Beginning in July 2001, NABP will transfer its examination item banks to a new management software package created by Schroeder Measurement Technologies, Inc (SMT). Currently, NABP has its item banks for all its competency assessment programs in-house. NABP is updating its software because the SMT software will allow NABP to more easily manage item banks by providing more sophisticated technology than the current software, with more flexible queries and reports.

“The new software has enhanced functionality and is more user-friendly than our current system,” states Richard K. “Mick” Markuson, NABP’s president.

The examination item banks will be converted one by one starting in July. With time allowed to complete the conversion and do a 30-day testing and quality check, the process will be completed this winter.

Thereafter, NABP will maintain all test items for its competency assessment programs in-house. NABP began this process in 1999, when the Association assumed responsibility for item development and banking for the NAPLEX® (North American Pharmacist Licensure Examination™) as directed by the Executive Committee and the Advisory Committee on Examinations (ACE). The Association has housed all Disease State Management (DSM) items in-house since that program’s inception. Items for the Foreign Pharmacy Graduate Equivalency Examination™ (FPGEE®) were transferred to NABP last year from a third-party vendor and are stored and maintained in-house. The Multistate Pharmacy Jurisprudence Examination™ (MPJE™) items will be banked at NABP; however, their management and updates will continue to be handled at least in part by a third-party vendor.

Renewal and Application Process Update

NABP’s Information Technology team met with several providers of Web-based solutions to select the vendor who will develop the Renewal and Application Process (RAP) system for each participating state board. As each board’s database system is unique, the link to the RAP system must be tailored to produce an effective end result. The analysis and creation of each link is progressing as planned with an anticipated launch date this fall.

Once activated, RAP will allow pharmacists and pharmacies to submit their initial licensure application and renewal via the Internet. “When fully operational, NABP’s RAP system will feature credit and debit card payment for fees and provide licensees with easy access to their professional information on file with

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The year 2001 marks the 25th anniversary of the National Association of Boards of Pharmacy Licensure Examination® (NABPLEX®) and the fourth anniversary of the North American Pharmacist Licensure Examination™ (NAPLEX®). The benefits these exams have brought to the state boards of pharmacy, licensure candidates, and NABP are indeed cause for celebration.

According to NABP’s Constitution, one of the purposes of the Association is to “provide for interstate reciprocity in pharmacy licensure, based upon a uniform minimum standard of pharmaceutical education.” NABPLEX was the first uniform competency assessment mechanism developed by NABP for the use of the state boards. The paper-and-pencil NABPLEX provided the practice of pharmacy with a nationally standardized, uniform tool to determine whether candidates who wish to practice pharmacy in a particular state are qualified to do so. In 1997, the NABPLEX was replaced by the computer-adaptive NAPLEX.

**NABPLEX**

Licensure examinations have been administered in one form or another since the earliest days of the practice of pharmacy in the United States. Unfortunately, these state exams often differed in their format, content, and difficulty. During the late 1950s, the idea of a national examination gained momentum. Under the aegis of Fred T. Mahaffey, now executive director emeritus of NABP, the Association established a Blue Ribbon Committee, composed of state board of pharmacy members, college of pharmacy faculty, and pharmacists from across the country. This select group developed the Blue Ribbon Licensure Examination, from which NABPLEX evolved. By 1970, 33 boards of pharmacy were using the Blue Ribbon Licensure exam. In 1975, NABP began to develop NABPLEX.

The first NABPLEX examination was administered in 1976. It was a five-part exam that covered pharmacy, mathematics, chemistry, pharmacology, and pharmacy law. The paper-and-pencil format, along with the Blue Ribbon Licensure Examination, provided the state boards with a uniform, reliable method of assessing the knowledge and skills of candidates.

**RAP Update**

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participating boards of pharmacy,” states NABP President Richard K. "Mick" Markuson.

Developed and operated at no cost to the state boards of pharmacy, the RAP system can handle an unlimited number of jurisdictions, while recognizing and addressing individual state laws, fees, and requirements for licensure. Using a form unique to each participating jurisdiction, pharmacists, pharmacies, technicians, and other entities licensed or registered by the state boards are able to process their applications in less time and at less expense than ever before.

The system will also provide licensees with quick access to their files. It will also have the capability of recording and verifying the continuing education credits of licensees. RAP helps the boards of pharmacy streamline their current licensure and renewal procedure, lower costs, and maximize their staff and resources to better monitor patient outcomes and quality of care issues.

RAP was initially unveiled at NABP’s 96th Annual Meeting in Nashville, Tenn. For more information about RAP, please contact NABP at 847/698-6227, or e-mail comm@nabp.net.
and the practice of pharmacy. It examined basic skills and knowledge without regard to territoriality or practice setting. The test items represented the minimal competence a person licensed as a pharmacist must possess.

This five-part NABPLEX format continued for 10 years, ending with the special April 1986 administration. The continuing evolution of NABPLEX, which closely paralleled the evolution of the practice of pharmacy, became the integrated NAPLEX. This new format debuted in June 1986.

