therapies, we may get the answer to this question sooner rather than later, possibly at the expense of patient outcomes.

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Collaboration: A Key Ingredient for Experiential Training

We enjoyed reading "Experiential Training for Pharmacy Students: Time for a New Approach", by Hall and others.[1] We applaud the authors for discussing this important topic and proposing suggestions for the pharmacist workforce to consider when working with faculties regarding experiential training.

In our experience, and as indicated in the literature, students are already providing value to patients during their experiential training,[2] but we acknowledge that there are opportunities to ensure that this occurs more consistently.

Hall and others[1] raised 2 concepts that we would like to specifically highlight. The first is the necessity of increasing early exposure to practice experiences. As faculties of pharmacy across Canada progress toward the entry-level PharmD, which requires a minimum of 40 weeks of experiential training, the opportunity now exists to design and implement experiential programs of sufficient *quantity* to address some of the concerns posed by Hall and others.[1] Such programs will include appropriate experience to support graduated independence for patient care from early years to the final year, consistent with the "medical model".[3] At the same time, ensuring *quality* of experience is a responsibility for both faculties and practitioner preceptors. Although some early-year experiential rotations may be partially designed for observation or exposure, baccalaureate senior-year rotations across Canada all include expectations of students' active participation on care teams and demonstration of their ability to provide pharmaceutical care. Preceptors should, if not already doing so, be requiring students to accept increased responsibility and accountability for the patient care they provide.

The second concept relates to supervision of students and how preceptors can provide such supervision in a meaningful way without feeling overloaded. Experiential education translates into a learning experience when actions are reflected upon and debriefed through discussion with a preceptor. Preceptors need to challenge their students, provide ongoing constructive feedback, and encourage self-directed learning. These aspects are critical to applying what is learned to new and more complex scenarios. As noted by the most recent Hospital Pharmacy in Canada report,[4] the biggest challenge associated with delivering experiential education is the associated workload. Preceptors must plan ahead for a rotation and anticipate whether they need to adapt their practice routine and schedule to create a supportive learning environment. An orientation during the first 72 hours is essential. An introduction to the work environment should be provided, along with discussion of previous learner experiences and the preceptor's expectations of the student. This will allow the preceptor to assign appropriate patient care responsibilities with limited supervision. The preceptor's investment of time into the student's development in the early phase of a rotation will usually lead to greater provision of care than if the preceptor were practising alone.[5,6] As noted by Hall and others,[1] additional mechanisms for increasing provision of patient care with a neutral effect on preceptor workload include peer-assisted learning[7] (i.e., multiple students with the same preceptor, with learning and problem-solving occurring among the students, before the preceptor becomes involved) and the pyramidal (medical) model[3] (i.e., attending pharmacist, resident, and senior and junior students creating a team). It was encouraging to note that a pyramidal model for learning is already being used by 28% of respondents to the Hospital Pharmacy in Canada

survey.[4] It is important for faculty members and practitioners to showcase how these models can be successfully implemented, as Cox and Lindblad have done,[7] thus providing guidance for practice sites and preceptors that have not yet adopted this approach.

Active dialogue among stakeholders about various strategies is required to explore what will work in different practice settings. The Steering Committee for the Blueprint for Pharmacy[8] has funded a proposal from the Pharmacy Experiential Programs of Canada (a subcommittee of the Association of Faculties of Pharmacy of Canada) to support a national multistakeholder workshop, which was held October 17, 2012. This workshop engaged participants to confirm the desired future for experiential education and actively discuss and prioritize collaborative strategies to address capacity for experiential education at the national level.

While some may agree with the analogy of a "perfect storm",[1] the move to entry-level PharmD programs could perhaps be seen as the "perfect norm". By increasing the number of senior students at practice sites, we can collectively increase the provision of patient care services. From a practice research perspective, we can design protocols to evaluate the quantity and quality of students' contributions to patient care services. Just as students need to learn to work effectively in teams, faculties, practice sites, and preceptors need to collaborate to create sustainable and beneficial experiential training models that will produce confident graduates, able to accept responsibility and accountability for medication management.

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Experiential Education for Student Pharmacists: CSHP's Endeavours

We thank Hall and others[1] for their thought-provoking article in the July–August 2012 issue of the *Canadian Journal of Hospital Pharmacy*, which supports the endeavours of the Canadian Society of Hospital Pharmacists (CSHP) over the past 8 years in advocating for a new approach to experiential education for student pharmacists. One of the 8 guiding principles proposed by Hall and others states that CSHP and the Association of Faculties of Pharmacy of Canada should be leaders in engaging various stakeholders to identify and address issues regarding experiential education in the hospital pharmacy setting. CSHP agrees with this principle, and we wish to highlight the Society's endeavours in this regard.

In 2004, CSHP surveyed members who were hospital pharmacy directors across Canada to gauge their institutions' capacity to accommodate more practical education for student pharmacists. Only 4 (12%) of 33 respondents indicated that they would be able to provide more comprehensive, longer, or additional clinical rotations. Inability to do so stemmed from lack of pharmacist practitioners, financial constraints, and other operational factors. These results were shared with participants in a symposium entitled "Managing the Change to Entry Level PharmD in Canada", hosted by the Leslie Dan Faculty of Pharmacy of the University of Toronto in November 2004.[2] A similar survey conducted in 2009 yielded comparable results, with only 11 (15%) of 73 hospital pharmacy directors and managers indicating that they would be able to provide longer or more clinical practice rotations, arguing the same main concerns as in 2004.[3] However, 46 (63%) of the respondents expressed their willingness to work with academic institutions in developing innovative models of experiential education for student pharmacists.

Hospital pharmacists have long played a pivotal role as providers of experiential education. So, since 2004, CSHP has taken every opportunity, both formally and informally, to convey to stakeholders the concerns of the hospital pharmacy community related to its capacity to expand experiential education for student pharmacists in the hospital setting. Furthermore, the Society has collaboratively sought solutions to mitigate these concerns. In particular, an advocacy campaign was conducted in 2006 to engage elected officials and senior bureaucrats in provincial ministries of health and of education, executive officers of academic institutions and associations, hospital leaders, and the broad pharmacy community in discussions on the impact of the increased demand for