EDITORIAL

Accreditation: We Want Standards, Not Standardization

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Changes that took effect with the implementation of the 2007 accreditation standards and guidelines for United States Doctor of Pharmacy (Pharm.D.) degree programs[1] have sparked broad concern and debate among pharmacy academicians, pharmacy practitioners, and the Accreditation Council for Pharmacy Education (ACPE), which accredits U.S. Pharm.D. programs. Many discussions have focused specifically on the introductory pharmacy practice experiences (IPPEs), but it is the nature of the accreditation standards and guidelines and how they have been implemented that have raised the following concerns and questions that relate to the role of our accrediting body:

1. Should ACPE standards and guidelines narrowly define and specify curricular elements, or should they require that outcomes and appropriate teaching methods be developed in specified areas? The latter gives schools the latitude to develop curricula within the context of their unique circumstances. It is an approach used by the Liaison Committee on Medical Education (LCME),[2] the accrediting body for U.S. Doctor of Medicine degree programs.
2. Should untested standards, particularly those whose implementation can substantially disrupt an existing curriculum, be implemented broadly and rapidly, without due consideration of the resources needed and the planning required and without supportive evidence for the importance of the standard to outcomes?
3. Does rigid application of quantitative standards suppress innovation and diminish a school's ability to advance a well-thought-out curricular plan?

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The IPPE Case Study

The 2007 revision of the ACPE Accreditation Standards and Guidelines for the Professional Degree Program in Pharmacy Leading to the Doctor of Pharmacy Degree[1] was adopted on January 15, 2006, and released on February 17, 2006. The rubric that expressed the interpretations of the standards was released on February 17, 2007, and the standards were made effective 5 months later, on July 1, 2007. The ACPE claims that there was sufficient input gathered from stakeholders before adoption and implementation of the IPPE standard. However, in reality, as the standard was being discussed, the expectation of the rapid implementation was not known, nor was the detail to which guidelines were going to be enforced.

The 2007 revision of the ACPE Accreditation Standards and Guidelines for the Professional Degree Program in Pharmacy Leading to the Doctor of Pharmacy Degree includes the following new standards and guidelines, which narrowly define the duration and nature of IPPEs:

- Standard 10. This specifies that pharmacy practice experiences shall not be less than 5% of the curricular length. Although no hours appear in the standard, an e-mail to deans from the ACPE, dated April 11, 2007, indicates that 5% shall be interpreted as 300 contact hours. Because curricula vary in length, for some schools, 5% represents less than 300 contact hours.
- Guideline 14.3. This states that students must not receive remuneration for experiences for

which academic credit is assigned.

- Guideline 14.4. This states that IPPEs must involve, at a minimum, actual practice experiences in both community and institutional settings and permit students, under appropriate supervision, and as permitted by practice regulations, to assume direct patient care responsibilities. The guideline goes on to say that additional practice experiences in other types of practice settings may also be used.

Although there is little disagreement among schools about the desirability of providing pharmacy practice experiences early in the curriculum, these new requirements and their implementation by ACPE have generated vigorous—and sometimes contentious— discussions among pharmacy faculty members, practitioners, and ACPE. Why?

- The new IPPE requirements emphasize process (hours, specific sites, preceptors), not outcomes, and have been rigidly enforced. The ACPE has not responded with due respect to inquiries from schools that have requested flexible interpretations of the standards in order to pursue innovative approaches while emphasizing learning outcomes, assessment, and continuous quality improvement. The ACPE responses are aggravatingly brief and indicate neither acknowledgment of the pedagogical approach nor the reason for its decision.

- The rationale for the new IPPE requirements is incorrect and misguided. According to ACPE, the new standards were introduced based on hearsay. Preceptors "told" ACPE that students were inadequately prepared for the advanced pharmacy practice experience (APPE) courses. Neither the prevalence of these comments nor their validation through surveys or other methods has ever been presented in a public forum. This is contrary to evidence-based decision-making.

  In addition, ACPE "observed" high variability in the implementation of IPPEs among schools. In fact, there is certainly huge variability in curricula across all schools of pharmacy. Evidence supporting whether this particular variability led to a good or bad outcome for students has not been forthcoming. In fact, there is no consensus among preceptors that students are inadequately prepared for APPEs, and there is no evidence that IPPEs, as now defined by ACPE, will lead to adequate preparation. Indeed, simulation, accompanied by appropriate assessment, might be a better way to teach students some of the professional skills they need rather than relying on the random, episodic experience a student encounters in the IPPE setting. Simulations are neither new nor radical; they are used by most other health professional schools because they successfully ensure that students receive an introductory level of skill education. Sadly, ACPE has rejected simulation as a substitution for even a single hour of the 300 hours it requires for IPPEs.

- Implementation of the new IPPE requirements jeopardizes the quality and availability of APPEs. Potential sites for APPEs that were sparse in the 1990s (they were then called clerkships) have become an endangered species in the first decade of the 21st century in some areas of the country due to the rapid proliferation of new schools of pharmacy across the nation. Furthermore, there is a severe shortage of pharmacists who are the pharmacy faculty on which APPEs rely to function properly. Consequently, many schools and colleges are already struggling to recruit a sufficient number of quality sites and preceptors for their APPEs, particularly in institutional settings. Concerns have been raised about patient safety in sites with many learners.

