

05_PDL _Peta Ann Teague_Scott Ames_Transcript Mastered

[00:00:03] **Nic:** Welcome to be Risk Ready, the PDL podcast your space to explore how risk intersects with pharmacy practice, leadership and professional growth. There's often excitement about the new opportunities that prescribing offers for patient care, but this conversation is about the accompanying questions that follow as pharmacists begin prescribing, important questions arise. What standard will pharmacist prescribers be held to? What records should support prescribing decisions? And where do professional responsibilities begin and end? Amy Minion, host of Be Risk Ready and Pdl's lead pharmacist in education and Professional development, is joined by Peta-Ann Teague, general practitioner and medical lead for James Cook University's Pharmacist Prescribing course and founder of CPD Plus and Scott Ames, principal lawyer at Meridian Lawyers. Together, they'll explore the practical medico legal considerations of pharmacist prescribing and what the expected standard of care may look like for pharmacists undertaking this new scope of practice.

[00:01:16] **Amy:** Good morning, Peta, and welcome to our podcast today.

[00:01:20] **Peta-Ann:** Thank you. Good morning Amy. Lovely to be here.

[00:01:22] **Amy:** And g'day, Scott. Great to have you also.

[00:01:25] **Scott:** Hi. Good to be here too.

[00:01:27] **Amy:** Pharmacist prescribing, as we know, is one of the biggest changes to pharmacy practice we've seen in recent years. And it's generating plenty of discussion about roles, responsibilities, and accountability. At the moment, this role is referred to in a number of ways. But for today, we'll use the term endorsed pharmacist to describe pharmacists who have completed the training and are qualified to prescribe. We're going to dive right in and explore the first theme of standards and accountability. And I'd like to start with Peta-Ann, and if I may. You've had a unique vantage point as both a GP and the medical lead in a pharmacist prescribing course. Would you be able to talk us through how you see the prescribing role being defined and its remit in the healthcare system, and how professional expectations might change when a pharmacist moves from supplying medicines to prescribing them.

[00:02:21] **Peta-Ann:** Yes. Thank you. I think this is a fundamental change for community pharmacists, one which I am very much in support of, because I can see the benefits for patients for access to care. Obviously, what comes with it is a whole change in medico legal risk and responsibilities. And I've got two main points to bring out. First of all, my analogy is that when the flags go up on the beach to swim between the flags, that just designates where you need to swim, it doesn't actually teach you how to swim. And I think one of the disadvantages to the profession has been calling this a prescribing pharmacist, but the decision to prescribe or not to prescribe is based on an adequate and appropriate assessment of an undifferentiated patient, which then leads to a diagnostic process, which then leads to an adequate and appropriate management plan. And so I think that's the real difference in what is happening now in this space for endorsed pharmacists.

[00:03:26] **Amy:** Thanks, Peta-Ann I really love that flags at the beach analogy.

[00:03:30] **Peta-Ann:** Thank you. I'm very proud of it.

[00:03:35] **Amy:** And what pharmacists are trying to get their head around and what this all means in practice. We talk about accountability, sure. But what standards are pharmacists, prescribers ultimately being held to, and is it the same standard they've traditionally worked within as pharmacists, or does that shift once they start making different decisions.

[00:03:55] **Peta-Ann:** I think it's a fundamental shift, and I think one of the difficulties for endorsed pharmacists at the moment, who are at the forefront of this change, is that there isn't really a peer group around them to against which we can measure practice. Now, obviously, the pharmacy board is working really hard behind the scenes to come up with the standards they currently don't exist. Once they do exist, who are we measuring people against and pharmacists against? I think it's a tricky space at the moment, because some of the rhetoric around the change has been, for example, that pharmacists are providing a GP level of care. I don't think that is the case. I think they're providing an endorsed pharmacist level of care. But nevertheless, would it be appropriate if there's a problem arising with endorsed pharmacists practice to measure them against or to assess them against what the patient would have got, for example, had they attended an urgent care clinic or a GP clinic.

[00:04:56] **Amy:** Hmm. That's a different way of thinking clinically altogether. So from your perspective, are there cultural or behavioural shifts that pharmacists may need to make as they move into these roles and take on that greater responsibility?

[00:05:11] **Peta-Ann:** I think it's all I think it's knowledge, skills and attitude. So knowledge for sure, and a sort of consolidation, as well as a development of new skills around clinical reasoning and diagnostic processing. I think that there is a change in the professional persona of an endorsed pharmacist from being at the front counter, chatty, friendly, handing out advice in a quite a friendly way to taking on a very different professional demeanour where you're in a private consultation space with a patient and thinking about that clinician patient boundaries, what that looks like, how to avoid transgression of those boundaries. I think that's very different. I also think that there are some very tricky topics that need to be thought about and navigated by the profession as a whole. For example, one of my local pharmacies I noticed the other day that they sell urine dipsticks that patients can purchase. And that to me, I was so struck by the fact that a patient might think they've got a urinary tract infection buy dipstick and stick their urine and bring that to the pharmacist and say, oh, I've dipstick my urine and it's positive for infection. Now, how does the pharmacist manage that medico legal responsibility in a way that they haven't before? So I think there's lots of interesting conversations to have.

