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# Nonmedical Prescribing in the United Kingdom

## Developments and Stakeholder Interests

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**Abstract:** This article reflects upon the introduction of nonmedical prescribing in the United Kingdom and describes the historical developments within the National Health Service over the last 2 decades, together with an assessment of the impact of this prescribing for various stakeholders, drawing upon relevant research. We argue that a number of issues are associated with the introduction and development of nonmedical prescribing, including benefits to patients, the promise of increased autonomy for professions such as nursing and pharmacy, explicit and implicit government objectives, and threats to medical dominance and autonomy. **Key words:** *Non-medical prescribing*, *nursing*, *pharmacy*, *United Kingdom*

THIS ARTICLE reflects upon the introduction of nonmedical prescribing (NMP) in the United Kingdom and describes the historical developments within the National Health Service (NHS) over the last 2 decades, together with an assessment of the impact of this prescribing for various stakeholders, drawing upon relevant research. We argue that a number of issues are associated with the introduction and development of NMP, including benefits to patients, the promise of increased autonomy for professions such as nursing and pharmacy, explicit and implicit government objectives, and threats to medical dominance and autonomy. From these various and potentially conflicting interests—from something "as simple as giving prescribing rights" (Jones, 1999, p. 5) to a "dangerous, uncontrolled experiment" (Horton, 2003, p. 1876)—an attempt is made to consider how successful NMP in the United Kingdom has been and how it may evolve in the coming years.

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### THE HISTORY OF NMP IN THE UNITED KINGDOM

To understand the significance of NMP, a relevant starting point is the statutory control of medicines in the United Kingdom, which has undergone a number of changes in recent years. Medicines in the United Kingdom have been increasingly regulated since the end of the 1800s, culminating in the Medicines Act (1968), which consolidated much previous legislation and defined medicines in terms of prescription-only medicines (POMs), pharmacy-only (P) medicines, and general sales-listed (GSL) medicines. POMs could be prescribed only by authorized practitioners—qualified doctors and dentists—using either

private prescriptions or, more commonly after 1948, NHS prescriptions. This situation effectively made the medical profession gatekeepers for medicines, and this was certainly the case for those medicines considered more likely to cause harm or abuse such as controlled drugs such as morphine. Although pharmacists retained a counter-prescribing role selling P and GSL medicines, since the 1980s, there has been a trend toward increasing deregulation of POMs (Blenkinsopp & Bradley, 1996) to P or GSL status in pharmacies and general retail outlets. These developments represented the first indication that medical control of medicines might be challenged (Britten, 2001) and were joined by a potentially more far-reaching proposal to extend prescribing rights to nonmedical professionals.

This arose in the form of the Cumberlege report (Department of Health and Social Security, 1986), which concluded that district nurses and healthcare visitors involved in neighborhood nursing should be allowed limited prescribing rights. This led to an advisory group being convened to consider nurse prescribing, which concluded in the Crown report (Department of Health [DoH], 1989) that there were inefficient practices in primary care that nurse prescribing could rectify. In particular, it was noted that: "a doctor often rubber-stamps a prescribing decision taken by a nurse [. . .] which is demeaning to both nurses and doctors [. . .and] action is now needed to align prescribing power with professional responsibility" (DoH, 1989, p. 12). By 1994, a national nurse prescribers' formulary for district nurses and healthcare visitors had been established and prescribing without a doctor was undertaken in several pilot sites following legislation. Appliances such as dressings, catheters, stoma products, and some medicines were included in the formulary (Nurse Prescribers' Formulary [NPF], 1994) (Table 1), and from 1998, all suitably trained district nurses and healthcare visitors could prescribe from the NPF.

A second Crown report (DoH, 1999) set out more far-reaching proposals for the prescribing and supply of medicines in the United Kingdom, including not only nurses but also pharmacists as potential prescribers, and proposals included a dependent, supplementary form of prescribing. This was introduced in

**Table 1.** Historical development of nonmedical prescribing in the United Kingdom

| | |
|---|---|
| 1992 | Primary legislation for independent nurse prescribing enacted (Medicinal Products: Prescription by Nurses etc Act 1992) for district nurses (DNs) and healthcare visitors (HVs) |
| 1994 | First prescribing pilots by nurses and introduction of Nurse Prescribers' Formulary (NPF) |
| 1998 | National independent nurse prescribing possible for DNs and HVs (with V100 training) from revised NPF |
| 2001 | All nurses (with V100 qualification) able to prescribe from NPF |
| 2002 | Prescribing from Nurse Prescribers' Extended Formulary possible for V200 trained nurses, including more prescription-only medicines |
| April 2003 | Legislation enabling suitably trained nurses and pharmacists to practice as supplementary prescribers (Health and Social Care Act, 2001) introduced |
| April 2005 | Regulatory changes allowed nurse and pharmacist supplementary prescribers to prescribe all controlled drugs except Sch.1 (The Misuse of Drugs (Amendment) (No. 2) Regulations 2005) and unlicensed medicines |
| May 2005 | Suitably trained physiotherapists, chiropodists/podiatrists, radiographers, and optometrists able to practice as supplementary prescribers |
| May 2006 | Legislation enabling nurse independent prescribing (formerly extended formulary nurse prescribing) and independent prescribing for pharmacists introduced |

