AMA QUEENSLAND

Leading Queensland Doctors
~~Creating~~ Better Health care Access
Blocking

AMA QUEENSLAND

~~SURVEY REPORT~~

OPINION (NOT CLINICAL FACT)

Urinary Tract Infection Pharmacy Pilot Queensland

and

North Queensland Pharmacy Scope of Practice Pilot

MAY 2022

22_000069

FOREWORD

Everyone who enters a healthcare profession does so out of a desire to help people and contribute to their community. We work as a team, focused on delivering the best outcomes for patients. Pharmacists are vital to this teamwork. Many patients end up seeing their GP because their pharmacist has suggested they seek medical opinion. Pharmacists provide a critical safeguard [illegible] potential errors or unintended adverse impacts. That is why prescribing and dispensing are separated by legislation – to ensure the checks and balances are there to protect patients and enhance the health of our communities. We respect and thank all pharmacists for the valuable contribution they make to the health of Queenslanders.

FACTUALLY WRONG

The Queensland Medicines and Poisons Act and Regulation allows practitioners to perform both roles.

This survey report is focused on health outcomes for patients. Patients rely on us all to take care of them, to advocate for the necessary policies, frameworks and support for doctors and all healthcare professionals to be able to help them get better, to recover and restore their health. Our survey shows that the *Urinary Tract Infection Pharmacy Pilot* has failed. Women did not receive the care they needed and an alarming number became more ill due to their participation in the trial. This is not fair to patients, pharmacists or doctors to op[illegible]. It undermines a key strength of [illegible].

False. It was based on the opinions of selected doctors and not patient focussed.

FACTUALLY WRONG

The Queensland Government is following other OECD countries like the UK and Canada.

The Queensland Government has been careless with patient health in this UTI pilot and failed to protect our community and investigate the health outcomes. There is no thorough analysis, scientific evaluation or genuine stakeholder engagement or feedback.

WRONG AGAIN! Two separate pilots not connected and the UTI Pilot was already state wide.

We hold grave concerns that the Queensland Government is now looking to expand this trial in North Queensland and wants to include more health conditions. Queensland is a renegade to this [illegible] in a fractured pathway that defies [illegible] works, and flies in the face of Australi[illegible] guidelines and standards. The results of our survey are unfortunately just the tip of the iceberg but we are compelled to stand up for better healthcare for our patients and community.

QUT has done a thorough examination of the service offered. AMA was a stakeholder – and had a seat at the table but pulled out due to arrogance.

FACTUALLY WRONG

I acknowledge that del[illegible]thout challenge and must em[illegible]t to continuous improvement. However, the UTI trial and proposed expansion in North Queensland are not improvements, but are an erosion of healthcare standards and patient outcomes. They undermine the collaborative strength, standards and expertise our current team-based healthcare system thrives on.

No overseas evidence to back up this claim.

Our survey report is a compelling read for anyone who cares about the health of Queenslanders. I urge you to join me in asking the Queensland Government to change their current collision course and put patients first by investing in strategies that strengthen, not fracture, our healthcare system.

If this was a book it would be in the Fiction section of the library.

Professor Chris Perry OAM
President AMA Queensland

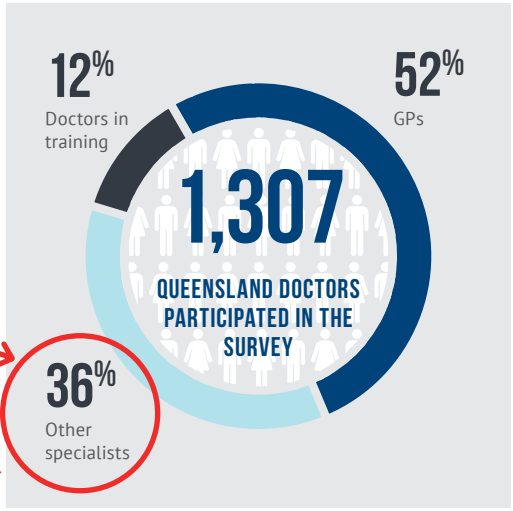
GRADE F FAIL

Failure to use factual findings.

Fails the basic standard of trust.

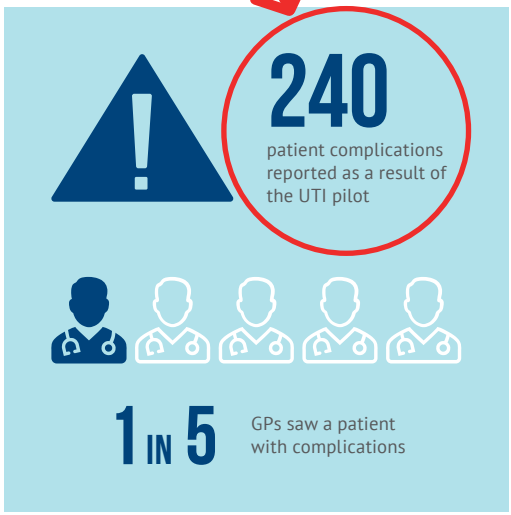
See Appendix A – Facts not fiction.