The integrated NABPLEX included two dramatic changes. The NABPLEX Competency Statements, derived from the Standards of Practice and Task Analysis Studies and formulated by the NABPLEX Review Committee (NRC) and the Advisory Committee on Examinations (ACE), were revised and a new format, predominately profile-based, was developed. The revised NABPLEX more closely reflected the diversity of decisions and tasks that actually occurred in the practice of pharmacy. The profile-based items required candidates to answer questions by patient issues rather than by subject matter.

By the 1990s, NABP examined the paper-and-pencil format, specifically, the types and nature of questions that can be asked, the new psychometric models that can be employed to measure a candidate’s competence, and the need of the boards to receive results almost immediately.

Computer adaptive testing (CAT), a new and improved method to ascertain the individual candidate’s ability level, seemed to be a logical next step for NABP’s licensure examination. The CAT algorithm selects questions from an item pool in an appropriate content area and difficulty and presents the question to the examinee. NABP was primarily interested in CAT’s benefits for the nation’s state boards of pharmacy, candidates, and NABP. After extensive research, ACE identified the following potential benefits for:

**State Boards of Pharmacy**

- the elimination or reduction of time and resources for administering the exam;
- a reduction in staff administrative tasks such as ordering test booklets and answer sheets; and
- the elimination of providing secure storage for examination materials.

**Candidates**

- easier access to examination sites;
- a more comfortable exam environment;
- an increase in the number of annual test dates;
- a reduction in the number of testing hours (because of CAT’s way of individualizing an exam); and
- a faster reporting of scores process and, ultimately, a quicker entrance into pharmacy practice.

**NABP**

- a further enhancement in fulfilling one of the Association’s constitutional purposes;
- a more accurate and efficient estimate of a candidate’s ability;
- the enhancement of test security; and
- added deterrents against cheating (because of test centers’ candidate identification technologies).

ACE prepared a timeline for the development of a CAT exam and considered whether external vendor support should be used to ease the transition from a paper-and-pencil test. In preparation for a computerized NABPLEX, NABP strove to ensure that the implementation of a CAT exam would not conflict with any state laws or regulations. The Association’s legal counsel determined that all states, except California, would be able to implement a CAT NABPLEX with little or no changes to their statutes or regulations.

At about the same time, the NABPLEX Review Committee and ACE again revised the NABPLEX Competency Statements with supplemental sources of practice information, such as the results of the national Scope of Pharmacy Practice Project and state pharmacy practice acts. NABP’s Executive Committee announced that the new NABPLEX Competency State-

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NABP’s April Legal Briefs posed several questions for pharmacy regulators to consider regarding the ability or inability of pharmacists to reveal information containing the records of a patient. Several questions related to inquiries, not only by a board of pharmacy but also by related boards such as a medical board. This article will complete the judicial analysis of the particular opinion. Although the opinion focuses on the psychotherapist-patient relationship and the exceptions to a privilege that might exist, such information is important to pharmacy regulators in understanding the interplay between various professions and regulatory boards.

As you will recall, the case involved a pharmacist who filed a complaint with a medical board, claiming that a psychotherapist had been prescribing unusually large quantities of drugs and controlled substances to certain patients. The medical board investigated the psychotherapist for possible illegal acts and issued a *subpoena duces tecum* to the psychiatrist for the questioned patient files. The psychotherapist refused to comply with the subpoena asserting his patients’ privacy rights and the psychotherapist-patient privilege.

The pharmacist not only filed a complaint with the medical board but also (along with other pharmacists) cooperated with the investigation by providing information to the medical board regarding the prescribing practices of the psychotherapist. Furthermore, enough information regarding each particular patient was revealed in order to substantiate the alleged over-prescribing.

Based upon information revealed during the investigative process, along with expert opinions that there was good cause to believe that the psychotherapist violated the Medical Practice Act by prescribing without good medical reason, the trial court held that an additional review of medical records was necessary to determine whether such prescribing practices were medically indicated. The patients of the psychotherapist refused to consent to the release of their medical records, and the psychotherapist asserted the privilege and refused to reveal the medical records.

In its petition to enforce the subpoena, the medical board claimed it had the right to review the records as part of its disciplinary and enforcement responsibilities under applicable state law. Furthermore, the board argued that the physician-patient privilege was inapplicable to a regulatory board’s investigative activities. In part, the applicable California law states:

> Notwithstanding . . . any other provision of lawmaking a communication between a physician and surgeon or a podiatrist and his or her patients, a privileged communication, those provisions shall not apply to investigations or proceedings conducted [by the board].

In spite of the psychotherapist’s argument that the statute was inapplicable because it applied only to physicians, surgeons, and podiatrists (not psychotherapists), the trial court granted the board’s petition and ordered the unconditional release of the patients’ entire files.

The psychotherapist, attempting to prohibit the release of the patients’ files, appealed this particular ruling. In its petition, the psychotherapist argued that the exception to privileged communications portion of the statute applied only to the physician-patient privilege and not to a psychotherapist-patient privilege. The psychotherapist also argued that revealing the patients’ records would violate the psychotherapist-patient privilege and the patients’ constitutional right to privacy. The board countered such
arguments stating it was merely seeking to investigate the medical aspects of those patients’ records to determine whether the prescriptions written were lawful.

