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Why aren't pharmacists included as prescribers in the Controlled Drugs and Substances Act?

Pharmacist involvement in pain management is increasing throughout Canada and the United States. In many clinics, pharmacists work effectively with their physician and nurse colleagues using prescriptive authority as part of collaborative practice agreements.[1] These arrangements can include the prescribing of narcotics and other controlled substances, with positive patient outcomes. The New Classes of Practitioners Regulations (NCPR)[2] developed by Health Canada present podiatrists, midwives and nurse practitioners with the opportunity to provide, administer and prescribe controlled substances within their provincial scopes of practice. In response to the NCPR, pharmacists are left to wonder why they were not included along with their fellow health care providers.

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In Canada, hospitals often establish medical directives entitling pharmacists to prescribe medications in association with a physician. These collaborative agreements are established in the interest of better patient care, with the goals of reducing physician workload and making optimal use of the medication expertise of pharmacists. Interprofessional collaboration has extended to chronic pain management, where pharmacists are commonly included as part of a multidisciplinary clinic. A systematic review of pharmacist involvement in chronic pain teams showed improvement in patient satisfaction, reduction of pain intensity compared to controls and 50% fewer medication events than control subjects.[3]

Similar strategies are also employed in the United States; for example, at the University of North Carolina, a pharmacist-led team focuses on pain management for oncology patients.[4] Under the collaborative practice agreement, the pharmacist prescribes medications, including narcotics. The resulting interventions have improved symptom scores and benefitted the patient population in this facility.[4]

The idea of pharmacists prescribing controlled drugs has progressed one step further in the United Kingdom. In 1997, the UK government established a review of prescription supplies and administration of medicines. The report concluded that expanded prescription authority would benefit patients.[5] Subsequently, in 2003, pharmacists were authorized to become supplementary prescribers in a partnership with a physician or dentist. Supplementary prescribers can presently prescribe any drug including controlled substances, as long as the medication follows an established care plan for a patient.[5] Unfortunately, the University of Southampton found that supplementary prescribing had its flaws; mainly an inability to help patients in emergencies and at primary care points without the consultation of a physician.[5] As a result, in 2006, pharmacists were able to certify as independent prescribers and in April 2012, independent prescribing of controlled drugs by pharmacists was legalized in the UK.[6] This progression was guided by input from expert committees in conjunction with clinical research and analysis. It is hoped that Canada will recognize the benefits these changes have created for patients in the UK and can modify the Controlled Drugs and Substances Act (CDSA) to effectively help their own citizens.

While pharmacist prescriptive authority can lead to improved clinical outcomes and broader access to patient care, it can also increase medication safety. With extensive education in pharmacology, pharmacokinetics and the therapeutics of disease state management, pharmacists are an obvious profession to prescribe controlled substances. A Spanish study of 314 patients using benzodiazepines found 132 drug interactions and 278 adverse drug reactions. As a result, there were 426 interventions performed by pharmacists.[7] If a pharmacist had been authorized to prescribe

these medications in the first place, countless interactions and adverse drug reactions might have been avoided.

In summary, including narcotics and controlled drugs as part of the prescriptive authority for pharmacists is not a new idea. Clinical pharmacists in New Mexico have had prescriptive authority since 1993.[1] This authority includes both narcotics and controlled substances once the pharmacist obtains a DEA prescriber number.[1] In one study, the inclusion of a clinical pharmacist with independent prescriptive authority as part of an outpatient pain clinic led to positive outcomes. There was a reduction in patient visual analogue scale pain scores, implementation of a controlled substance monitoring system, reduction in "medication misadventures," a 9% increase in clinic revenue and improved quality of life for health practitioners involved.[1] These benefits can be reproduced in Canada; however, pharmacists must first be included in the NCPR. It is time for the CDSA to be updated logically, with pharmacists included as controlled drug practitioners subject to provincial/territorial prescribing regulations. ■

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