



# Competency for new prescribers

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In 2006 it became legal under Britain's 'non-medical prescribing programme' for nurses 'to prescribe any licensed medicine for any medical condition within their competence, including some controlled drugs'. This was the culmination of a movement, which started 20 years ago, to extend prescribing rights to more members of the healthcare team. Earlier debate had been keen and prolonged with the British Medical Association, in particular, expressing concerns about the quality and safety of prescribing by non-medical health professionals.

The decision to grant nurses extended prescribing rights was, appropriately, accompanied by the requirement for special training and accreditation. New prescribers undergo a minimum of 25 days formal instruction, including pharmacology and principles of prescribing, and 12 days of medically supervised prescribing practice, usually over a three-month period. Some of the first nurses trained became 'supplementary' prescribers working alongside a doctor. This prescribing was later broadened to allow independent prescribing from a limited list of medicines for selected conditions. A formal evaluation of this program was completed in late 2004 by members of an

academic nursing unit (rather than an independent research team). They found satisfactory competence, mostly appropriate prescribing and little evidence of unsafe practice.<sup>1</sup> No direct comparison was made with medical prescribers, but in other comparative studies very few differences have been detected, although clinical outcomes were not reported.<sup>2,3,4</sup>

Perhaps what matters most is not the range of health professionals who may prescribe, but the adequacy of their training and continuing professional development. The extension of prescribing should be done with extreme care, adequate training and ongoing evaluation as the concept is very vulnerable to outside criticism. However, this brings into focus the competence of doctors and pharmacists – the current prescribers in our society. Prescribing worldwide is not uniformly of high quality (for example, overprescription of antibiotics) and until recently training in prescribing has been inadequate. One British medical student contrasted the full program provided for new nurse prescribers with the few **hours** of training in her own medical school.<sup>5,6</sup> Retail pharmacists prescribe, dispense and sell so they have a potential conflict of interest. The sparse evidence that exists suggests that pharmacists – at least in the UK – do not make evidence-based recommendations about over-the-counter products.<sup>7</sup>

The essential ingredients of prescribing competency start with an adequate diagnosis as, in its absence, all prescriptions are likely to be irrational. Specifying a therapeutic goal focuses the prescriber's intent. There must be an appreciation of the pharmacology of the drugs prescribed, whether from a limited or an extended list. Selection of a safe and cost-effective drug from those available can often be aided by evidence-based guidelines. Writing a legal prescription, especially with computer support, is comparatively simple to master. Helping patients adhere to their treatment requires skill and knowledge of the factors that aid or hinder compliance and that help them incorporate the new regimen into their daily lives. In particular, patients must be alerted to the possibility of adverse reactions and know what to do if they occur. This was one of the few areas in which the British evaluation found that nurse prescribers were sometimes deficient.<sup>1</sup>

In Australia, nurse practitioners prescribe from limited lists, often in tightly defined specialty areas. There is clearly support

### In this issue...

Extending prescribing rights to health professionals other than doctors is controversial. Tony Smith suggests that no changes should be made until there are improvements in our monitoring of prescribing.

Under the current system, there are still opportunities to enhance the quality use of medicines. Paul Abbott tells us antibiotics are often inappropriate treatments for dental pain, and Michael Abramson, Nicholas Glasgow and Christine McDonald say that many patients are not receiving optimum care for chronic obstructive pulmonary disease.

There remain areas of medicine where the optimum treatment is uncertain. Examples include the role of long-term antidepressants in bipolar disorders, discussed by David Pyle and Philip Mitchell, and the use of metformin during pregnancy, discussed by Bill Hague.

for this, especially in remote and rural areas not served adequately by doctors and pharmacists. The Society of Hospital Pharmacists<sup>8</sup> endorsed the need for special training if prescribing by pharmacists was to be extended to prescription drugs, and emphasised the need to separate wherever possible the prescribing and dispensing roles. Other health professionals (for example optometrists and physiotherapists) commonly have very limited prescribing needs and the convenience of patients must be one factor in deciding whether to extend their prescribing rights. With adequate training, supervision (where necessary) and regular evaluation, non-medical health professionals working with limited formularies should be capable of prescribing to an appropriately high standard.

Medical educators have belatedly awakened to the need to train students for the task of prescribing which, conservatively, will be undertaken at least 200 000 times in a general practitioner's career. The new computer-based prescribing curriculum assembled by the National Prescribing Service is being adopted by medical schools and has received positive support from teachers and senior medical students who have worked with it.<sup>9</sup> It may be useful for training other health professionals.

Any extension of prescribing must be evaluated using routinely generated data. In Australia, prescribing data are captured in pharmacists' computers, but only prescriptions for drugs listed on the Pharmaceutical Benefits Scheme are held in Commonwealth databases. This means that at least 20% of all prescriptions, whoever writes them, are not available for any form of evaluation. This has long been a major stumbling-block for the quality use of medicines. Our legislators appear powerless to take the simple steps needed to make complete, de-identified prescribing data available. This enabling step should be a prior requirement to any extension of prescribing rights.

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## Letters

Letters, which may not necessarily be published in full, should be restricted to not more than 250 words. When relevant, comment on the letter is sought from the author. Due to production schedules, it is normally not possible to publish letters received in response to material appearing in a particular issue earlier than the second or third subsequent issue.

### Can we deny patients expensive drugs?

Editor, –We read with interest the editorial 'Can we deny patients expensive drugs?' (*Aust Prescr* 2006;29:146–8). We agree with many of the author's arguments, but take exception to the suggestion that Pharmaceutical Benefits Advisory Committee (PBAC) processes be bypassed for drugs targeting rare diseases and for which no PBAC submission has been made. The authors suggest that in such cases the Pharmaceutical Benefits Scheme (PBS) 'subsidise the use of these medicines for an indication after conventional therapies have proven ineffective'. We infer that such medicine be subsidised irrespective of costs. This implies society is willing

to accept a higher cost per unit of health (for example a year of life) on the basis that the disease is rare. Some things need to be clarified; rare does not mean severe and expensive does not mean better. We acknowledge that efficiency should not be the only criteria in resource allocation decisions and that equity considerations need to be taken into account also. However, the fact that a person has a rare, as opposed to a common, condition is not a good moral basis for accepting higher opportunity costs. Such a system would send all the wrong signals to the research and development community. Locally, pharmaceutical companies would stop applying for PBS funding for drugs that target rare diseases. On a global