In narrowing the issue, the court sought briefs and arguments on the issue of whether the crime/tort exception to the psychotherapist-patient privilege applied to this situation. The crime/tort exception to the privilege provides that there is no privilege if the services of the psychotherapist were sought or obtained to enable or aid anyone to commit or plan to commit a crime.

The board argued that it is a crime to prescribe controlled substances to an addict outside an authorized narcotic treatment program or authorized institution. Furthermore, California law makes it a crime to prescribe controlled substances outside a course of treatment and without a legitimate medical purpose. Accordingly, the board claimed that the declarations of the pharmacist alone demonstrate the crime exception to the privilege and mandate disclosure of the patients’ records.

The psychotherapist argued that the statutory language addressing the crime exception focuses on the “patient’s motive” for seeking the psychotherapist’s services. Accordingly, the psychotherapist argued that the crime/tort exception only applies where the purpose of the patient is to use the doctor’s services to commit a crime.

Because no reported California decisions interpret the crime/tort exception to the psychotherapist-patient privilege, the court turned its attention to similar cases in the attorney-client privilege arena. In its analysis, the court held that the purpose of both the client and attorney (or patient and psychotherapist) must be analyzed. As stated:

Where the entire attorney-client relationship is embarked upon in furtherance of criminal activity, and the relationship is permeated by criminal activity, and the client takes an active part in it, the crime/fraud exception is satisfied, notwithstanding that it may have been the attorney who originally conscripted the client for the illegal purpose.

That is, the court held that the crime/tort exception to the psychotherapist-patient privilege is applicable when the alleged criminal acts are those of the psychotherapist, the patient, or both.

Furthermore, the court assessed the implications of federal law upon the issue. It held that in situations where the psychotherapist-patient relationship itself is potentially criminal in nature, the privilege must give way to the federal government’s interest in probing the true nature of the relationship. That is, subpoenaed records must be revealed for the process to adequately assess whether a crime was probably committed.

Based upon the foregoing analysis, the court held that under state and federal law, the crime/tort exception to the privilege does not circumvent the professional relationship and is designed to prevent the privilege from shielding a psychotherapist’s own criminal or fraudulent acts.

The court next addressed the issue of whether the declarations of the pharmacist were sufficient to justify the application of the crime/tort exception. Before documents must be revealed, a party must establish a prima facie case of a crime. In formulating the rule, the court held that in order to justify a review of the documentation, some objectively reasonable, factual basis amounting to a prima facie case demonstrating the exception applies must be forthcoming. Based upon the knowledge of the pharmacist and the declarations made, the court held that the acts of the psychotherapist likely constituted violations of the health and safety code sections of the applicable state law. Should such allegations by the pharmacist be substantiated, they would likely demonstrate the

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Study Evaluates Pharmacists’ Knowledge of and Attitudes Toward Pain Medication Dispensing

A recent study published in the March/April 2001 issue of the *Journal of the American Pharmaceutical Association* suggests that some pharmacists’ knowledge of and attitudes toward the prescribing and dispensing of opioid pain medication could contribute to a failure to dispense valid prescriptions for opioid analgesics to pain patients.

Researchers David E. Joranson and Aaron M. Gilson of the Pain & Policy Studies Group, Comprehensive Cancer Center, University of Wisconsin, surveyed Wisconsin pharmacists on their knowledge of, and attitudes toward, the use of opioid analgesics in the management of chronic cancer and non-cancer pain in an effort to explore the potential for these beliefs to interfere with the dispensing of such medications. A 51-item questionnaire was sent to 1,000 randomly selected licensed pharmacists in April 1998. The questionnaire queried pharmacists about their views on dispensing Schedule II opioids; opioid addiction, abuse, and diversion; judging the validity of prescriptions; and knowledge and perceived effects of federal and state controlled substance regulations.

According to Joranson and Gilson, the survey responses indicate “a significant minority [of pharmacists] might not dispense a valid prescription because they have incorrect knowledge or misconceptions about what is legitimate practice under federal or state policy.”

The study suggests, for instance, that some pharmacists would refuse to dispense a prescription for an opioid analgesic received via telephone in an emergency situation, even though state and federal laws allow such dispensing. Some pharmacists did not know that federal and state regulations allow the partial dispensing of Schedule II opioids for terminally ill patients living at home. A significant minority felt that opioids used for more than several months should be discouraged or investigated, even when lawfully prescribed. The study also suggests some confusion regarding the issues of opioid addiction, dependence, and tolerance, as well as concerns regarding diversion.

