New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

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By email: consultations@pharmacycouncil.org.nz

Pharmacist Prescriber Competence Standards

Dear Michael

Thank you for inviting the New Zealand Medical Association (NZMA) to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Board and Advisory Councils.

We note that the current version of the Pharmacist Prescriber competence standards was published in 2010 as part of the development of the prescriber scope of practice. We understand that there are presently 36 Pharmacist Prescribers holding an annual practising certificate in the Prescriber scope of practice.

The NZMA is broadly comfortable with the proposed revised competence standards for Pharmacist Prescribers registered under the Prescriber scope of practice. However, given the need for close integration with other relevant expertise, we believe the draft standards need to describe more explicitly the role of Pharmacist Prescribers with respect to multi-disciplinary teams and the importance of close liaison, including shared records and closely adhering to true scopes of practice and competencies. This is particularly important given that the schedule of permitted medicines includes over 1200 items, many of which need highly specialised prescribing and for which senior medical specialists have long advocated very tight restrictions on the basis of the medicines' or underlying medical conditions' highly specialised nature. Examples include zonisamde (refractory epilepsy), vinorelbine/vincristine (cytotoxic poisons), mesna (not even registered for use in New Zealand, albeit highly necessary to prevent haemorrhagic bladder complications with ifosfamide chemotherapy), natalizumab/fingolimod (relapsing-remitting multiple sclerosis, significant risks of fatal progressive multifocal leukoencephalopathy with natalizumab), ambrisentan (pulmonary arterial hypertension, a diagnosis and with treatments

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really reserved to 4–5 senior clinicians in New Zealand. Safely prescribing such medicines requires decades of experience/training, beginning with the foundational breadth of medicine.

We note that Council intends that these competence standards could provide the basis for a joint set of prescribing competencies for all prescribers practising in whatever scope of practice (including Medicine), and that this idea has the full support of the Director General of Health. The NZMA has previously expressed concerns with the concept of a single competency framework for all prescribers. Our view remains that the prescribing of medicines is not a discrete activity but rather a tool in the practice of medicine and the overall care of the patient. Prescribing cannot be considered in isolation from diagnosis and/or monitoring of disease progression. These require knowledge and skills built on years of study of anatomy, pathology and physiology, accompanied by training in clinical methods. For this reason, we have previously called for non-medical prescribing to take place under a delegated model of prescribing that we believe would mitigate the risks involved in non-medical prescribing while achieving the collaborative team based care that is the shared objective of the medical and non-medical healthcare professions. This continues to be our position although we understand that a new Therapeutic Products Act may disestablish existing categories of prescribers.

With respect to the proposed revised competences relating to assessing the patient, particularly competencies 1.1 and 1.4, we suggest that it would be useful to stipulate ensuring privacy given concerns that have been raised about the lack of privacy when assessing patients in some pharmacies. With respect to proposed revised competencies about considering the options, we suggest reordering these such that competency 2.4 (Identifies non-pharmacological options) is placed above competency 2.3 (Identifies all pharmacological treatment options). We also suggest that it would be useful to give greater emphasis to equity, perhaps by including an overarching statement at the beginning of the document or in section one.

We suggest that the revised competencies include a point about assessing family history (for example, drug allergies, sudden death and medicines that prolong the QTc interval). There is also a view that the prescriber competence standards should include continuing education although we note that these may be covered in the general competence standards. Finally, we suggest that it would be useful to mention and encourage electronic prescribing, perhaps in competency 4.9.

We hope our feedback is helpful.

Yours sincerely

Dr Kate Baddock
NZMA Chair