RACGP

RACGP response to Australian Pharmacy Council Accreditation Standards for pharmacist prescriber education programs. Consultation paper one

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1. Introduction

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide a submission to the Australian Pharmacy Council's accreditation standards for pharmacist prescriber education programs – consultation paper one.

The RACGP is Australia's largest professional general practice organisation, representing over 43,000 members working in or toward a specialty career in general practice including four out of five general practitioners (GPs) in rural Australia.

The RACGP sets and maintains the standards for high-quality general practice care in Australia and advocates on behalf of the general practice discipline and our patients. As a national peak body, our core commitment is to support GPs and their broader healthcare team to address the primary healthcare needs of the Australian population.

2. RACGP overarching comments.

2.1 RACGP is concerned about conflation of diagnosing and prescribing skills

The RACGP is concerned about conflation of diagnosing and prescribing skills and that the role of diagnosis in prescribing is being diminished. Medical training is required to diagnose. Algorithms and checklists (used in protocols) have limited utility because they are unable to assimilate and convey all the relevant information about a patient including baseline assessment on temperature, heart rate, respiratory rate and blood pressure. It is unreasonable to expect pharmacists to take on this level of risk and it is unsafe for patients who may have alternative diagnoses missed in addition to the elevated risk of an incorrect diagnosis, or a delayed diagnosis of a significant medical or surgical condition.

- This concern is shared by other medical and surgical colleges. In their recent submission to the South Australian Select Committee on Access to Urinary Tract Infection Treatment, the Royal Australian College of Surgeons and the Urological Society of Australia and New Zealand stated:

  > *"The presentation of a classic urinary tract infection (UTI) is not uniform. The symptoms may NOT be present in some cases – in patients with diabetes, there may be no burning or stinging during urination; in patients with a neurological condition or the elderly, the only symptom may be change in behaviour or cognition. There is also the very real possibility that the symptoms of a classic UTI may NOT be due to an infection. Frequency and burning on urination can be seen in cases of kidney stones, bladder cancers, interstitial cystitis, cancers in the pelvis, fistulae (connection between bladder or urethra and vagina or bowel) or foreign body reaction (e.g. eroded mesh). Therefore, this condition, so easily diagnosed when there is no knowledge to exclude other diagnoses, can result in significant harm if poorly or inadequately assessed."*

- GPs complete over a decade of medical training where differential diagnosis is interwoven throughout before prescribing. A GP must have a good working knowledge of at least 167 problems to cover 85% of the conditions they will see most frequently.[1] Uncertainty, unpredictability and undifferentiated presentations are common challenges of general practice and GPs have been trained to manage uncertainty and hone their investigative skills for the wide variety of conditions they see day-to-day. This necessitates traversing the fine balance between ordering investigations in such a way that important pathologies are not missed, while avoiding over-investigation.

2.2 RACGP is concerned about a two-tiered health system - Appropriate settings and workforce capacity are important for comprehensive, high-quality diagnosis and prescribing that is equivalent to medical care

The settings in which diagnosing and prescribing skills are practised is important. A busy retail pharmacy setting does not provide the optimal environment for critical thinking and complex diagnostic reasoning when the pharmacist has multiple distractions switching between tasks such as dispensing (sometimes 400-500 scripts per day), recommending over the counter medicines for symptom management and selling retail products. A proprietor pharmacist would also be balancing operational and management related tasks. There is research and other reports that support RACGP's concerns:

- Despite the availability of consultation rooms in *some* (not all) pharmacies, evidence shows these are not well-utilised and sensitive conversations are happening at the counter.[2,3,4,5] Comprehensive, high-quality diagnosis and prescribing equivalent to medical care is not able to be provided 'over the counter' or where there are multiple distractions, both for the patient and the prescriber. Studies have found that there is information loss during interruptions and that multitasking creates higher memory load, both of which contribute to medical error.[6,7] This would likely be exaggerated in the retail setting, due to opportunistic patient consultations competing with other priorities.