SURVEY SNAPSHOT

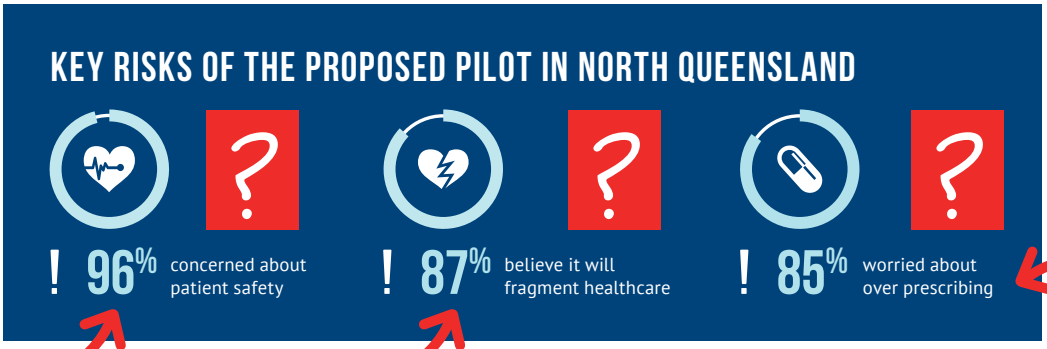


Specialists don't treat uncomplicated UTI's but were included to boost numbers = Push Poll!

No clinical evidence to support this number and no independent assessment of these claims.



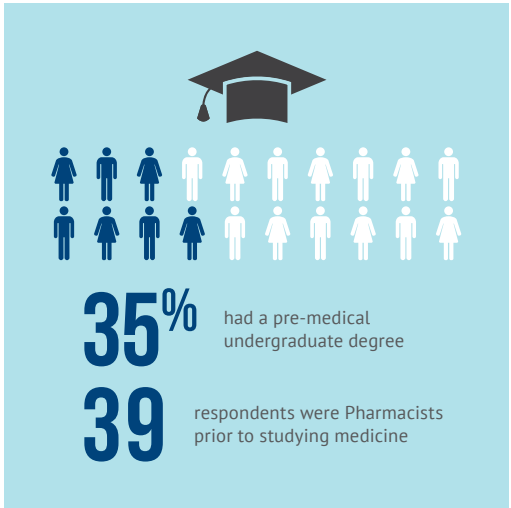
KEY RISKS OF THE PROPOSED PILOT IN NORTH QUEENSLAND



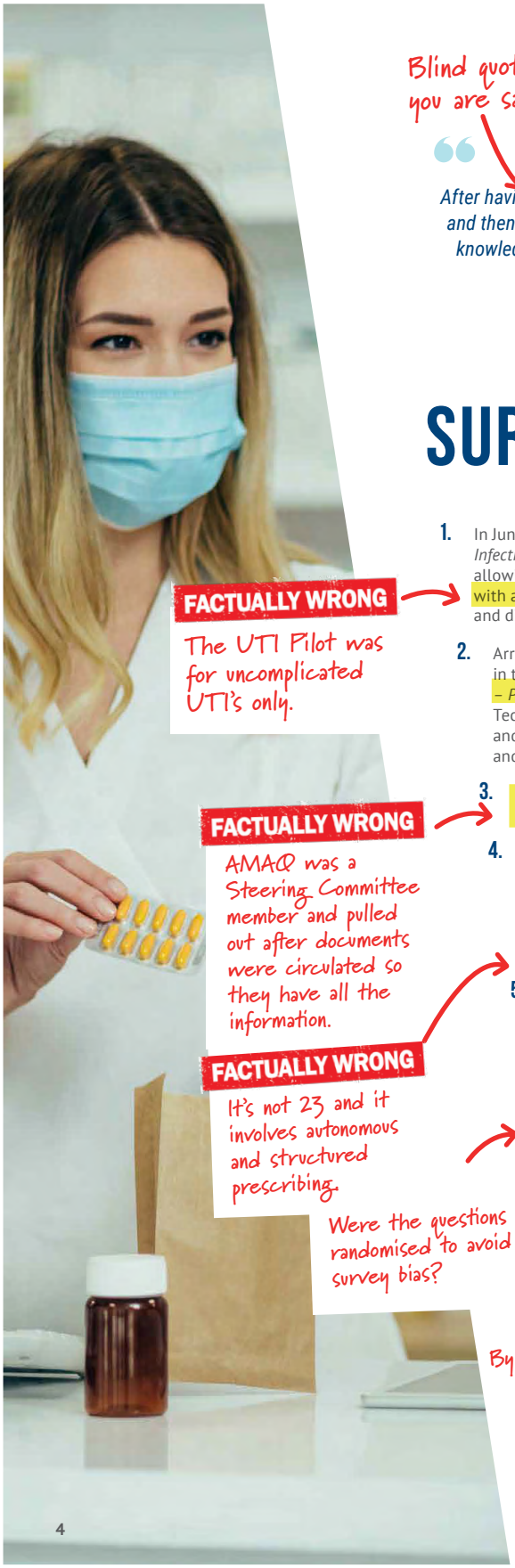
Pharmacists are also concerned which is why in the North Queensland Pilot, pharmacists will have to follow the same Therapeutic Guidelines as doctors and will be independently evaluated.

You can't fragment care of patients if they can't see a GP to get care.

Overprescribing is a well known Doctor affliction not shared with pharmacists, this projects your issue onto another profession.



Really? Strange how the largest doctors in North Queensland keep closing GP clinics, like in Innisfail.



Blind quotes are a lazy way to say nothing but look like you are saying something!

FACTUALLY WRONG

> *After having been a community pharmacist for several years and then a doctor, I know of the huge, indescribable gap of knowledge and training between pharmacist and doctor.*
>
> **(Pharmacy-trained doctor)**

The scope of the North Queensland Pilot is less than a GP or Nurse Practitioner. Pharmacists are not seeking to become GPs.

