New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

4 August 2021

Ministry of Health
Wellington

By email: pharmacy@health.govt.nz

Proposed amendments to the schedule of specified prescription medicines for designated pharmacist prescribers

Dear Colleague

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with about 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, Advisory Councils and members.

We note that the Pharmacy Council has recommended the addition of 198 prescription medicines to the schedule of medicines for designated pharmacist prescribers as well as 3 controlled drugs to the schedule of controlled drugs. We understand that the existing schedule of 1,517 prescription medicines has been in effect since the Medicines (Designated Pharmacist Prescribers) Regulations passed into legislation in 2013. We are aware that pharmacists who wish to prescribe are required to have an additional qualification to be registered with a pharmacist prescriber scope of practice and must prescribe within a collaborative and multidisciplinary health team setting.

We have serious concerns with the proposed amendments due to the very specialised nature of many of the medicines on the list. Several of these medicines should only be used in highly specialised settings and under specialist medical supervision. We are particularly concerned by the proposed inclusion of several anaesthetic medicines including alfentanil and some muscle relaxants. We cannot envisage when, or why, it would ever be appropriate or necessary for pharmacists to prescribe such medicines, even within a multidisciplinary health team setting. Anaesthetists undergo years of training and supervision to learn how to use these medicines, and then only administer them in highly controlled circumstances with sophisticated equipment and monitoring.

We have similar concerns at the proposed addition of obstetric and gynaecological medicines. We cannot conceive of a role for pharmacists to prescribe Carboprost or Dinoprostone, both of which are used for treating post-partum haemorrhage in the emergency situation. The drug Mifepristone is used for managing missed miscarriages or for early medical abortion (EMA). The former indication will have been diagnosed by a GP, midwife or obstetrician, all of whom would then write the prescription. It is not something a pharmacist would be diagnosing. EMA care requires experience in the diagnosis and management of early pregnancy complications and is best provided in a multidisciplinary team of health practitioners who have knowledge and experience in sexual and reproductive health or gynaecology and obstetrics. After an EMA, people require follow up to ensure a successful abortion and absence of complications. We do not believe that pharmacists in New Zealand are currently well placed to provide safe and effective abortion services.

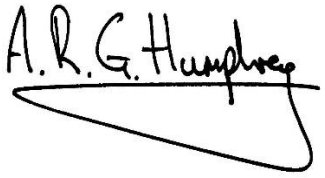
Our view is that the case for the proposed amendments has not been satisfactorily made. We note that the stated rationale for amending the existing schedule of specified prescription medicines for delegated pharmacist prescribers is that "additional medicines have become available in New Zealand, to which wider access would benefit patients". Yet 89 of the 198 proposed medicines on the list are not yet approved for use in New Zealand. It would be concerning if pharmacists are actively seeking to prescribe unapproved medicines under Section 29 of the Medicines Act 1981. We ask the Ministry to share any data it may have on the extent of current pharmacist prescribing as well as any evidence of the impacts of pharmacist prescribing on access to medicines.

While a delegated pharmacist prescriber scope of practice requires work in a collaborative health team, such a team could be comprised of a pharmacist, a nurse who works for them, and a pharmacy technician. Accordingly, we would like to see a specification that pharmacist prescribers must work in a multidisciplinary team that includes a medical practitioner. While there may be some value in differentiating between initiating and repeat prescribing for some of the proposed medicines, continuation prescribing still entails considerable responsibility and consideration of various clinical factors.

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 nonmedical 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.

We hope our feedback is helpful.

Yours sincerely



Dr Alistair Humphrey
NZMA Chair