- There is evidence that community pharmacies also lack cultural safety and appropriateness and in some cases community pharmacists seemed to be unaware that Aboriginal and Torres Strait Islander people often feel uncomfortable entering their pharmacies.[8,9,10,11,12,13] National Aboriginal Community Controlled Health Organisation's 3 February 2023 press release raised concerns about pharmacist expanded scope of practice "threatening to further fragment care for priority conditions such as otitis media and hearing loss, hepatitis management, and further exacerbate the crisis in antimicrobial resistance seen in many Aboriginal and Torres Strait Islander patients." NACCHO's Integrating Pharmacists within Aboriginal Community Controlled Health Services to Improve Chronic Disease Management (IPAC) study has provided a good model of how pharmacists can be integrated within appropriate team-based health settings to improve health outcomes for Aboriginal and Torres Strait Islander peoples.

- The 2022 report[14] of New Zealand community pharmacists highlighted that suboptimal practice had increased in the last 5 years. The changes (related to the pandemic) resulted in poor communication with patients, poor workflow, lack of safety standards, lack of staffing, high volume, stress and not working to best practice standards.

- Profession Pharmacists Australia found that 79% of pharmacists believed their workplace was not adequately staffed to deal with the extra workloads that resulted from the COVID-19 pandemic and many were feeling negative about their working experience. The CEO of Professional Pharmacists Australia stated that the survey reveals a pharmacy system buckling under the weight of ever-increasing responsibilities, without adequate consultation with working pharmacists. PPA's press release accompanying a 3 March 2023 submission to a South Australian Parliament Select Committee also flagged workforce shortages and doubts over the capacity of existing employee pharmacists to absorb further demands, particularly in regional and rural areas. Stating that any additional work demands on pharmacists will increase their already high workloads, further adding to work-related stress and risks to workplace health and safety in community pharmacy settings. The submission went further, raising the oversight of separate prescribing and dispensing roles and concerns for employee pharmacists who could face pressure from their employer to prescribe propagating unethical practices.

- Consumer Health Forum's March 2023 Consumer Voices e-News announced that consumer consultations have revealed that pharmacist prescribing trials are complex and nuanced and that they "see extending pharmacist prescribing rights as a response to symptom, not a cure."

In a medically supported multidisciplinary team-based setting, pharmacists have access to comprehensive patient records, medical practitioners for diagnosis, other staff to share or redistribute workload and/or assist

with administrative tasks. Additionally, there is separation of pecuniary interest between prescribing and dispensing.

The RACGP would like the accreditation standards for pharmacist prescriber education programs to consider these views and assess the ability for pharmacists in the retail pharmacy setting to truly work with each patient's individual health care team when prescribing collaboratively.

3. RACGP comments about the stakeholder forum.

The efforts made to provide a virtual forum concurrently with the 20 March 2023 face-to-face forum is commendable and technical challenges are not entirely unexpected. RACGP would like to offer the following feedback to assist with future virtual forums:

- The registrations for the virtual forum closed earlier than expected, which prevented interested GPs from being able to attend. The RACGP would recommend indicating when virtual registrations will close to encourage participants to register on time.
- Breakout rooms on zoom are a great idea for consultation. However, an RACGP staff member (and some other virtual participants) were not assigned to the breakout rooms and remained in the 'main zoom meeting room'. Therefore, they missed an opportunity to contribute to the virtual discussions.
- Another staff member had connection issues which are outside the control of the APC, but connection issues resulted in leaving the virtual forum early. The RACGP recognises that these issues can be overcome by the provision of alternate feedback pathways, which APC has already established.
- It was curious that some facilitators were also key (lead) researchers. Independent facilitation would remove conflicts of interest and any potential and unintended influence on participants or discussions. APC could consider asking one of the consumer organisations in the Stakeholder Reference Group to lead facilitation at future forums.

4. RACGP response to the consultation questions

The consultation paper posed a number of questions to assist in the development of the first draft of the accreditation standards and the RACGP has provided responses to each below.

4.1 Prescribing terminology

4.1.1 Current terminology to describe pharmacist prescribing across various implementation models is inconsistent and creating confusion. How should this be resolved?

The RACGP agrees that the current terminology to describe pharmacist prescribing across various implementation models is inconsistent and creates confusion. There is a continuum of pharmacist prescribing authorities around the world, from collaborative (which can be patient-specific or population specific) to independent (structured protocol or unrestricted, but category specific). Some countries still have large variations in prescribing authorities between their states, provinces and territories, despite more than a decade of pharmacist prescribing. There are definitions that are also specific to some settings (e.g. partnered charting). It is important that the definitions are clear as they will reflect level of accountability and professional liability.