SURVEY CONTEXT

1. In June 2020, Queensland Health commenced a two-year *Urinary Tract Infection Pharmacy Pilot – Queensland* (Queensland-wide UTI pilot) allowing pharmacists across Queensland to provide treatment to women with a suspected UTI. This involves pharmacists diagnosing, prescribing and dispensing treatment for UTIs.

FACTUALLY WRONG

The UTI Pilot was for uncomplicated UTI's only.

2. Arrangements pertaining to the Queensland-wide UTI pilot are outlined in the *Health (Drugs and Poisons) Regulation 'Drug Therapy Protocol – Pharmacist UTI trial'*[1], stating that the Queensland University of Technology (QUT) were engaged to manage the pilot's implementation and evaluation. QUT confirmed a research study has been undertaken and that a report has been provided to Queensland Health.

FACTUALLY WRONG

Legislation changed in Sept 2021. AMAQ must have missed it.

3. None of this information is available to the public, nor to AMA Queensland.

FACTUALLY WRONG

AMAQ was a Steering Committee member and pulled out after documents were circulated so they have all the information.

4. Nonetheless, based on the 'success' of the UTI pilot, Queensland Health intends to significantly expand the pilot in North Queensland by implementing the *North Queensland Pharmacy Scope of Practice Pilot* (NQ Pharmacy Pilot). This expansion would facilitate pharmacists' autonomous prescribing for 23 conditions from June 2022.

FACTUALLY WRONG

Two separate pilots – UTI Pilot is not linked to North Queensland Pilot.

FACTUALLY WRONG

It's not 23 and it involves autonomous and structured prescribing.

5. In the absence of available data, reporting or evaluation of the Queensland-wide UTI pilot, AMA Queensland invited doctors across the state to report on their experiences with patients treated under the UTI pilot. The survey also sought doctors' views on the expansion of the pilot to additional conditions in the NQ Pharmacy Pilot.

How would the doctor know if they don't pass on the suspected cases and have failed to report to the Health Ombudsman for independent assessment. Potential issues could have come from other doctors.

6. The survey was open to all Queensland doctors from 18 to 28 March 2022. Access to the survey was publicised via the Queensland Doctors' Community, the GP Alliance, the Australasian Medical Publishing Company, the Business for Doctors Facebook group, Local Medical Associations, and communications with AMA Queensland members via the *Connect* fortnightly newsletter and direct messaging.

Were the questions randomised to avoid survey bias?

7. Survey results were subject to independent statistical analysis, and that analysis forms the basis of this report. The results of this survey are the only publicly available information on patient outcomes from the UTI pilot.

By who?

1 https://documents.parliament.qld.gov.au/tableOffice/TabledPapers/2020/5620T974.pdf

PROFILE OF RESPONDENTS

Only half were GP's = 4.8% of the 27,109 medical practitioners in Queensland – hardly a true representation.

8. A total of 1,307 doctors responded to the survey, comprising both AMA Queensland members and non-members.

9. Respondents included general practitioners (52%), other specialists (36%) and doctors in training (12%), and were geographically spread across Queensland.

10. More than one third of respondents had an undergraduate health or science qualification prior to qualifying as a doctor (35%), including 39 respondents who had obtained a Bachelor of Pharmacy prior to studying medicine.

How many dermatologists, opthamologists or hematologists treated patients for uncomplicated UTI's?

> *During the pharmacy degree there was little to no education on the process of diagnosis. There was a basic education on the pathophysiology, with no education on the choices in diagnosis methods. As a pharmacist we never had any education on how to examine a patient. Yes there was very good education on appropriate drug treatment choices. And often this would be equal to or even superior to the drug treatment education we received in medical school. However, there was very little focus on the non-drug treatment options.*
>
> **(Pharmacy-trained doctor)**

FACTUALLY WRONG

This comment (not fact) demonstrates a complete lack of understanding. Pharmacists already diagnose in daily practice in relation to Schedule 2 and 3 medicines.

KEY FINDINGS

> *Diagnosis is more than a set of symptoms described by a patient. It involves examination and targeted investigations. Often times there is subtlety involved in teasing out symptoms or finding signs. If you have not had appropriate training and experience this is very difficult. We do not let junior doctors practice unsupervised. Therefore, it would be remiss to allow other fields to also do the same.*
>
> **(Pharmacy-trained doctor)**

Pharmacists have undertaken the appropriate regulator approved education and training to diagnose and prescribe for uncomplex UTI's.

RESPONSES RELATING TO DOCTORS' EXPERIENCES WITH THE QUEENSLAND-WIDE UTI PILOT (RUNNING SINCE JUNE 2020)

11. Doctors were asked about their experience with the UTI pilot, specifically:

Question 8 – The Queensland Government has conducted a trial allowing pharmacists to prescribe medications for patients with suspected UTIs. Have you seen patients with complications after accessing the UTI pharmacy trial?

Question 9 – If possible, please describe the issues your patient/s experienced in a de-identified manner.

Simply unverifiable! If doctors have suspected cases, they should gain consent to report them but have not done so.

12. Approximately 15% of respondents (184 doctors) provided care for patients with complications following their treatment by a pharmacist as part of the UTI pilot.

This is not a surprise, it's what the protocol recommends – that is, referral to a GP if symptoms are unresolved.

13. Of the 184 respondents who reported post-trial complications, 148 of these were GPs. This equates to one in five GPs seeing patients with complications.

