House of Delegates, pharmacy students were given official recognition as members of this representative body. A 1952 graduate of the Philadelphia College of Pharmacy and Science, she has served APhA in a variety of capacities, including APhA Vice President, member of the Pharmacists Insurance Trust Board of Trustees, and APhA Honorary President.

In her career in public service, Andersen was Special Assistant to the Deputy Assistant Secretary for Health Operations of the Health Resources and Services Administration (HRSA). During her tenure, Congress passed the legislation to establish the drug pricing program, and Andersen established the procedures, guidelines, and operating policies for this program, which still stand. The change in title and mission of HRSA Office of Drug Pricing to the Office of Pharmacy Affairs also is directly a result of her long affiliation and influence within the federal agency.

Measurable Progress

For the past 5 years, I have worked with community coalitions across America that have decided to tackle the issues of access and health status disparities. As many as 600 communities have convened to address these issues. They can *no longer* wait for a national solution. They know they can have better health care for more people for less cost. They have the measurable goals of 100% access to care and no health status disparity.

These coalitions include medical societies and group practices, hospitals, county commissioners, United Way chapters, health departments, academic medical centers, community health centers and, sometimes, the pharmacists. They examine a lot of the local issues that have an impact on the uncompensated care and the poor health statistics in their community. It is in this manner that the players find the critical role that each entity uniquely can play, and they recognize that not one of them can do it alone. Not the hospital, not the health department, not the community health center nor the practitioners. If they are to improve health care in their community, they have to recognize their interdependence. Only then does the patient become the center of all that they do.

The coalitions look at how people are enrolled in public insurance programs, how many times the same data are collected and entered into myriad databases, how many financial surveys result in how many sliding fee scales. Then they look at what happens to providers. Almost all providers take on some uncompensated care; it is one of the unknown costs of doing business. They work together to identify the population in real need and equitably share the load. They set up support systems to relieve individual providers of the administrative burdens of taking care of this population, and they make it easy for providers to participate. They establish specialty banks so that primary care physicians are able to get specialty services for needy patients. They move patients from costly emergency rooms to primary care offices and save significant systems dollars. They cooperate on case management for those high users of the system to see if they can get better compliance and better health outcomes. And they know that without comprehensive pharmacy services, there is no comprehensive health care.

Is this lady on the road to Oz? No, but I have been to Buncombe County, North Carolina; Middlesex, Connecticut; and Pittsburgh, Pennsylvania. I have seen pharmacists who provide comprehensive pharmacy services and make a difference as full partners with the physicians and hospitals in their towns where each contributes in his or her own way.

With very few exceptions these community plans call for organized, integrated, affordable, comprehensive pharmacy services. The pharmacists who are graduating from our colleges and universities are practicing in exciting environments. They are being recruited and challenged to help these communities design such systems. They are required to understand the health care disparities, the language implications of drug therapy, formulary development with quality standards, and procurement systems that take advantage of the various favorable pricing structures. It is most exciting to see pharmacists come together as a group in a community to work with all providers and community leaders to address

their local needs. Communities know that drug products are not free, and they have learned to seek resources for medications as part of their development process.

In these systems, I have seen newly emancipated pharmacists serving as independent, essential, valued, and equal partners in the care of the patient community. An example is in this room tonight. When working with Middlesex, Connecticut, the community brought to my attention how Peter Tczykowski of Pelton's Pharmacy has contributed to the development of their health system that serves the underserved. When the community first organized to form a community health center, his pharmacy joined into the planning and found how it could help. It has remained a core linkage in this town as the programs have grown from health centers to health systems. Peter studied the 340B drug pricing laws, became a contract pharmacy to help the health center with the complexity of pharmacy practice, found ways to use this benefit to serve as many people as possible, and learned how to leverage his work in the community to benefit all his patients in Middlesex. This community knows that there is no primary care without comprehensive pharmacy care because Peter has shown them.

Staking Out the Pharmaceutical Care Ground

When APhA leadership under Executive Vice President John Gans put a stake in the ground about the clinical role potential for the profession, it was one of those *not yet's*. The Association was not being safe—or popular. We were making a statement that would affect every pharmacist yet to be educated. We were establishing a minimal level of care that every patient has a right to receive. That vision has been realized, and pharmaceutical care is gradually becoming the standard.