The RACGP does have concerns with the implied message in recent pharmacy pilots that structured (protocol-based) prescribing is a lower risk prescribing model. Structured prescribing/protocols that are being used in decision making when supplying medicines for management of symptoms of very minor ailments (where symptoms are likely to resolve themselves over time) presents quite a different level of risk to the use of structured protocols where diagnosis of a medical condition is required. Flowcharts cannot replace a decade of medical training. The use of algorithms and checklists can be unhelpful and they do not capture and take account of the full complexity of the patient in front of the clinician and the baseline assessment tools – temperature, heart rate, respiratory rate and blood pressure. Conflation of diagnosing and prescribing skills may present a risk to patient safety. This is mitigated by pharmacists working within

medically supported multi-disciplinary teams (e.g general practice, ACCHSs, hospitals) where there is access to medical diagnosis, comprehensive patient records and interprofessional support.

Additionally, terminology for “primary care”, “multidisciplinary team-based settings” and “community pharmacist” may also require definition for further clarity. Retail pharmacy and general practice might both be considered primary care yet are very different. A consultant (accredited) pharmacist and an intern pharmacist could both work in the “community” but have very different level of competency.

4.2 Education program type

4.2.1 What level of education or training is required to support pharmacist prescribing in Australia? Please explain your answer.

If pharmacists are diagnosing prior to prescribing, then pharmacists should complete the same level of training as a GP.

If pharmacists are prescribing collaboratively within a medically supported multidisciplinary team-based setting, then diagnostic skills are not required as they will have access to medical practitioners for diagnosis. At a minimum, a graduate certificate or graduate diploma level of education should be required for pharmacist prescribing collaboratively in a team-based setting (e.g. hospital, general practice, Aboriginal Community Controlled Health Settings). This should be followed by 6 months practical placement in a general practice or similar setting for supervised practice.

The current pharmacist workforce is a mix of pharmacists who have completed a 3-year degree plus one year internship, and 4-year degree plus one year internship. Some pharmacists have undertaken further accreditation and/or advanced clinical training courses to work in hospital settings. A minimum pre-requisite entry level must be established that also determines how much patient-facing work experience the pharmacist has been exposed to prior to entry to the prescriber training. It is recommended that the medical schools are engaged within the universities where post-graduate pharmacist prescriber education programs are conducted to provide prescriber education expertise and prerequisite input.

A 2020 Australian study of universities with a pharmacy faculty, identified 26 areas of education that a newly registered pharmacist would be required to address to competently perform services within a general practice setting.[15] Clearly, post-graduate studies are needed.

The allied health post-graduate prescribing training program that was developed, delivered and evaluated in the implementation of a state-sponsored research trial in Queensland Health public facilities was composed of two modules and mandatory supervised workplace learning. Remote blended learning, comprising online pre-recorded lectures, self-directed learning, teleconference seminars and a 2-day-on-campus intensive residential were used to deliver content. The study[16] of the training program highlighted challenges with program development and delivery. Recommendations for improvements included more direction about their supervised learning and improving the way prescribing ability was assessed.

RACGP would expect that issues raised in both studies (in addition to the RACGP’s comments within this submission) will have been addressed in the final accreditation standards for pharmacist prescriber education programs.

4.3 Program entry criteria

4.3.1 What should an education provider consider before applying entry criteria requirements for their programs?

As previously stated, the RACGP has concerns about conflation of diagnosing and prescribing skills and believes medical training is required to diagnose. RACGP also believes that any pharmacist prescribing should be undertaken within medically supported multi-disciplinary team-based settings.

General practitioners must meet entry criteria before being accepted to GP training programs. A two-year minimum experience after general registration in patient-facing pharmacy or clinical environment relevant to area of practice in which they plan to prescribe would be an acceptable entry criteria requirement for pharmacists. RACGP was alarmed to read that intern pharmacists were being enrolled in the North Queensland Community Pharmacy Scope of Practice Pilot.

4.3.2 What entry requirements should be considered and why?

Refer to response to 4.3.1.

4.4 Interprofessional collaboration

4.4.1 How should education providers ensure the principle of interprofessional collaboration is embedded in their training programs?