14. Some doctors saw more than one patient with complications. Through the survey, approximately 240 incidents were reported of doctors treating patients experiencing complications[2].

What is the definition? Is this not an unresolved UTI symptom or unsatisfactory response to an antibiotic?

15. The most frequent comments from doctors related to:

Comments, not FACTS! WHERE ARE THE FACTS?

- inappropriate or ineffective antibiotic use
- misdiagnosis and treatment of a condition that was not a UTI
- patients needing hospitalisation as a result of ineffective or inappropriate treatment or misdiagnosis
- patients being reluctant to disclose accurate and relevant information to the pharmacist due to lack of privacy and proximity of other customers

Patients give consent to receive the UTI service. Almost all pharmacies have private consultation rooms.

- patients being up-sold unnecessary products
- treatment of male patients (trial was limited to female patients).

No evidence!

16. **Misdiagnoses of another condition** as UTI was the most commonly seen complication reported by doctors[3].

FACTUALLY WRONG

There is no clinical evidence that men were treated.

2 Question 8 saw 184 doctors respond 'yes' when asked whether they had seen post-trial complications. Of those 184 respondents, 157 respondents provided details of their experiences, with some doctors seeing up to five patients with complications. Based on analysis of written responses, at least 239 patients experienced complications.

3 A conservative analysis of respondents' comments indicated at least 73 occurrences of misdiagnoses.

17. The most common misdiagnosis related to the patient having a **sexually transmitted infection** (STI) rather than UTI. These included [illegible], herpes and [illegible] were also reported to [illegible] disease.

FACTUALLY WRONG

18. **Pregnancy** was misdiagnosed as UTI on at least six occasions, with a number of patients prescribed antibiotics that are unsafe in the first 12 weeks of [illegible]ed to have been [illegible] were actually related to an ectopic pregnancy.

FACTUALLY WRONG

19. **Cancerous conditions** were overlooked on at least nine occasions, with doctors reporting incidents of patients being treated for UTI when the symptoms related to [illegible] including bladder, [illegible] cancers.

FACTUALLY WRONG

20. Other misdiagnosed conditions treated as UTI included lichen sclerosis, prolapse, menopausal symptoms, [illegible]ss, renal colic, [illegible] syndrome, pyelonephritis and interstitial cystitis.

FACTUALLY WRONG

No clinical data or independently verified data to support these claims.

21. After misdiagnoses, **inappropriate or ineffective antibiotic use** was the next most commonly occurring complication[4]. Of the 240 incidents reported through the survey, approximately 30% related to antibiotics. Specifically, comments related to:

- the UTI-causing bacteria being resistant to the prescribed antibiotic
- repeated courses of the same antibiotic being prescribed
- patients being prescribed an antibiotic to which they were allergic.

FACTUALLY WRONG

Repeat courses are not allowed under the UTI protocol.

22. Through the survey, doctors reported eight cases where misdiagnosis or ineffective treatment resulted in **hospitalisation** of patients suffering urosepsis or pyelonephritis.

FACTUALLY WRONG

According to an Australian Newspaper 4 cases or 0.05% of cases resulted in ED presentation which were reviewed by a GP and Sexual Health practitioner and the pharmacist followed the protocol correctly. One woman had a super bug that no GP prescribing antibiotics would have picked up.

23. Three doctors reported having seen complications in **male patients** treated for UTIs, despite the pilot being specifically limited to 'uncomplicated cystitis in a non-pregnant woman'[5].

24. A common theme among doctors' comments, especially relating to misdiagnosis of STIs, was patients' reluctance to provide full and frank information to a pharmacist in the presence of other customers or to discuss sexual history over the counter. Non-disclosure of sensitive or embarrassing information due to a **lack of privacy** may have contributed to misdiagnoses.

4 A conservative analysis of respondents' comments indicated at least 67 occurrences of problematic use of antibiotics.

5 https://documents.parliament.qld.gov.au/tableOffice/TabledPapers/2020/5620T974.pdf page 2.

FACTUALLY WRONG

No pharmacy I ever worked in had an appropriate set up for where accurate diagnosis and a consultation could occur. Often the 'consultation rooms' were simply a cordoned off section of the pharmacy behind the makeup. This had no privacy for patients at all.

(Pharmacy-trained doctor)

80% of pharmacies now have a consult room.

When I was practising as a pharmacist, patients would say 'yes' and nod through any questions just to get what they are after. Patients were always hesitant to discuss topics over a counter where others were picking up Panadol and throat lozenges.

(Pharmacy-trained doctor)

If this was true, the person's practice lacked the proper questioning.

RESPONSES RELATING TO DOCTORS' VIEWS ON THE NQ PHARMACY PILOT
(DUE TO COMMENCE IN NORTH QUEENSLAND IN JUNE 2022)

Had these people completed their intern year and actually practised in community pharmacy?

Or did they go straight on to medicine and never practice in community pharmacy?

25. A number of respondents (39) had obtained a Bachelor of Pharmacy prior to studying medicine. These respondents were asked whether they thought they could have diagnosed and treated patients as a pharmacist, to which the overwhelming response was 'no'.

26. Overwhelmingly, respondents considered the proposed **training inadequate**. Fewer than 2% of respondents believed the training required for pharmacists to participate in the NQ Pharmacy Pilot (120 hours of online training) was adequate for pharmacists to safely diagnose and treat patients for the 23 conditions covered in the NQ Pharmacy Pilot.

27. All of the respondents with a Bachelor of Pharmacy considered the proposed training to participate in the NQ Pharmacy Pilot to be inadequate.

