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Discussion paper

Nurse prescribing: the elephant in the room?

Barry Strickland-Hodge BSc MSc PhD MRPharms
Senior Pharmacy Lecturer, School of Healthcare, University of Leeds, UK and Visiting Professor of Rational Pharmacotherapy, Medical University of Southern Africa (MEDUNSA)

ABSTRACT

Nurse prescribing has become established in the UK, though the number of prescriptions written in primary care in 2006 by nurses remained small at 0.8% of the total. Healthcare teams employ nurse prescribers to streamline the service and improve patients' access to medicines. As the range of medicines available to nurses for prescribing increases, so questions about the need for more training in pharmacology arises. Old-style hierarchical relationships may still exist, and the term non-medical prescriber helps to maintain this. The prescribing process is shown to consist of much more than the issuing of a prescription, and the nurse is well suited to this holistic approach to patient management. Nurse prescribing is a natural extension of the work of many nurses, removing the need for them to obtain a doctor's signature. Nurse prescribing enhances the nurses' role and benefits the patient in their ease of access to healthcare professionals and also potentially to medicines and continuity of care.

Keywords: access to medicines, non-medical prescribing, nurse prescribing, pharmacology

How this fits in with quality in primary care

What do we know?
Prescribing is a central activity to primary care, and nurse prescribing is becoming an integral element of that. Pharmacology is important in prescribing but it is only one aspect of the whole process.

What does this paper add?
This paper tries to dispel some of the expressed beliefs about the pharmacological knowledge of nurses in prescribing practice. It is hoped that this will lead to a further discussion about nurse prescribing, which will lead to a better understanding within the medical and nursing professions as to its importance and relevance in today's primary care.

Introduction

I recently attended a professional meeting in London where I met a retired physician. After a very brief chat he talked about his wife, a nurse who knew what nursing was about. 'Nurses aren't prescribers' he said, 'they don't know the pharmacology'. This got me thinking, and as a pharmacist I suppose I had to conclude that the amount and level of pharmacology taught to undergraduate nurses is basic. This is not to say that the specialist nurses are not as expert in their field as any other specialist but the question remains in the air. Do nurses have sufficient knowledge of pharmacology to prescribe from the whole *British National Formulary* (*BNF*)?[1] Discussing this with colleagues in nursing and pharmacy received, not surprisingly, mixed responses. Now that nurses are able to prescribe from the whole *BNF*, with a few exceptions, the nurses' depth of knowledge of pharmacology has become the elephant in the room – but is it fair?

What is prescribing?

Churchill's Illustrated Medical Dictionary defines the verb to prescribe as 'to order for use in treatment or prevention of a disease or injury, a drug, diet or regimen'.[2]

This seems very narrow. In Andrea Mant's book, while acknowledging that prescribing is a physical act of ordering something for a patient, she defines quality use of medicines in broader terms than merely being up to date in pharmacology.[3] She includes working with patients, thinking about influences on them and the prescriber, understanding evidence-based medicine, understanding why patients don't always take their medicines in accordance with instructions, and follow-up. Clearly there are additional areas that should be included in a definition of prescribing. Barber considered that there were four main aims of prescribing: namely that it should be effective and should minimise risk, minimise costs and respect the patient's choice.[4] In a study using focus groups, participants were asked the necessary skills a nurse required to undertake prescribing, in this case as a supplementary prescriber.[5] Although pharmacology was mentioned it was fifth in a list of six necessary skills, the others being to:

1 be a good communicator with observation of interpersonal and organisational skills
2 be a team player
3 be assertive and not be intimidated by doctors
4 be an advocate who can act in the best interests of patients
5 have a keen interest in pharmacological interventions
6 have good information technology skills.

Perhaps I would have added the need to know your limitations and know where to go for further information – but I wasn't in the focus group!

