The Pharmacist Activist

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"Be strong and courageous, and do the work." I Chronicles 28:20b

Editorial

Pharmacy Degree and Licensure Requirements Continued: Part 3

Editor's note: *I am pleased that so many are contributing to the discussion of this topic that was initiated in the January issue. The four responses provided below are comprehensive and extend the scope and depth of the discussion.*

Response of Lowell Anderson, APhA Past President, Minnesota

In reading the February Pharmacist Activist I was particularly interested in Dr. Doluisio's response to the series on Degrees and Licensure. My interest stems from having served on ACPE and the MN Board of Pharmacy, as well as pharmacy practice and as a faculty member.

He captures a significant challenge for colleges and boards in his observation: "It has always been my belief that our colleges had the responsibility to prepare our students for the current practices of pharmacy as well as to prepare them to adapt to future practice opportunities."

I think the bigger challenge is preparing the students "to adapt to future practice opportunities" -- for careers in pharmacy that we can't describe, or envision, because the science of healthcare and its delivery is changing so quickly. Knowledge is growing as well as the opportunities and technologies to apply the growing knowledge.

Unfortunately, we have not kept up with how our graduates apply their knowledge. We know that many do not enter a traditional practice. Anecdotally we are aware that they work in industry, managed care, insurance, corporate management, and so on. But we don't know what many of our graduates do. Many graduates will say that they relied on "on the job training" for their non-practice positions.

It is essential that colleges survey their graduates as to their career paths – 5, 10, 20 years out. Without knowing what pharmacists ultimately do with their education, it is impossible to provide the opportunities in the curricula for them to prepare themselves.

As Marshall McLuhan observed: "We look at the present through a rear-view mirror, so that we march backwards into the future." ◆

Response from Denise H. Rhoney, Pharm.D., Ron and Nancy McFarlane Distinguished Professor, University of North Carolina Eshelman School of Pharmacy

Thank you for continuing to host this important discussion.

I read your recent editorial and the response from Dr. Doluisio with great interest.

I agree strongly that change is needed. After 25 years of the all-PharmD era, it is difficult to argue that educational structure, practice expectations, and workforce realities are well aligned. However, I am not yet convinced that returning to a previous model is the right solution. Instead, I wonder whether the profession should use the wisdom of the past to intentionally design a structure that fits the future of healthcare rather than recreate a structure built for past practice.

One point that stood out to me is the comparison to the post-BS PharmD era. Those programs assumed learners entered advanced training already possessing comprehensive drug knowledge. That allowed educators to extend learners into ambiguous clinical reasoning and decision-making. Today we teach foundational drug knowledge and complex reasoning simultaneously, and the progression is not the same. I believe this contributes to why many stakeholders perceive graduates as insufficiently prepared for practice, not because learners are weaker, but because the cognitive development pathway is compressed and misaligned.

In a recent American Journal of Pharmaceutical Education (AJPE) study examining stakeholder perspectives on the most pressing challenges in pharmacy education (https://www.sciencedirect.com/science/article/abs/pii/S0002945925005455), we observed a persistent competency-practice gap, fragmented professional identity, and structural misalignment across the educational continuum.

My own work focuses on competency-based pharmacy education in the U.S., and I increasingly wonder whether the central issue is not degree length but role alignment. Our single license applies across every practice environment and level of responsibility. As a result, programs attempt to prepare graduates simultaneously for distributive accuracy and high-level clinical decision-making in an increasingly complex therapeutic environment.

Compounding this, the educational continuum is fragmented. Professional education, postgraduate training, certification, and continuing professional development are designed by different groups with limited coordination, making the novice-to-expert trajectory discontinuous rather than developmental.

Rather than framing the future primarily as BS versus PharmD, I wonder whether the profession should consider a more adaptive model built around responsibility and progression. For example, licensure could reflect what a pharmacist is entrusted to do rather than how long they sat in school, progressing from medication safety and distribution, to therapy management under protocol, to independent therapeutic decision-making, and ultimately to consultation and system-level care. Education could then become competency-based rather than time-based, allowing learners to advance from foundational knowledge to applied therapeutics to entrustment when ready, rather than uniformly progressing by calendar year.