> *As a pharmacist, I thought I could [diagnose and treat] and said this multiple times. However, having trained as a doctor, I realise how inadequate my knowledge and training was in the area of prescribing. It's the Dunning-Kruger effect.*
>
> **(Pharmacy-trained doctor)**

> *Pharmacists are not trained to diagnose or treat patients. Having studied both pharmacy and medicine, the latter involves two full time clinical years seeing patients and learning how to take a history, perform a physical examination, order investigations and come to diagnostic and management decisions. This process is not able to be delivered at a pharmacy counter.*
>
> **(Pharmacy-trained doctor)**

FACTUALLY WRONG

Training for the North Queensland Pilot includes 12–16 months of additional university postgraduate study and a practical training component. This includes face-to-face learning.

28. Respondents frequently highlighted the important **separation between prescribing and dispensing** functions, and the invaluable safety net embedded in the health system when pharmacists check medication decisions through the dispensing process.

29. Doctors clearly value their working relationships with pharmacists and the safety net pharmacists provide, with a number of doctors commenting about personal experiences of their patients benefiting from this safeguard.

30. Concerns about **conflicts of interest** related to potential **financial incentives** in both diagnosing and selling products were raised repeatedly. Similarly, doctors held concerns about upselling of non-essential products, and the potential for pharmacists to feel obliged to sell a medication for every condition even when conservative management would be more appropriate.

This is an outrageous professional "ethical slur". Many medical/health professions have potential conflicts which are governed by robust clinical governance processes and codes of conduct.

Examples are:

- Dentists who recommend procedures and supply dental products.
- GPs who specialise in dermatology and supply topical products or treatments.
- Specialists who recommend surgical procedures.

Correct. We agree this is simply not only the domain of doctors – nurse practitioners and other health practitioners are also well skilled in this regard.

Patients need appropriate history, examination and investigations on consultations prior to provision of treatment. Other conditions unrelated to the presentation may be exposed on consultation. The skill of consultation and appropriately managing a patient requires skills and in-depth medical knowledge.

31. Doctors held concerns over patient safety relating to the NQ Pharmacy Pilot, with 96% of respondents highlighting this as a key risk of the pilot.

32. Commentary often reflected doctors' concerns about risk of **'misdiagnosis and missed diagnosis'**. This included myriad other issues canvassed by doctors during a consultation beyond the specific trigger for the appointment. Examples included opportunities to conduct routine or overdue screening, monitoring and management of other conditions, and checking-in with patients about their mental health.

Can't get your numbering right which calls into question all of your other numbers.

23. A high proportion of doctors (87%) perceived risks associated with the **fragmentation of healthcare**. Respondents' reflections on this issue frequently highlight concerns about a pharmacist autonomously altering treatment without the doctor's knowledge or consent, and without adequate record keeping of that decision. Inadequate or incomplete medical records, and absence of patient monitoring or follow up were significant concerns.

Nice attempt at a 'scare campaign'! You can't fragment care when patients aren't receiving care or are having to wait in pain because doctors won't see patients.

Recent survey data from North Queensland:
- 37% of patients had to wait more than a week.
- 48% of patients said wait times for a GP were unacceptable.

[Doctors use] skills and experience in all the nuances of patient care – communication, compassion, history-taking, diagnostic skills, building differentials and following up my patient to ensure that I have done no harm and that they are well and satisfied with their care.

24. **Over-prescribing** was also a significant concern to doctors, with 85% of respondents reflecting concerns about this issue. Commentary from respondents included frequent discussion of over-prescribing of antibiotics, antimicrobial stewardship, and the potential use of inappropriate antibiotics due to insufficient clinical investigation prior to prescribing leading to antibiotic resistance.

Correct. GP's routinely overprescribe, if they didn't we wouldn't have any need for better anti microbial resistence practices.

35. **Medico-legal issues** were raised by 75% of respondents, with many doctors expressing apprehension about ambiguity over responsibility for adverse effects experienced by patients.

A professional indemnity insurer and the Pharmacy Board of Australia were part of the Steering Reference Group – the same group the AMA and RACGP were on. The AMA must not have paid attention in the meetings they attended.

36. Around a third of doctors held reservations that the NQ Pharmacy Pilot would exacerbate **workforce shortages** (36%).

Pharmacists are good at being pharmacists and I appreciate their scope of expertise and enjoy working with pharmacists doing Home Medicines Reviews. However they are not doctors and do not have the clinical training or expertise to take an appropriate history and do a physical examination.

No logic to this opinion. If a patient can't get into a GP and has to wait, that practice is obviously busy and sustainable. Doctors won't leave when they are busy given they are paid 70–90% of billings per patient.

FACTUALLY WRONG

At a grassroots level, GP's work collaboratively with pharmacists.

37. Other risks identified by respondents included:

- worsening relations between doctors and pharmacists
- increased ED presentations
- pharmacists being pressured by customers wanting certain medicines
- conflict of interest for pharmacists
- lack of responsibility and accountability to patient
- undermining of doctors
- 'second rate' care for vulnerable populations
- dealing with misdiagnoses and delayed treatment
- pharmacists lacking key skills
- being a disincentive to study medicine
- pharmacists are too busy
- pharmacy does not provide the setting to discuss private health matters (patients may not feel comfortable to disclose)
- over-reliance on medication as the treatment approach
- inability to use the opportunity to provide broader health screening.

