Should Service Contracts be Invoked after Completion of a Hospital Pharmacy Residency Program?

THE "PRO" SIDE

Spencer Johnson's popular book about change, entitled *Who Moved My Cheese?*, documents the antics of 4 characters and the lessons they learn in response to changes in the cheese supply in their maze.[1] Similarly, hospital pharmacy managers must respond to changes in the supply of trained hospital pharmacists. A strategy that we have embraced in Pharmacy Services at Vancouver Coastal Health – Providence Health Care is to associate a contract for pharmacist services with the acceptance of a hospital pharmacy residency position. I am delighted to participate in the dialogue in this issue of *CJHP* because I believe there are several very good reasons to adopt this practice, reasons that benefit the resident, the organization, and hospital pharmacy more generally.

First, service contracts are a commonly used approach to ensure a supply of individuals with the required training in a challenging marketplace. For example, the military has always paid people to learn, with an explicit term of employment expected once training is complete. Similarly, apprenticeships provide compensation while the trainee learns, but the employer also benefits from the trainee's productivity during the program. In health care, nurses are often supported in obtaining specialty training in return for a promise to work for a defined period on completion of the training. In fact, it is hard to think of a situation in which the money invested in a training program is not compensated by service during or after the program.

Second, I would suggest that this approach is neither new nor radical, but rather a return to the original concept of the hospital pharmacy residency training program. Thirty years ago, when I completed my residency, I received approximately half of a fully qualified pharmacist's wage in exchange for a significant contribution of service while receiving my residency training. In those simpler times, 1 year was adequate to prepare pharmacists for hospital pharmacy practice, to expose them to a significant project and the breadth of functions in the department, while still leaving time for them to provide a service component. Over the past 30 years, hospital pharmacy has become much more complex, and it now takes an entire year to train a pharmacist to provide direct patient care services, which has meant reduced exposure to other aspects of hospital pharmacy practice and little or no time for distribution-related service. In particular, residents' contributions to services through their clinical rotations probably don't offset the time that preceptors spend teaching and overseeing the residents' work. Given that it is impossible to obtain a significant service contribution from the resident during the 1-year residency, it makes sense to extend the relationship in order to obtain that contribution. In fact, graduates of the hospital pharmacy residency program have indicated (in recent conversations) that it takes 2 to 3 years of additional experience after completion of the residency program to gain confidence in their skills and to be exposed to a wider range of practice areas so that they can plot their own area of specialized practice. The contracted service period assures candidates, before they enter the program, that they will have that continuous period to continue their development and start their careers.

Third, over the same 30-year period, the financing of residency programs has changed substantially. Although British Columbia appears to provide the highest salary for pharmacy residents, the stipend that residents receive in most provinces is still much greater than a cost-of-living-adjusted version of the compensation of 30 years ago. For example, in our institution, we pay 85% of a starting pharmacist's wage, provide a significant benefits package, and incur substantial internal and external operating costs. All told, the estimated cost for our organization to provide the residency program to one individual is $100 000. For us to justify the ongoing investment of the $1.4 million it costs to train our 14 residents each year, there must be a significant, tangible, measurable, and predictable benefit to the organization. History suggests that approximately two-thirds of our graduates will stay with our organization, at least initially. By entering into a contracted-service arrangement, we can bring this up to 100% of successful graduates.

Fourth, our analysis of the benefits of the existing "gamble" (i.e., without any contracted service) has identified a number of disturbing trends. Most concerning is the number of individuals who seem to see the hospital pharmacy residency program as a stepping stone to another profession, especially medicine. This may make for better physicians, but it contributes very little to the sponsoring organization or to hospital pharmacy in general. Another possible consequence is that residents proceed to another organization (often one with no residency program or an inadequately sized program) to begin their hospital pharmacy career. While this trend does benefit hospital pharmacy in general, it is not within the mandate of the organization sponsoring the residency. Furthermore, it rewards and enables organizations that choose to "freeload" off the industrious organizations that sacrifice both financial and human resources to run their residency programs. In today's regionalized health care system (which is in place throughout Canada, except in Ontario), there is no justification for a region not organizing and operating its own residency program, if it wishes to hire residency-trained pharmacists. Of less concern are pharmacists who complete the residency program and then enter a postgraduate PharmD program. We will happily defer the service compensation until such pharmacists have completed their PharmD program and will then find suitable employment (i.e., employment that recognizes their advanced training) within the organization.

Finally, the direct benefit in terms of recruitment and service delivery offered by the contracted service model

provides a much stronger justification for organizations seeking the financial resources to initiate or expand their residency programs. Given the excess number of applicants relative to the number of positions currently available, an increase in the number of residency programs would enhance the careers of the additional pharmacists receiving this excellent experience; would improve the supply of competent, trained hospital pharmacists available to the sponsoring organizations (which are also the employers); and would increase the strength of hospital pharmacy as a profession by expanding the ranks of highly skilled pharmacists contributing to patient care and to the reputation of our profession.

Getting back to *Who Moved My Cheese?*, we have a choice of who we want to emulate: Sniff and Scurry, who are always prepared to respond to a change in supply; Haw, who reluctantly moves on once he realizes that the existing supply no longer meets his needs; or Hem, who simply denies the failure of supply and suffers accordingly. I choose to be proactive and embrace contracted service as a solution with benefits for all.