As previously stated, the RACGP has concerns about conflation of diagnosing and prescribing skills and believes medical training is required to diagnose. RACGP also believes that any pharmacist prescribing should be undertaken within medically supported multi-disciplinary team-based settings. Developing accreditation standards that are aimed at collaborative prescribing models within medically supported multidisciplinary team-based settings will be the best way of ensuring principles of interprofessional collaboration. Undertaking supervised practice in multidisciplinary team-based settings will further embed these principles.

If prescribing is only being performed in medically supported multidisciplinary team-based settings (ie not retail pharmacy) then interprofessional collaboration will be easier. It is RACGP's view that the degree of interprofessional collaboration required for safe prescribing by pharmacists is not able to be achieved in the retail pharmacy setting.

4.4.2 Can you provide examples of interprofessional collaborative learning that have been effective in addressing safe prescribing competency in the context of the multidisciplinary health care team?

Nurse Practitioner (NP) models where NPs work in multidisciplinary team-based settings such as palliative care teams, emergency departments and general practice work well.

Hospital settings have good models.

ACCHOs have good examples of interprofessional collaboration.

General practice has good models of interprofessional collaboration. Practices host pharmacists as part of training in addition to employing pharmacists who provide medication management services, deliver medication safety initiatives, manage the stock-control systems for medicines stored within general practice and collaborate with the GP to optimise patient medication therapy and achieve treatment goals.

4.5 Assessment

4.5.1 What factors should an education provider consider when developing an assessment strategy for pharmacist prescriber training programs?

As previously stated, the RACGP has concerns about conflation of diagnosing and prescribing skills and believes medical training is required to diagnose. RACGP also believes that any pharmacist prescribing should be undertaken within medically supported multi-disciplinary team-based settings. Therefore, RACGP's comments are framed through this lens.

Where pharmacists are working within general practice, competency assessments should have significant input from the discipline of general practice.

4.5.2 What factors should an education provider consider to ensure fair, valid, reliable and consistent assessment of learners in the workplace?

GPs complete a minimum of four years supervised medical practice, two of these years within a general practice setting.

APC should establish a workplace-based supervision and assessment program to ensure that pharmacist prescriber education standards are implemented in a fair, valid, reliable and consistent manner. General practice has developed a comprehensive program and some of the below components could be similarly applied:

- Clinical Case Analysis related to appropriate prescribing within a multidisciplinary team
- Multi-source feedback from patients and colleagues
- Clinical audit of clinical performance e.g rational ordering of pathology related to prescribing etc
- Mid and end term appraisals.

A training and assessment program for supervisors will need to be developed alongside the accreditation standards for pharmacist prescriber education programs to provide quality assurance processes for supervisors.

4.6 Work integrated learning (WIL)

4.6.1 Should there be a similar requirement for WIL in pharmacist prescriber training programs in Australia? Please provide rationale for your answer.

Yes. This is the core of the training as short online modules, 'book learning' and/or utilisation of flowcharts and protocols does not provide the real experience of a patient consultation. Practice-based learning is invaluable and it is important to have direct supervision in early stages of skill development. WIL programs followed by formal assessment of competency would also provide a mechanism for standardising level of competency.

4.6.2 What factors might determine how an education provider decides the most appropriate duration of WIL in their program?

As previously stated, the RACGP has concerns about conflation of diagnosing and prescribing skills and believes medical training is required to diagnose. RACGP also believes that any pharmacist prescribing should be undertaken within medically supported multi-disciplinary team-based settings. Therefore, RACGP's comments are framed through this lens.

The WIL duration should be 6 months full time within medically supported multidisciplinary team-based settings.

4.6.3 What measures should an education provider consider for assurance of the quality of the supervision, the supervised practice site and the learner experience?

General Practice is a very mature industry with a network of general practice supervisors who undertake regular supervisor training with quality assurance monitoring. General practices that supervise registrars must also be accredited practices.

GP feedback is provided during term and end of term on the quality of their training. APC could consider an Educator assigned to the pharmacist to check learning is progressing appropriately. This would be supplemented by surveys of learner experiences. The pharmacist prescriber training program should also be regularly evaluated.

4.7 General questions

4.7.1 Is there anything else you think we need to consider when developing the standards?

- The evidence indicates that more studies are needed to determine cost-effectiveness of non-medical prescribing. An economic evaluation should be considered comparing the pharmacist prescribing model of care to usual care. Internationally and locally, appropriate reimbursement models have been a challenge to the success of pharmacist uptake. It would be responsible to ensure that this will be the most cost-effective use of limited health resources.