Pure doctor ARROGANCE! Why is pharmacists' care considered second rate when nurses, dentists, physios and optometrists are all able to prescribe and provide great care?.

FACTUALLY WRONG

80% of pharmacies have private consultation rooms.

According to the Australian Family Physician, 85% of GP encounters result in a prescription for a medicine.

38. More than 50% of GPs said the NQ Pharmacy Pilot would deter them from working in North Queensland. Common reasons for this deterrent effect were expectations that GPs would need to 'pick up the pieces' and deal with the consequences of the pilot, and the undermining of patient safety.

39. When asked about options for addressing workforce shortages, respondents endorsed other solutions, including collaboration with local governments to provide appropriate supports for doctors in rural and regional areas, appropriate financial arrangements, GP training programs and pathways for allied health professionals to obtain medical qualifications.

There are currently 97 GP vacancies in the North Queensland Primary Health Network – patients need care now and not on the never never.

40. Doctors also expressed concern over the **evaluation** of the pilot. Given the inaccessibility of information about the UTI Pilot, doctors are seeking clear information about how the pilot will be evaluated and how outcomes will be measured.

41. Fewer than 4% of respondents believed the NQ Pharmacy Pilot should proceed.

75% of people in North Queensland support the trial according to consumer research concluded by Insightfully.

FACTUALLY WRONG

UTI Pilot found that 14.8% of women would have gone to an ED if the pharmacist couldn't treat them. That's 999 presentations to an ED reduced by the pilot.

FOLLOW UP WITH RESPONDENTS POST-SURVEY

42. A number of survey respondents who reported patient complications consented to being contacted by AMA Queensland for further information. These respondents were asked about whether they reported their patients' adverse results to Queensland Health.

43. Despite efforts to find a way to report patient complications to medical authorities, respondents conveyed they were not able to find such a mechanism and their patients had not been given information about how to report complications.

44. Some doctors were unaware of the UTI pilot until their patients presented with complications from failed treatment from a pharmacist.

FACTUALLY WRONG

> *One of my patients ended up in hospital with a kidney infection after being prescribed an antibiotic for UTI by a pharmacist with no urine test. It was subsequently shown that the infection was resistant to the prescribed antibiotic.* ***I spent two days trying to find out where to report patient outcome without success.***
>
> *A true trial would have had a reporting mechanism. Patients should have had a piece of paper outlining what to do if they had complications.*

No clinical data to support this claim.

Reporting to the Health Ombudsman has been in place for many years.

> *[The pilot] does not address issue of doctor shortages. Access to drugs is not healthcare.*

[When studying] pharmacy, the teaching centred around medicines – mechanism of action, indication, side effects, drug interactions and associated counselling. When we learnt about conditions, it was brief. The objectives of our course never focused in detail about pathophysiology, diagnostics, differentials.

(Pharmacy-trained doctor)

SURVEY QUESTIONS

The survey sought the following information from respondents.

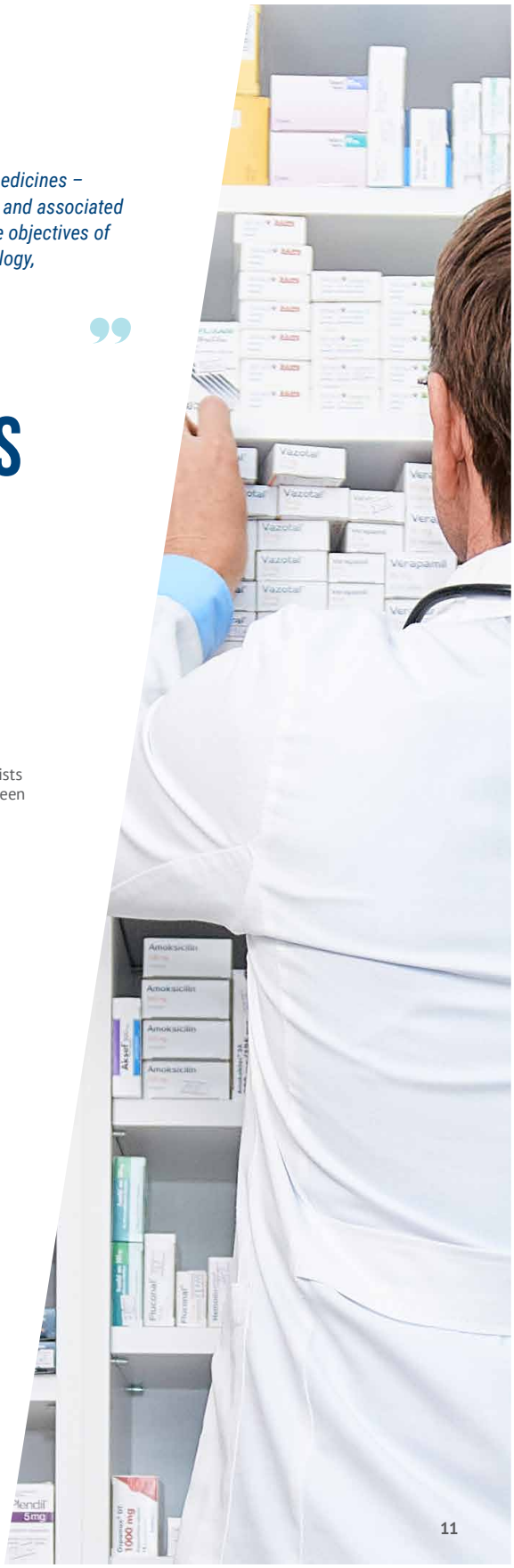
- What area do you work in?
- What is the primary region you work in?
- Before qualifying as a doctor, did you obtain an undergraduate qualification in health and/or science?
- What was your undergraduate qualification?
- (If Pharmacy) Do you think you could have diagnosed and treated patients as a pharmacist, and why?
- The Queensland Government has conducted a trial allowing pharmacists to prescribe medications for patients with suspected UTIs. Have you seen patients with complications after accessing the UTI pharmacy trial? If so, please describe the issues your patient/s experience.
- Should the North Queensland Scope of Practice Pilot allowing pharmacists to autonomously prescribe go ahead?
- Would this trial deter you from working in North Queensland, and if so, why?
- Do you believe 120 hours of additional online training will enable pharmacists to safely diagnose and treat patients for the conditions include in this trial?
- What do you believe are the key risks of this trial?
- What other solutions should the Queensland Government consider to address medical workforce shortages?

