Comparing nurses’ and doctors’ prescribing habits

In this article...

- Nurses’ views on prescribing
- Doctors’ views on nurse prescribing
- Differences and similarities between nurses’ and doctors’ views

Keywords: Nurse prescribing/Medical prescribing/Medical mentor
- This article has been double-blind peer reviewed

Nurses’ prescribing behaviour at a mental health trust was compared with that of their medical mentors to assess similarities and differences.

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This study was prompted by:

- A shortage of doctors below consultant grade;
- Huge variance between individual nurses’ recorded prescribing activity;
- Disparate stated views on prescribing among NPs.

The study examined whether NPs at one mental health trust prescribe in the same way as their medical mentors.

Literature review

The NHS Plan (Department of Health, 2000) highlighted the importance of extending nurse prescribing to the success of NHS reforms, while the Scottish Government (Watterson et al, 2009) found widespread benefits of nurse prescribing. The British Medical Association has also acknowledged non-medical prescribing as important in care development (Stuttle, 2010).

The NHS Commissioning Board (2012) urged organisations to consider the benefits of independent non-medical prescribing in service design. Evidence – for example, Ndosi et al (2013) and Arts et al (2012) – shows prescribing decisions of specialist nurses are as safe and clinically effective as those of doctors, while patients value the consistency of NPs (Ross, 2011). Nurse prescribing improves services, care and resource management (Carey and Stenner, 2011), with patients believing nurses understand their needs more than doctors and advocating nurse prescribing (Wix, 2007).

Aim

The primary objective of our study was to explore similarities and differences in prescribing habits and decision making of nurses and medical mentors to inform future nurse-prescribing strategy.

Method

The 14 NPs who wrote the most prescriptions, as shown in monthly prescribing

Authors Frazer Funnell, Kathy Minns and Kim Reeves are nurse specialists in child and adolescent mental health services, all at South Staffordshire and Shropshire Healthcare Foundation Trust, Stafford.


Background Nurses’ prescribing activity in a mental health trust prompted examination of whether nurse prescribers replicate their mentors’ prescribing habits.

Aim To explore nurses’ and medical mentors’ prescribing habits to inform nurse-prescribing strategy.

Method The trust’s 14 most-active nurse prescribers and nine of their medical mentors were interviewed. Transcripts underwent phenomenological analysis.

Results 64 themes emerged showing nurses and doctors approach prescribing differently. Themes were grouped into four categories.

Discussion Nurse prescribers tend to have greater holistic awareness of patients but are also more risk averse.

Conclusion Greater strategic vision is required to incentivise nurse prescribing; on its current trajectory it will not meet identified prescribing needs.

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logs, were recruited to a purposive sample, along with nine designated medical mentors. Three clinical nurse specialists – all qualified prescribers – then conducted semi-structured interviews with them.

Interviews focused on prescribing habits and decisions (Box 1). These were transcribed and phenomenological analysis of prescribing patterns and decisions carried out using those transcriptions. In total, 64 emergent themes were identified then detailed into a coding frame. This allowed comparison of nurses’ prescribing decisions and those of medical mentors.

**Results**

The data analysis reflected a variety of perspectives, most of which were concordant with available evidence. Findings are grouped into four main categories. The key points from each are summarised in Box 2.

**Nurse prescribers’ views**

Twelve of the nurse participants saw themselves as comparative juniors in prescribing partnerships with doctors, wanting to discuss prescribing decisions with a doctor. In contrast, a quarter expressed frustration at formulary limitations and at being limited to dose titration instead of initiating treatment. Three made independent prescribing decisions; most said they would be prepared to take some prescribing responsibilities when doctors were on leave.

The nurse participants perceived doctors to have a broader knowledge of general physical medicine and greater experience of prescribing and related issues. Thirteen felt any complexities – for example, polypharmacy or prescribing off-licence medicines – increased risks and dictated the need for a doctor to manage the prescribing.

All sought the teaching and influence of doctors but did not aspire to prescribe in exactly the same way as their medical mentors. While feeling they picked up the same cautions in decision making as doctors, most also identified therapeutic risk taking (such as reliance on medication to manage risk, dose changes or regimens, or polypharmacy) by their medical mentors, which they were less inclined to adopt. Seven thought nurse prescribing only elicited cost savings if nurses shared prescribing burdens equitably with medics; however, seven thought equitable prescribing with doctors was undesirable.

