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► **Ms. B. Sullivan, Chair**

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Members of the Health Professions Regulatory Advisory Committee,

I am writing in response to the submissions made by the Ontario College of Pharmacists (OCP) and the Ontario Pharmacists Association (OPA) regarding potential changes to pharmacists' scope of practice. My purpose for responding is twofold. Firstly, in my seven years of practice, I have yet to utilize the full extent of my training and I have a strong desire to apply all of my knowledge in providing patient care. I feel limited in the care I can provide under the current pharmacy laws and regulations. Secondly, and more importantly, I believe strongly and have many real-life examples demonstrating that patients would benefit significantly if I, and other like-minded pharmacists, were able to practice in a manner reflective of their education and training.

I feel it is relevant to share the details of my practice with the members of the Council. I practice in both a hospital and community setting. In both practice environments, I am afforded prescribing privileges based on medical directives.

In the community setting, I provide pre-travel consultations and prescribe travel-related medications and vaccines. Under the context of impending travel, I also authorize renewals of chronic medications such that patients will have an adequate supply for their trip. When merited, I have also partnered in medical directives that allow me to prescribe Schedule II and III medications or change Schedule I medications for patients in order to meet the requirements of their third-party or provincial insurance payers or to accommodate their special needs (e.g., physical disabilities). In all cases, all relevant information is immediately forwarded to the physician(s) participating in the medical directive to ensure continuity of care.

In the hospital setting, I manage anticoagulation and antibiotics via medical directives that allow pharmacists to change doses of medications such as warfarin, gentamicin, tobramycin, and vancomycin based on laboratory results. I have the ability to order certain laboratory tests when needed for medication monitoring. Similar to the

community setting, I also have the ability to independently change a patient's medications, with their knowledge and consent, to reflect the hospital's formulary. In all cases, all relevant information is immediately documented in the patient's chart to ensure continuity of care.

In many ways, I already routinely practice at the levels being proposed by OCP and OPA ... and I still don't feel as though I am practicing to the extent of my education and training. Still, I feel that patients benefit from the above examples of an expanded scope for pharmacists in that they receive timely advice and action from a medication expert to resolve or prevent medication-related problems. The unfortunate reality of working within medical directives is that the population to which they apply is limited. I am routinely forced to turn away individuals who could benefit from my intervention because, for example, they are not a patient of one of the participating physicians. For this reason, I am encouraged by efforts to expand the scope of all pharmacists so that more patients can benefit from our medication expertise.

I would like to emphasize the aspect of timely care from the paragraph above. The reality of health care in Ontario is that patients, if they are fortunate enough to have a family physician, must sometimes wait weeks or months for an available appointment with their doctor. Expanding the scope of pharmacists is one way to address such gaps in care. OCP, and OPA have provided the theory of how this might work, so I would like to provide a real-life example of the urgent need to make these changes to pharmacy practice:

M.L. came into the pharmacy for a MedsCheck appointment with me. She has a medical history that includes chronic atrial fibrillation and hypertension among other conditions. This day she was concerned about prolonged bouts of atrial fibrillation in recent weeks, whereas this condition had been well-controlled in the past. She also disclosed that she felt anxious and jittery and that she had recently tested her blood pressure and it had been much higher than normal. Her INR was also fluctuating much more than usual. She could not get an appointment with her physician as he had moved away and, although she had found a new doctor, it would be several weeks before he was able to see her.

I completed my evaluation of her medications per the MedsCheck protocol, but the scope of the MedsCheck program was inadequate to address her real needs. Having had some training in Medication Therapy Management (MTM), I completed a more comprehensive assessment and gave her a copy of my findings to take to her new physician, including my suspicion that her symptoms were the result of an adverse drug reaction.

Two weeks later, she returned to the pharmacy, having seen her physician. She had a requisition for blood work, including many of the tests I had suggested in my assessment. She wanted to make sure the requisition addressed all of the concerns I had identified during our MTM appointment. She disclosed that she had another appointment with her new physician in two weeks. This was the earliest available slot.

Two weeks passed and M.L. again returned to the pharmacy with a prescription for prednisone. The physician had acted on my suggestion to obtain TSH, T3 and T4 levels, which confirmed my initial suspicion of amiodarone-induced thyrotoxicosis. While relieved that a diagnosis had been made, I was concerned that more intensive INR monitoring had not been ordered given the potential interaction between warfarin and prednisone. In addition, no tapering schedule for prednisone had been provided to M.L., and her prescription for her ongoing proton-pump-inhibitor (PPI) had not been renewed despite the addition of a new risk factor for a GI bleed in a patient on warfarin. I advised M.L. to contact her

physician's office to obtain a prescription for her PPI, a requisition for the blood work necessary to more closely monitor her INR over the coming month while on prednisone, and to ask about tapering this medication at its conclusion. It took a week for her to get an appointment to see her physician to have these needs addressed as the physician did not accept phone calls from pharmacists.