Joranson and Gilson suggest additional education is necessary for pharmacists to appropriately understand pain management and addiction issues. The investigators also recommend that state boards of pharmacy, like the majority of state medical boards, adopt guidelines or policy statements that further pain management efforts and address diversion issues. Such guidelines should: 1) encourage pharmacists to become more involved in pain management; 2) encourage continuing education regarding pain, opioid analgesics, addiction, and controlled substances policy; 3) describe board criteria for judging the validity of various dispensing practices that may be at issue; and 4) correctly define pain and addiction-related terms, such as tolerance, physical dependence, addiction, and pseudoaddiction.

The article can be viewed on the Pain & Policy Studies Group Web site at www.medsch.wisc.edu/painppolicy/publicat/01japhak/01japhak.htm.

DEA Issues Guidance on Dispensing and Purchasing Controlled Substances over the Internet

The US Drug Enforcement Administration (DEA) published a guidance notice in the April 27, 2001 *Federal Register* for prescribers, pharmacists, law enforcement authorities, regulatory authorities, and the public concerning the application of current laws and regulations as they relate to the use of the Internet for dispensing, purchasing, or
importing controlled substances. The notice describes the circumstances under which sales of controlled substances via the Internet are legal, and emphasizes the illegality of having controlled substances shipped into the United States from a foreign Web site without being registered with the DEA as an importer. This notice may be viewed on the DEA Web site at www.deadiversion.usdoj.gov/fed_regs/notices/2001/fr0427.htm. For further information contact Patricia M. Good, Chief, Liaison and Policy Section, Office of Diversion Control, DEA, Washington, DC 20537, 202/307-7297.

Oklahoma Grants USP Legal Protection for Medication Error Reporting

The Oklahoma State Board of Health recently approved the United States Pharmacopoeia (USP) as a national organization to which reports or other data may be submitted by authorized persons, hospitals, nursing homes, and other organizations under Oklahoma’s Public Health and Safety statute 63-1-1709, which declares that information submitted to approved organizations for the purpose of reducing morbidity or mortality is privileged and therefore may not be introduced as evidence in any legal proceeding. It is hoped that the legal protections provided will encourage health care practitioners and facilities to more consistently report medication errors, thereby increasing the chances of identifying trends and implementing system-wide improvements and safety measures. Oklahoma is the first state to provide legal protection to USP’s medication error reporting programs.

FDA Proposes Legislation Banning Illegal Prescription Imports via Web

The Food and Drug Administration (FDA) is proposing zero-tolerance legislation to prevent the importation of unauthorized prescription drugs into the United States, according to Health News Daily. The proposal was discussed at a House Energy and Commerce subcommittee hearing in Washington, DC, on June 7, where pharmaceutical company executives, the Drug Enforcement Administration (DEA), US Customs, and other government officials testified about the growing trend among US citizens using the Internet to illegally buy prescription drugs from overseas.

According to an article from the ePharm5 Newsletter, an e-business intelligence system newsletter published by Medical Broadcasting Company, several witnesses stated that the Internet has contributed to the dramatic rise in the importation of prescription drugs through the mail and that the FDA and US Customs Service lack sufficient personnel and technology to monitor flooded mail-inspection sites.

Recent government studies estimate that as many as 200,000 uninspected packages make their way through the country’s 13 international mail reception centers each month. In response, subcommittee chairman James Greenwood (R-Pa) is asking Health and Human Services Secretary Tommy Thompson to review the FDA’s proposal and respond within 60 days. If the proposal becomes law, then officials at US mail inspection sites would be required to return all unapproved medicines to the foreign-based pharmacies that sent them.

According to ePharm5, this hearing follows government studies showing that thousands of prescription drugs, many of which are counterfeit and unsafe, are making their way into the country every month.
Crystalline water, challenging golf courses, and peaceful whale-watching are just a few of the things you’ll enjoy during NABP’s 2001 Executive Officers Conference, November 10-13, 2001. Scheduled at the Hyatt Regency Monterey, the sights and sounds unique to Monterey Peninsula are just minutes away.

Maritime Magic in Monterey
Located a short distance from Monterey Bay, the Hyatt Regency is near famous Bay attractions such as John Steinbeck’s Cannery Row, Fisherman’s Wharf, the Monterey Bay Aquarium, and the Maritime Museum.

While strolling Cannery Row, visitors will pass by Fisherman’s Wharf, where gift shops and seaside restaurants offer an up close and personal view of sea lions, harbor seals, and sea otters. Stop by the Maritime Museum and learn about the life of a mariner through an entertaining chronicle of nautical life. The end of the road leads to the Monterey Bay Aquarium, the nation’s largest marine sanctuary, which houses more than 300,000 unusual and colorful creatures native to the Bay area, from mischievous sea otters and delicate jellyfish, to powerful sharks, giant ocean sunfish, and the elusive octopus. Visitors can experience the mysteries of the ocean through an innovative “hands on” exhibit that lets participants stroke the rough skin of an ochre star or the velvety back of a bat ray. The more than one hundred galleries and exhibits recreate the Bay’s many inhabitants, from shallow tide pools to the deep Pacific Ocean. Learn firsthand about the life of those who make the sea their home.