[00:06:38] **Amy:** Yeah. Thank you. And that's a really good example as well, which segues nicely into my next point with you, PDL. We talk a lot about understanding and practicing within your individual scope of practice. And as we all know, that's much more than simply selling a urine dipstick in your pharmacy, isn't it? So how can pharmacists identify when a patient presentation may be moving beyond their scope? And what would you recommend should happen next in those situations?

[00:07:06] **Peta-Ann:** Look, I think the space that's difficult to navigate is to thread the needle of an undifferentiated patient coming in to consult with an endorsed pharmacist, rather than categorizing the consultations before they happen as a inverted commas UTI consult or a skin rash consult. A patient comes in with a set of symptoms that need to be adequately and appropriately assessed, and it's only once that assessment has occurred and a diagnostic reasoning process has taken place that a pharmacist will be able to determine what can I manage here safely and competently. That's within my

scope. What needs to be co-managed and what needs to be referred on straight away or escalated? I think that's a learning for every pharmacist to go through. The least useful thing for patients is to start talking to a pharmacist and the pharmacist say, oh, I can't do this. It's outside of my scope of practice. When the pharmacist hasn't even had the opportunity yet to adequately inappropriately assess the patient, I think that would be a disservice to the patient, because what the pharmacist will be able to do is effectively triage the patient appropriately and pick up the phone now and see if we can get you into your GP today. Or actually, this needs urgent referral and sort of sorted the patient out already. So one of the things I say to the pharmacists that I teach is that I, as a GP, I refer all the time, I refer to specialists, I refer from investigations. I refer to allied health colleagues. It doesn't mean that I haven't done my job. It just means that I have determined what is the appropriate management plan and safety netting for this patient today, and what is my role in this, and how am I going to review the patient?

[00:09:00] **Amy:** That's fantastic. That's a really good angle to take on the holistic approach to care. And I particularly love what you said about not jumping too soon to categorizing what you think this consult could be. Take a moment to reflect and take your due processes before going on to your next steps.

[00:09:18] **Peta-Ann:** And I think that idea of an adequate bio psychosocial assessment of a patient is where it needs to start. And then at the end of that, this pharmacist will be able to determine whether it's in or out of their scope.

[00:09:30] **Amy:** So what I'm already taking away is safe prescribing doesn't simply happen by accident. It relies on significant conscientiousness and care. But what if a prescribing decision is ever questioned? And how is that judgment assessed and by whom? And that's where I'd like to bring Scott. Now, if I may, into the conversation. Scott, you've acted for almost every category of health practitioner registered under national law. So I'm sure you've got a very unique perspective on how these situations unfold. Can you help us understand who may be scrutinising a prescribing decision and what they're looking for and why?

[00:10:08] **Scott:** Sure. One thing I would encourage new pharmacists, prescribers, to understand is that their prescribing decision could be questioned by a patient, another healthcare professional, an employer, or a health service. If a complaint is made about

an endorsed pharmacist's professional conduct, statutory regulators such as the Pharmacy Board of Australia and the Australian Health Practitioner Regulation Agency can become involved. Depending on the circumstances, there could also be litigation, a coronial inquest or other legal or regulatory processes for which a response is required. But I don't think that pharmacists should approach prescribing with the mindset that every decision will eventually end up in court. That's not helpful. I think a better question upon which to start prescribing is this. If my decision is questioned in the future, will I be able to demonstrate that I made a reasonable clinical decision based on the information available to me at the time? That's really the starting point for managing legal risk. Sometimes the outcome that was hoped for will not be achieved because medicine is inherently uncertain. A good clinical decision can sometimes result in a poor outcome. The issue is therefore not simply whether the patient got better. It is whether the pharmacist's decision making was reasonable within scope and competence, and consistent with applicable professional and legal obligations. And that's why I'll probably keep coming back to today, the theme of clinical reasoning and documentation. They provide the evidence of how and why a prescribing decision was made.

[00:11:40] **Peta-Ann:** The other thing I would say is that one of the crucial points in your management plan is how do you safety net this and when are you going to review the patient? You know, when I teach pharmacists, I say, look, you've got to tell them what you expect is going to happen. So say you decide not to prescribe something. You're managing just symptomatically. You're going to say, look, I don't think you need anything in the way of prescribed medication here. This is what I expect is going to happen. This is what we're going to do. And I want to see you. You know, we're going to make it a follow up appointment to see you in 48 hours or 72 hours or whatever it is. If that doesn't happen, if you start feeling more unwell, you develop a high fever, you know, whatever symptom is appropriate for that presentation. This is what I want you to do. And I think if pharmacists can demonstrate that they've safety netted in that way, I think any clinical decision that we make around management is probably going to be okay because, you know, you've really thought about and you've explained it to the patient. The patient knows what they should do.

