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AMA submission to NPS MedicineWise – Prescribing Competencies Framework Review

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Introduction

The AMA thanks NPS MedicineWise for the opportunity to provide feedback on the Prescribing Competencies Framework (the Framework) Review.

The AMA regards the existing Framework as a critical document to set out basic competencies required for prescribing. The Framework is essential for patient safety and the Quality Use of Medicines.

While the AMA understands that NPS MedicineWise aims to simplify the structure and language of the Framework, the AMA believes that significant prescribing competencies have been lost in the process. The AMA is concerned that in doing so may be considered as an invitation for other health professionals to expand their scope of practice when this is not in the best interests of patients. This has serious consequences for the safety and quality of prescribing in Australia.

AMA's 10 minimum standards for prescribing

The AMA has developed 10 minimum standards for prescribing[1,2] some of which the revised Framework does not align with. Most notably not aligned are Standards 1, 2, and 5 (see Appendix).

Prescribing by non-medical health practitioners

AMA Standard 1 states that 'Prescribing by non-medical health practitioners should only occur within a medically led and delegated team environment in the interests of patient safety and quality of care.'

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

[1] Australian Medical Association (2019) *AMA 10 minimum standards for prescribing*
[2] See also Australian Medical Association (2019) *Medicines 2019 position statement*

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

Prescribing is not an independent action. It should be considered only as a part of, or as a result of, a medical assessment with a holistic view of the patient and diagnoses, offering options and informed consent in a consultation, followed up by a review. Only a registered medical practitioner who has a wide knowledge of medicine and the patient's condition should carry this out.

The draft revised Framework's reference to a 'shared prescribing process' may be misinterpreted to state that other health professionals are equal decision makers in the prescribing process when the responsibility lies with the prescriber. The AMA recommends changing this to 'person-centred prescribing process'. This still recognises that patients' goals and preferences are central to prescribing while avoiding misinterpretation.

Competency Area 1 should be renamed from 'understands the person and their clinical needs' to 'understands the person, their diagnosis, differential diagnosis, and clinical needs.' The AMA is concerned that the Framework does not emphasise the importance of being able to diagnose a medical condition to be able to prescribe. These must come hand in hand. The existing Framework under 1.2.6 places an emphasis on the prescriber's ability to prepare and perform examinations on the patient however this is largely missing in the draft revised Framework. Instead there is more of an emphasis on reviewing examination information. While this is important for any prescriber, they must also be able to perform and interpret the clinical examinations necessary to prescribe and diagnose.

The AMA also supports a system of mandatory referral to a registered medical practitioner where appropriate clinical criteria and outcomes are not achieved within a specific timeframe.

Pecuniary or non-pecuniary benefits

AMA Standard 2 states 'There must be no pecuniary or non-pecuniary benefit to the prescriber related to the choice of medicines prescribed or the dispensing of those prescribed medicines.'

To ensure there is no perceived or actual conflict of interest in prescribing a medication to a patient, no benefit to the prescriber can be afforded for prescribing a specific medication or combination of medicines or the dispensing of those medications. In addition, to facilitate safer prescribing and ensure a system of checks and balances the functions of dispensing or administering medicines must be separate from the function of prescribing.

While the draft revised Framework states that prescribers should (at 7.6) 'implement strategies to address influences that may bias prescribing decisions', it does not state a hard line on prioritising the patient's interests over prescriber biases or avoiding pecuniary or non-pecuniary benefits[3]. Prioritising the patient and avoiding conflicts of interest is an important distinction to make instead of just 'addressing' them.

[3] See also: Australian Medical Association (2016) *AMA Code of Ethics 2004. Editorially revised 2006. Revised 2016.*

Clinical independence

AMA Standard 5 states 'prescribers must maintain clinical independence'.

Prescribers must exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by external parties[4]. Patients have an expectation that their prescriber is making a professional judgement based on their clinical expertise, professional rules, standards and evidence, using the resources they have available. The draft revised Framework should include a line on maintaining clinical independence that mirrors the intent of the AMA's Standard.

The AMA notes that prescribers should carry out communication that is respectful of the other health professional's expertise within their scope of practice. Similarly, under '4.4 Provide clear information to other health professionals when implementing new medicines or modifying existing medicines or treatment plans', 'timely' should be inserted before 'information' to recognise respectful communication with other health professionals, to reduce the risk of fragmentation of care and medication related adverse events, and promote the coordination of holistic care across the healthcare team.

Missing standards from the existing Framework

The AMA has determined several missing Standards from the existing Framework in the draft revised Framework that should be kept.

Knowledge, skills and behaviours sections

The AMA notes that the knowledge, skills, and behaviours section has been removed under the draft revised Framework. The AMA is particularly concerned that this section for Competency Area 1 has been removed. Prescribing is a complex process that requires years of clinical training and experience. Prescribers must have knowledge in the educational fields outlined on page 12, such as clinical medicine, medicinal chemistry, anatomy, physiology, and pathology. In addition to those listed on page 12, organic and inorganic chemistry and biochemistry should be included. Only after completing an educational program that offers this level of core training, would a health practitioner meet the competency requirements to prescribe.

Prescribers have professional responsibility for their patients and need to understand indemnity insurance and implications of their practice, medico-legal risks of prescribing medications. This has been removed in the draft revised Framework. Prescribers must understand that in addition to risks to the patient there are also professional risks to prescribing that they need to prevent and prepare for.

