James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

April 27, 2023

The Honorable Adrian Smith
U.S. House of Representatives
502 Cannon House Office Building
Washington, DC 20515

The Honorable Brad Schneider
U.S. House of Representatives
300 Cannon House Office Building
Washington, DC 20515

Dear Representatives Smith and Schneider:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express our opposition to H.R. 1770, the "Equitable Community Access to Pharmacist Services Act," which would inappropriately allow pharmacists to perform services that would otherwise be covered if they had been furnished by a physician, test and treat patients for certain illnesses including illnesses that address a public health need or relate to a public health emergency, and expand Medicare payment for pharmacists in limited but significant ways. We opposed legislation with the same title last Congress and, despite the modifications to the version introduced in the 118th Congress, the bill still inappropriately expands pharmacists' scope of practice in a manner that threatens patient safety.

The AMA strongly supports the team approach to patient care, with each member of the team serving in a clearly defined role as determined by his or her education and training. While we greatly value the contribution of pharmacists to the physician-led care team, their training is not equivalent to the four years of medical school, three to seven years of residency training, and 10,000-16,000 hours of clinical training that is required of physicians. In short, pharmacists do not have the education and training necessary to assume the role of a physician and this fact in isolation raises serious concerns about the underlying merits of this legislation.

But it is more than just the vast differences in hours of education and training, it is also the differences in the curriculum and clinical training of medical school and residency compared to that of pharmacy programs. In order to be recognized as a physician with an unlimited medical license, medical students' education must prepare them to enter any field of graduate medical education and include content and clinical experiences from which they develop their clinical judgment and medical decision-making skills directly managing patients in all aspects of medicine. By gradually reducing teaching physician oversight, residents are able to develop their skills with progressively increasing autonomy, thus preparing these physicians for the independent practice of medicine. As such, 95 percent of U.S. voters in a recent survey said it is important to them for a physician to be involved in diagnosis and treatment decisions.[1]

By contrast, pharmacists are not prepared to practice medicine. Pharmacists are well-trained as medication experts within an interprofessional team; however, their training in patient care is limited. Most of the Doctor of Pharmacy (PharmD) curriculum across the country consists of instruction in applied sciences and therapeutics. Residency is not required, and the overwhelming majority of pharmacists working in the community setting have not undergone residency training. While pharmacy

[1] https://www.ama-assn.org/system/files/ama-scope-of-practice-stand-alone-polling-toplines.pdf.

students do engage in a modest amount of "practice experiences" during their education, the training is not focused on providing medical care to patients. In fact, the practice experiences in the PharmD curriculum do not include performing a physical examination, making a diagnosis, triaging severity, or prescribing. As a result, we are particularly troubled by new language in H.R. 1770 that would permit pharmacists to evaluate and manage patients for the testing or treatment of COVID-19, influenza, respiratory syncytial virus (RSV), or streptococcal pharyngitis.

Equally concerning is the fact that pharmacists in the community setting said they already have so much work to do that everything cannot be done well. The problem appears systemic: 71 percent of all pharmacists and 91 percent of pharmacists working in community pharmacies rated their workload as high or excessively high. Moreover, pharmacists reported that the "three most common 'highly stressful' job aspects were 'having so much work to do that everything cannot be done well' (43 percent reporting 'highly stressful'), 'working at current staffing levels' (37 percent reporting 'highly stressful'), and 'fearing that a patient will be harmed by a medication error' (35 percent reporting 'highly stressful')."[2] Scope expansions like the one proposed in this bill only add further responsibilities to an overburdened pharmacist workforce and threaten patient safety due to their insufficient training in these activities. Therefore, it is inappropriate to authorize pharmacists to diagnose, prescribe, or assume the role of a physician.

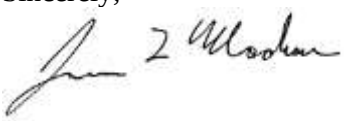
Furthermore, each member of the physician-led health care team has an important role to play while working together to ensure improvements in patient care, and public health emergencies do not necessitate or automatically require the degradation of state scope of practice laws. H.R. 1770 would allow pharmacists to test, treat, and, therefore, initiate drug regimens for COVID-19, influenza, RSV, or streptococcal pharyngitis. This extensive list has the potential to vastly expand pharmacists' scope of practice beyond state licensure laws that have been thoughtfully put in place, most often by the state board of pharmacy. Moreover, pharmacists, though trained in the chemical components of medication, do not have the holistic or comprehensive medical knowledge and approach of physicians. As such, allowing pharmacists, simply because they are licensed in a specific state in that profession, to initiate drug regimens, administer drugs, and generally treat certain illnesses, could cause major complications for patients when their complete health is not adequately considered or adequately documented within an electronic health record for patient safety. In fact, select COVID-19 therapeutics, while highly effective, are accompanied by multiple pages of information related to drug interactions which may negatively impact an individual's health if their complete health history is not adequately considered. Moreover, special populations, such as patients under 18 years of age or pregnant or breastfeeding, require the specialty knowledge brought by a physician to make evidence-based, patient-centered decisions.

Physician-led, team-based care has a proven track record of success in improving the quality of patient care, reducing costs, and allowing all health care professionals to spend more time with their patients. We are concerned that the policy changes within H.R. 1770 conflict with this approach to health care delivery and could result in patients forgoing holistic wellness exams, comprehensive preventive care, early diagnosis, and optimal therapy, which could have devastating long-term consequences. With millions of Americans forgoing all types of wellness visits and preventive screening exams, Congress should be focused on advancing policies that encourage patients to visit their physicians for routine care.

[2] https://www.aacp.org/sites/default/files/2020-03/2019_NPWS_Final_Report.pdf.

We appreciate your consideration of our position on H. R. 1770 and would be happy to discuss further our aforementioned concerns.

Sincerely,



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