
Commentary

Room for a New Standard? Response to Comments by Heiby



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Heiby's (this issue, pp. 104–112) claim that psychologists' training in psychopharmacology is substandard is predicated on the assumption that existing training models offer the only acceptable approach to achieving competence. This assumption both prohibits innovation and is demonstrably false. Our comparison of training models must be judged from the perspective of a reasoned analysis of the competencies most important to prescribing, not the claims of other professions. © 2009 Wiley Periodicals, Inc. *J Clin Psychol* 66: 112–115, 2010.

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We take exception to Dr. Heiby's (this issue, pp. 104–112) attempt to depict psychologists' training in preparation for prescriptive authority as substandard. We celebrate the results of our study as showing that this training is superior in many aspects to training that leads to the right to prescribe psychotropics for entry-level physicians and nurse practitioners. Not only does the study show this, but the competency of psychologists trained within this curriculum is borne out by the fact that psychologists have been prescribing for years without a single documented major adverse event.

Dr. Heiby's commentary on our article rests on two invalid assumptions. The first is that psychologists pursuing prescriptive authority want to practice *medicine*. What psychologists want to practice is *psychopharmacotherapy*, integrated within a broader biopsychosocial approach to the treatment of mental health disorders. Historically, any clinical application of pharmacology was considered an aspect of the practice of medicine, just as other therapeutic interventions, including psychotherapy and the use of a blood pressure cuff, were once considered activities

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only appropriate in the context of the practice of medicine (Crenner, 1998). Nevertheless, over time it was recognized that specific skill sets could be taught outside the context of medicine (though members of our own field objected at first to training psychologists in psychotherapy on the grounds that psychology should not aspire to practice medicine; Shakow, 1965). The de-monopolization of therapeutics from the medical establishment has resulted in a net benefit to society in terms of cost and access to care. At the same time, there is no evidence that expanding the scope of practice of another profession trained in the specifics of a given intervention previously considered traditionally under the umbrella of the practice of medicine has ever compromised the safety of the public (Nolan, Carr, & Harold, 2001; U.S. Congress, Office of Technology Assessment, 1986).

The second invalid assumption is that the training practices of existing professions define the minimum training necessary to achieve the safe and effective practice of activities formerly considered part of medicine. If that were the case, we would still live in a society where only physicians provide psychotherapy, prescribe, and read blood pressures. The only objective basis for drawing conclusions about whether training is sufficient to ensure safety is whether expanding scope of practice to other professions using different training models affects public safety. We now have more than 15 years experience with psychologists prescribing in the military, and hundreds of thousands of prescriptions written by civilian practitioners in two states to serve as a database. So far, not one complaint has ever been lodged against a psychologist as a prescriber, and all three healthcare-providing branches of the military have adopted policies for incorporating prescribing psychologists trained in civilian programs. As members of a scientific discipline we are impressed by the degree to which the data support the adequacy of psychologists' training, and we are unsure why Dr. Heiby's beliefs about sufficient training are more informed by the unsubstantiated assertions of members of other disciplines with an investment in a different model of training than by the empirical record.

To our knowledge, our study represents the first attempt to consider content domains essential for the practice of psychopharmacology as a distinct clinical competency. The key content areas selected for our study have face validity to the extent that they cover those competencies needed for integrating pharmacotherapy into a more complete therapeutic approach to treating mental health conditions. The content areas not only cover basic biological science such as biochemistry and pathophysiology but also address pharmacology as it directly pertains to prescribing. The additional content areas, which include psychodiagnostics and psychosocial interventions, are essential for a balanced evaluation and treatment of mental health issues, just as the ability to critically evaluate research in psychopharmacology through firm foundations in statistics and research design is paramount in allowing the professional to select among evidenced-based options and critically evaluate the claims of pharmaceutical companies. Accordingly, we developed our study as an attempt to provide the first realistic evaluation of what are the necessary domains of competence relevant to psychopharmacological practice. We even dared to consider the possibility that some competency domains not traditionally covered in medical or nursing training should be considered essential to that practice.

