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SUBMISSION

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AMA submission on the consultation of the revised National Prescribing Competencies Framework

Introduction

The Australian healthcare system is increasingly facing the challenge of improving community access to medicines amid workforce shortages and rising demand from growing and ageing populations with increased chronic disease. The Australian Medical Association (AMA) is at the forefront of discussions relating to workforce solutions and non-medical prescribing. The AMA holds concerns with non-medical prescribing, which is when healthcare professionals — such as pharmacists and nurses, for example — who are not medical practitioners prescribe prescription-only medicines to patients.

If healthcare is to be safe, effective and evidence-based in Australia, non-medical prescribers must be required to work collaboratively with medical practitioners to avoid care fragmentation and ensure patient safety. Appropriate regulations, clinical governance guidelines, protocols, monitoring, and evaluation of frameworks will also need to be implemented to ensure these models are safe and effective. In the context of collaborative settings, non-medical prescribers have increased responsibility within their scope of practice, and are usually implementing recommendations accepted by the patient and the medical practitioner as part of collaborative team-based care.

The National Prescribing Competencies Framework has significant proposed changes that build on those made during the last revision. We are concerned the framework has insufficient regard to the potential for inappropriate models of prescribing to emerge, particularly models which fall outside a collaborative model where a medical practitioner has clinical leadership. The fragmentation of prescribing presents a real risk to patient safety, and medicines management is a high skill which presents opportunities for catastrophic events to occur. The AMA is concerned the framework and proposed changes will accelerate this problem. The AMA position on medicines and prescribing is outlined in the AMA 10 Minimum Standards for Prescribing position statement.

While concerns around fragmentation in healthcare delivery are valid, it is equally important to highlight the positive evidence supporting effective care coordination, particularly in the context of medicines management. Medicines management is a highly skilled area of practice, where coordinated care plays a critical role in ensuring patient safety and therapeutic efficacy. Recognising

and reinforcing the value of integrated approaches can help mitigate risks and enhance outcomes, especially in complex medication regimens where the potential for error is significant.

To ensure consistency and uphold the integrity of the Australian Medicines Framework, it is essential to resolve the ongoing discrepancies between national and state-based medicines laws.

1. Do you support option 1 or option 2? Please provide details as to your preferred option.

In principle, the AMA supports updating the framework with the view that changes to the framework address the concerns raised in this submission.

Receiving training in safe prescribing does not mean a practitioner will then appropriately prescribe. The decision on diagnosis, management and medication prescription are all outside of the action of prescribing which can evoke potential error in the prescribing process. Therefore, non- medical prescribers must be held accountable for their actions in the same way medical prescribers are.

2. The revised framework aims to empower the person receiving care to actively participate in shared decision-making with their health professionals. Do you agree with this? Why/Why not?

The AMA agrees the person receiving care should be part of the decision-making process with their healthcare professional. Care must be patient-centred, with patients actively involved in their treatment decisions and their needs and concerns kept at the forefront of care.

3. One new competency around 'off-label' prescribing has been added. Do you have any feedback or suggestions regarding this new competency and supporting examples?

The addition of Competency 4.2, off-label prescribing may be clinically appropriate in some instances, but there are clinical, safety, ethical, medico-legal and financial issues related to off-label use that must be considered. The AMA supports the guiding principles for the quality use of off-label medicines developed by the Council of Australian Therapeutic Advisory Groups for public hospitals. [1] For example, the AMA is particularly cautious about the use of Ozempic for off-label purposes.

Only medical practitioners have the rigorous background training to have achieved adequate competence in understanding all aspects of the biopsychosocial model, thus enabling them to have

[1] Council of Australian Therapeutic Advisory Groups. (2013). Rethinking Medicines Decision-making in Australian Hospitals: guiding principles for the quality use of off-label medicines.

adequate judgement to prescribe off-label safely. Because off-label prescribing can be very dangerous, it should be prescribed only by medical practitioners.

The review should consider the guiding principles mentioned above. It outlines the following:

a) off-label use of a medicine should only be considered when other options are unavailable, exhausted, not tolerated or unsuitable
b) the patient/carer must be fully involved in decision-making
c) outcomes, effectiveness and adverse events should be monitored and reported to facilitate evidence-based decisions.

4. Would the revised framework result in any potential negative or unintended effects for people requiring healthcare?

Yes. The AMA raises concerns in relation to negative impacts in the instance where the framework is used in the context of independent non-medical prescribing.

Patient safety

Non-medical prescribers do not have the necessary expertise or experience to autonomously diagnose conditions, assess patients, and make decisions about prescribing medicines outside of collaborative healthcare settings. Non-medical practitioners do not receive the detailed training, nor have extensive experience and knowledge to safely diagnose and prescribe medicines autonomously, particularly in an environment of growing complexity of chronic disease.