I was a specialist pharmaceutical chemist, and I worked in a community chemist shop too, but with most of my experience in hospital pharmacy I would say I never examined a person until medical training.

I just didn't know what I didn't know.

(Pharmacy-trained doctor)

We agree.
Hospital and Community Pharmacy are different and shouldn't be deliberately confused.



APPENDIX 1 FACTS not Fiction

POOR PATIENT CARE

- The AMA have failed to acknowledge their own fragmentation of care via the increasing proliferation of online prescribing business models (owned by medical practitioners) we are seeing in Australia.
- These online platforms offer immediate prescriptions for certain medications via digital surveys generated by an Artificial Intelligence (AI) bot. On completion of the short survey, the patient is notified if their prescription request is successful. This can often occur within minutes and without any contact with a trained medical professional. **If a robot can do the task, why can't a pharmacist do it after additional university post graduate education and training?**
- There is no onus on the online prescriber to advise the patient's usual general practitioner (if the patient has one) of the consultation.
- The Guild has received many deidentified reports from pharmacies of patients' questionable experiences with online prescribers:
  - A non-asthmatic receiving two different strengths of a combination inhaled corticosteroids and long acting bronchodilator (ICS/LABA) – no direct questioning from the doctor on why they would need two.
  - A patient seeking the oral contraceptive pill being advised to get their blood pressure checked by the pharmacist at the time of dispensing (rather than prior to prescription being generated).
  - A patient answering the online survey, being advised by an automated message that a prescription cannot be approved because of a 'wrong' answer and then the IT allowing the patient to just change the answer to generate the prescription.
  - A female being prescribed sildenafil and when the pharmacist contacted the prescriber to question, the prescriber advised the female selected 'male' in the online survey.
- Many online prescribers (examples below) offer urinary tract infection prescribing empirically – in line with the Australian Therapeutic Guidelines.

Provider	Website	UTI
Burst Health	https://bursthealth.com.au/pages/frequently-asked-questions	Yes
Doctors on Demand	https://www.doctorsondemand.com.au/blog/faqs/prescriptions/	Yes
Instant Consult	https://www.instantconsult.com.au/faq/	Yes
InstantScripts	https://www.instantscripts.com.au	Yes
National Telemedicine Doctors	https://www.nationaltelemedicinedoctors.com/for-pharmacies/	Yes
Qoctor	https://www.qoctor.com.au/pharmacy-value-proposition/	Yes
Simple online doctor	https://www.simpleonlinedoctor.com.au/about/	Yes
Web Doctor	https://webdoctor.com.au/treatment/cystitis-and-uti/	Yes

FACTS ABOUT THE UNCOMPLICATED URINARY TRACT INFECTION PILOT – QLD (UTIPP-Q)

1. The UTIPP-Q is not a world first. There is precedent for this pilot based on the experience of colleagues in:
    - Canada
    - New Zealand
    - United Kingdom