- Impact on antimicrobial resistance.

- Clear parameters around what can be prescribed. Medical practitioners cannot prescribe everything.

- APC may need to consider whether prescribing will require pharmacies to instal additional software or record patient notes in a standardised way. If so, the accreditation standards may need to consider a standard for the appropriate recording of prescribing in electronic records.
- RACGP is deeply concerned that the current pharmacy prescribing pilots are unregulated, unlike other parts of the health system where there is close regulation regarding patterns of services and quality prescribing practices.

  The Pharmacy Programs Administrator is authorised under its service agreement with the Department of Health to undertake monitoring and compliance in relation to 7CPA programs. The Department of Health and the Professional Services Review agency monitors GP compliance in relation to patterns of service and quality prescribing practices.

  The APC may need to consider which agency would be responsible for monitoring quality prescribing and patterns of service for pharmacists and ensure pharmacists are audited for compliance.

5. RACGP comments regarding the environmental scan and literature review.

5.1 Part A – literature review

5.1.1 Method

Providing a list of the MeSH headings may have also been helpful in producing more records. Searching permutations of Australia like 'Sydney', 'Canberra', 'Melbourne' may have also produced more information. Refining the search to only full text availability is limiting but may reflect on the resources available to APC and time restrictions.

5.1.2 Background

No additional comments.

5.1.3 Prescribing in Australia

No additional comments.

5.1.4 Implementation of prescribing

No additional comments.

5.1.5 Prescribing and scope of practice

The definition of scope of practice - "*a time sensitive, dynamic aspect of practice which indicates those professional activities that a pharmacist is educated, competent and authorised to perform and for which they are accountable*" - is nebulous. It doesn't provide a framework within which the role can be defined. Where boundaries have been blurred in other professions, there have been adverse outcome. Scope of practice needs to be well defined for safety.

The additional comments that "*[i]n practical terms, there may be a difference between the recognised professional scope of practice, (i.e. the roles a profession has traditionally undertaken), and a personal scope of practice (i.e., the roles and/or tasks for which the individual is competent, authorised and accountable) …professional and personal scope evolves over time and this must be recognised and respected*" are also broad.

It would be helpful to provide a defined professional scope of practice for which personal scope of practice is then compared against.

5.1.6 Prescribing professions in Australia

The RACGP recognises that pharmacists working in hospitals and general practices may have undertaken advanced training. In these settings, they have access to charts or comprehensive patient health records and easy access to medical practitioners. The same cannot be said in the retail pharmacy setting and therefore RACGP's comments below apply to the retail pharmacy setting.

There is a comment that "*pharmacists have traditionally contributed to aspects of the prescribing process, largely by providing recommendations and medicines-specific information to inform prescribing decisions. However, the final responsibility for the prescription has commonly rested with another prescribing health professional*. *Australian pharmacists are authorised to provide medicines that are available without a prescription. In this context, pharmacists are required to understand the consumer need, formulate a diagnosis for a limited number of conditions and decide on the most appropriate medicine/s.*"

The RACGP is of the view that patients present to pharmacy seeking treatment to manage symptoms (e.g headache, muscular ache which would hopefully resolve on their own if untreated) and that to "formulate a diagnosis" is outside the scope for a pharmacist.

The National Competency Standards Framework for Pharmacists in Australia 2016 appear to demonstrate that the pharmacist is not qualified to diagnose:

> "[r]ecommends over-the-counter medicines and treatment regimens based on a *presumptive* diagnosis or *the presenting signs and symptoms* and after considering the safety and effectiveness of the medicine as well as its potential for misuse or abuse."
>
> "[u]ses an *established* diagnosis and clinical information to prescribe required medicines according to the terms of the prescribing arrangement."
>
> "[i]n collaboration with the patient, identifies agreed treatment goals, *monitors progress and outcomes*, including undesirable effects and makes required adjustments."

If a pharmacist is recommending over-the-counter medicines for *symptom management,* and this does not involve "dispensing" the RACGP wonders if this is in fact "supplying" a medicine and perhaps the term "prescribing" is being misused. There does not appear to be a strong enough distinction between "supply" and "prescribe". RACGP is concerned about conflation of diagnosing and prescribing.