[00:12:36] **Scott:** Absolutely.

[00:12:37] **Amy:** Scott, what records would you generally expect to see that would help support and defend a prescribing decision should it come to that.

[00:12:45] **Scott:** Pharmacists need to think of their clinical record as the story of the consultation. Someone reading the record should be able to understand what information was available to the pharmacist, what assessment was undertaken, what was considered, what was decided and why. That would generally include the relevant history, clinical findings, medicines and allergies where relevant, the assessment, the treatment decision and any important risks or contraindications that were considered. It should also capture relevant discussions with the patient, including treatment options, material risks and benefits, and follow up arrangements. It's also important to record what was decided against and why. For example, if a certain prescription was considered, but a decision to refer to a doctor or other healthcare professional was determined to be more appropriate. That reasoning is just as important to document significant Communications with other healthcare professionals, and any other information that materially influenced a decision should also be documented. I would suggest a simple test be thought about when preparing clinical notes. If another pharmacist or regulator or lawyer reads this record without speaking to me, will they understand my clinical reasoning? If they can, then the record is much stronger.

[00:14:02] **Peta-Ann:** And I think one of the things that tricky at the moment, Amy, this kind of looks back to what we were saying earlier, because I've been a doctor for so long, my usual practice for something is X, and I can demonstrate that, and there will be notes somewhere to attest to that. And so if on a particular day, my notes didn't completely adequately reflect that, and that comes up for question, I can point to my usual practice. And so I think for pharmacists, if you agree that story makes sense and say you comprehensively reviewed the patient last month, and then when you saw them at the moment, that has led to the problem or the complaint, but you can show that happened in the past. I think that that's really helpful. Most endorsed pharmacists at the moment, they can't point to a usual practice because they haven't been doing it long enough. So I think in the first instance, being more inclusive with notes is going to be really, really important. So it's a kind of slightly overshooting rather than trying to be too concise. It's going to be the way forward here.

[00:15:01] **Scott:** I think that's right. The better the notes, the better the defense will be. There's no expectation that someone will remember a particular prescribing event months or years in advance. And if the notes are sufficient to tell that story, then you're 9/10 of the way there.

[00:15:18] **Amy:** That's really helpful. And on that note, traditionally or in the olden days, if I can say that now, notes and record keeping were fairly straightforward in their definition. But as we all know, digital platforms, electronic systems, and more recently, AI enabled tools are becoming much more prevalent. So, Scott, what privacy considerations would you suggest our pharmacists keep in mind as technology becomes more and more integrated into the way we work?

[00:15:44] **Scott:** This is an area where pharmacists need to be particularly careful, because new technology can create a temptation to put information into the system simply because it's convenient. The starting point that a pharmacist really needs to think about is what information am I putting into this system? Why does the system need it? Where is it going? And who may have access to it? Identifiable patient information should not be put into free AI tools such as ChatGPT or Claude. From a legal perspective, convenience is no justification for disclosing patient information inappropriately. Don't assume that because a platform is widely used or describes itself as secure, that this automatically means privacy and professional obligations are met with AI. There's an additional issue, which is that it can be potentially a very useful tool, but it must not become the prescriber. If an AI tool is used to help with information drafting or clinical support, the prescriber remains responsible for checking the output and applying their own professional judgment and making the final decision. I'd also be cautious about assuming that an AI generated answer is accurate, simply because it sounds authoritative. AI can produce information that is plausible but wrong, incomplete or inappropriate for the particular patient. So I treat AI like any other clinical support tool, one which is potentially very useful, but something that requires professional judgment, verification and appropriate safeguards.

[00:17:22] **Amy:** And in addition to all of this, prescribing also changes the nature of our relationship between pharmacists and patients. Are there any situations where professional boundary considerations can become particularly important to be across.

[00:17:37] **Peta-Ann:** I think making sure that as the endorsed pharmacist, you are up to date with your clinical practice. So if you are going to be doing an examination and appropriate examination based on the presentation, you are comfortable and confident that you know what you're doing and what you're looking for when you do the examination. You know, I say to pharmacists, don't ask a question unless you know why you're asking it. Don't do an examination unless it's going to either confirm or refute what you thought you were going to be looking for after the history. I think the issue of chaperone is really important, and I think that's been quite confronting for pharmacists to get their heads around. Certainly, there is no way, in my view, that it's appropriate to not offer a chaperone or, in fact, to have a chaperone in the room. If the patient has to displace or remove clothing. I think that's really important. The third thing is stepping outside the consultation room is that endorsed, pharmacists will be asked by friends and colleagues to prescribe for them, and that is a really important professional boundary to be aware of, to understand how not to transgress that. That's going to be something very new for the profession to think about. And finally, and Scott, this kind of just goes back to what you were saying a bit earlier around privacy. I think there's a very immediate privacy risk, which is not to do with AI, but it's to do with the community pharmacy about who has access to those patients notes. And currently, I think pharmacy assistants can have a look into the notes and unless they're specifically excluded. So for me, this is a big medico legal risk where you have to not have that happen in your practice. So I think there's a change there around processes and policies.