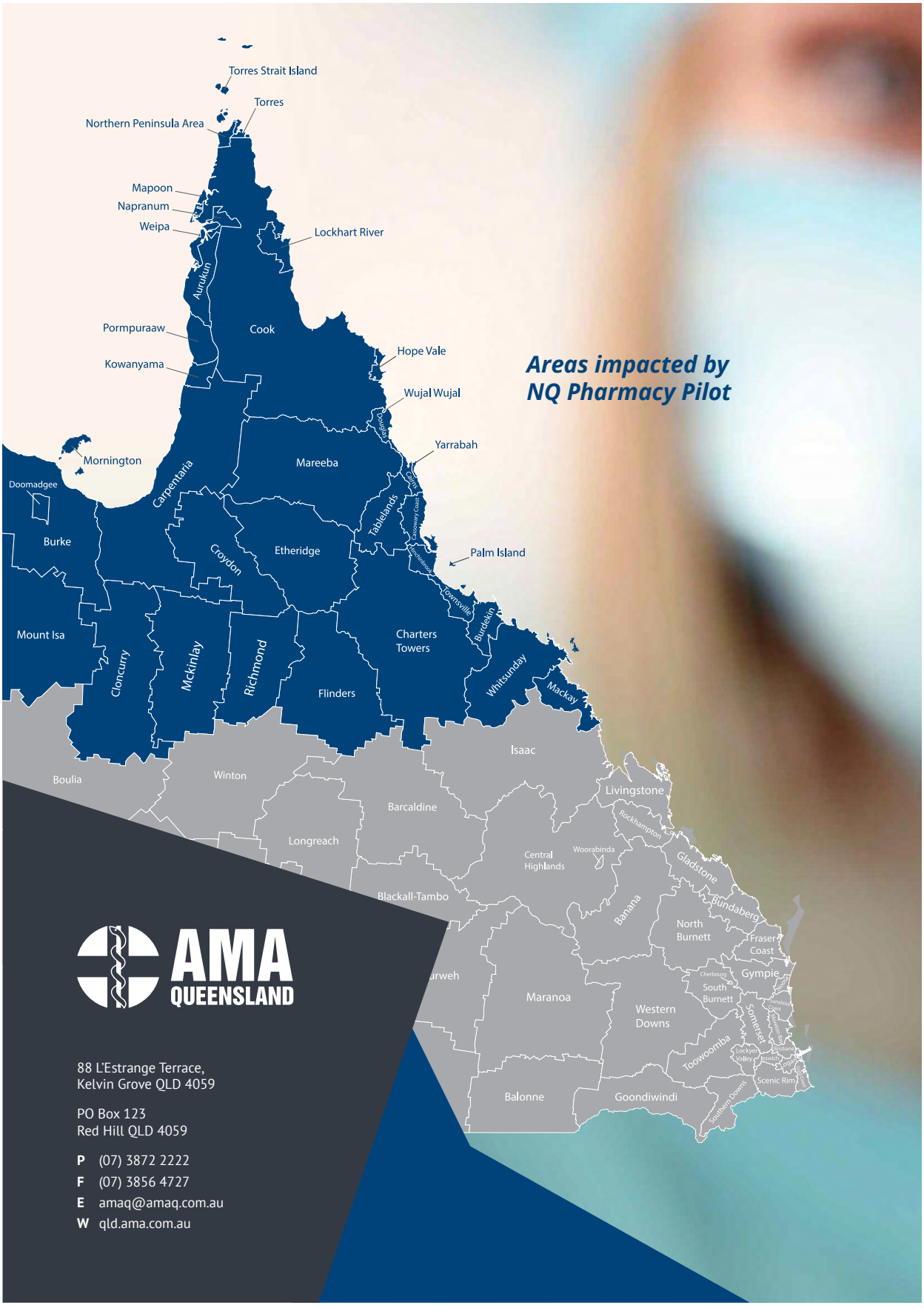
Community pharmacists in these fellow OECD countries have been prescribing antibiotics to women for uncomplicated urinary tract infections for 10 years.

2. As reported by The Australian on 16th May 2022, according to the leaked draft report prepared by the Queensland University of Technology:
    - 6751 women in Queensland had their UTI symptoms identified and managed by their community pharmacist.
    - 87% of patients reported that their UTI symptoms had resolved after antibiotic treatment.
    - The remaining 13% who did not have symptom resolution had sought further guidance and care from another healthcare professional (including their GP) – as per the pilot protocol.
    - Just four patients had worsening of symptoms and presented to the emergency department. All of these patients should have received the same primary care by a GP which would have resulted in the same outcome. Pharmacists follow the empiric treatment of UTIs as recommended in the Australian Therapeutic Guidelines. These Guidelines underpin how all clinicians should practice.
        - All four of these patients were reviewed up by a General Practitioner and Sexual Health Practitioner, and in each case the pharmacist followed the treatment protocol.
3. The Outcomes Report has not been made publicly available while it has been reviewed internally by the Queensland Department of Health, this is standard across all pilots and trials while evaluation is underway.
4. If the Australian Medical Association of Queensland truly viewed women's and Queenslanders' health as a priority, they would not have chosen to decline to participate in the pilot's Steering Advisory Group (SAG) in early 2020. Had this decision not been made, they would have had access to the confidential report at the same time as other SAG members.

FACTS ABOUT THE NORTH QUEENSLAND COMMUNITY PHARMACY SCOPE OF PRACTICE PILOT

- To effectively improve health outcomes for Queenslanders and remove health pressures on hospitals, we need to use all health professionals at their full scope of practice. The purpose of the pilot is to improve access to high quality and effective health care for communities in North Queensland.
- Pharmacists are not trying to become or replace GPs. The Pilot will see a pharmacists' scope of practice remain significantly narrower than both a GP and a nurse practitioner. This pilot recognises that there are some conditions that could be triaged appropriately in a community pharmacy setting.
- If a patient can be managed in a timely manner by their local pharmacist, this may prevent them waiting weeks to see their GP or presenting to the emergency department. This will also support the GP by having greater capacity to have appointments (including longer consultations) available to see their patients with more complex needs.
- Under the auspices of the Queensland University of Technology and James Cook University, participating pharmacists will undertake post graduate level, evidenced-based training over a 12-16 month timeframe, which is currently used in other Australian non-medical prescribing pathways.

- Many of the proposed conditions such as impetigo, otitis media, herpes zoster are considered acute conditions with distinct symptoms and require timely care. A patient should not have to wait a week or more to see their GP to manage these conditions. Some conditions are considered chronic, however, the interventions proposed are supporting existing care arrangements and about optimising therapies to achieve better outcomes. At all times the pharmacist will be required to notify the patient's usual GP (if they have one) about the consultation and outcome.
- Full scope is not a new concept. The services available from community pharmacists in countries with comparable economies and health systems such as the United Kingdom, Canada, USA and New Zealand are far more advanced than in Australia.
- **Rather than the AMA spreading alarmist, false information, they should be working with the Queensland Government on this pilot - not against it.** They should re-join the pilot's Steering Reference Group, after quitting so abruptly, and work collaboratively with stakeholders to find solutions for patients not barriers.



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