2003 following legislation, allowing suitably trained nurses and pharmacists to prescribe all medicines except controlled and unlicensed drugs in accordance with a clinical management plan (CMP) produced after an initial doctor's diagnosis and with the agreement of the doctor, the supplementary prescriber, and the patient. Controlled drugs were also prescribable by nurses and pharmacists using supplementary prescribing from 2005.

In 2005, allied healthcare professionals such as physiotherapists, radiographers, podiatrists, and optometrists were also able to become supplementary prescribers (DoH, 2005), reflecting the rapid development of NMP in the United Kingdom, which could be contrasted with the more gradual introduction of prescribing rights in the United States, for example, for nurses (Armstrong et al., 1995) and pharmacists (Emmerton et al., 2005). The most recent development in NMP involved legislation permitting trained nurses and pharmacists to independently prescribe almost all medicines within their clinical competence (DoH, 2006). This represented the first independent prescribing opportunity for pharmacists and consolidated the position of nurse prescribers, who were then able to access almost the full formulary of medicines, as per doctors. Some controlled drugs remain excluded from independent NMP, although at the time of writing (September 2007), this is currently under review.

## IN WHOSE INTERESTS? IMPLICATIONS OF NMP FOR UK STAKEHOLDERS

This historical summary overlooks how key stakeholders have both sought to influence and also been influenced by such changes to prescribing in the United Kingdom. These stakeholder groups, including the nursing, pharmacy, and medical professions and their members, patients, and also the UK government, are now considered and references to research are also made, highlighting current knowledge about NMP in the United Kingdom.

### The nursing profession

Nurses were the first nonmedical professionals to gain prescribing rights, and a number of reasons may be advanced as to why this occurred. This description of the development of NMP hinted at several reasons for nurses acquiring prescribing privileges: first, allowing nurses to prescribe addressed the unsatisfactory and inefficient system whereby nurses had to ask doctors to write prescriptions for conditions that were already effectively under their management, such as wound care and incontinence; second, NMP offered a better deployment of the nurses' skills and afforded them greater professional autonomy, challenging their traditionally subordinate position within the division of labor in healthcare (Turner, 1995). However, at the same time, the nursing profession had become an increasingly vocal (and indeed powerful) profession and its effective political lobbying may also have played a part in nurses being afforded prescribing privileges (Sims & Gardiner, 1999) before pharmacists. That nurses became prescribers before pharmacists may also be explained by the nature of the respective professions and their members as well—most nurses are NHS employed, whereas the majority of UK pharmacists still work in the community (or retail) sector as pharmacy owners or increasingly as locums or employees and have been perceived to be commercially motivated "shopkeepers" (Eaton & Webb, 1979; Hughes & McCann, 2003). Perceptions of these motivations may not have been conducive to pharmacists obtaining prescribing status. In addition, nurses have also enjoyed a much closer proximity to patients (Malone, 2003) and doctors than pharmacists, which also made prescribing a more viable proposition in terms of understanding the background and needs of the patient and securing medical prescribers' necessary trust and confidence in nurses' abilities.

There are now almost 42,000 nurses with a prescribing qualification in the United Kingdom (around 6% of all UK registered nurses), of whom nearly 13,000 are able to prescribe from the full formulary using independent

or supplementary prescribing (Nursing and Midwifery Council, 2007). Furthermore, research suggests that nurses appear to have welcomed their prescribing roles (Luker et al., 1997; Rodden 2001) and early frustrations about prescribing from a limited formulary were identified but allayed by the subsequent legislative changes to full formulary prescribing. Despite the benefits of increased professional autonomy, there is evidence, however, that nurses have been cautious in undertaking prescribing and may even be reluctant to do so once qualified (Bradley et al., 2007; Hall et al., 2006). Linked to the benefit of increased professional autonomy is the prospect that NMP will enhance perceptions of nurses through gaining new skills and knowledge. An opposing concern, however, is that NMP focuses upon nursing *qua* medicine rather than nursing *qua* nursing (Fawcett, 2007) with a resultant overemphasis upon a biomedical model of curing rather than what has been described in the past as the traditional value of holistic caring, embodied in nursing practice (Baummann et al., 1998). Furthermore, despite acquiring new skills and knowledge through the accredited training nurses have to undertake before prescribing, there have been concerns that nurses' pharmacologic knowledge remains inadequate for prescribing responsibilities (Leathard, 2001; Offredy et al., 2007; Sodah et al., 2002), a concern not considered problematic (Fawcett, 2007) for the second NMP stakeholders to be considered as prescribers: pharmacists.