Similarly, the profession may benefit from multiple preparation pathways within a single professional identity, community care, clinical decision-making, systems and safety, evidence and policy, or prescribing-focused practice, not as hierarchy but as domains of expertise. A unified competency framework across the entire continuum could create natural on- and off-ramps across a career rather than a single point of readiness.

In that sense, your discussion may be pointing us toward a principle more than a structure: the profession functions best when education aligns with the responsibilities pharmacists are actually expected to perform.

I would be very interested in your thoughts and in how you think the profession could realistically move toward a future-oriented model rather than choosing between historical ones. It may also be valuable to continue this discussion within pharmacy journals and professional meetings, as this is an important issue to address, particularly as learners assume increasing educational debt under the current structure.

Thank you again for continuing to stimulate this important conversation. ◆

Response from Carl Forster, pharmacist and physician (retired), Pottsville, PA

(Although I did not specifically identify him in my February issue, Carl Forster is the pharmacist/physician I mentioned who is an advocate for integrating a pharmacy education with a physician assistant studies education).

I was happy to see that you included my experience in the Activist, and it triggered an additional thought. My wife and I just received a notice from a local Internal Medicine practice that we use announcing that two of their Physician

Assistants have left to pursue other opportunities. In the event of our continued need for care, we were made aware of several network locations that would be available both locally and in neighboring counties. We questioned the replacement of the internist by a P.A. as an option to the initial need for medical care.

The utilization of Physician Assistants in Primary Care has extended to the specialties of medicine, and common to all areas of the medical profession is a paucity of drug therapy education compared to that of a Pharmacist. In essence, the nature of the P.A.'s role in practice is that of an apprentice to the employer or supervising physician, particularly evident with respect to prescribing medications.

If the basic entry into Pharmacy changes back to a 4-year B.Sc. degree, it would increase the applications to Pharmacy school by those individuals who, at least initially, are not interested in pursuing advanced education. It would decrease the expense of becoming a community or hospital pharmacist while complementing the salary expectations associated with the degree. Post-graduate Pharm.D. education and residency programs could be pursued by those with advanced professional practice interests, including those in physicians' offices. The drug therapy and related expertise of pharmacists are far more comprehensive than that of P.A.s and nurse practitioners, and would enable more effective utilization of the expertise of these professionals and the physicians in working in such office practices.

I hope there is some utility in these thoughts that opens to doors of opportunity for the future of Pharmacy. I deeply cherish the years I practiced as a pharmacist that made me more confident and effective in my role as a physician. ◆

Response from Henry T. Kozek, community and regulatory pharmacist (retired), Williamsburg, VA

I have always believed that 5-year degreed pharmacists were shortchanged with only a bachelor's degree, rather than a master's in pharmacy. The only other profession that granted 5-year bachelor's degrees at the time was architecture. I worked with many architects in government who also felt shortchanged. Who else accumulated 160+ credits and only received a bachelor's degree?

Students should also be admitted directly from high school, without having to obtain any additional degrees. Some pharmacy schools seem to prefer that applicants hold a baccalaureate degree before entering the pharmacy program, at additional costs to the students, without any real gain to the profession. This is entirely unnecessary, although I understand that some applicants may apply to pharmacy school later in their careers or if their initial degree did not prepare them for the job market.

When I graduated in 1972. only three in my class of 132 showed any interest in continuing their education leading to a PharmD. The current sixth year is clinical rotations at various sites. While I can understand that these rotations may prove helpful in some instances, it is burdensome and entirely unfair to the student, who pays tuition for that entire year (with no classes), is not paid for work, and may have to relocate to another city to complete their rotation. I worked with a couple who were completing their clinical rotations and had acquired student debt of $250,000. According to students that I have worked with, rotations can be both boring and meaningless. Not an effective way to start your career. Then someone had the idea of PGY1 and PGY2 that pay less than a full-time pharmacist's salary. Even with this additional training, a decent job opportunity is not guaranteed. All of this to be called "doctor?"