Seven nurse prescribers felt their prescribing preferences were due to their past prescribing experiences as opposed to medical role models.

Nine nurse participants felt they did not prescribe like their medical mentors or arrive at prescribing decisions in the same way. At the end of their semi-structured interviews, participants were invited to make any final comments. Nurse participants seemed keen to highlight the impact of deliberate caution on their prescribing decisions; 12 said formulating prescribing decisions differently from doctors was not related to levels of prescribing knowledge and experience, but because nurse prescribers were being deliberately cautious – doctors were simply more ready to prescribe than they were.

When they did prescribe, nurse participants generally felt they elicited greater patient participation in decision making and concordance, and that they were better than doctors at liaising with other services in respect of medication.

Thirteen nurse participants said additional responsibilities and a lack of financial reward were disincentives to prescribing. Eleven felt prescribing should be limited to those with suitable post-qualification and clinical experience and, even then, that nurses should prescribe as they wished to and not to a service agenda.

**Doctors’ views of nurse prescribing**

Most medical participants (all were consultant psychiatrists) wanted nurses to make more independent decisions and broadly envisaged NPs developing towards the same formularies as themselves; they expected nurses to develop at different rates but work towards prescribing on an equal footing with doctors. Only one cited nurse prescribing as involving a limited formulary and uncomplicated cases. Five expressed frustration at NPs’ slow development; they thought NPs shared skills rather than usurping roles, but felt they lacked confidence and were unnecessarily cautious when prescribing. All felt doctors would continue to have their own roles and NPs would work alongside them.

Five medical participants broadly expected experienced NPs in specialist areas to have a similar level of clinical expertise to themselves and be able to make equally effective prescribing decisions. They also felt nurses were better at engaging patients who were non-concordant and noted medication responses more quickly.

**Nurse prescriber behaviour**

Most nurse prescribers did not commence medication independently, despite a quarter citing diagnostic remit or cover for the leave of their medical mentors. All said they were less likely than doctors to arrange physical screening for patients; regarded off-licence medicines as more risky than licensed medicines; were experienced nurses and experts in their field; felt first-hand knowledge of patients’ medication management was vital.

Eleven nurse prescribers wanted more advanced training on physical health issues but felt they had a basic awareness of physical health conditions. All completed a monthly prescription log but did not have access to that of their medical mentor. All were happy with levels of scrutiny, mostly received in formal, monthly supervision sessions, and all regularly accessed peer supervision and informal supervision from medical mentors or other doctors on an ongoing basis.

All nurse participants felt able to challenge other prescribers about decisions. They felt knowledge gaps between doctors and nurses had narrowed greatly, with most using the 10th revision of International Classification of Diseases’ multiaxial inventory (World Health Organization, 1990) to support formulation. They often used Maudsley prescribing guidelines (Taylor et al, 2012) to confirm prescribing decisions.

**Commonalities**

Both groups of participants felt a decision not to prescribe was as important as prescribing. All focused on a risk/benefit analysis when decision making. A quarter of the nurses were happy to independently review and rationalise medication already prescribed by a doctor; most of the doctors felt nurses should do this more often as they knew patient circumstances.

Both groups felt patients were highly satisfied with nurse prescribing and thought nurses had a more holistic view, understanding the contextual, situational and practical impact of medication for patients better than doctors. They also envisaged NPs being most used in specialist areas but felt nurse prescribing resulted in no real cost benefit and reduced therapeutic capacity increased medication use.
Nursing Practice
Research

**BOX 2. STUDY FINDINGS**

**Nurse prescribers’ (NPs’) views**
- Most saw themselves as juniors in prescribing partnerships with doctors.
- Most independent NPs did not initiate treatments independently.
- NPs sought the teaching and influence of doctors but felt they did not prescribe like their medical mentors.
- NPs were deliberately more cautious in prescribing than doctors.

**Doctors’ views of nurse prescribing**
- Specialist nurses could develop to equitable prescribing.
- NPs were sharing responsibilities, not usurping roles.
- Nurses facilitate greater concordance and discern patients’ treatment responses more quickly.
- Nurses were cautious prescribers and developed slowly, but more prescribers are needed and nurses could fill the gap.

