Pharmacy Board of Australia: Public discussion paper on pharmacist prescribing

Responses to discussion paper questions about pharmacist prescribing

Your feedback is sought on the questions outlined in the Pharmacy Board of Australia 'Public discussion paper on pharmacist prescribing' published on 4 March 2019.

Please provide your feedback as a Word document (or equivalent)[1] by close of business on Monday 15 April 2019.

Some of these questions request details of evidence to support your views or views of your organisation. This discussion paper and other reports about prescribing published by the Board reference published information and evidence about pharmacist prescribing locally and overseas.

The Board is seeking further details about additional evidence (published or unpublished) that you may be aware of or believe should be considered. Evidence could include information about new initiatives in practice currently being developed or in progress; or relevant information about prescribing by other non-medical health professions that may provide further information or evidence to inform pharmacist prescribing. For example, evidence may include data demonstrating cost effective health outcomes or qualitative data demonstrating patient satisfaction with pharmacist prescribing.

Stakeholder Details

If you wish to include background information about your organisation please provide this as a separate word document (not PDF).

Organisation details
Organisation name: ASCEPT (Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists) **Contact name: Nicholas Farinola** **E-mail address:** [redacted]

[1] You are welcome to supply a PDF file of your feedback in addition to the word (or equivalent) file, however we request that you do supply a text or word file. As part of an effort to meet international website accessibility guidelines, AHPRA and National Boards are striving to publish documents in accessible formats (such as word), in addition to PDFs. More information about this is available at www.ahpra.gov.au/About-AHPRA/Accessibility.aspx.

Much of this feedback is influenced by the experience of physicians working with pharmacists in the hospital environment more so than the role of the pharmacist in the community or within a multidisciplinary GP practice.

The Pharmacy Board has asked for feedback in relation to the discussion paper regarding pharmacist prescribing. It is acknowledged that pharmacists already prescribe schedule 2 and schedule 3 medicines. There is also acknowledgement that pharmacists are able to dispense emergency supplies of certain medication to patients who have previously been prescribed this medication by a physician (with some conditions) – in a sense a type of "prescribing"., though not by the definition used herein. This paper is more about discussing the potential role of pharmacists to prescribe medications that up to now can be prescribed by a medical practitioner as well as limited other health practitioners. The aim of this would be to free up the valuable resource of medical practitioners, but also to allow for pharmacists to be able to use their skills to potentially improve the health of the patient and wider health system.

It should be remembered that prescribing is more than just writing up a drug treatment on a script. Prescribing is a set of multiple actions culminating in the writing of the right medication for the right patient at the right time and right dose and right route. In addition to this "prescribing mantra", there needs to also be recognition that it should be written by the right prescriber, who has the skills to assess and evaluate outcomes of their prescription.

It is noted that within some hospital systems, despite attempts to extend prescribing to nursing and allied health professionals, there has not been the expected take-up, mainly because their prescribing is limited to the scope of practice of their specialization. This has therefore not led to the freeing up of medical resources as much as possible. However, because the specialization of pharmacists is "medicines", there is potentially a wider scope and therefore greater liberation of resources. Pharmacists have the basic knowledge of prescribing - they know the effects and side effects of drugs, they are trained to have superior communication skills, they are by their very nature more analytical and considered during decision making.

Regardless of which model is implemented the prescribing pharmacist should not be able to dispense their own medication, as per the current medical model of prescribing.

Current training does not provide pharmacists with the sufficient skills to make the diagnostic and clinical assessments. This is probably the defining criteria between a pharmacist and a medic. Once other models of prescribing have been in place and established that the benefits of pharmacist prescribing in Australia outweigh the costs, there could be consideration of implementing a specific training program for pharmacists to be able to autonomously prescribe.

Some of the more experienced pharmacists that our members deal with on a regular basis have voiced that that feel more comfortable in an advisory role within the multidisciplinary team. If the other members of the multidisciplinary team can provide the appropriate diagnostic and assessment skills, then a structured prescribing arrangement may be reasonable. This could work, say, in a public hospital setting or in a multidisciplinary GP practice. However, this does not make use of the pharmacist's core skills and it still relies on a prescribing plan from the doctor. Also, if you have a multidisciplinary team, the likelihood is that there are adequate resources and the time it saves the doctor is probably not enough to justify the cost of implementing a pharmacist prescribing programme. The greater value is in resource-poor areas such as rural and remote areas, where patients cannot get in to see their GP or specialist, and a pharmacist who can effectively prescribe ongoing treatment according to a structured prescribing arrangement from the medical prescriber may facilitate this.