5.1.7 International view of pharmacist prescribing

Implementation

The RACGP feels that statements like "*Australian pharmacists lag behind many other countries in their ability to contribute to the prescribing workforce*" are somewhat misleading. It is extremely difficult to make direct comparisons between overseas pharmacy models and the Australian setting. Each country applies differing prescribing models, education and training standards as well as registration requirements.[17] Independent prescribing is generally accompanied by much more education and training (e.g PharmD) and experience than Australian pharmacists have at point of registration. Some countries still have large variations in prescribing authorities between their states, provinces and territories, despite more than a decade of pharmacist prescribing. Some of the drugs that overseas pharmacists prescribe are *already* able to be provided by Australian pharmacists over the counter via Schedule 3 (pharmacist-only) medicines. Conversely there are some medicines our pharmacists can dispense without medical prescription which overseas pharmacists cannot.

- For example, in the UK, community pharmacists cannot provide Ventolin puffers over the counter, yet in Australia, pharmacists can dispense these without a prescription.
- Similarly in the USA, community pharmacists cannot dispense the equivalent of Combantrin with Mebendazole (worm tablets) without a prescription, whereas Australian pharmacists can supply these over the counter.

There is a statement that "[i]ndependent prescribing occurs in the UK and Alberta, Canada". Whilst the RACGP acknowledges that the UK and Alberta both have "independent prescribers", the models in each country, registration requirements and education and training standards are not exactly the same. The UK model includes both "independent" and "supplementary" prescribers.

Safety and effectiveness

RACGP does not intend to comment on trials undertaken in hospital settings as this is outside the scope of primary care. However, hospital settings have good governance, access to medical practitioner support (for diagnosis) and are better settings for collaborative prescribing than retail pharmacy.

A review[18] of pharmacy services in Canada in 2016 highlighted that the availability of good-quality evidence on the effectiveness and cost-effectiveness of community pharmacy interventions and programs remains a continual challenge. There are issues with research employing before-and-after study designs as opposed to randomised controlled trials, and there is a lack of connection between interventions and health outcomes and cost effectiveness. The lack of appropriate reimbursement models seems to be a key challenge. Compensation models can incentivise behaviours. Fee-for-service without appropriate quality monitoring and oversight can result in perverse incentives such as high volume of services (and overprescribing) rather than focussing on appropriateness of service. Remuneration models that emphasize volume without guidelines to ensure appropriateness of service, may result in unnecessary care and costs.

When there is no separation of pecuniary interests for dispensing and prescribing there is additional risk of overprescribing.

- A 2021 Australia study showed the dramatic rise in topical chloramphenicol prescribing after it was rescheduled to pharmacist only in 2010.[19]
- Following the reclassification of chloramphenicol, there were significant increases in the supply of the ophthalmic antibacterial in both England and Wales.[20,21,22]
- In New Zealand, the most commonly prescribed medicines by non-medical providers were antibiotics and analgesics.[23] An analysis of New Zealand community pharmacy prescribing habits found that use of trimethoprim was high and norfloxacin use could also be reduced further and many prescriptions were for a dose or duration outside those recommended in New Zealand guidelines.[24]
- In the United Kingdom, when the number of pharmacist prescribers tripled it coincided with a five-fold rise in the number of items prescribed by pharmacists outside of hospitals in England in the same timeframe.[25]
- The Queensland Urinary Tract Infection Pharmacy Pilot (UTIPP-Q) which allowed pharmacists to prescribe antibiotics for uncomplicated UTI in women aged between 18 and 65 years of age, showed evidence that less than 1% (5) pharmacies provided about 10% of the scripts for antibiotics during the pilot duration to which the report offers little to no explanation.[26]

Systematic reviews

The Weeks et al Cochrane Review was provided in support of pharmacist prescribing. However, RACGP would like to highlight that the analysis of this Cochrane Review by Duarte et al found that the non-medical prescribers frequently had medical support available to facilitate a collaborative practice.[27,28]

RACGP does not intend to comment on trials undertaken in hospital settings as this is outside the scope of primary care. However, hospital settings have good governance processes and are medically supported multidisciplinary team-based settings which provides better opportunity for collaborative prescribing.