Starting at the Monterey Bay Aquarium and ending at the 17-Mile Drive gate, stop by the rich historical area called Pacific Grove. Since its inception in 1875 as a Methodist summer retreat, the character of Pacific Grove has changed little. Stately turn-of-the-century Victorian houses line the streets where tents were once pitched. Many of these “grand ladies” have been transformed into charming bed and breakfast inns or fine restaurants.

Cruise to Carmel
For world class golf courses and wineries, Carmel Bay is located only four miles away from the resort. While on the way to hit the links at the Pebble Beach Golf Course or the Spanish Bay Golf Course, take the scenic 17-Mile Drive. Some of the sights along the way include The Lone Cypress, Point Joe, Seal and Bird Rocks, and Fanshell Beach. After playing a game of golf or taking in the breathtaking sights, enjoy a glass of wine at one of the numerous wineries in Carmel Valley. Many of the world’s best wineries make their homes in Carmel Valley, including Joullian Vineyards and River Ranch Vineyards.

While in Carmel, do not forget to stop by Carmel-By-The-Sea, with Point Lobos, Carmel and Lagoon Beaches, Ocean Avenue, The Tor House, Carmel Mission, and a variety of art and photography galleries.

Transportation
Attendees have a choice about how they would like to arrive at the conference. The Hyatt Regency Monterey is only five minutes from the Monterey Peninsula Airport, with connecting flights through San Francisco and Los Angeles International Airports. Otherwise, attendees may opt to fly directly to San Jose, which is just an hours drive away.
Executive Officers Conference Program

November 10-13, 2001  Hyatt Regency Monterey  Monterey, Calif

Saturday, November 10

6 - 10 PM  Optional Event: Scenic Tour and Dinner

Sunday, November 11

7:30 AM - 7 PM  Registration/Information Desk Open
7:30 - 8:30 AM  Continental Breakfast
8:30 AM - 12:30 PM  Management Training Seminar for Executive Officers
Program # 205-000-01-011-L04  (0.4 CEUs or 4.0 Contact Hours)

Law Enforcement Training Seminar for Compliance Officers
Program # 205-000-01-012-L03  (0.4 CEUs or 4.0 Contact Hours)

Monday, November 12

7 AM - 4 PM  Registration/Information Desk Open
7 - 8 AM  Continental Breakfast
12:30 - 2:00 PM  Lunch Break (lunch on your own)
2 - 3 PM  Keynote Address
Dr Holly Atkinson
3 - 3:30 PM  Refreshment Break
3:30 - 5:30 PM  Preparing for a Biodisaster
Program # 205-000-01-013-L04  (0.2 CEUs or 2.0 Contact Hours)
6:30 - 8:30 PM  Welcoming Reception

Tuesday, November 13

7:30 - 9:30 AM  Breakfast Dialogue - Internet Portals

Participants may earn up to 12 hours of ACPE-approved continuing education credit from NABP. Participants in continuing pharmaceutical education programs will receive credit by completing a “Certificate of Continuing Pharmaceutical Education Participation”, and submitting it to the NABP office. A validated Certificate will be sent as proof of participation within approximately six weeks. Full attendance and completion of a program evaluation form for each session are required to receive continuing pharmaceutical education credit and a Certificate of Participation.
The following article was written by Evelyne Aguirre Patterson, director of the Test of Spoken English and SPEAK and associate director of the Test of English as a Foreign Language.

The quality of an assessment instrument depends on the quality of the development process and the expertise of the developers of that instrument. The way tests perform and the extent to which they measure what is intended depends on the design of the test and the way it is operationalized.

Overview of the Test of Spoken English

The Test of Spoken English™ (TSE®) measures the ability of nonnative speakers of English to communicate orally in English in a North American context. Initially launched in 1981, the current TSE test format has been in effect since July 1995. The TSE has broad applicability because performance on the test indicates how oral language ability may affect the examinee’s ability to communicate successfully in either academic or professional environments, and is appropriate for examinees regardless of native language, type of educational training, or profession. TSE scores are used for certification and licensing purposes in education and health professions such as medicine, nursing, pharmacy, and veterinary medicine, as well as for selection of international teaching assistants.

Professional Testing Standards

Educational Testing Service (ETS) tests conform to the professional standards of the American Research Association, the American Psychological Association, and the National Council on Measurement in Education’s Standards for Educational and Psychological Testing (1999), and the ETS Standards for Quality and Fairness (2000), which reflect a strong commitment to the principles of openness in testing, public accountability, quality, and fairness. Every test question is reviewed by the TSE Committee, made up of external reviewers, to ensure each question’s quality, legal defensibility, and clarity. All questions must provide fair, valid, and reliable assessment of the skills and knowledge being tested, and all tests also undergo a rigorous fairness review, which addresses issues of access and equity. Ultimately, the TSE committee approves the final specifications that guide all subsequent assessment-development activities, and TSE staff is involved in ongoing planning and review.