The best role in fulfilling the public need is the prescription under supervision, as not only does this free up medical resources, but also allows the pharmacist to apply their knowledge about drugs and therefore has direct benefits for the patient, but also with the back-up of having a medical prescriber who can essentially provide some of the diagnostic and assessment skills required, if necessary. The main challenge here is getting the medical fraternity to be willing to provide that back-up.

From the briefing paper, it is understood that there are other regulators internationally that allow pharmacists are allowed to prescribe under an array of different models. However, there is little evidence that these systems deliver either safer prescribing or at least increasing access whilst maintaining the same level of safety as a medical only prescribing model. It would certainly be pertinent to perform well designed trials of supervised prescribing, either under a structured prescribing arrangement or under direct supervision, that takes into account the Australian context and assesses not only the efficacy and safety of such models, but also the feasibility of these models in Australia taking into account resource and financial implications.

		Prescribing under a structured prescribing arrangement	**Prescribing under supervision**	**Autonomous prescribing**
	PUBLIC NEED			
1	How would these models of prescribing by pharmacists fulfil a public need?	It frees up medical staff to attend to diagnosing rather than prescribing, however the additional skills of the pharmacist with regards to their knowledge of medicines and adverse effects, etc is unable to be utilised fully as the pharmacist is limited to prescribing to what is explicitly stated in the protocol. This may still be advantageous for areas where there is minimal medical resources – for instance, in rural and remote areas where there is a shortage of GPs and specialists, appropriately trained pharmacists may be able to continue Schedule 4 drugs previously prescribed.	This fulfils a need in that it allows the pharmacist to use their skills in knowledge about medicines and adverse effects – which is frequently better than that of the physician (and I say that as a physician) – to adjust medications, but also have the adequate supervision by another authorized health professional (presumably medical) to turn to when there are diagnostic or clinical issues. This model offers the patient timely access to prescribing but also potential improved safety from having a pharmacist more intimately involved with the prescribing process. However this model is dependent on the medical practitioner engaging in the process.	It allows for the pharmacist to use their knowledge of medicines and adverse events to potentially improve patient safety, at the same time as freeing up the medical officer for other tasks. However, in the example given in the discussion paper, there would be a question whether it is appropriate for the pharmacist to prescribe if there are other prescribers available. It does not reduce the need for medical officers to be available for prescribing. Current practice is that the pharmacist identifies the issue and asks a medical officer to prescribe, and this is still most appropriate. The ability to autonomously prescribe should and must be limited only to the rare cases when other prescribers are not available routinely AND in a setting where the prescribing pharmacist also has the

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				capacity to follow up on the treatment commenced AND has appropriate referral pathways in case it hasn't. It is the view of ASCEPT members generally that there is currently no justification in Australia for a need for autonomous prescribing, and would recommend against investing resources and training.
	EVIDENCE (published or unpublished)			
2	What is the evidence that these models of prescribing by pharmacists would be a safe and effective way of improving access to medicines for the community?	Well designed clinical trials would need to demonstrate feasibility in the Australian context with regards to financial cost and resource availability, as well as the standard efficacy and safety requirements. ASCEPT would support trials being performed using this model.	Well designed clinical trials would need to demonstrate feasibility in the Australian context with regards to financial cost and resource availability, as well as the standard efficacy and safety requirements. ASCEPT would support trials being performed using this model.	Well designed clinical trials would need to demonstrate feasibility in the Australian context with regards to financial cost and resource availability, as well as the standard efficacy and safety requirements.
3	What is the evidence that these models of prescribing by pharmacists support the *Quality Use of Medicines (QUM)*, i.e. judicious, safe, appropriate and efficacious use? (For example, by minimising overuse of medicines, reducing adverse events, improving health outcomes and/or other elements outlined in QUM)	See above	See above	See above
4	Are there any gaps in the evidence for pharmacist prescribing under these models? If so, how could this evidence be obtained?	See above	See above	See above. In addition, the additional gap in the evidence is in the ability for pharmacists to be able to provide the clinical assessment to support autonomous prescribing. Current training does not provide pharmacists with the sufficient skills to make the diagnostic and clinical assessments, and is probably the defining criteria between a

