VIEWPOINT

Do We Need More Utility Infielders?

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The game of baseball has remained pretty much unchanged during its more than 100 years of existence. Vivid memories from my childhood in the 1960s include listening to the Chicago White Sox broadcast on the local AM radio station (yes, as hard as it is to believe, I would sit and listen to an entire game) and gathering around the television with my brothers on Saturday afternoon to watch the one and only baseball game televised each week (it really did not matter who was playing as there was no ESPN, ESPN2, or subscription channel as options). As I recall, it was not uncommon for each team to have a player on the roster referred to as a “utility infielder.” Usually, this player rode the bench but possessed exceptionally good defensive skills, was likely a marginal hitter, and could easily play second base, shortstop, third base, and would not gasp if the manager asked him to play an inning at first base or even one of the outfield positions. I am not aware of any utility infielders enshrined in the Baseball Hall of Fame in Cooperstown, NY. However, their role on each team was valued and essential when starters were injured or needed a rest when playing a doubleheader on Sunday.

Baseball, just like health care, has evolved into a game with more specialists. Today, it is rare to find a current player on a major league roster listed as a utility infielder. Every team has a pitching staff made up of starters, middle-relief specialists, and the essential closer. Some teams even have a set-up player to work the inning between the middle-reliever and the closer (in my youth, they were all just relief pitchers). A team may have one infielder and one outfielder who feel comfortable playing a second position. But, that is about the extent of their capacity. It is only during a prolonged extra-inning game or when key players are injured during a game that managers may long for the days when they could call on their utility infielder to fill a needed role.

As the most recent academic year came to a close, our college completed the implementation of the P3 year of our new curriculum. As chairman of our college’s curriculum committee and co-chair of the task force that developed the new curriculum, I was pleased that the implementation process, although associated with a few ups and downs, went more smoothly than most had expected. That being

said, the focus of the curriculum committee’s work shifted from implementation to evaluation. Key questions that surfaced included: What did we get right? What is missing? How does our newly implemented curriculum line up with Standards 2016 released by the Accreditation Council for Pharmacy Education (ACPE) in February of 2015? Do we have the faculty necessary to teach and evaluate the knowledge and skills areas outlined in the new standards?¹

Like most pharmacy educators, my first opportunity to review the draft standards was in February 2014. I found myself highlighting text and writing comments in the margins. I then engaged our curriculum committee in a discussion of the standards and encouraged committee members to identify standards our college would need to make some curricular or programmatic adjustment to satisfy at an exemplary level. After sifting through the committee members’ comments and discussing the standards with colleagues from other institutions, it became clear to me our profession has evolved but the background, expertise, and responsibilities of our current faculty members were a reflection of practice and education models developed before the year 2000 when the first set of standards for the PharmD curriculum went into effect. The 2016 ACPE standards describe several content and skill areas (eg, leadership, patient-safety, informatics, communications, innovation, entrepreneurship, patient safety, inter-professional collaboration) that do not align with our faculty members’ historical and traditional expertise or training. Our traditional models for recruiting and assigning faculty lines may be outdated and may not support areas of teaching, practice, and assessment required in our evolving curriculum and standards. In the private business or health care world, this situation would likely be addressed by eliminating personnel who do not meet current needs and replacing them with new personnel whose skills and abilities better match the desired faculty profiles. Making such changes in academia are typically met with great resistance, require approval at multiple levels, and can occur at a snail’s pace.

With this in mind, I decided I should not only raise the red flag, but also propose potential solutions as we moved toward meeting the new standards and enhancing

the educational experience of our current and future students. I reflected that my mentors probably addressed the same issues when clinical pharmacy was introduced into curricula back in the 1970s and again when the first set of standards for the PharmD curriculum were implemented in the early 2000s. Sure enough, a review of literature revealed several articles and reports published shortly after new accreditation standards expressing similar concerns and possible solutions.²⁻⁶

I thought of my mentor and former department head, Bob Chalmers, and wondered what he would do in this situation. For readers who did not have the pleasure of knowing Bob Chalmers, he earned his graduate degrees in pharmacology and later became a champion for pharmacy practice and education. He was a true visionary. He pushed our college and the academy to think about school-directed experiential learning, service learning, and the assessment of outcomes within the pharmacy curricula long before most of the academy was ready to consider these issues. Some of his contributions were captured by Robert E. Smith during his presidential address to the AACP House of Delegates in July 2000.⁷ Bob had to reinvent himself as an educator and encouraged young faculty members trained as generalists (such as me) to step forward and assume new and evolving pharmacy practice faculty roles. There was a job to be done, a role to take on, and one did not have to be an expert to fill such a position.