TSE Pilot Testing

After TSE questions have been finalized, they are assembled for pretesting. Pretesting is the process of gathering statistical information about a question without the question counting toward a test taker’s score. The main reasons for pilot testing questions are to detect flaws in the questions and to obtain reliable statistics about question difficulty, appropriate timing of questions, and how well questions discriminate between high- and low-performance test takers. Pretesting is undertaken outside of the test-administration process through special pretest administrations. Every TSE test question is pretested before appearing in an operational final test form.

TSE Administration

The TSE is administered 12 times a year worldwide by the Educational Testing Service through the Test of English as a Foreign Language (TOEFL) program, which is under the direction of the TOEFL Board established by and affiliated with the College Board and the Graduate Record Examinations Board.

TSE test administrations are usually given at colleges or other appropriate settings and are administered under standardized conditions. Response cassettes are returned to ETS for scoring by two, trained, independent raters.

The TSE Program Office arranges for special accommodations to facilitate the testing process for TSE candidates with disabilities.

Validity of the TSE Test

Validity is the extent to which a test measures what it is intended to measure. Although many procedures exist for determining validity, there is no single indicator or standard...
index of validity. The extent to which a test can be evaluated as a valid measure is determined by judging all available evidence, including its suitability for particular uses.

A series of validation activities was conducted during the revision of the TSE to evaluate the adequacy of the test design and to provide evidence for the usefulness of TSE scores.

One type of validity is content evidence, which represents the extent to which the content of a test represents a balanced and adequate sampling of relevant knowledge and skills. Evidence of content validity is generally evaluated by comparing the test’s content with courses of study, instructional materials, and statements of instructional goals. In addition, expert judgment is often used as evidence of content validity. This is especially true for tests used in licensing and certification.

A second type of validity is construct validity. TSE construct validity research was initiated in the theory paper commissioned by the TSE Committee (Douglas and Smith, TOEFL MS-9, 1997). This document discusses the dynamic nature of the construct of oral language ability in the field of language assessment and points the way to a conceptual basis for the revised test. As a result of the paper and discussion among experts in the field, the basic construct underlying the test was defined as communicative language ability. In evaluating validity of the test design, Hudson (1994) noted the high degree of congruence between the test’s theoretical basis and the test specifications. As a means of validating the test content, a discourse analysis of both native – and nonnative – speaker speech as elicited by the prototype test was conducted (Lazaraton and Wagner, TOEFL MS-7, 1996). The analysis indicated that the language functions intended were reliably and consistently elicited from both native and nonnative speakers, all of whom performed the same types of speech activities.

The test rating scale and score bands were validated through another process. ETS rating staff wrote descriptions of the language elicited in speech samples, which were compared to the rating scale, and score bands were assigned to the samples. This exercise determined the degree of agreement between elicited speech and the scoring system. The results confirmed the validity of the rating system.

A third type of validity is concurrent validity, which was investigated in a large-scale research study by Henning, Schedl, and Suomi (TOEFL RR-48, 1995). A prototype revised form of the TSE was compared with a form of the original TSE in terms of interrater reliability, frequency of rater discrepancy at all score levels, component task adequacy, scoring efficacy, and other concurrent and construct validity evidence, including oral proficiency interview correlations for a subset of the examinee sample. The sample for this study consisted of subjects representing the primary TSE examinee populations: prospective university teaching assistants (N=184), and prospective licensed medical professionals (N=158), including pharmacists seeking licenses in the United States. The subjects in both groups represented more than 20 native languages. In addition (continued on page 107)

New Executive Committee Officer Training
Donna S. Wall, NABP treasurer, met with members of NABP staff on June 7 at the Association’s headquarters in Park Ridge, Ill. Staff members gave presentations about the Association’s programs and services.
Hawaii Develops Plan to Defend Against Bioterrorism

Bioterrorism – it is no longer confined to the realm of science fiction. Chemical and biological warfare are real concerns as evidenced during the Gulf War and in 1995, when a terrorist cult released sarin, an organophosphate nerve gas, at several points in the Tokyo subway system, killing two people. An increase in the occurrence of bioterrorism combined with its remote location has led Hawaii to develop a program against bioterrorism.

Hawaii is unique in that its State Board of Pharmacy, which falls under the Department of Commerce and Consumer Affairs, deals primarily with licensing and some disciplinary actions. It is the Hawaii Department of Health (DOH) that serves as the public health watchdog.

In 1998, the US Department of Health and Human Services Office of Emergency Preparedness awarded a contract to the state of Hawaii to develop the Metropolitan Medical Response System for the city and county of Honolulu. Through the DOH Food and Drug Branch and in cooperation with the Department’s Communicable Disease Division and the Hawaii Pharmacists Association, the city and county of Honolulu developed the Honolulu Biological Incident Response Plan (HBIRP) to guard against terrorist incidents involving nuclear, biological, or chemical agents, or weapons of mass destruction.

This plan was expanded in 2000 to include serious biological infectious diseases, either naturally occurring or those arising from an act of terrorism, or any communicable disease. Just recently, the plan was expanded once again to encompass the entire state of Hawaii.