In the end this case is an example of both the benefits of and barriers to inter-professional collaboration. It raises several concerns, all of which could be addressed via an enhanced scope of practice for pharmacists.

- An enhanced MTM assessment was needed to properly identify and act on M.L.'s medication-related problems, the cost of which was not covered by OHIP or her third-party insurance. Allowing pharmacists to be classified as practitioners under the Health Insurance Act and reimbursing them for this type of assessment would help to address this barrier to accessing care.
- M.L. had to wait a total of five weeks for a serious medication-related problem to be addressed. In this case, allowing pharmacists to order lab tests would have cut this time in half and eliminated the need for an additional physician visit, thereby improving care for M.L. as well as freeing up time for the physician to see a different patient in that time slot.
- Despite having her initial problem identified and addressed, M.L.'s new medication therapy necessitated ongoing monitoring and adjusting (INR), which she could not obtain in a timely manner. Allowing pharmacists to order lab tests, to perform point-of-care testing, and to adjust doses of chronic medications would have allowed for an immediate solution to this need.
- M.L.'s new medication regimen put her at risk for a potentially serious adverse drug reaction (G.I. bleed) which could have been at least partially addressed using one of her existing medications (PPI). Allowing pharmacists to renew prescriptions for chronic medications would have ensured this was addressed in a timelier manner.

M.L.'s case is real and there are many other real cases that I could cite to provide evidence supporting an expanded role for pharmacists. However, the resulting suggestions would be similar and would mirror those of OPA and OCP. For the most part, I agree with and support the change to pharmacy practice proposed by OPA and OCP. However, I would also like to provide further suggestions for change based on my experience in practice.

I would like to add to the suggestions made by OPA and OCP for changes to the scope of practice of pharmacists to include the following:

- Piercing of the dermis for the purpose of point of care testing (e.g. blood glucose, INR, cholesterol) and the communication of the meaning of these results of these tests where they relate to medication therapy.

This change would appear to go hand in hand with the ability for pharmacists to adjust the dose of medications based on laboratory results or other monitoring techniques and could have assisted M.L. in the above example.

Furthermore, I wholeheartedly endorse OPA's proposal to extend limited independent prescribing rights to pharmacists. (i.e., "Initiating prescription therapy for minor ailments from a set formulary using an established protocol for assessment." from page 2 of OPA's submission)

I find that OCP's statement:

This College is recommending “dispensing without further authorization from a prescriber subject to terms and conditions” over “prescribing” on the basis that these activities fall within the cognitive aspects of the controlled act of dispensing and are already thus within the realm of the pharmacists scope of practice.

from page iv of its submission ignores the reality of current pharmacy practice. From my earlier description, it is clear that I already prescribe (i.e., initiate therapy) Schedule I medications under a protocol as part of my daily practice. I am quite comfortable initiating prescription medication therapy as are many of my colleagues who practice under similar medical directives. That so many medical directives of this nature exist in the hospital setting and, to a lesser extent, in the community setting suggests that other health professionals accept the medication expertise of pharmacists and the role they can play in prescribing certain types of medication. It also shows that pharmacists are ready to accept this role. Moreover the use of such tools demonstrates the need that already exists in healthcare to circumvent the barriers presented by the current pharmacy laws and regulations so as to provide better care for patients in Ontario.

Outside of medical directives, I “diagnose” minor ailments and “prescribe” Schedule II and III medications pursuant to my “diagnosis” on a daily basis in my practice. There are many occasions where Schedule II and III options for treatment have been exhausted or where Schedule I medications offer more effective treatment of minor ailments. Under the current pharmacy laws and regulations, patients must be referred to a family physician, if they have one, to obtain a Schedule I medication. As I stated earlier, the reality of health care in Ontario is that patients must then sometimes wait weeks for an appointment to treat a minor condition. Moreover, the appointment slot used to see that patient with a minor condition is made unavailable for another patient who may have a more acute need for physician care. When these patients do finally see a physician, I would surmise that they return with a prescription for the exact class of medication I would have suggested in almost all cases. Allowing pharmacists to prescribe (i.e., initiate therapy) for minor ailments from a defined schedule of medications would provide a solution to the above problems and, as such, is clearly in the best interest of patients.

In closing, I hope I have provided some “real-life” examples to support the changes being proposed to pharmacy practice by OPA and OCP and I hope this assists you in moving forward in expanding the role of pharmacists in the healthcare system for the benefits of the citizens of Ontario.

Please feel free to contact me for further information.

Regards,

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Pharmacist

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Past-President

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