NZMA
New Zealand Medical Association

12 February 2013

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By email: dietitians@dietitiansboard.org.nz

Dietitians Board proposal to prescribe selected oral prescription only medicines as Designated Prescribers

Dear Jane

Thank you for requesting the NZMA to provide a letter in response to the proposal by the Dietitians Board to give dietitian prescribers authority as designated prescribers to prescribe the following selected nutrition related oral prescription medications (zinc sulphate, cholecalciferol [Vitamin D] and pancreatic enzyme replacement therapy).

The NZMA is New Zealand's largest medical organisation and has a pan professional membership. We have more than 5,000 members who come from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values, and the health of New Zealanders.

It appears that due to an administrative oversight, the NZMA was not given the opportunity to comment on the original consultation survey (which closed on 1 October 2012). Nevertheless, we have had the opportunity to review the full proposal contained in the Dietitians Board Submission to the Ministry of Health. Our comments on this proposal have been informed by feedback from our Board, our General Practice Council and our Specialist Council.

The NZMA recognises the important contribution dietitians make as part of the multidisciplinary team and we value their nutritional expertise in contributing to improving patient care. We believe that there is certainly merit in the proposal to confer dietitian prescribers with the authority to

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prescribe the three specific medicines for which this authority is being sought (zinc sulphate, cholecalciferol and pancreatic enzyme replacement therapy). However, the NZMA has a number of concerns relating to the justifications being advanced by the Dietitians Board to support this proposal, as well as with the model of prescribing authority that is being sought.

The NZMA is not convinced that extending designated (and therefore independent) prescribing rights to dietitians is the appropriate approach. We believe that it is misleading to refer to the notion of dietitians having 'independent care' of the patient as defined by their 'nutrition diagnosis'. As such, using this claim as a basis to call for designated prescribing rights is flawed. Nutritional considerations are consequent to a medical diagnosis. While nutritional assessment by a dietitian as part of a collaborative team approach to patient care is crucial, if prescribing rights are being sought by dietitians, the NZMA believes that these rights should entail a delegated model rather than a designated model. It is our view that a delegated model of prescribing best facilitates the collaborative team based care that is the shared objective of our respective professions.

We also caution against the assumption that operating at the 'top of scope' should be interpreted as meaning the right to prescribe medication. While the NZMA is not opposed to the principle of extending the rights to prescribe medicines to other health groups, subject to certain caveats (notably a 'delegated' rather than 'designated' model of authority), we believe that extending prescribing rights to different professional groups may have unintended consequences that are detrimental for patients. Inappropriate polypharmacy is already problematic. There is a real concern that some patients being prescribed different medicines by different healthcare professionals could end up confused and less likely to adhere with their medication regimens. The NZMA also believes that the purported benefit to medical practitioners in terms of time saved has been overstated; completing a prescription is not necessarily an onerous task.

The NZMA has recently developed a set of principles for health workforce redesign and we have evaluated the proposal being put forward by the Dietitians Board against these principles. While the proposal by and large aligns with these principles, concerns over accountability stand out as a major issue. Extending prescribing rights to dietitians has fundamental implications in terms of accountability that we believe the designated model of prescribing being proposed does not address. By way of example, if a designated dietitian prescriber prescribed Vitamin D for a patient who had hyperparathyroidism with worsening hypercalcaemia, would they accept professional responsibility and accountability for their actions or would the senior medical consultant be held ultimately responsible?

The Dietitians Board Submission refers to the right to prescribe 'after the medical diagnosis has been made' and describes the proposal as being a 'voluntary partnership between the responsible independent prescriber[1] (usually a medical practitioner) and a designated prescriber to implement an agreed patient-specific clinical management plan'. Yet the same document goes on to list examples where a proposed designated dietitian prescriber would prescribe independently – for example, during home visits or at aged care facilities. This appears to be an apparent contradiction, with important implications for accountability that need further clarification.

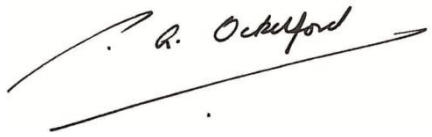
Our other major concern relates to the possible fragmentation of care rather than any specific concerns about the three listed medicines per se. While we share the goals of improved services outlined in the submission, there is the very real possibility that extending independent prescribing

[1] Although the Dieticians Board Submission uses this terminology, we suggest the term 'responsible authorised prescriber' be used instead. Furthermore, the model being articulated here appears closer to what we envisage as a delegated model of prescribing.

to yet another group of health professionals could actually lead to fragmentation rather than integration of care. One way to mitigate these risks would be to ensure that sufficient emphasis is given to the need for an integrated health record. We agree strongly with the Dietitians Board that the key to the success of this initiative is good communication between dietitians, general practitioners and specialist medical practitioners working in both the public and private sectors. However, we envisage that this will be difficult, if not impossible, to ensure without a shared integrated electronic health record that is accessible to all providers. As such, we reiterate the importance of implementing a shared integrated health record so that initiatives such as that being proposed by the Dieticians Board can succeed.

Extending prescribing rights to dietitians has fundamental implications in terms of accountability and potential fragmentation of care. The NZMA hopes that these two areas are given sufficient attention if this proposal is to be progressed successfully. We hope that our feedback is helpful and look forward to working constructively with the Dietitians Board on this matter or future issues of mutual relevance.

Yours sincerely



Dr Paul Ockelford
NZMA Chair