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				pharmacist and a medical professional – ie, if they plan on learning about the appropriate assessment of a patient, they may as well do a medical degree.
	EDUCATION AND TRAINING			
5	What education requirements (if any) would pharmacists with general registration need to complete to competently prescribe under each model? (i.e. postgraduate education)	As prescribing is under a guideline/protocol, there is little more education that is required, though a post graduate course would certainly help provide the experience necessary	While most skills would be obtainable, a post graduate course is probably necessary to provide the appropriate experienced to support structured prescribing.	This would require more in depth post-graduate education – requires more in depth knowledge of physiology and clinical assessment.
6	Are current undergraduate program providers addressing the competencies to prescribe under each model? If not, what are the gaps and how can they be addressed?	While most skills would be obtainable, a post graduate course is probably necessary to provide the appropriate experienced to support structured prescribing.	While most skills would be obtainable, a post graduate course is probably necessary to provide the appropriate experienced to support structured prescribing.	No, there needs to be improvements in physiology, diagnostics (labs, imaging), interpreting subtleness of clinical situation
7	Before being authorised to prescribe under each model, would a pharmacist need to accumulate a minimum period of supervised practice under the supervision of an authorised prescriber (e.g. during the internship, before gaining general registration or after gaining general registration)?	Between 0-6 months after general registration	Yes, at least 1 year of face-to-face clinical work	Yes, supervision after gaining general registration, need at least 5 years of supervised practice to acquire sufficient experience with clinical nous required.
8	Before prescribing under each model, would a pharmacist need to have achieved a minimum period of practice experience as a pharmacist with general registration? If so, for what period?	Yes – experience is the greatest teacher. Need at least 1 year Admittedly, we currently allow 1st year medical officers to prescribe straight away (under supervision) without any experience, but generally it takes a medical officer about 1 year of continual prescribing to become familiar with medicines, what to look out for in different situations.	Yes – experience is the greatest teacher. Need at least 1 year Admittedly, we currently allow 1st year medical officers to prescribe straight away (under supervision) without any experience, but generally it takes a medical officer about 1 year of continual prescribing to become familiar with medicines, what to look out for in different situations.	Yes – experience is the greatest teacher. A pharmacist who is going to autonomously prescribe requires experience to see what happens with different situations, appropriateness of treatment, etc; to be confident with prescribing safely. It takes medical officers at least 5 years to gain sufficient experience to prescribe confidently and safely –

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				would need to be the same for pharmacists
9	Would pharmacists prescribing under each model need to meet different annual CPD requirements to pharmacists who do not prescribe?	Yes, because the prescribing role is different to the dispensing role.	Yes, there would need to be CPD about specific area of prescribing that is within the scope of that pharmacist	Yes, CPD about prescribing within the specific area of the pharmacist's scope of practice, but also CPD about general prescribing quality use of medicines
	REGULATION			
10	Would these models of prescribing by pharmacists require additional regulation by the Pharmacy Board or could it be adequately governed through relevant jurisdictional policy or legislation?	Should be covered under existing regulation	May need some additional regulation regarding requirement for continued professional development in the chosen field of prescribing	An endorsement for scheduled medicines in accordance with Section 94 of the National Law would be required for pharmacists to prescribe under this model. S8 medicines should probably not be prescribed under this model.
11	What are the risks associated with each model of pharmacist prescribing and how could they be managed?	Low risk, but prescribing pharmacist should not be the dispensing pharmacist, which has implications in how the prescribing pharmacist earns their salary.	Low risk, but prescribing pharmacist should not be the dispensing pharmacist, which has implications in how the prescribing pharmacist earns their salary.	Responsibility of the outcomes of prescribing – either by training the pharmacist to be able to make assessments, or improve communication with medical teams to ensure appropriate follow up
	OTHER			
12	What factors would contribute to sustaining each model of pharmacist prescribing if introduced?	This model is heavily reliant on other resources – it requires a multidisciplinary approach, and it requires the support from other healthcare professionals and managers.	This still relies on having a medical practitioner willing to provide supervision of prescribing.	This relies on significant changes in training. It is the most resource intensive. In the UK, where this model is in place, there is still low uptake, mainly due to lack of confidence in diagnosing conditions and a lack of time and interest invested by their designated medical practitioner. It seems that this is a large investment of resources but without significant output.
13	Do you have any additional comments about these models of prescribing by pharmacists?	Anecdotally, pharmacists can be more trusted to prescribe appropriately than final year medical	This is the best model to fulfil the requirements. The main concern is	This model has the potential for patients to get the greatest benefit from pharmacist prescribing, but it

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		students / interns, because pharmacists will tend to take a more cautious approach – relying on available resources to do what's right – rather than accept what the senior doctor does. This structured prescribing model constrains the pharmacist to a protocol which is designed by a medical practitioner and does not allow the pharmacist to really use their skills	that the need for acceptance by medical practitioners.	also has the potential to cause the most harm. This model may work for specialist hospitalist pharmacists, but it is resource intensive. I see the potential for "prescribers under supervision" to subsequently become autonomous prescribers down the track, but I still think we still lack the infrastructure and resources to support this currently.

To be clear, even if significant resources were invested into autonomous prescribing and sufficient experience was obtained under appropriate supervision and the appropriate maintenance of prescribing skills – including clinical assessment - the autonomous prescribing model is still not favoured, due to the lack of the independent check and the lack of a niche area where autonomous prescribing would fulfil a role which is currently not adequately filled.