Many pharmacy students still appear to gravitate towards retail pharmacy, since that is where the jobs are – at least for now. However, that is also where the most stress is encountered, especially in the chain stores, where conditions are awful. I worked for both Thrift and Eckerd Drugs early in my career and determined that I could not spend the rest of my life dispensing prescriptions 8-12 hours per day, with no breaks. Applying for a state inspector position with the NJ Department of Health was the best move I ever made. I was able to utilize my education, acquire good benefits, have a meaningful career, and felt that I was making a difference in people's lives. Plus, no working nights, holidays, and weekends! However, my pharmacy license still allowed me to work part-time, since my government pay was low initially.

Back in the early 70s there was a pushback or concern that pharmacists with 4- and 5-year degrees would encounter discrimination from health care HR departments or other professionals without the title of "doctor." Pharmacy schools promulgated this theory to try and elevate the profession. It failed. I had classmates in pharmacy school who were brilliant. A PharmD would not have helped. A 4-year graduate, Bob Kocsardy, produced the best lectures I ever attended. He made his own slides, often drawing cell structures for his lectures on medications. The public does not care and is not impressed if you have a title of "doctor" after your

name. This "doctor" title seemed more important than the additional year(s) of servitude and debt. I remember one pharmacist-in-training coming to a health care facilities meeting with a stethoscope around his neck, I guess to try and impress us non-PharmD's. This title still does not place you on an equal educational footing with an MD, DO, PhD, DDS, EdD, etc.

I currently work part-time at a college student health center and volunteer at Colonial Williamsburg, where I interpret 18th-century pharmacy, medicine, and surgery as an Apothecary, who, in the 18th-century, was also called "doctor!" And I made it without clinical rotations! ◆

Extending the discussion

Almost all of the pharmacists who have responded have voiced the opinion that the decision to adopt the Pharm.D. degree as the entry-level degree to become licensed as a pharmacist has not achieved the anticipated outcomes including the widespread expansion of the roles and responsibilities of practicing pharmacists. Some contend the decision has had negative consequences that include the increased length and cost of their education, the failure of the colleges and associations to provide sufficient practice employment opportunities that enable pharmacists to use their advanced knowledge and skills, and the increased frustration and disillusionment that many pharmacists experience. Many acknowledge the external influences over which our profession has no or little control, while also voicing concern that our profession has not been more effective in addressing the challenges/opportunities. A few have cautioned that revisions of degree and licensure requirements must be pursued in the context of the current and anticipated standards of pharmacy practice and the probable availability of positions with responsibilities that align with the goals and content of the degree programs. In this regard, we should learn from the experience and what many consider to be the mistakes of going all Pharm.D. (i.e., "those who ignore history are destined to repeat it").

A primary motivation for my addressing this topic and its multiple ramifications is my opinion that the path to pharmacy licensure is too long and costly to prepare graduates for assuming considerably more professional responsibilities than most community and hospital pharmacists have now. It is my observation that the same experience exists in most other health professions, and it is noteworthy that some medical schools have revised their programs in a manner that permits completion of the requirements for the doctorate degree in 7 years rather than the traditional 8 years.

In considering the responses I have received, I want to be clear that I am NOT recommending that we return to previous educational models but rather am urging that we pursue the opportunity to substantially revise the length, structure, content, and methodologies of the educational process in a manner that aligns with current and anticipated practice opportunities and other pertinent factors.

I was very encouraged to learn from Denise Rhoney (see her response above) that she and other pharmacy faculty have conducted and published research studies that correspond to and extend those considered in this and the January and February issues of The Pharmacist Activist. I highly commend them on the work they have initiated of which I was previously not aware. Their work requires vision, as well as courage as their work will be considered unnecessary and/or opposed by many within our profession.

I and pharmacists such as Jim Doluisio and Lowell Anderson have retired from our full-time responsibilities in the profession. However, we can help increase the awareness of the importance of these initiatives for the future of our profession, and to support and encourage Denise and other pharmacy leaders in their continuing efforts. As Jim Doluisio concluded his comments in the February issue, "The status quo is not an option."

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