- The implementation timetable for the new IPPE requirements (it has to be done now!) poses a sudden drain on the resources of many schools and colleges of pharmacy, for which there has been inadequate time to plan or secure additional budget. Rapid implementation has led to curricular disruption, affected student learning in other areas, and severely strained already-scarce faculty, site, and fiscal resources. This has been particularly true for established schools whose curriculum design does not already include 300 hours of IPPEs. Some schools have estimated a recurring cost of about $500,000 per annum to establish high quality IPPE programs.

- Profound disparities exist in the prelicensure practice requirements among states. Some state Boards of Pharmacy require significant internship hours in addition to hours of experience required by Pharm.D. program curricula. In addition, Board rules in some

states limit the number of interns and students in any given site to one per preceptor, making it particularly difficult to use the same sites for IPPEs and APPEs. The ACPE has rejected proposals that would formally acknowledge student knowledge and skills gained through these paid internship hours, even when linked to learning outcomes and assessment by a school.

- Restricting IPPEs to traditional practice settings fails to acknowledge other experiences and extracurricular activities that add important dimensions to a student's professional qualities and competencies. These include leadership, community engagement (e.g., health fairs, public health initiatives), education about the context of health care, and interprofessional teamwork.

Call to Action

We contend that this situation cannot continue. We call on our ACPE colleagues to make three essential IPPE changes immediately. These changes require only slight modification to the current ACPE Accreditation Standards and Guidelines for the Professional Degree Program in Pharmacy Leading to the Doctor of Pharmacy Degree.

1. Define a set of core competencies that must be achieved by students before entry into APPEs. These could include some basic clinical as well as dispensing skills, communication skills, patient safety skills, practice improvement skills, and professionalism and caring. Each school must be able to provide evidence that such skills are accomplished in its overall pre-APPE curriculum. A variety of assessment techniques, including surveys of APPE preceptors, should be employed.
2. Permit flexibility in how students acquire pre-APPE competencies, provided students are appropriately assessed. All the experiences a student has—in actual practice settings, in simulated practice settings, in active learning experiences in the classroom, and in paid or volunteer work experiences—will contribute to the overall skills and abilities of the student. Without a doubt, some skills and knowledge are better acquired in one manner or another, but there is little evidence yet to determine the best modes of teaching them. What is important is that students acquire defined skills and abilities, are able to demonstrate them, and that time is allocated within the curriculum for this to happen. Therefore, we should eliminate a set number of hours as a criterion if a program has developed measurable outcomes and can adequately measure the required skills.
3. Charge schools, especially those with a long history of strong accreditation records and student outcomes, to experiment with optimal ways for students to acquire the desired competencies, using sound educational measurement and educational research techniques. Evidence-based education serves students and faculty well and provides a rationale for standard setting.

If the three IPPE changes called for above are not made, consider the fourth recommendation below. We pose it based on the strength of our convictions and in the best interests of the students we educate and the patients we serve.

4. Consider an alternative way to ensure standards among our schools that avoids standardization, favors and facilitates evidence-based education, and promotes achievement of competencies over standardization of learning processes. We contemplate this dramatic action because we are so concerned that the current situation endangers true innovation and advancement of pharmacy education at a time of tremendous fiscal constraint and scientific discovery.

An accrediting process that facilitates evidence-based education and favors outcomes measures over process measures is vital to the future of pharmacy education and practice. Other professions have created new accrediting bodies when it became necessary to do so. We must begin now to consider this option because the ramifications are so profound, and the process to implement such a change would be complex.

We believe that the mission of tomorrow's accrediting body should be to ensure that U.S. pharmacy schools are universally producing the most skilled, dedicated, adaptive, and caring practitioners possible. Our ideal accrediting body should not be concerned about how our schools meet academic requirements, but rather that requirements are met.

Unfortunately, somewhere along the line, ACPE has permitted formulas to creep into some, if not many, of its standards. Formulas are fairly easy to write, and once written, they are easily understood and followed, if only for fear of

sanctions. Their breach is also easily detected, and they are therefore easily enforced. The problem is that formulas, like traffic laws, are inflexible. They do not allow for deviation, even if justified. Worse yet, formulas do not permit experimentation. Without flexibility and experimentation, everything in pharmacy education is essentially the same, and nothing evolves. If the current standards had been in place 40 years ago, clinical pharmacy never could have been invented.

Thoughtful and intellectual responses to schools requesting exemptions based on sound educational rationales, a willingness to step back and reassess the impact of the new standards and their enforcement, and the elimination of ideologic statements and hearsay from accreditation team reports are examples of the kinds of actions ACPE could take to signal a willingness to work with its constituents and forestall such a dramatic alternative.

Thoughtful standards ensure strong educational programs for pharmacists that adjust to the rapidly changing health care environment and societal needs. Standardization stifles these greater goals. We must act now to preserve the farsightedness that has characterized pharmacy education.

References

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