Reference

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THE "CON" SIDE

In 2008, we find ourselves in a phase of rapid development in hospital pharmacy practice, and exciting opportunities to advance our profession abound. However, these opportunities require sufficient human resources if their potential is to be fully realized. In 2005/2006, there were, at a minimum, 270 vacant hospital pharmacist positions in the country and over 250 pharmacists eligible to retire within 5 years,[1] and there is little to suggest that the situation has improved since that time. The recruitment, engagement, and retention of experienced hospital pharmacists have therefore become major issues facing health care institutions across Canada.

One proposed strategy to maximize retention of trained hospital pharmacists is to invoke service contracts for pharmacy residents on completion of their residency programs. However, as a solution to our human resources problem, I find return-of-service contracts for hospital pharmacy residents a hard pill to swallow.

Service contracts for pharmacy residents are a threat to the guiding principles upon which residency programs have been founded. According to the Canadian Hospital Pharmacy Residency Board (CHPRB), the purpose of a hospital pharmacy residency is "to provide an experiential learning environment using pharmacy practitioner role models, so the necessary skills, knowledge, and values can be acquired and applied by the resident in the provision of exemplary patient care" and "to develop competent and progressive pharmacy practitioners in health care organizations and encourage future leaders for the profession."[2] Service contracts shift the focus from learning and professional development as the primary objectives to recruitment and retention. While at first glance this change may seem unimportant, it is not difficult to imagine the subtle yet devastating shifts in residency programming that might develop—greater emphasis on site-specific distribution issues and fewer opportunities to explore clinical options outside of the particular hospital or health region—all in an attempt to maximize the pharmacy department's "bang for the buck". Implementation of the CHPRB recommendations has resulted in the development of excellent programs graduating phenomenal practitioners. Formally linking such programs with a period of bonded service threatens the integrity of hospital residencies.

Service contracts are also an impediment to residents at a time of critical developmental momentum. Many pharmacists use the residency as a springboard to further training and professional development, such as specialty residencies, post-baccalaureate Doctor of Pharmacy (PharmD) programs, or Master's and PhD work. In a recent national survey, 42.9% of Canadian pharmacy students reported their intention to pursue additional education after graduation from their current pharmacy program.[3] At the University of British Columbia, more than one-third of graduates from the PharmD program began their Doctor of Pharmacy immediately after completing a pharmacy residency.[4] Residents may also wish to pursue nontraditional career options, such as international, industry, or government positions. If we are to take seriously the CHPRB's challenge to use residency programs as a way to develop progressive pharmacy practitioners who are leaders in their profession, we must not allow service contracts to inhibit residents' professional growth.

The very idea of service contracts for residents suggests a misunderstanding of what may motivate pharmacists in general, especially those from the so-called Generation X (people born from the mid-1960s to the early 1980s) and Generation Y (born from the early 1980s to the late 1990s). Maslow's theory of the hierarchy of needs suggests that as basic physiologic, security, social, and self-esteem needs are met, individuals are motivated by the need for self-actualization.[5] Herzberg's motivation–hygiene theory describes 2 sets of factors that are present in the workplace.[6] Intrinsic components of a job, such as achievement, self-growth, and autonomy, can motivate individuals, while extrinsic or "hygiene" components of work, such as interpersonal relationships, agreement with organizational policies, and salary, function only as potential sources of dissatisfaction. Personal freedom to explore opportunities for self-actualization, along with acceptable working conditions, is critical in light of the rapid evolution of health care and the expanding role of pharmacists today. A service contract is likely to be perceived as a barrier to reaching one's full potential and a source of dissatisfaction with work. As such, pharmacists are likely to react negatively toward such contracts. Thus, although service contracts may be successful in retaining residency graduates for the designated period, the negative feelings they engender may lead these graduates to leave as soon as their obligation is complete.

The vast majority of future pharmacy residents will be members of either Gen X or Gen Y. Broadly speaking, those in Gen X tend to question authority, are loyal to themselves and

not to institutions, have a general sense of entitlement, and seek to start at the top, whereas those in Gen Y are highly collaborative team players who want to participate in decision-making, have high expectations of themselves and the workplace, and are more apt to change jobs frequently than generations before them.[7] To meet the challenges of health care human resources, experts suggest that recruitment and retention strategies must be equitable yet customized to reflect not only generational preferences, but gender and cultural preferences as well.[8] In the current health care environment, characterized by shortages of hospital pharmacists and expansion of career options, service contracts may actually lead to a decline in applications to residency programs, as young clinically trained pharmacists find that an extra year of obligatory service does not meet their personal and professional needs.

Instead of forcing service contracts on pharmacy residents, let's work to implement positive, value-added ideas for recruitment and retention. Pharmacy departments should use the residency program as an opportunity to showcase strengths and opportunities within the hospital or health region. Structured mentoring programs, recognition and awards, time for projects or committee work, an emphasis on positive peer relationships in the workplace, and staff-development opportunities are retention strategies that have been suggested by our US counterparts.[9] Flexible work schedules and job-sharing opportunities might be especially appealing to pharmacists with young families, who are more likely to place a higher priority on family than work relative to their baby boomer predecessors.[10]

Service contracts are not a progressive solution to the problem of hospital pharmacist recruitment and retention. Instead of resorting to this authoritarian, outmoded, and punitive practice, which has the effect of hijacking pharmacy residency programs, let's think holistically, be innovative, and engage pharmacy students and residents in the dialogue. For hospital pharmacy programs considering service contracts, I suggest following the sage advice of R A Harris: "Be careful not to look for a solution until you understand the problem, and be careful not to select a solution until you have a whole range of choices."[11]

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