Pharmacist prescribing in residential aged care

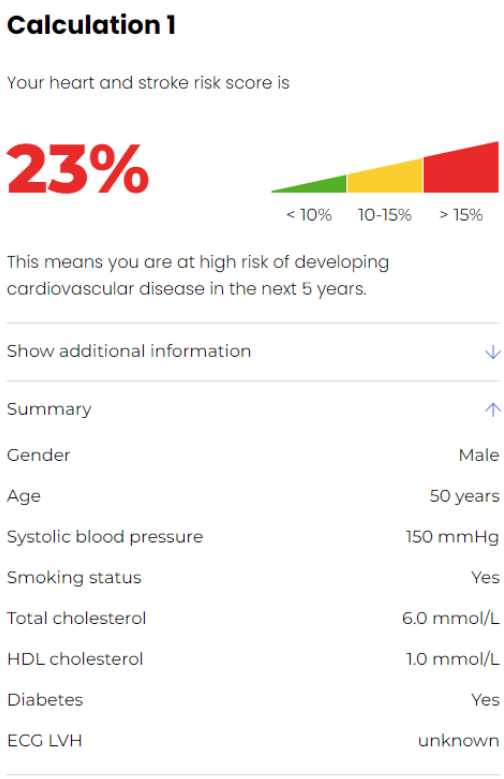
RACGP recognises the benefits of pharmacists working in residential aged care facilities (RACF), particularly when transitioning from hospital back to RACF. Pharmacists in these settings will hopefully form relationship with patient's GP. RACGP notes that the APC is developing separate standards for pharmacists working in aged care. Therefore, it should be clear whether there is any overlap in the standards.

Pharmacist prescribing in primary care

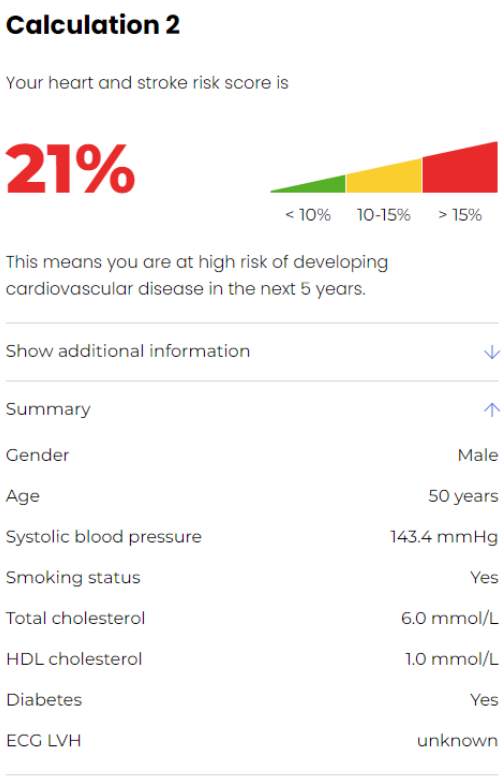
RACGP notes that the focus is on trials conducted by community pharmacists. The blood pressure studies appeared to be short-term trials with surrogate end points and neglect to discuss the Hawthorne effect of regular face-to-face blood pressure checks. The paper from Tsuyuki et al., was highlighted as demonstrating a clinically important statistically significant reduction in blood pressure (6.6mmHg). RACGP does not believe that this adequately translates to an improvement in cardiovascular risk as demonstrated in Figure 1 below. An earlier meta-analysis of randomised controlled trials found that pharmacist interventions had differential effects on blood pressure "from very large to modest or no effect; and determinants of heterogeneity could not be identified. Determining the most efficient, cost-effective, and least time-consuming intervention should be addressed with further research".[29]

Figure 1: Using https://www.cvdcheck.org.au for a fake hypertensive patient who had (a) initial systolic blood pressure 150mmHg and (b) reduction in blood pressure of 6.6mmHg to 143.4mmHg.

a.



b.



There is no international evidence provided in the literature review for pharmacists prescribing within general practice settings. This seems like a gap in research which could potentially demonstrate better patient health outcomes and cost-effectiveness.

5.1.8 Australian studies investigating pharmacist prescribing

Pharmacist prescribing in the hospital setting
RACGP does not intend to comment on trials undertaken in hospital settings as this is outside the scope of primary care. However, the RACGP does believe this setting provides a medically supported multidisciplinary team-based setting to support collaborative prescribing.