There are concerns of autonomous non-medical prescribing models resulting in overprescribing of medicines, as studies on collaborative models reveal non-medical prescribers often initiate and prescribe more drugs and titrate drugs to a higher dose compared to medical prescribers. [2] [3] They lack the training to weigh up the potential risks and benefits of other treatments, as they are only authorised (and therefore trained) to diagnose and prescribe within their limited scope of practice. Additionally, like medical prescribers, non-medical prescribers feel pressure from patients to prescribe medicines. [4] However, non-medical prescribers do not have access to the range of

[2] Cohen, L. B., Taveira, T. H., Khatana, S. A. M., Dooley, A. G., Pirraglia, P. A., & Wu, W. C. (2011). Pharmacist-led shared medical appointments for multiple cardiovascular risk reduction in patients with type 2 diabetes. *The Diabetes Educator, 37*(6), 801-812. Doi: 10.1177/0145721711423980

[3] Ansari, M., Shlipak, M. G., Heidenreich, P. A., Van Ostaeyen, D., Pohl, E. C., Browner, W. S., & Massie, B. M. (2003). Improving guideline adherence: a randomized trial evaluating strategies to increase β-blocker use in heart failure. *Circulation, 107*(22), 2799-2804. Doi: 10.1161/01.CIR.0000070952.08969.5B

[4] Lum, E.P.M., Page, K., Whitty, J.A., Doust, J., & Graves, N. (2018). Antibiotic prescribing in primary healthcare: Dominant factors and trade-offs in decision-making. *Infection, Disease & Health, 23*(2), 74–86. Doi: 10.1016/J.IDH.2017.12.002

alternative treatment options that a medical practitioner has access to, and do not have the knowledge and experience to consider differential diagnoses.

Continuity of care

While collaborative non-medical prescribing models can maintain continuity of care, the AMA raises concerns of autonomous prescribing models fragmenting care, resulting in missed diagnoses, inappropriate prescribing, and failure of preventative medicine. [5] The pharmacy prescribing trials, increases in registered nurse prescribing via urgent care centres, and nurse practitioners prescribing out of pharmacies are causing fragmentation of patient care. These practitioners sit in siloed environments where continuity of care with a general practitioner does not exist. We must look at models where there is good evidence around care co-ordination and not look to further silo practitioners.

Prescribing practices and conflicts of interest

There is clearly a conflict of interest when a prescriber — medical or non-medical — is employed by or contracted with any organisation that has the underlying intent of making corporate profits in the setting of patient care. The less knowledge and education one possesses makes one more vulnerable to the manipulations of corporate interests and less capable of advocating for the patient. Clearly having non-medical health practitioners housed within a pharmacy is a conflict of interest and will lead to inappropriate prescribing as well as over prescribing. This principle should be embedded in policy to prevent misuse and uphold ethical standards in clinical practice.

The AMA acknowledges the attempt of the framework to address this in competency 7.6 (d), however, poor prescribing practices can lead to patients receiving treatments not appropriate for their condition, which can be detrimental to their health. It also results in increased costs to the patient and healthcare system, medicine wastage and shortages, and — in the case of antimicrobials — antimicrobial resistance. [6]

Prescriber confidence

Prescribing medicines requires a high level of knowledge and skills, including the ability to accurately diagnose a condition, choose appropriate medicines, and monitor and manage effectiveness and potential side effects. Studies reveal non-medical prescribers feel as though they lack confidence in prescribing, despite receiving additional education and training. This may be due to a variety of reasons, including limited access to medical expertise, the need for further education and training

[5] Price, K., & Dawson-Smith, S. (2023, January 26). *GPs dissect pharmacy prescribing folly.* NEWSGP. Retrieved 09/04/2025 from: https://www1.racgp.org.au/newsgp/gp-opinion/gps-dissect-pharmacy-prescribing-folly

[6] Australian Medical Association (2022). *Antimicrobial resistance: the silent global pandemic.* Retrieved 09/04/2025 from: https://www.ama.com.au/antimicrobial-resistance

(including supervised training), lack of familiarity with medication guidelines, and infrequent use of prescribing authority. [7] [8] [9] These challenges related to prescriber confidence could be mitigated through collaborative prescribing models led by medical practitioners, ongoing education and training programs, and ongoing professional development opportunities.

5. Would the revised framework result in any potential negative or unintended effects for Aboriginal and Torres Strait Islander peoples?

Yes. For the reasons mentioned in question 4.

6. Is the content of the proposed framework clear and reflective of safe, contemporary and ethical prescribing practice?

Models of prescribing are moving forward at alarming rates. Pharmacist prescribing trials are being given permanent status without evaluation, and bypassing established national processes with respect to the approval of pharmacist prescribing. The AMA remains concerned the framework and proposed changes do not consider these developments or seek to promote best practice models of prescribing. We also note pharmacist prescribing involves inherent conflicts of interest and undermines the long-standing separation of prescribing and dispensing that has been a key safety mechanism in the Australian context.