The plan was developed so that Hawaii could survive on its own for 72 hours, if needed, before assistance from the Continental USA arrives. It defines levels of response based on the number of casualties and the type of event. If the number of people affected is fewer than 500, the city, county, and DOH will be involved. Between 500 and 5,000 casualties depending on the event, trigger statewide involvement. An event resulting in greater than 5,000 casualties will activate federal resources to supplement existing state efforts to control a public health emergency. The plan was designed to deter people from inundating hospitals and causing chaos.

John Fleming, food and drug inspector for the DOH Food and Drug Branch in Hawaii, points out that the plan includes a mass prophylaxis program, which will be implemented in as timely a manner as possible in response to either a naturally occurring infectious disease outbreak or to a confirmed bioterrorism event.

“In addition, a National Pharmaceutical Stockpile (NPS), based in four [mobile] localities across the US, can be shipped to Hawaii within 12 hours and is expected to provide prophylaxis for approximately 846,000 people for three days or 357,000 people for seven days or therapeutically treat 14,000 people for three days or 6,000 people for seven days,” states Fleming. “The need for further support will be based on the magnitude of the event and local needs and assistance will be provided by the Centers for Disease Control and Prevention (CDC) and the National Pharmaceutical Stockpile Prevention Branch.”

According to Todd Inafuku, executive director of the Hawaii Pharmacists Association, Hawaii developed the Response Plan with various factors in mind, including:

- Hawaii's remote location;
- Eight percent of the population is military personnel;
- The vast number of tourists visiting Hawaii (in 1998 alone, there were 159,000 daily visitors); and
- There are an estimated 8,000 Asian visitors each day.

Because Hawaii is a popular tourist destination, the possibility of visitors carrying pathogenic agents is significant. In 1998, Hawaii had a population of 1.2 million, with 80% of the population concentrated on the island of Oahu (city and county of Honolulu).

Currently, the NPS contains three broad spectrum antibiotics and ancillary medical supplies.

According to Dr Laurence M. Raine, project coordinator and planner for the Hawaii Department of Health, Communicable Disease Division and Emergency Medical Services System, “The CDC last year awarded three...
grants to the DOH to explore the state’s public health capacity to respond to an act of biological terrorism. These grants address Preparedness Planning and Readiness Assessment, Surveillance and Epidemiology Capacity, and Laboratory Capacity.”

Following the riots in Seattle during the 1999 World Trade Organization convention, Hawaii trained and prepared for a possible bioterrorism attack during the May 2001 Asian Development Bankers Conference. There were no reported problems during this conference. The DOH increased its surveillance capacity by initiating a pilot project at selected area emergency rooms to electronically report a daily census of all illness conditions that were then analyzed for any illnesses, which occurred above and beyond normal incidence rates. The department also asked the Hawaii Pharmacists Association (HPHA) to determine a state-wide inventory of selected antibiotics. Dr Raine stated that the response from the HPhA was phenomenal which reinforced the communication between local, state and private agencies.

Modern air and sea travel, coupled with Hawaii’s isolated location, makes it vulnerable to infectious and emerging disease outbreaks. Dr Raine stated that the DOH has made progress in addressing epidemiological surveillance, mass prophylaxis, mass casualty care, mass fatality, and environmental surety concerns. However, the planning process should always be a work in progress. Raine said that local, state, federal, and private stakeholders must be involved in the planning process so in case of an emergency, everyone will be ready. “Many experts involved with countering biological terrorism agree that it is not a question of if, but when, such an event will occur,” he says. NABP

NABPLEX/NAPLEX Marks Its 25th Anniversary (continued from page 95)

ments would be distributed for validation in late September 1995 to all state boards of pharmacy and to a nationally representative survey of practicing pharmacists. The survey results were presented to ACE, the NABPLEX Blueprint Committee, and the Association’s Executive Committee. Responses to the survey’s questions indicated that the competencies were generally complete as presented.

NABP’s Executive Committee approved an ACE recommendation that the Association transition the paper-and-pencil NABPLEX to a computer-adaptive format. The Educational Testing Service with its network of Sylvan Technology Centers was selected to administer the computer-adaptive NABPLEX. Candidates would continue to apply for the examination through the state board of pharmacy in the jurisdiction to which they were seeking licensure.

With the March 1997 implementation of the computer-adaptive test, the Executive Committee decided to change the name of the NABPLEX to North American Pharmacist Licensure Examination, or NAPLEX in order to reflect that the Competency Statements had been validated for pharmacy practice in both the US and Canada. As former NABP Chairman Paul G. Boisseau stated at the time, “Once the revised Competency Examinations were shown by NABP to be valid for both US and Canadian pharmacy practice, changing the name of the NABPLEX to NAPLEX was a natural progression towards achieving this goal.”

In this 25th anniversary year, it is worth remembering that the history of NABPLEX and NAPLEX is deeply rooted in the commitment and hard work of the men and women who contributed to the development of the Blue Ribbon examination and the paper-and-pencil NABPLEX. NABP
To ensure that the North American Pharmacist Licensure Examination* (NAPLEX®) remains a high quality assessment mechanism, regular reviews of the examination are conducted. The processes of examination development and administration are complex and are consistently monitored to continually assess the integrity of the program.