However, hospital settings have good governance, access to medical practitioner support (for diagnosis) and better setting for collaborative prescribing.

Implementation
No additional comments.

Charting
No additional comments.

Discharge prescribing
No additional comments.

Medicines initiation
No additional comments.

5.1.9 Pharmacist prescribing in the primary care setting

Management of minor ailments
No additional comments.

Pharmacist vaccination – vaccination does not require diagnosis
No additional comments.

Pharmacist prescribing for urinary tract infections in Queensland
RACGP has already provided comment via this submission.

North Queensland Community Pharmacy Scope of Practice Pilot (NQCPSPP)
RACGP has already provided public comment regarding our safety concerns with this pilot. RACGP believes this pilot far exceeds the scope of practice of pharmacists. The pilot is managing conditions that go beyond the traditional definitions of minor ailments (non-complicated medical conditions which can be self-diagnosed and managed with or without the support of a healthcare professional). The NQCPSPP would require pharmacists to have skills in developing a differential diagnosis, performing a clinical assessment of deterioration or a need for change in chronic disease management and managing uncertainty and these are not the foundational skills of pharmacists. RACGP has concerns about the conflation of diagnosing and prescribing skills. A post-graduate certificate is not a substitute for a decade of medical training. Pharmacists do have the opportunity to enrol in a medical degree to learn medical skills.

Pharmacy reform in New South Wales
RACGP has already provided feedback to the New South Wales Government and commented publicly about the pharmacy reforms involving trials in retail pharmacy.

Victorian Government pharmacist prescribing trial
RACGP has already provided feedback to the Victorian Government and commented publicly about the pharmacy reforms involving trials in retail pharmacy.

Continued dispensing
RACGP believes that the provisions within the National Health (Continued Dispensing) Determination 2022 and PBS Continued Dispensing Arrangements are sufficient. Whilst this wasn't specifically mentioned, RACGP is of the view that continued dispensing (for one month or shorter supply) is not prescribing as another prescriber has already undertaken this task when providing the initial prescription.

Pharmacist prescribing in general practice

RACGP believes that the term "General practice***-based*** pharmacist" should be used rather than "General practice pharmacist" because the latter is often shorted to "GP pharmacist" and this can be misleading for patients who may think the health professional is both a GP and a pharmacist. Or could be misunderstood as a pharmacy located in a general practice.

RACGP is supportive of pilots for collaborative prescribing models within a general practice setting where a GP is available to diagnose and provide support to the pharmacist. However, these pilots would require medical diagnosis by medical practitioner and would require rigorous evaluation of patient health outcomes and cost-effectiveness.

5.1.10 Studies investigating stakeholder views of prescribing

Consumer views

With respect to consumers, the RACGP does not believe that they have been sufficiently informed on the difference in professional competencies between pharmacists and medical practitioners and therefore patient satisfaction should not be the predominant reason for implementation of pharmacist prescribing. Medical services are designed based upon cost-effectiveness and clinical efficacy rather than consumer surveys without health outcome measures.

Pharmacist views

Whilst some pharmacists may be supportive of expanding the prescribing role, RACGP believes there are concerns from community pharmacy sector that haven't been reflected in this evidence. Refer RACGP comments in 2.2 of this submission.

Difference between views of pharmacists working in different sectors

RACGP notes with interest that community pharmacists appeared to have more confidence in their clinical assessment skills than hospital pharmacists who were more likely to consider prescribing roles limited to specific therapeutic areas and work in medically supported team-based settings. However, if the community pharmacist group is largely retail pharmacists, then RACGP wonders if the hospital pharmacist have self-limited due to having a better informed view of the risks of prescribing.

Views of other professions

RACGP is supportive of pilots for collaborative prescribing models within a general practice setting where a GP is available to diagnose and provide support to the pharmacist. However, these pilots would require medical diagnosis by medical practitioner and would require rigorous evaluation of patient health outcomes and cost-effectiveness. Once there have been appropriately evaluated pilots, RACGP would be able to update its position statements.

5.1.11 Education and training to prescribe

No additional comments.

5.1.12 Studies investigating the cost-effectiveness of pharmacist prescribing

RACGP agrees that there is insufficient evidence to demonstrate cost-effectiveness of pharmacist prescribing.

6. References

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