18 April 2019

Open Letter to Royal Australian College of General Practitioners

I am writing to object to the egregious assertions made in the RACGP's submission to the Pharmacy Board of Australia – 'Pharmacist Prescribing' and the public statements that your President, Dr Harry Nespolon, has made against pharmacists, our role in healthcare, and the future role of pharmacists with regard to Collaborative Prescribing.

The RACGP submission to the Pharmacy Board of Australia makes several unfounded and prejudiced statements in relation to pharmacists being able to prescribe.

Statements such as the "the provision of medical services by health professionals lacking the necessary medical training or registration is an inappropriate and unsustainable solution to address the health needs of Australians and that pharmacists simple do not have the healthcare training required to safely deliver healthcare services" are inflammatory, disrespectful and ignore the five years of university and clinical training undertaken by pharmacists, in addition to ongoing regulated continuing professional development similar to other health professionals.

Indeed, pharmacists have the greatest level of clinical training regarding medicines compared to any other health professional. Indisputably, pharmacists are the medicines experts.

The ageing population, increasing incidence of chronic disease, advances in medicines and health technologies, rising health care costs, evolving health service delivery models, and a need for a responsive health workforce are all factors which have contributed to health practitioners, other than medical practitioners, to be authorised to prescribe within their scope of practice. The RACGP should be well aware that Australia's healthcare system rates poorly on access and equity, an issue Australian pharmacists are all too familiar with, given the rising out of pockets costs that are prevalent in accessing general practice and general practitioners.

These factors, in addition to the alarming incidence of medication-related harm, the availability and access to pharmacist care and our medicines' expertise all add to the need for pharmacists to be able to do more in our health system, including prescribing, just as dentists, midwives, nurse practitioners, optometrists and podiatrists are able to in Australia.

We must recognise and acknowledge that pharmacists already prescribe medicines. As much as the RACGP might like to rewrite history, and to dismiss the vital role that pharmacists in the community play, consumers and pharmacists know that the care that they deliver benefits patients and our healthcare system. Pharmacists already make clinical assessment and diagnoses within their scope of practice and prescribe lower-risk medicines. The Pharmacist Only Medicines schedule, which allows a pharmacist to assess the clinical needs of the patient, make an assessment, communicate and discuss that assessment with the patient and allows them (based on the risk of the medicine) to supply that medicine as well. In this context based on the risk profile of the medicine, pharmacists do both – prescribe and dispense. This vital primary care function of triage and referral, may result in the pharmacist referring the patient to a General Practitioner for additional assessment, without the provision of a medication and with no out of pocket expense to the patient.

The PSA has been very clear about the separation of prescribing and dispensing functions according to the risk profile of the medicine. In addition, we believe that where the independent decision is made to initiate a schedule four or eight medicine, that this should be separated from the dispensing activity. Within a collaborative prescribing agreement between a pharmacist and a general practitioner that the pharmacist, pharmacists should be able to adjust the doses of prescribed medicines to reach treatment targets, to extend the life of a prescription and to order any necessary tests to monitor the safety of the medicine. This role should be able to be performed across sectors, within the hospital, within general practice and importantly because of the accessibility of community pharmacists, within community pharmacy – but again, within a collaborative care agreement.

The outrageous statement “that patients will be exposed to unnecessary risk, including increased incidences of medication misadventure” disregards the fact that there is already an enormous issue around medication-related harm in Australia, many of these medicines prescribed by general practitioners.

PSA’s report Medicine Safety: Take Care 2019 revealed the enormity of the issue of medication-related harm and its cost to our economy. The report found there were 250,000 hospital submissions annually as a result of medication-related problems with an additional 400,000 presentations to emergency departments due to medicine misuse costing $1.4 billion annually.

Three in five hospital discharge summaries, where pharmacists were not involved in their preparation, had at least one medication error and over 90 per cent of patients have at least one medication-related problem post-discharge from hospital.

The evidence is clear, pharmacists have significant potential to reduce the number of medication-related hospital admission and adverse medication events in Australia but are prevented from doing so due to barriers in fulfilling our scope of practice. As experts in medicines, pharmacists can identify medicines that are causing harm and reduce adverse events through monitoring, frequency of patient contact, and through our expertise and knowledge of how medicines interact.

RACGP’s statement that “the business needs of a pharmacy may be prioritised over the needs of patients” blatantly disregards the fact that GPs themselves work in a business that provides services that have their own potential conflicts of interests. All health professionals are subject to professional standards codes and guidelines which demand health professionals place the health and welfare of patients ahead of any other interest. In this context pharmacists are no different to general practitioners.

PSA has stated that clear risk frameworks would need to be put in place for any model for pharmacists’ prescribing to avoid business needs being prioritised over patients. Pharmacists should not be considered any different in the provision of health services to other health professionals.

PSA has argued that collaborative prescribing should be designed so that the pharmacist and the medical practitioner support each other. They are complementary roles that would be designed to actually address the safety concerns of patients in an already fragmented care system. PSA believes pharmacists, medical practitioners, other allied health professionals and consumers should all work together as part of a wider health care team for the benefit of patients.

Pharmacists have long identified and referred patients to doctors to help manage chronic disease and believe that any future collaborative prescribing model would strengthen and enhance these partnerships.

It is essential that all health professionals work together for the benefit of patients as part of health team and PSA is disappointed that RACGP has chosen to diminish the role of pharmacists and their role as a trusted, patient-focused health care professional rather than work together towards fostering relationships and models of care that will greater benefit all Australians.

Yours Sincerely,

Dr Chris Freeman

National President

Pharmaceutical Society of Australia