The following comments are submitted in response to the OCP public consultation on proposed learning requirements for selected high-risk expanded scope activities – specifically acute pharyngitis – and address consultation questions 1, 2b, and 3. These comments reflect my perspective as a pharmacist educator with a focus on infectious disease, and my commitment to antimicrobial stewardship. I do not offer opinion on the scope expansion itself; my concerns are directed at the adequacy of the proposed competency framework as a mechanism for ensuring safe practice.

1. The Self-Declaration Model Is Structurally Insufficient for This Activity

The proposal requires pharmacists to self-declare that they have met the learning requirements prior to engaging in the assessment and management of acute pharyngitis. No external verification, no defined minimum standard of evidence, and no assessment of competency are required to support that declaration. A pharmacist could fulfill this requirement through a single online continuing education module completed on the day they activate the service.

Self-declaration is particularly problematic for clinical skills where the gap between perceived and actual competence is not visible to the practitioner. Pharyngeal assessment and the clinical decision-making that precedes it fall squarely into this category. **A self-declaration framework cannot detect what the declarant does not know they do not know.** This may be acceptable for activities with lower diagnostic complexity or more forgiving error margins. However, for acute pharyngitis, where the consequences of misdiagnosis include antimicrobial resistance and unnecessary antibiotic-related adverse effects, it is not.

The College must require a demonstration of competency – not merely the completion of learning activities – before a pharmacist is considered ready to provide this service.

2. Patient Selection Must Be the First Competency Assessed, Not Throat Examination

The draft guidance lists physical assessment and the application of the modified Centor score as core requirements, which is appropriate. However, the guidance does not address what is clinically **the most critical competency: knowing which patients should never enter the group A streptococcal (GAS) assessment pathway at all**.

The modified Centor score is a pre-test probability tool. It is only valid when applied to patients for whom GAS pharyngitis is a plausible diagnosis after initial clinical assessment. A patient presenting with coryza, cough, hoarseness, or other features consistent with a viral upper respiratory tract infection should be excluded from GAS assessment (and rapid antigen detection testing; RADT) entirely. Applying the Centor score to these patients produces a meaningless result from an invalid application of the tool.

This concern is not theoretical. The Paediatric Choosing Wisely Canada recommendations explicitly advise against testing or treating for GAS in children with symptoms that suggest a viral etiology (Choosing Wisely Canada, 2023). The failure to apply exclusion criteria before proceeding to RADT has been documented as a real

practice problem in Canadian pharmacy. In May 2018, the Nova Scotia College of Pharmacists (NSCP) issued a professional notice following reports from the IWK Emergency Department of a high volume of patients presenting after receiving positive RADT results at community pharmacies who, on examination, lacked clinical indication for testing (Nova Scotia College of Pharmacists, 2018). The notice confirmed that positive results in those cases were attributable to GAS colonization rather than active infection. These clinical errors began not with a misinterpreted throat examination, but with a failure to exclude patients with predominantly viral symptoms before initiating GAS assessment. Notably, the NSCP acknowledged at that time that it was uncertain whether pharmacists could be adequately prepared to perform the required physical examination. The OCP must demonstrate, in its final guidance, what specific structural safeguards prevent recurrence of this failure pattern in Ontario.

3. Physical Assessment of the Oropharynx Requires a Higher Training Standard Than the Guidance Proposes

The draft guidance requires that pharmacists have acquired learning that includes how to perform physical assessments for acute pharyngitis. No specification is provided regarding what form that learning must take, what standard of performance it must produce, or whether any skills validation is required.

This stands in notable contrast to the requirement for otitis externa, where the guidance explicitly mandates in-person training on otoscope use. That distinction is not clinically defensible. Otoscopic findings in otitis externa are relatively limited, with consistent anatomical structures across patients and relatively unambiguous pathological changes (e.g., canal erythema, discharge). Otitis externa is also usually unilateral, providing the pharmacist with a “normal” baseline to compare to. Pharyngeal examination, on the other hand, presents a different challenge: the clinician must interpret a spectrum of mucosal change, tonsillar size and texture, exudate quality, lymphadenopathy, and uvular position against a backdrop of substantial normal variation across patients. Reliable performance requires visual discrimination that cannot be achieved through didactic learning alone.

This is a clinical reality that I highlight in my teaching. When we discuss how to use the Centor score, I show students a classic image of tonsillar exudate, which most recognize as abnormal without difficulty. I also show an image that is classified in the teaching literature as demonstrating pharyngeal erythema and edema, but which – at least in my own clinical judgement – is indistinguishable from a normal oropharynx. I do this intentionally to convey the inherent difficulty of the discrimination task. If this uncertainty exists for a pharmacist with infectious disease training, while reviewing a still image with time to reflect, it is reasonable to assume that the risk of misjudgement in a community pharmacy encounter – under time pressure, without a comparator, and without feedback – would be substantial.

I recognize that it is not feasible to require pharmacists to accumulate the volume of supervised clinical exposure that physician or nursing trainees receive, and I am not proposing equivalency. I am proposing that the current standard, which imposes no

requirement for hands-on training or skills validation for pharyngeal examination while explicitly requiring in-person training for otoscopy, is inconsistent and inadequate.