[00:19:35] **Scott:** If I could just add a couple of things that Peta Ann said, the issue of chaperone is absolutely one that I would wholeheartedly support. I've acted for many, many practitioners of the hands on variety who have had complaints made against them about inappropriate touching. This is not a space that pharmacists have been in before, but they may very well be in the future. And the best way to guard against those types of complaints is to have a chaperone there, or to offer a chaperone. Definitely. The other issue, which is boundary related, is relevant to a decision around what is clinically appropriate for this patient versus what is commercially convenient or beneficial to the prescriber. The pharmacist now has the ability to prescribe a medication which may be more expensive or more profitable for a particular patient. And obviously the medication that's prescribed should be the one that is best fit for the presenting condition.

[00:20:39] **Peta-Ann:** Yeah. I think you've touched on a really important thing there, Scott, which is that separation between prescribing and dispensing. And obviously, it's one that the medical profession has been particularly exercised by. And I think it's one that the pharmacy board is taking very seriously. The idea is that you should not be the prescriber and the dispenser unless it's in some, you know, really urgent situation where not dispensing at the time is going to make a material difference to the outcome for that patient. So for example, you're the sole pharmacist in a rural pharmacy, you know, and if you don't dispense the medication, the patient's not going to get their antiviral for their shingles. Nobody would contest that. But outside of that, I think that's going to be really important. I also think that the profession is going to have to manage this new space between their retail aspect of their pharmacy owners versus their prescribing responsibilities, and how to clearly articulate those potential conflicts of interest to a patient, I think is going to be difficult, but needs to be carefully thought about.

[00:21:46] **Amy:** Thanks both. You've given us plenty to chew on and digest there. And I keep going back to your analogy, Peta Anne of the flags on the beach and recognizing where those flag posts are and what it means to stay within them. So it's becoming apparent that prescribing is far from an additional clinical service. It's a full change to daily practice. And therefore, the emphasis of this episode isn't so much around prescribing itself, but more so the ability to create a holistic healthcare discussion, which of course includes plenty of good interprofessional collaboration. And we've covered a whole lot of ground today, and I'd love to finish by checking in with our guests about where our responsibilities begin and end. If referral is where a conversation with a patient concludes on that day, is that the end of the story?

[00:22:35] **Scott:** The short answer is no. Referral is not simply handing the patient to someone else. Once a patient is referred, a pharmacist needs to be clear about what they are expecting the other healthcare professional to do, and importantly, what they will continue to do in the meantime. For example, if something is identified that requires medical review, consideration needs to turn to whether the patient requires interim management, what advice they need while waiting, and whether the time frame for the referral is clinically appropriate. Patient communication needs to be clear. They should understand why they're being referred, how urgently they need to be seen, and what they should do if their condition changes. That is particularly important where there may be a delay before they can see the other healthcare professional refer. But don't forget.

[00:23:25] **Amy:** And in this rapidly evolving area of practice, when we talk about individual scope of practice, Peta-Ann, how can our pharmacists maintain their competence in this space?

[00:23:37] **Peta-Ann:** I think that the continuing professional development space is a really important one. The profession is aware that the pharmacy board is mandating extra hours of CPD, and I think it's going to be very important to ensure that those are fit for purpose and that the CPD includes an audit component, a reflective component, and a recency of practice component. And that what I really hope to see from the profession is that when these additional ten hours is a minimum, and what I really hope is that endorsed pharmacists will go above and beyond that so that they can ensure that the care that they're providing to their communities is competent and safe, and patients are really getting the best care that they can from pharmacists.

[00:24:25] **Amy:** Thank you, Peta-Ann, I think you've both brought some really practical perspectives, and hopefully our listeners will leave with a better understanding of the opportunities as well as the responsibilities that this area of practice brings. So on that note, thanks for the conversation, Peta-Ann, great to have you.

[00:24:43] **Peta-Ann:** Thank you.

[00:24:44] **Amy:** And Scott, fantastic to have you join us as well.

[00:24:47] **Scott:** Thanks for having me.

[00:24:51] **Nic:** You've been listening to be Risk Ready, the PDL podcast produced by Sound Cartel. Listen at pdl.org.au/podcast and follow free wherever you listen to podcasts.