Public health risks emerge in the instance of unnecessary or inappropriate prescribing. The AMA is particularly concerned about the rising trend and the significant risk of antimicrobial resistance spreading through the over-prescription of antibiotics. This is not a small risk, and given the emerging evidence, it is irresponsible for any discussions of prescribing to not include specific risk analysis related to antimicrobial resistance. The AMA has called for all future expanded prescribing protocols to include a specific protocol to measure and report on antimicrobial resistance. The AMA welcomes the framework noting consideration of this specific aspect in reflecting ethical and safe prescribing in competency 2.9 (a).

[7] Woit, C., Yuksel, N., & Charrois, T. L. (2020). Competence and confidence with prescribing in pharmacy and medicine: a scoping review. *International Journal of Pharmacy Practice, 28*(4), 312-325. Doi: 10.1111/ijpp.12595

[8] Maddox, C., Halsall, D., Hall, J., & Tully, M. P. (2016). Factors influencing nurse and pharmacist willingness to take or not take responsibility for non-medical prescribing. *Research in Social and Administrative Pharmacy, 12*(1), 41-55. Doi: 10.1016/j.sapharm.2015.04.001

[9] Khumra, S., Mahony, A. A., Bergen, P. J., Page, A. T., & Elliott, R. A. (2021). Exploring the practice, confidence and educational needs of hospital pharmacists in reviewing antimicrobial prescribing: a cross-sectional, nationwide survey. *BMC medical education, 21*(1), 1-10. Doi: 10.1186/s12909-021-02664-1

7. Is there any specific content that needs to be changed, added or removed in the proposed revised competencies and / or supporting examples? If yes, please provide details.

The AMA would like to take this opportunity to restate its general position in relation to models of non-medical prescribing. The AMA supports collaborative models of healthcare where non-medical health practitioners work as part of a medically led team around the patient.

Non-medical prescribing may only occur in specific situations underpinned by the following principles:

- Non-medical prescribing occurs in a medically led and delegated team environment
- Non-medical prescribing occurs in the context of 'role delegation' not 'task substitution'
- There must be formally documented, collaborative arrangements ensuring:
    - diagnosis, ongoing monitoring, and evaluation of adverse events by a medical practitioner
    - clear lines of accountability and responsibility
    - separation of prescribing and dispensing (with limited exceptions as appropriate in rural/remote circumstances)
- Non-medical health practitioners must have core skills and appropriate competencies for safe prescribing attained by completing high quality, accredited education, and training courses
- Course curriculum must meet core competencies in determining when not to prescribe and/or when to refer patients to a medical practitioner
- As occurs for medical practitioners, non-medical health practitioners should be closely supervised during their first years of prescribing practice
- No clinician should be allowed to prescribe without the ability to physically examine the patient in a timely manner. This examination should be conducted by a practitioner operating under the same clinical governance structure and using the same patient records system
- Non-medical health practitioner prescribers must bear risk for their prescribing decisions.

Models of non-medical prescribing supported by the AMA include:

- continuation of therapy initiated by a medical practitioner as the predominant model and continue to remain with medical oversight.

Where this is not practicable or possible:

- prescribing by a protocol or limited formulary
- initiating therapy according to protocol or symptoms
- continuing, discontinuing, and maintaining therapy according to a pre-approved protocol.

The framework can be interpreted as a means of non-medical health professionals engaging in independent assessment for the purpose of making prescribing decisions. As detailed above, medical practitioners are currently the only health professionals trained to fully assess a person, initiate further investigations, make a diagnosis, and understand the full range of clinically appropriate

treatments for a given condition, including when to prescribe and, importantly, when not to prescribe medicines.

Medical practitioners have undertaken 10–14 years of training. Using their training, they holistically assess, examine, investigate, diagnose, refer and co-ordinate multidisciplinary teams for patients. Therefore, a consultation between a medical practitioner and a patient is not a simple transaction about prescribing a medicine, it is a process of differential diagnosis where a range of treatments and management pathways are considered in the context of the patient. Consultations allow for opportunistic discussions with patients about a range of health needs, including evidence-based prevention and screening services.

Continuation of Therapy and deprescribing oversight

The AMA recommend strengthening the policy around the continuation of therapy model. While continuity of care is important, this model must not become a loophole for patients to obtain repeat prescriptions without appropriate medical oversight. This approach supports both patient safety and the principles of quality use of medicines.

To safeguard against this:

- Continuation of therapy should be time-limited, with a maximum duration (e.g., 1–2 years) defined for each medicine
- all continuation prescriptions must be reviewed periodically by a medical practitioner
- deprescribing should be actively considered as part of rational medicines use, ensuring that ongoing therapy remains clinically justified.

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