VIEWPOINT – POINT/COUNTERPOINT

Should a Pharmacy Dean be a Pharmacist?

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As my colleague Dr. Svensson correctly points out (and to put to rest this aspect of the conversation), there is no restriction in the profession on who *can* be a dean of a college or school of pharmacy other than the condition stated in the Accreditation Council for Pharmacy Education's (ACPE's) Standard 8.2: "The dean must be qualified to provide leadership in pharmacy professional education and practice, research and scholarship, and professional and community service."¹ In fact, ACPE Standard 8.3 broadens the leadership qualifications to the entire administrative team by stating "other college or school administrative leaders must have credentials and experience that have prepared them for their respective roles and *collectively* [my emphasis] have the needed backgrounds to effectively manage the educational program."¹ In the concept of a team collectively leading a school of pharmacy, pharmacists as well as scientists of pharmaceutical, biomedical, clinical and social-administrative backgrounds and other members of the health care and education teams, contribute in a way that fully serves the school.

The question of whether a pharmacist *should* be the only person to lead a college or school of pharmacy has to be based on a standard beyond that articulated by ACPE. To understand this higher standard, we must look at the duties of the dean. The reality of the dean's role is clearly stated in the first bullet point of the guidance document produced by ACPE: the dean has "the authority and responsibility for ensuring acceptance of the mission, vision, and goals by the stakeholders."² By including stakeholders, an important aspect of the dean's role is defined as a fiduciary. A fiduciary role is someone entrusted with the care of money or property and their fiduciary duty is the legal obligation to act in the best interest of others, namely stakeholders.³

As fiduciaries, to whom are deans accountable? In the United States (and other nations), the quality and outcomes of professional education are monitored by professional organizations given the right and authority of governance. For pharmacy, that organization is ACPE. The rights and authority for this governance are given to such professional organizations by the US Department of Education, which began operations in May 1980. The

department's mission includes increasing "the accountability of Federal education programs to the President, the Congress, and the public."⁴ I argue that for the purpose of health professions education, the key stakeholder *is the public*. In my opinion, therefore, the two characteristics required of a dean, relative to this fiduciary standard, are an uncompromising patient-centered attitude and a firm understanding of the role of formative and summative evaluation in shaping the outcomes of professional education.

In 1999, the Institute of Medicine (IOM) published its landmark report "To Err is Human," which documented the medical error epidemic in this country. Based on their statistics, it was estimated that medical errors represented the sixth leading cause of death in the United States and were responsible for one death, on average, every five minutes and eleven seconds.⁵ Shortly thereafter, IOM published the report "Crossing the Quality Chasm," which outlined six aims necessary to tame this epidemic: safe, timely, effective, efficient, equitable, and patient-focused care.⁶

In the report, "patient-focused" is further elucidated as, "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." The evidence from "To Err is Human" suggested that when examining the root cause of medical errors, rather than focusing on patients, the health care system was provider-centric, which led to communication and professionalism issues that impacted care quality. In the 2000s, multiple professions, such as allopathic and osteopathic physicians, pharmacists, physician-assistants, and nurse practitioners, began outlining patient-centered competencies for all practitioners that aligned with the IOM aims for improvement. Within pharmacy, the Center for Advancement of Pharmacy Education (CAPE) Outcomes, developed by the American Association of Colleges of Pharmacy, represent outcome competencies inherent in demonstrating patient-centered practice.⁷ This transformation in health professions education now requires that leaders place the six aims, most importantly the value of patient-centered care, above all other concerns. Our leaders must be defined by their advocacy for

patient-centered care if they are to fulfill their fiduciary responsibility to the public. Specifically, pharmacy deans must advocate strongly for the absolute requirement of the pharmacist's role—even above their license and education—in a patient-centered health care system that ensures the highest quality care. Moreover, deans must role-model patient-centeredness through their leadership of schools. Fortunately, the values articulated by IOM translate well to the educational context: providing education that is respectful of and responsive to individual student and faculty preferences, needs, and values, and ensuring that patient values guide all educational decisions. In this regard, the patient is common to both the clinical and educational setting for the pharmacy profession. Preferences, needs, and values of individual students and faculty members include teaching and learning styles, respect for diversity, acknowledgment of past experiences, and aptitude for teaching and learning new and complex material.

While arguing that the dean need not be a pharmacist, I emphasize that faculty pharmacists are central to the formative development of the student. Education, on many levels, is driven by assessment. Educational assessment within professional education can be categorized as formative and summative evaluation. Formative evaluation is intended to help the learner master the knowledge, skills, and attitudes necessary to demonstrate competence in their profession. Faculty members must partner with learners in order to provide feedback, encouragement, and direction necessary for success.⁸ They must be role-models of the highest regard. Toward this end, pharmacists in particular must play a significant role in formative evaluation. In my experiences in family medicine residency education, I was often struck at how often family medicine delegated the formative evaluation of its learners to specialists. This often required family medicine faculty members to discuss with learners how to apply what was learned and assessed in specialty rotations to the discipline of family medicine. This observation led the Task Force on Competency-based Education of the Society of Teachers of Family Medicine to develop a set of competencies for family physicians. The competencies were intended to guide formative development in compassionate and expert patient care, professionalism, communication skills, and teamwork skills, and were best modeled by family physician educators themselves.⁹ In the same spirit, it is imperative that doctor of pharmacy (PharmD) students be formatively evaluated by those within the pharmacy profession (primarily faculty pharmacists) so that the same professionalization (ie, socialization into the profession) can occur.

In contrast, summative evaluation in pharmacy is conducted to determine whether a learner is qualified to progress to the next level (eg, first professional year to second professional year) or to graduate, receive the PharmD, and be eligible to take the NAPLEX and MPJE licensure examinations. Summative evaluation is conducted, therefore, as a fiduciary step to ensure the public is served by qualified and competent practitioners. The dean makes the ultimate recommendation for who can graduate, and must, therefore, be a strong and unflinching advocate for the six aims of improvement for quality care, especially patient-centeredness. This is the responsibility to public safety as operationalized by accrediting bodies such as the National Association of Boards of Pharmacy (NABP). A passion for advocacy of patient-centered care is not specific to any one profession. A degree should not, therefore, be the measure for a dean of a pharmacy school (or medical school, or nursing school, etc). The measure should instead be that person's willingness and ability to advocate for patients through their values, beliefs, and most importantly, their actions.

In fact, we can extend this argument to what I believe is an evolutionary step for health professions education. With the introduction of both the Interprofessional Education Collaborative IPEC competencies and interprofessional education into the accreditation standards of many health professions, it seems logical to begin considering a common educational pathway for all health professions students, studying together as undifferentiated health care professionals, in the same classrooms and clinical settings, before they enter their specialized profession. And who should lead this effort? Clearly, educational leaders who value, above all else, patient-centered care.

In conclusion, pharmacists are essential to the formative development of future pharmacists and for this reason, they must be central leaders in the education of every student who will earn the PharmD. Ultimately, summative evaluation demands that the final say regarding who will become a pharmacist be in the hands of a leader who fully understands the responsibility of being a fiduciary for the public in terms of IOM's six aims for improvement, namely patient-centeredness. Deans must embrace patient-centeredness regardless of their health professions or educational background. This is the defining factor for a dean of a pharmacy school, not the PharmD.

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