Dr. Heiby's commentary also displays several fundamental misunderstandings about the nature of professional practice. Nurse practitioner programs do not divide into those intended to prepare its students for independent versus supervised practice, nor do licensing boards in nursing formally distinguish between two types of programs. A nurse practitioner licensed in two states may act as an independent

practitioner in one and a supervised practitioner in the other based on exactly the same training experiences. Even the concept of supervised practice for nurse practitioners varies widely, from mandated regular contact with a physician to occasional check-ins. The proposition that we could have restricted our analysis to programs training nurse practitioners for independent practice is therefore fallacious. Dr. Heiby makes a similar error when she suggests that it is possible to identify certain postdoctoral master's programs in clinical psychopharmacology that meet or do not meet the credentialing criteria for New Mexico and Louisiana. Neither board evaluates psychopharmacology programs; they evaluate individuals from such programs who have applied for authorization to prescribe.

The suggestion that undergraduate work should be taken into account in calculating the preparedness of the various professions for prescribing psychotropics appears to us to be misdirected. It is a given that nursing students, premed students and undergraduate psychology students all study curricula relevant to their specialties. An undergraduate neurophysiological psychology class does not qualify a psychology major to perform brain surgery any more than an undergraduate biochemistry class qualifies a nursing or premed student to prescribe. We are, after all, comparing graduate (professional) education, and not prerequisite formative preparation. If we were to include undergraduate training, then we would find that both nursing and premed preparation incur an even larger deficit relative to psychology majors in the areas of behavioral science, psychosocial therapeutic interventions, and statistical/experimental analysis, which we have stated to be essential to an integrated approach to psychopharmacologically based mental health care. Along the same line, we continue to believe it is appropriate to exclude psychiatric residency from the tabulation because physicians are licensed to prescribe psychotropics upon completion of medical school. In addition, more psychotropics are prescribed by family practice and primary care than any other group (Pincus et al., 1998) while more than 60% of family medicine residency programs have no formal pharmacotherapy curriculum at all (Bazaldua et al., 2005).

Finally, the assertion that there is no oversight of the quality of the training programs in R×P is simply wrong, as these programs follow the American Psychological Association (APA) curriculum; furthermore, the extent to which the graduates of these programs meet the knowledge areas specified by APA is verified by the Psychopharmacology Exam for Psychologists (PEP), a rigorous examination that is a prerequisite for licensing in those jurisdictions where psychologists are currently prescribing. In addition, the APA has been working on a formal system of oversight for some time to ensure quality control in the various programs offering postdoctoral training in clinical psychopharmacology, and the association's Council of Representatives voted to create such a mechanism in August 2009. Nonetheless, the PEP is currently in place and it should be recognized that performance on a licensing exam is the same mechanism for quality control used by medical and nursing boards to address the 25–30% of physicians and 14% of nurses who receive their training in foreign institutions, where direct oversight is all but an impossibility (Bennett, 2008; Brush, Sochalski, & Berger, 2004; Mullan, 2005).

References

- Bazaldua, O., Ables, A.Z., Dickerson, L.M., Hansen, L., Harris, I., Hoehns, J., et al. (2005). Suggested guidelines for pharmacotherapy curricula in family medicine residency training:

- Recommendations from the Society of Teachers of Family Medicine Group on Pharmacotherapy. *Family Medicine*, 37, 99–104.
- Bennett, C. (2008). *McFly goes to medical school: Your physician in the unraveling US health crisis*. Bloomington, ID: AuthorHouse.
- Brush, B.L., Sochalski, J., & Berger, A.M. (2004). Imported care: Recruiting foreign nurses to U.S. health care facilities. *Health Affairs*, 23, 78–87.
- Crenner, C.W. (1998). Introduction of the blood pressure cuff into U.S. medical practice. *Annals of Internal Medicine*, 128, 488–493.
- Heiby, E.M. (2010). Concerns about substandard training for prescription privileges for psychologists. *Journal of Clinical Psychology*, 66, 104–112.
- Mullan, F. (2005). The metrics of the physician brain drain. *New England Journal of Medicine*, 353, 1810–1818.
- Nolan, P.W., Carr, N., & Harold, L. (2001). Mental health nurse prescribing: The U.S. experience. *Mental Health Practice*, 4, 4–7.
- Pincus, H.A., Tanielian, T.L., Marcus, S.C., Olfson, M., Zarin, D.A., Thompson, J., et al. (1998). Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. *JAMA*, 279, 526–531.
- Shakow, D. (1965). Seventeen years later: Clinical psychology in light of the 1947 Committee on Training in Clinical Psychology report. *American Psychologist*, 20, 353–362.
- U.S. Congress, Office of Technology Assessment. (1986). *Nurse practitioners, physician assistants, and certified nurse-midwives: A policy analysis (Health Technology Case Study 37), OTA-HCS-37*. Washington, DC: U.S. Government Printing Office.