**NP behaviour**
- NPs were usually experienced nurses.
- NPs had monthly formal and ongoing informal supervision from doctors and complete monthly prescribing logs.
- NPs used Maudsley guidelines to confirm prescribing decisions.
- NPs felt able to challenge other prescribers’ prescribing decisions.

**Commonalities**
- The decision not to prescribe was as important as prescribing.
- Patients were highly satisfied with nurse prescribing.
- Nurses understood patient circumstances and progress better.
- NPs could be most used in specialist areas.
- NPs gave no real cost benefit.

**Discussion**

This survey suggests NPs perceive independent prescribing as a risky activity that is not remunerated, which fosters reluctance to independently initiate medication and share responsibilities with doctors. However, their approach was different to that of doctors. They demonstrate a greater holistic awareness of the patient, as well as practical and clinical implications of medication and the impact of prescribing on significant others. Doctors reflected greater physiological understanding, prescribing confidence and therapeutic risk taking, seemingly based on their greater prescribing experience and breadth of training.

Doctors generally thought nurses were better placed to observe responses to medication that might require dose changes or other action. Despite doctors feeling nurses should rationalise medical prescribing more often, most NPs look to doctors to either make most prescribing decisions or endorse their decisions before they act.

NPs and doctors are trained to show use of the same evidence and guidance when making clinical decisions, but our study indicates that nurses’ observations seemed more practical and patient centred. Doctors said that, with the same evidence, guidance and assessment processes, NPs should come to equitable clinical conclusions and prescribing decisions as themselves.

The fact that nurses sometimes avoided off-licence prescribing seemed to stem from assumptions that such prescribing denotes significant clinical complexities and risk. Nurses were far more reluctant to take therapeutic risks than doctors. Doctors generally expressed frustration at nurses’ reluctance to prescribe independently, not least because their broad expectation was of NPs developing to equitable prescribing and formularies. A few nurses were also frustrated, but this was a result of formulary and prescribing limitations.

Nurses felt prescribers should stick to formularies with which they were comfortable, and that networking, awareness of evidence, organisational support and supervision were vital for them to progress. Overwhelmingly, NPs said only clinicians with extensive experience would be suitable for prescribing training.

Most respondents thought nurse prescribing was cost neutral. Doctors did not feel their roles would be usurped, but rather that responsibilities would be shared, which they envisaged would increase capacity and responsiveness of services. Most doctors foresaw that as being necessary.

**Conclusion**

Nurses’ prescribing habits and decision making do not enerally emulate those of medical mentors; neither do nurses generally aspire to prescribe equivalently. There is a perception that a greater holistic perspective and understanding of patients’ needs means nurses are better placed than doctors to make some prescribing decisions; however, nurses displayed a reluctance to make independent prescribing decisions even within their specialist fields, and to adopt the therapeutic risk taking of mentors.

Whether apparent risk aversion is allied to a more holistic focus or anxiety at prescribing is unclear. In general, NPs do not share prescribing responsibilities equivalently with doctors. Two participants in this study demonstrably did so but it was unclear whether they took greater prescribing responsibility because they prescribe in teams where doctors are sparse, or whether they would naturally graduate to that through preference. That phenomenon requires further investigation and clarity. Such individuals may hold the key to achieving a balance between nurse prescribing being distinctly different from that of doctors in the way nurses arrive at prescribing decisions (in terms of caution and understanding of patient circumstances) and meeting prescribing needs as doctors, patients and service designers might wish.

A shortage of doctors, reduced therapeutic capacity, increased referral rates and growing evidence for pharmacological treatments could make nurse prescribing central to service delivery. However, on its current trajectory, nurse prescribing will not meet identified prescribing needs.

Greater strategic focus and vision are needed so nurse prescribing can develop to meet patients’ needs and lead to a more equitable sharing of prescribing responsibilities with doctors. Using the expertise of more advanced NPs to drive that represents a logical pathway but it is unclear whether increasing NPs’ clinical confidence will make them less reticent to prescribe – the basis for prescribing reticence among nurses requires further investigation.

**References**


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