[4] World Medical Association (2018) *WMA declaration of Seoul on professional autonomy and clinical independence.*

The role of medical practitioners

In Australia, a general practitioner is a patient's main healthcare provider. The AMA notes that under Competency Area H2 of the existing Framework this is acknowledged, however is removed in the draft revised Framework. This change is contrary to promoting the concept of the medical home and the general direction of primary care policy in Australia. It undermines efforts to improve continuity of care and may lead to further fragmentation of care, poorer health outcomes for patients and increased costs long-term[5]. The AMA is supportive of multidisciplinary care teams, however not when this excludes general practice. This change does not align with a person-centred approach and ignores the benefits of continuity of care[6].

Ensuring the patient understands their treatment plan

Competency Areas 1 and 3 under the existing Framework emphasised the importance of communication in ensuring the patient and their family/carers understood their medical condition and treatment goals. This appears to be missing in the draft revised Framework. Understanding medication instructions and medication adherence is associated with health literacy[7]. Prescribers should consider the level of health literacy their patient and their family/carers have and adapt their communication accordingly to ensure understanding.

Evidence to inform decision-making

'2.5 - Obtain, interpret, and apply current evidence and information about medicines to inform decision making'

Add the word 'reliable' before 'evidence'. The hierarchy of evidence quality should be recognised. Prescribers must be able to critically analyse evidence and be aware of credible sources to ensure their decision making is based on high quality evidence.

Active ingredient prescribing

Under 4.2 Use the active/generic ingredient name of medicines

The AMA supports the government's initiatives to improve the understanding of active and generic ingredient names of medicines and supports education around ensuring the patient understands the difference between active ingredient and brand name (4.5). However, as with active ingredient prescribing, there are good clinical reasons why a prescriber may prescribe by brand name. For example, older people on multiple medications may be more familiar with the brand name and it is important to avoid confusion. Different brands with the same active ingredient may also have excipient ingredients or different dosage mechanisms that are

[5] Australian Medical Association (2020) *Delivering better care for patients: the AMA 10-year framework for primary care reform.*
[6] Pereira Gray DJ, et al (2018) *Continuity of care with doctors – A matter of life and death? A systematic review of continuity of care and mortality.* BMJ Open.
[7] Australian Commission on Safety and Quality in Health Care (2014) *Health literacy: Taking action to improve safety and quality.*

unsuitable for the patient. The AMA would suggest rewording 4.2 to 'use the active/generic ingredient name of medicines, and the brand name if clinically necessary'.

Conclusion

In its current form, the AMA does not support the draft revised Framework. NPS MedicineWise should work to ensure the Framework aligns with the AMA's 10 minimum standards for prescribing and to ensure important standards from the existing Framework are carried over to the draft revised Framework.

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Appendix: Draft revised Framework alignment with the AMA's 10 minimum standards for prescribing

AMA Standard		Does the Framework align?	Comments
1	Prescribing by non-medical health practitioners should only occur within a medically led and delegated team environment in the interests of patient safety and quality of care.	No	No reference to this in the Framework. References a collaborative care model and a shared prescribing process.
2	There must be no pecuniary or non-pecuniary benefit to the prescriber related to the choice of medicines prescribed or the dispensing of those prescribed medicines.	Partially	The Framework states that prescribers should (at 7.6) 'implement strategies to address influences that may bias prescribing decisions' however does not state a hard line on prioritising the patient's interests over prescriber biases or avoiding pecuniary or non-pecuniary benefits[8].
3	Before prescribing establish a therapeutic relationship with the patient and perform a comprehensive medicines assessment to identify what other medicines, including complementary medicines, the patient is taking and consider any implications to the patient's treatment plan.	Yes	See competency area 1.
4	Prescribers ensure they: a) consider the necessity and appropriateness of medications in managing the patient's health care needs, b) choose the most suitable and cost effective medicines when medicines are considered appropriate, taking into account the efficacy, potential for self-harm and the ability of the patient to adhere to the dosage regimen,	 Yes Yes	 See 2.1 See 2.5, 2.8, 5.1, 5.3, 5.5

[8] See also: Australian Medical Association (2016) *AMA Code of Ethics 2004. Editorially revised 2006. Revised 2016.*

	AMA Standard	Does the Framework align?	Comments
	c) advise patients are aware of the relevant side effects of prescribed medications as well as relevant interactions between medications, and d) report any adverse reactions to the TGA.	Yes Yes	See 2.4 See 6.4
5	Prescribers must maintain clinical independence.	No	No reference to this in the Framework.
6	Prescribers must operate only within their scope of practice and comply with state, territory and legislative requirements including restrictions under the Pharmaceutical Benefits Scheme.	Yes	Does not reference the Pharmaceutical Benefits Scheme specifically however outlines that medicines must be prescribed within regulatory frameworks.
7	Prescribers work in partnership with the patient to set therapeutic goals and with other health professionals as appropriate to select medicines and to tailor and implement a treatment plan.	Yes	See 2.6 and competency area 3.
8	Prescribers provide clear instructions to delegated prescribers within the health care team and to other health professionals who dispense, supply, or administer the prescribed medicines.	Partially	Does not reference delegated prescribers.
9	Prescribers with the patient consent communicate with other health professionals within the patient's health care team about the patient's medicines and treatment plan.	Yes	See 2.6
10	Prescribers monitor and review the patient's response to treatment and adjust the treatment plan as appropriate.	Yes	See competency area 5.