

VIEWPOINTS

Making Residency Training an Expectation for Pharmacists in Direct Patient Care Roles

Stuart T. Haines, PharmD

School of Pharmacy, University of Maryland

Over the past year there has been considerable dialog about whether residency training should become a requirement for new pharmacy graduates before they can assume direct patient-centered care roles. I believe it is the right course for our profession to chart toward the future and I hope we will exert considerable effort toward making residency training an expectation by 2020.

Admittedly, my personal experiences as a student and resident have shaped my opinion. While I believe I received an excellent education that prepared me to enter practice, I was professionally unsophisticated, naïve, and a bit scared when I graduated. I had not developed the level of confidence or proficiency that comes from experience. Moreover, as a student I was not “really” responsible for my actions. Legally speaking, I was not permitted to make independent decisions. And most preceptors did not allow me that much autonomy – rightfully so. During my 4-week practice-based experiences there was barely enough time to figure out the day-to-day operational logistics. Don’t get me wrong. I learned a great deal from those experiences. They helped me integrate the concepts that I had first heard about in the classroom. They gave me opportunities to practice the skills I had first attempted in labs. And they helped me make decisions about the direction of my career. But they did not give me the depth of experience necessary to become a confident, autonomous practitioner. Residency training did.

My viewpoint has also been influenced by the Joint Commission of Pharmacy Practitioners (JCPP) vision statement, approved by all pharmacy practice organizations in 2004, entitled “*JCPP Future Vision of Pharmacy Practice.*” Among other things, the vision statement specifically declares: “Pharmacists will have the authority and autonomy to manage medication therapy and will be accountable for patients’ therapeutic outcomes.”¹ If we are to achieve this vision, pharmacy practitioners must

possess a level of clinical maturity that, in my opinion, can only be achieved during residency training. No doctor of pharmacy curriculum – no matter how well constructed – can provide students with the depth of experience needed to “autonomously” manage drug therapy. Nor should it. An entry-level degree begins the preparation of individuals for a variety of professional roles. And while “medication therapy manager” will (hopefully) become the primary role of most pharmacists, it should not be the only role.

My opinion regarding the need for residency training has been further influenced by a recent meta-analysis that found that pharmacist who were given autonomous authority to manage drug therapy were able to positively impact outcomes.² Conversely, pharmacists who were not given this authority had minimal impact on outcomes. These data validate the JCPP vision and demonstrate that empowering pharmacists to make and implement drug therapy decisions is an important ingredient of the practice model. Yet to make these decisions autonomously requires considerable clinical judgment and experience.

Not everyone agrees that residency training should become a prerequisite for new graduates to assume direct patient care roles. Some argue that the doctor of pharmacy degree adequately prepares graduates for these roles – and if it does not, it should. Additional training, they argue, is redundant, costly, and only exacerbates the pharmacist shortage. I agree that our pharmacy graduates today are better prepared for patient care roles than any previous generation of pharmacists. Many graduates eagerly seek “advanced” direct patient care responsibilities and want to manage drug therapies – but most are simply not ready to do so autonomously. Schools of pharmacy can and should provide students with a breadth of experiences in many areas of practice. However, by design, these experiences are relatively short (usually 4 to 6 weeks) and occur in a variety of settings – each with its own patient care practice procedures, technology, and culture. Residency training may have some goals and objectives in common with the doctor of pharmacy degree, but the experiences in a residency training program are often deeper because they occur in a single institution under

Corresponding Author: Stuart T. Haines, PharmD.
Professor and Vice Chair for Education, University of Maryland School of Pharmacy, 20 North Pine Street, Room 405, Baltimore, MD 21201.

the guidance of preceptors who all work together. Residents are licensed professionals who are paid for their contributions to patient care . . . and they are responsible for their actions. A residency is a transitional year – a time for individuals to gain the confidence and clinical maturity to become autonomous practitioners.

Many practitioners share my belief that residency training should be an expectation in the future. In 2000, the American Society of Health-System Pharmacists (ASHP) House of Delegates adopted official policy that states: “. . .optimal direct patient care by a pharmacist requires the development of clinical judgment, which can be acquired only through experience and reflection . . .” Moreover, ASHP policy states: “pharmacists who provide direct patient care should have completed an ASHP-accredited residency.”³ In its 2002 strategic plan, the American College of Clinical Pharmacy (ACCP) articulated a similar vision for the future: “Formal, post-graduate residency training will become mandatory before one can enter practice.”⁴ In 2006, ACCP published a comprehensive argument supporting this position and recommended achieving the vision by 2020.⁵ Currently, the American Pharmacists Association (APhA) is considering a similar policy statement.

Does this mean that *every* pharmacist in the future should complete a residency? No. There will be some roles that may not require residency training. For example, pharmacists in the future who primarily focus on the order fulfillment role may require additional training in the areas of robotics and systems engineering. Pharmacists who pursue research careers may or may not need to complete a residency (depending on the type of research they intend to conduct) prior to pursuing a PhD and/or fellowship. Pharmacists whose primary role is to develop institutional or public policy should probably have a master’s degree in public health, health policy, or health care management.

Some have argued against residency training as a prerequisite for new graduates in direct patient care roles because it is an unrealistic goal. They contend that there are not enough residency positions to meet current demand much less the 7500 or more residency positions

needed to make the vision a reality. Moreover, there are not enough financial resources to create new residency positions. Further, the demand for pharmacists to serve as medication managers is small and there are meager economic incentives to create these positions. Granted, these are all significant challenges our profession will have to address if the vision is to become a reality. But to argue against residency training as a prerequisite for direct patient care roles simply because the goal is difficult to achieve is, in my opinion, a cop out. If one believes that residency training is the best way to prepare pharmacists for direct patient care roles, the argument should not be about *whether* the vision is correct, but *how* to achieve it.

ACKNOWLEDGEMENT

Dr. Haines is currently the President of the American College of Clinical Pharmacy (ACCP). However, the views expressed in this editorial are those of the author and not intended to represent the official position of either ACCP or the University of Maryland School of Pharmacy.

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