It is accepted that prescribing, however we define it, is a central part of modern medicine. It is perhaps salutary to remember that effective pharmaceuticals are a modern approach to healing and that before 1950 the number of proprietary medicines that were available was small. The Medicines Act of 1968 increased the requirements for medicine quality by license and regulation.[6] In the *BNF* of 1948 there were some 260 proprietary medicines listed (personal communication, Royal Pharmaceutical Society of Great Britain (RPSGB) library), today, there are over 2000, with an additional 2000 or so off-patent non-proprietary products also available for prescription.[6]

Non-medical prescribing

Following the publication of the final Crown Report in 1999,[7] the term non-medical prescribing was used extensively to differentiate medical prescribers in hospital and primary care from other prescribers. The largest group of non-medical professionals is nurses and pharmacists. Prescribing by those other than doctors has pushed at the boundaries of medicine and perhaps, in order to curb the perceived erosion of roles and professional margins, terms such as 'dependent prescriber' and 'non-medical prescriber' have been used. Dependent prescribers were first described in the final Crown Report,[7] and while this title was subsequently altered to the slightly less-emotive term 'supplementary prescriber', the latter term of 'non-medical prescriber' has been accepted.

Independent prescribing

To be truly independent means having the responsibility of assessment and management from start to finish. The Department of Health definition is:

> Independent prescribing is prescribing by a practitioner (e.g. doctor, dentist, nurse, pharmacist) responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.[8]

Whether in hospital or primary care we, as professionals, tend to work in teams, so who are the truly independent prescribers – Harold Shipman? Beverley Allitt? Independence allows professionals to prescribe for patients for conditions within their competence and without the need to get a countersignature from a doctor. It is the breaking down of unnecessary barriers to access to medicines, not role erosion, that gives greatest benefits to patients.

Why the need for change?

There have been many reasons given for the increased number of potential prescribers.[8] For example:

- growing expertise in advanced clinical roles in many professions
- an increasing tendency for professionals to work together in multiprofessional teams

- the need for the responsibility and accountability for clinical care to be clear and unambiguous
- a growing expectation from patients that they will experience a 'seamless service'
- a growing wish on the part of patients to choose the particular pathway through the clinical system which is convenient or appropriate to them, in cases where there are equally safe and effective clinical alternatives.

And are there any missing issues from this list? Perhaps other elephants? For example, lower cost? The perception that the driver for non-medical prescribing was to reduce escalating healthcare costs appears to be widespread amongst commentators. For example, Hay *et al*, suggests this.[5]

Safeguarding the public

The Medicines Act of 1968 was enacted to safeguard the public from harm that might arise from the new range of pharmaceuticals increasing daily.[6] It identified three groups of people who could legally prescribe medicines to the public. These were doctors, dentists and vets. This small elite group of practitioners was considered to be properly educated and trained. Hobbs and Bradley, in their book on prescribing in primary care (where incidentally most prescriptions are issued), refer to Talcott Parsons' description of what makes a doctor, which identified, even in 1952, the central role of prescribing in the activity of doctoring.[9] Parsons goes on to say that one of the key responsibilities of being a doctor is legitimising the patient in the 'sick role', and using the prescription to acknowledge this legitimisation. Many would add that it is also a sign that the consultation is completed. Many authors have tried to show how to end a consultation without issuing a prescription (see Mapes[10]), but the number of prescriptions continues to increase year on year. The number of prescription items dispensed in 2006 was 752 million in England alone, with an estimated 97.9% written by general practitioners (GPs) and 0.8% by nurses or other non-medical prescribers.[11] This proportion issued by nurses and others will obviously increase as the number of prescribers who are nurses increases. In the study of Redsell *et al*, of the views of patients consulting a nurse instead of a GP for acute minor illness, nurses were viewed as a resource to facilitate the smooth delivery of care, to help with minor ailments and in giving reassurance.[12] Patients thought doctors had greater skills knowledge and authority, while nurses' tasks were viewed as delegated. This recent study suggests that a professional hierarchy of tasks in primary care still persists. In this empirical study of 28 patients carried out in 2004 before many of the prescribing changes had been fully enacted, some participants were frustrated that nurses had to defer to doctors for prescribing aspects of their care.

So do current courses meet the needs of prescribers?

The curriculum used in institutes of higher education to train nurses and pharmacists to become supplementary and independent prescribers emerged from consultation with the Nursing and Midwifery Council (NMC) and the RPSGB. It covers seven main areas:

1 consultation, decision making, assessment and review
2 influences on and psychology of prescribing
3 prescribing in a team context
4 applied therapeutics
5 evidence-based practice and clinical governance
6 legal, policy, professional and ethical aspects
7 prescribing in the public health context.