With the current movement towards greater specialized training, faculty members may hesitate to assume teaching and assessment responsibilities reflective of their education and training as generalist practitioners instead of as specialists in, for example, oncology, pediatrics, infectious diseases, or outcomes research. Practice faculty members often overlook that they are educated and trained first as generalist pharmacists with a broad scope of knowledge and skills. Specialized training does not erase the foundation they had to demonstrate to qualify for any type of advanced education or training.

I reflect on my situation as a young faculty member who had only completed a one-year hospital pharmacy residency program (there was no specialized training at that time). After 2 years of experience in a faculty role on an inpatient general medicine adult unit, I changed institutions and was asked to assume a faculty and practice role at a children's hospital. Even though I had no clerkship or practice experience dealing with pediatric patients at the time, I did not hesitate to take on the new role. Although younger colleagues may find this hard to imagine, such a scenario was not uncommon for those of us educated and trained in the 1970s when clinical pharmacy services were in their infancy. I simply took my foundational pharmacy knowledge, and with an intense dive into the pediatric

literature, applied both to a different patient population. The physicians, pharmacists, and students I worked alongside did not compare me to pharmacists trained in pediatrics as they did not exist at the time. With time, I gained confidence and credibility as my knowledge of the pediatric literature and my experience with the pediatric practitioners and patients grew.

I ask each of you, do your traditional faculty descriptions and responsibilities align well with the changing landscape of health care, higher education funding, and the educational needs of tomorrow's practitioners? Does your college have the resources (new faculty lines) to hire faculty experts in these emerging areas? Should we be hiring faculty members with narrow specialties when the skills desired of most of our graduates will be in the ambulatory environment as general practitioners? The answer to these and similar questions is, most likely, no. Only new programs, with curriculum based on the new standards and current and future practice trends, have the luxury to align new faculty hires to address teaching, research, and practice needs associated with current standards. As in the early days of clinical pharmacy, it will be essential for administrators and department chairs to assess current practice faculty members (who all should possess a strong foundation of pharmacy knowledge, skills, and abilities) and determine who among them are best suited to assume new teaching, service, and/or research roles with some minor re-tooling by means of additional education, training, and/or experience in the new area.

Just like in baseball, it is critical for schools to first look at their current rosters to identify utility infielders . . . faculty members with foundational practice skills and experience who can assume multiple positions and thereby fulfill some of the identified teaching, practice, and assessment gaps within the curricular roadmap. In most schools, it is unlikely there will be enough faculty lines available to devote a full-time equivalent position to informatics, another to pharmacogenomics, another to leadership, another to patient safety, and yet another to interprofessional education. Content and general skill area voids are likely the easiest items to address as most faculty members should have a solid foundation of pharmacy knowledge and skills, which can be augmented by minimal faculty development resources. Some new areas may best be addressed by using resources to support the expanded use of practitioners with expertise in key areas to teach in the classroom and practice environments.

Another approach to fill identified gaps in faculty alignment may be to use faculty members from other departments and colleges on campus. Those practice faculty members educated and trained during the turbulent 1960s and 1970s likely had to adapt to uncharted practice

environments and faculty roles and thus may be best positioned and least intimidated to help fill curricular gaps as we address the new accreditation standards. Will you consider becoming the utility infielder on your team and/or coach a young prospect on the finer points of playing another position? If you do, you will be filling a valuable need of your school and its future students. You may also find your immersion into this new area exciting and professionally fulfilling. Change is always daunting, but it also can be quite exciting.

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