The national debate continues about the financing of health care for all Americans. We see the issue in every newspaper and hear it on the commentators' tongues. So how soon can we expect to have this issue settled for us again to be secure in our coverage? I personally believe that we may never have a national system of health care in this country. The policy issues at the national level are very divisive and fraught with vested interests and very large amounts of money. I do believe that we can have a national system that assures access for all persons through community organized and managed health systems. Community-driven reforms mandate cooperation in ways that recognize their own local cultures and values. Some depend on volunteer support; others are led by the local government efforts. Some institute small sales taxes, some develop small employer packages, and some reapportion the savings. All such emerging systems need support for the required infrastructure and financing of care for the truly needy.

The integration of these systems today comes as a result of the information systems that are being implemented in the community. All providers have access to common information, scheduling availability, and feedback to referral sources. When the pharmacist participates, this knowledge system of pharmacy is integrated no matter where you locate the drug product.

Our challenge is to make our knowledge system accessible to

the community at large and to make its value understood and appreciated. We can demonstrate in cold, hard terms the economic value that pharmacists contribute to the system in terms of improved health outcomes and the impact on costs. As more and more of the responsibility for health care is transferred to the patient and more medications become available without a prescription, self-medication will increase exponentially. Insurers will demand that only those drugs that really require physician oversight in their use will carry the Rx legend because they will generally pay only for prescription drugs. It is happening now. The site of decision making about drug product selection has moved from the doctor's office, to the prescription counter, to the shelves of retailers.

We have all discussed the pharmacist's role in assuring safety in this self-medication world. I have seen the real life challenges of many patients: those who are illiterate or do not speak or read English; those whose dietary customs are not familiar to the rest of us and cause problems with some products; those with diabetes who continue to use corn pads until they have the amputation; or those with hypertension or glaucoma who continue to take the ephedrine-type drugs, and I have wondered why they are still having more troubles. They deserve better from us. And we can give them better.

Values: Making the Future Happen Again

I began these remarks by discussing the combination of genes and environment. During the next 25 years, while we will still have our genes, we will be required to create a response to change that will test our ethics and our value structures. I grew up in the last century in a United States that was predominantly white, Judeo-Christian, and English speaking, with a two-party political democracy and opportunity open to all.

As we enter this new millennium, dramatic change is the norm, especially in health care. Our society will be vastly different from that which we have known. It will be as multilingual as that of Europe, with mosques and Buddhist temples in the community, as well as churches and synagogues. The role of democratic government will be debated in every system, including health, education, communication, and transportation. Threats of terrorism challenge the civil rights we once took for granted. The people we now refer to as minorities—African Americans, Latinos, and Asian Americans—will outnumber whites. The real numbers, as well as

the percentage of those vulnerable populations, will grow. Doing nothing is inviting a disaster of social unrest that none of us can contemplate.

Follow the Road to Oz

Earlier, I mentioned Oz. I think there is a road map here for us as individuals and for APhA as an association. Listen carefully, fellow APhA members!

You remember the cowardly lion who wanted courage, the scarecrow who wanted a brain, and the tin man who wanted a heart. We have a need for some new answers, and sometimes I feel like the scarecrow who sang, "If I only had a brain." The most critical part of the brain allows us to see the opportunities and to understand the power of the different choices. It gives us the ability to think of the consequences. But it will take more than a brain to answer these questions. It takes the tin man, who knows that knowledge is not enough. We need the right understanding with a commitment to care.

The cowardly lion should have thought a bit about what he wished for—because he just might get it. Courage is tough to live with because it is the personal and organizational quality that makes a difference. It is what lets you *stand in that lonely place between the no longer and the not yet*. Once courage is present, you have no choice but to act. You know the options and the consequences, and you care about those at risk. You begin traveling down the road of small, directed choices to do what is right. You work with others, value the differences, and take risks.

There are plenty of brains and very good hearts in this room. I am asking you to go home, each to your own community, and see who is organizing for change. Then, I ask you to have the courage to join and to bring your community into the movement for 100% access to care and no health status disparity. Know that we can have better health for more people at less cost. Make it happen, and remember that there is no comprehensive primary care without comprehensive pharmacy services. Lead the way. Because...

Leaders are called to stand in that lonely place between the "no longer" and the "not yet." We are not called to be popular. We are not called to be safe. And, we are not called to follow. We are the ones called to change attitudes—to risk displeasures. We are the ones called to gamble our lives for a better world.