At a minimum, the guidance should require:

- Exposure to a curated image library that includes the **full spectrum of normal oropharyngeal variation alongside pathological findings**. The normal variation component must be as prominent as the pathological examples.
- A structured assessment component – not just passive viewing – in which the pharmacist must correctly classify a set of oropharyngeal images including normal variants before declaring competency for this element of the skill. The assessment must use a sufficiently large and varied image bank such that repeated attempts do not yield passing scores through question familiarity rather than genuine clinical discrimination.
- Explicit guidance that image-based training does not confer competency equivalent to supervised clinical exposure, and that pharmacists who are uncertain about a finding are obligated to refer rather than proceed with testing.

The College must ensure that any required training and assessment tools are accessible to pharmacists practicing in rural and remote settings prior to implementation, and that activation of this service is not permitted until those resources are equitably available across the province.

4. Antimicrobial Stewardship Implications Warrant Explicit Attention

The draft guidance includes prescribing decisions based on current clinical guidelines and the application of antimicrobial stewardship principles as learning requirements, which is appropriate. However, **given the opportunities for clinical misjudgement discussed above and the scale at which community pharmacy could generate antibiotic prescriptions for GAS colonization, the stewardship stakes deserve more explicit treatment.** Two specific concerns warrant acknowledgement in the training requirements:

- Although penicillin and amoxicillin remain the agents of choice for GAS pharyngitis and are relatively narrow spectrum, macrolide prescribing in patients with a history of penicillin allergy carries significant resistance selection pressure. Canadian GAS macrolide resistance rates are not negligible, and increased prescribing volume through a community pharmacy channel warrants explicit recognition in the stewardship guidance.
- A positive RADT in a patient with predominantly viral symptoms most likely represents GAS colonization, not infection. GAS colonization is common, particularly in children, and does not warrant treatment. The distinction between GAS infection and colonization is a nuance that the Centor score cannot resolve, is not addressed in the current draft, and is not reliably applied even by physicians with substantially more clinical training in oropharyngeal assessment. The reflex to treat a positive microbiological result, irrespective of clinical context, is a well-documented driver of unnecessary antibiotic prescribing and is precisely

the judgment error that comprehensive training in patient selection and test indication is meant to prevent.

5. The Stakes Extend Beyond Patient Safety

The arguments above are grounded primarily in patient protection and antimicrobial stewardship, which are the appropriate priorities for a regulatory framework. However, the adequacy of the competency framework also has direct implications for the pharmacists who will deliver this service. A self-declaration model that authorizes practice without ensuring genuine preparedness does not protect pharmacists – it exposes them. When a pharmacist operating within an approved framework makes a clinical error that a more rigorous training and assessment requirement might have prevented, the professional and personal consequences fall on that individual. **The College has an obligation not only to protect patients from undertrained practitioners, but to protect practitioners from being placed in clinical situations for which they have not been adequately prepared.** A framework that conflates completion of learning activities with demonstrated competency fails both obligations. The recommendations in this submission are intended to raise the standard for both.

Summary of Recommended Changes

The following specific changes to the draft guidance are recommended:

- **Replace self-declaration with verified competency assessment** for acute pharyngitis. Completion of learning activities should not be sufficient; a validated, assessed demonstration of competency, including both clinical decision-making and image interpretation, should be required before a pharmacist engages in this service.
- **Add an explicit requirement for training in patient selection and exclusion criteria** and require that this be assessed before any training or assessment related to throat examination or Centor scoring. Pharmacists must demonstrate competency in identifying which patients should not enter the GAS assessment pathway before they demonstrate competency in managing those who should.
- **Require structured image-based training with assessed performance for pharyngeal examination**, consistent with the standard already applied to otoscopy for otitis externa. Training must include normal variation as prominently as pathological findings, and the assessment component must draw from a sufficiently large and varied image bank such that repeated attempts do not yield passing scores through question familiarity rather than genuine clinical discrimination.
- **Expand the stewardship requirements** to address explicitly the distinction between GAS infection and colonization and the resistance selection pressure associated with macrolide prescribing in patients with a reported penicillin allergy, in the context of the increased prescribing volume a community pharmacy channel represents.

These comments are offered in the interest of ensuring that expanded pharmacist scope for acute pharyngitis is implemented in a manner that protects patients, supports antimicrobial stewardship, and empowers pharmacists. I hope these comments are useful to the College as it finalizes its approach to learning requirements for acute pharyngitis.

References

1. Choosing Wisely Canada. (2023, October 25). *Don't routinely test for Group A Streptococcal (GAS) throat infections in children with sore throats with clinical symptoms, such as cough, rhinitis, or hoarseness, suggesting viral pharyngitis.* Canadian Paediatric Society. https://choosingwiselycanada.org/recommendation/paediatrics/
2. Nova Scotia College of Pharmacists. (2018, May 3). *Professional notice: Rapid strep testing in community pharmacies.* https://staging.nspharmacists.ca/wp-content/uploads/2018/11/Notice_RapidStrepTestingInCommunityPharmacies.pdf