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VIEWPOINTS

Immunization Training: Right or Privilege?

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Immunization training in US colleges and schools of pharmacy has progressed quickly and significantly. The first formal national training and certificate program aimed at pharmacists was introduced by the American Pharmacists Association in 1996 and was quickly adopted as a curricular model and component by many colleges and schools.[1-3] The 1990s also saw extensive changes to many pharmacy practice acts, expanding the pharmacists' scope of practice to include the administration of immunizations. By 2004, forty-three states recognized pharmacists as immunizers, and now all 50 states, including the District of Columbia and Puerto Rico, have authorized such privileges.[4] Despite the significant progress made in recognizing the role of the pharmacist as immunizer, academic pharmacy still appears to be lagging in it responsibilities to uniformly educate students in preparation for this role. A 2009 report found that approximately 38% of colleges and schools of pharmacy were providing immunization education and training as a component of their core curricula.[5] Gaps and lack of uniformity in education are creating challenges for pharmacy students and practicing pharmacists alike as boards of pharmacy and employers adopt different legislative and workplace regulations regarding the preparedness and privilege to immunize. From a public health standpoint, these educational gaps may contribute to low immunization rates and the ability or inability of the US health care system to achieve quality health indicators in this area as targeted in Healthy People 2020.[6] The profession has not clearly established or advocated for the doctor of pharmacy (PharmD) degree as the sole credential necessary to immunize.

Despite immunization training being introduced into the curricula of many institutions some 10 to 15 years prior, many colleges and schools still do not mandate such training. It is common for immunization-related course work and materials to be relgated to elective status, aimed at students with expressed interest in this area. Accreditation Council for Pharmacy Education (ACPE) Standards 2007 (Version 2.0) for programs leading to the PharmD degree refer to instruction in the area of immunizations only esoterically as a component of formal instruction in immunology and/or as a component of larger preventative health programs. The standards do, however, state that students should be prepared for "administering medications where practical and consistent with the practice environment and where legally permitted."[7] The mismatch between practice standards (where pharmacists are granted varied levels of immunization privileges from state-to-state) and educational standards (which do not recognize, mandate, and/or enforce formalized immunization training as a minimal competency in granting of the PharmD degree), continue to create a confusing dichotomy for employers and regulatory agencies. Pharmacy educators and accreditation bodies should recognize that both the profession and the public have embraced the concept of "pharmacist as immunizer." The literature is now replete with references to the impact of pharmacist-provided immunization services on public health indicators related to vaccine-preventable diseases.[1,8] This should serve as a mandate to colleges and schools to develop practitioners with both the knowledge and skills to immunize. Training in this area should not be relegated to an elective component of curricula but rather recognized as a standard of practice that demands that all students demonstrate competency in providing immunizations upon graduation. Uniform and standardized instruction in this area, without a need for external validation (certificate programs, etc.), would increasingly serve to further establish the PharmD degree as the sole credential required to immunize. Graduates are not expected to gain additional credentials beyond the PharmD degree to dispense medications, counsel patients, or compound pharmaceuticals. Similarly, in a modern curriculum, students should not be required to seek additional training in order to immunize. In future revisions of PharmD standards, ACPE should consider inclusion of lecture-based and hands-on immunization training as discrete and required elements of all curricula. Such

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standardization would assist employers and regulatory bodies in understanding the abilities and competencies of PharmD graduates. Certainly, peripheral training programs play a significant and important role in providing opportunities for pharmacy school graduates and existing practitioners who were not trained as immunizers either as a component of their degree work or through postgraduate experiences.

The dichotomies between immunization education in US colleges and schools, state-mandated regulations, and professional practice privileges and employer requirements should be a lesson for the profession in terms of more proactively and uniformly reacting to contemporary changes in practices. The fragmentation and discrepancies between teaching, practice, and legislation can only serve to frustrate students, slow progress towards improved patient care, and confuse the public. As the profession moves forward with continued advances in practice and practice standards (eg, pharmacist-prescribing, triage and referral, primary care, medication therapy management), we should be cognizant of remaining proactive in our construct of curricula and unified in our approach to regulation and credentialing.

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