So, although applied therapeutics is part of the course, the curriculum recognises that there are many other relevant and important aspects to the role of prescriber.

Scope and protocols for the independent prescriber

We need to accept that the number of new drugs available to prescribers continues to increase. However, there is a greater availability of relevant national and local guidelines and protocols that can be followed while still maintaining the independent prescribing status. Perhaps this is where we should start. If the professional prescriber is working to scope and to protocols, what is the need for a detailed understanding of the scientific basis of prescribing? If we take prescribing as a patient-focused activity, then we need to accept that there will be times when the patient's other illnesses or the range of drugs they are currently taking mitigate against the use of simple protocols, and that a broad knowledge and understanding will be essential. This is when an ability to synthesise the data about the new drug, with information about those drugs already being taken, based on a fundamental understanding of where issues are likely to arise, is needed.

Understanding the potential for adverse drug reactions with certain drug or patient groups, or drug interactions caused by the action of one drug on, for example, liver enzymes are all needed. The main question is – can this be taught and learned on a short prescribing course? Well, an appreciation of the issues can be taught, and the professionalism of the nurse used to ensure this is used appropriately. Continuing professional development is also an essential element of any professional role. As long as courses teach an acceptance of one's own limitations and where to look if further information is required, the need for a fundamental understanding of *all* aspects of pharmacology can be minimised.

Understanding one's own limitations

Nurses, probably more than any other healthcare professionals, understand the term working to scope. One of the learning outcomes expected by the NMC and the RPSGB is that the prescriber will know their limitations – know when the signs and symptoms are outside the experience of the prescriber, and know when and where to refer. In order to complete the course successfully, the student prescriber must demonstrate achievement of a series of competencies outlined by the National Prescribing Centre.[13] These competencies cover the range of areas from the curriculum, including knowing the limits of your own knowledge and skills, working within them and knowing when to seek guidance from another member of the team or a specialist.

Conclusion

Creating more independent prescribers should not encourage isolation but allow decisions to be made simply and efficiently for patient benefit within the prescriber's sphere of competence. This benefits the patient in their ease of access to professionals, and potentially also medicines and continuity of care. It is this aim and not the enhancement of one profession or the role erosion of another that is at the heart of the change.

Each individual healthcare professional chose their profession with care because of some distinct characteristics of that profession – whether it is caring for people, a desire to understand more about how drugs work or the desire to specialise in ophthalmics or whatever. These distinct characteristics need to be maintained within the emerging roles not as barriers but to empower the individual to practise in their chosen way for the benefit of the patient.

There are implications for practise from a number of the cited papers but perhaps in particular from the paper by Hay and colleagues.[5] As healthcare teams employ nurse prescribers more and more to help provide a streamlined service, the nurse prescriber must be fully integrated into the team. If it is true that the nurse needs more pharmacology training, then the healthcare teams also need more information about what the nurse prescribers actually are and do. The RPSGB asks that each pharmacist undergoing training as a prescriber presents a session to their colleagues about the role of the pharmacist prescriber. If nurses were encouraged to do this, it might help bridge some of the knowledge gaps about nurse prescribing within the medical profession and the wider team.

We can conclude that nurse prescribing is a natural extension of the work of many nurses both in the primary/community care settings and in the hospital environment, removing the need for them to require doctors' signatures on prescriptions of an already carefully selected medicine. We can also suggest that titles such as 'non-medical' prescribing help to maintain the old hierarchies within medicine.

When the elephant is gone, what do we want to be left? One of the reflections in the paper by Charles-Jones *et al* (2003) suggests that the changes in the primary healthcare workforce will produce a different type of general practice – more efficient but less personal.[14]

So is the true elephant in the room ignorance, a fear of role erosion among medical colleagues, or a lack of understanding of the prescribing role and educational preparation of the nurse? Can we now accept that with a greater understanding of the actual prescribing process, the elephant can be safely talked about and waved goodbye?

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Barry Strickland-Hodge, School of Healthcare, Baines Wing, University of Leeds, Leeds LS2 9UT, UK. Email: B.Strickland-Hodge@leeds.ac.uk

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