During a recent psychometric analysis, a statistical inconsistency caused by an inadvertent programming error by the Chauncey Group International was discovered that impacted the results of a limited number of NAPLEX examinations administered between April 16, 2000, and April 10, 2001. The Chauncey Group, which has administered the computer-adaptive NAPLEX since 1997, corrected the problem as soon as it was discovered. A new NAPLEX examination was immediately distributed to test centers and is now being used. In addition, the Chauncey Group rescoring all data for candidates who tested during the affected dates. All candidates whose test scores were impacted by the programming error will be contacted by the Chauncey Group.

"NABP deeply regrets the inconvenience this statistical error may have caused some examination candidates," states NABP President Richard K. "Mick" Markison. "We do commend the Chauncey Group for its proactive and prompt response once the error was identified. The NAPLEX has been one of the nation’s premier professional licensing examinations for more than 25 years. By continuing to regularly monitor its performance to facilitate the early detection of statistical inconsistencies or anomalies, we will ensure its reliability for many years to come."

The Chauncey Group International accepts full responsibility for this error and will refund NAPLEX test fees to all failing candidates who should have passed.

For additional information, please contact the NABP headquarters at 847/698-6227.

Chauncey Group Detects and Corrects Error on NAPLEX

Legal Briefs (continued from page 97)

commission of a crime and/or violation of other applicable laws. Accordingly, the trial court held that such documents must be turned over for an in-camera review by the court. As stated by the appellate court:

In determining what portions of the medical records, if any, should be released to the board, the trial court should be mindful of the patients’ privacy rights and the legitimate expectations of confidentiality. Because the trial court issued an order providing for the unconditional release of the patients’ entire files, the appellate court remanded the matter back to the trial court to perform an in-camera review of the documents and determine what, if any, must be revealed to the board based upon the allegations.

This case presents a good analysis of the interplay between regulatory boards and the potential difficulties in uncovering evidence that may provide a basis for both administrative action against a license as well as criminal action against the rights of individuals, including both licensees and patients. This case also presents an example of accessibility to information from one source (the pharmacist) to other sources (the psychotherapist). Because the confidentiality or privilege statutes differ from profession to profession, regulatory boards may find accessibility to information through sources other than their regulated practitioners.

Rademan v. Superior Court, 103 Cal.Rptr.2d 283 (Cal.App.Ct. 2001)

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to the usual group of trained raters for the scoring of the original and prototype versions of the test. 16 native adult raters – representative of the native English-speaking population with whom successful TSE examinees would interact – were purposely selected. These 16 raters (eight females and eight males) provided concurrent judgments of the comprehensibility and communicative effectiveness of a subset of 40 recorded prototype examinations. In general, the comparative evidence gathered appeared to underscore the psychometric quality of the prototype revised Test of Spoken English and to support conclusions of its adequacy as an instrument used to make judgments of the oral English language proficiency of nonnative speakers in the targeted populations.

**TSE Publications**

Additional information about the TSE test can be found in the *TSE Information Bulletin*, which is available from most colleges and universities, government offices, and many private educational organizations worldwide. Currently there are three different editions of the *TSE Information Bulletin* (Regular, India/Korea/Taiwan, and the People’s Republic of China). The regular edition can be downloaded or ordered online at [www.toefl.org](http://www.toefl.org) by clicking on the “Test of Spoken English” link. Other free TSE publications are:

- IN 407521 - *TSE and SPEAK Score User’s Guide* (available in July 2001)
- IN 988352 – *TSE Sample Test Flyer*
- IN 407531 - *TSE Sample Responses Tape*

For information about ETS, access the ETS Web site [www.ets.org](http://www.ets.org).

**References**


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**Footnote**

The reader is referred to the American Research Association, the American Psychological Association, and the National Council on Measurement in Education’s *Standards for Educational and Psychological Testing* (1999), as well as Wainer and Braun’s *Test Validity* (1988), for a thorough treatment of the concept of validity.
NABP Meeting Dates

Sunday-Tuesday, August 5-7, 2001
NABP/AACP District III Meeting.
Amelia Island Plantation, Amelia Island, Fla

Thursday-Saturday, August 16-18, 2001
NABP/AACP District V Meeting.
Rushmore Plaza, Rapid City, SD

Thursday-Sunday, October 4-7, 2001
NABP/AACP District VI Meeting.
TBA, Lawrence, Kan

Thursday-Sunday, October 11-14, 2001
NABP/AACP District VII & VIII Meeting.
Sheraton Old Town Hotel, Albuquerque, NM

Thursday-Saturday, November 1-3, 2001
NABP/AACP District I & II Meeting.
Otesaga Hotel & Resort, Cooperstown, NY

Friday-Sunday, November 9-11, 2001
NABP/AACP District IV Meeting, Concourse Hotel, Madison, Wis

Saturday-Tuesday, November 10-13, 2001
Executive Officers Conference.
Monterey Hyatt Regency,
Monterey, Calif