## The pharmacy profession

In contrast to nursing, pharmacist prescribing in the United Kingdom was a later development that arose from the recommendations of the second Crown report into the prescribing and supply of medicines (DoH, 1999) although earlier reports (Nuffield Report, 1986) had highlighted the need for pharmacists to take on new roles. From a professional perspective, there was concern about deskilling and dissatisfaction with current roles, particularly in the community or "retail" sector (Bissell et al., in press). From a policy perspective, the government recognized that pharmacists represented an underutilized healthcare group in the United Kingdom (DoH, 2005). Prescribing, it seemed, might address both these issues. Despite having enjoyed some increased control over medicines because of deregulation of POMs (Britten, 2001), the promise of NMP provided a welcome opportunity for a profession that has been considered restricted by occupational limitation (Turner, 1995) and isolation (Cooper, 2007) to not only to increase their professional autonomy but also to develop, in the community setting, closer links with the primary care team. Like nurses, pharmacists appear to have welcomed their prescribing role according to the published literature (George et al., 2006; Weiss et al., 2006), and although this is presently limited mainly to supplementary prescribing (almost 1300 pharmacists are now qualified to undertake supplementary prescribing but only 153 independent prescribing; Royal Pharmaceutical Society of Great Britain, oral communication, 2007), many expect and want to become independent prescribers (Lloyd & Hughes, 2007; Warchal et al., 2006).

Perhaps, a key difference between nurse and pharmacist prescribing, however, is that claims about inadequate pharmacologic knowledge have not been leveled at the pharmacy profession in contrast to the nursing profession (Avery & James, 2007; Horton, 2003). NMP has not been without problems on a practical level, however; both pharmacists and nurses have identified problems with the implementation of their prescribing, and, as regard to supplementary prescribing, have criticized the inflexible, time-consuming nature of CMPs, delays in practicing, problems accessing patients' records, and a lack of support at various levels (employers, peers, doctors, financial, and information technology) (Cooper et al., 2008).

## The medical profession

NMP potentially offers doctors a number of benefits and it has been anticipated that it will reduce doctors' workloads and result in "freeing up their time to concentrate on

patients with more complicated conditions and more complex treatments" (DoH, 2005, ¶10). It might also be argued that such benefits would also strengthen doctor's professional dominance through increasing the indeterminacy of their work in such complex cases in contrast to the increasingly regulated, technical, and routinized nature of prescribing (that is informed by evidence-based medicine and guidelines from bodies such as the National Institute of Health and Clinical Excellence). This would increase what has been referred to as the indeterminacy/technicality (I/T) ratio of doctors' work and help to further distance doctors from patients and other healthcare professionals and enhance their status (Jamous & Peloille, 1970). However, UK doctors have not been spared significant changes and even threats to their work and professional autonomy despite traditionally being regarded as the dominant profession in the healthcare division of labor (Britten, 2001; Friedson, 1970; Turner, 1995; Weiss & Fitzpatrick, 1997). Beside the threats of proletarianization (due to routinization and bureaucratization of medical roles) and deprofessionalization (due to an increasingly sophisticated lay public; Britten, 2001), the introduction of NMP might be considered another challenge and a possible encroachment on doctors' territory (Eaton & Webb, 1979).

Research also suggests that doctors do feel threatened by pharmacist prescribing (Buckley et al., 2006; Child & Cantrill, 1999; Hughes & McCann, 2003) and that, for nurse prescribing, there may be a resulting confusion or blurring of professional boundaries (Hay et al., 2004). Other studies, however, have indicated generally positive attitudes toward NMP by some doctors and especially those involved in mentoring supplementary prescribing nurses and pharmacists (eg, Avery et al., 2004; Lloyd & Hughes, 2007). Despite this, a number of critical voices within the medical profession have emerged. Horton (2002), for example, has argued that nurse prescribing represents a "dangerous and uncontrolled experiment," and Keighley (2006) has questioned the safety and financial security of permitting nurses to prescribe from a full formulary. Independent rather than supplementary prescribing appeared to be particularly contentious, raising concerns about the diagnostic competencies of NMP nurses and also pharmacists. Patient safety and costs appear to be commonly invoked concerns among doctors, and Avery and Pringle (2005) have argued that a lack of research into safety and costs has fueled the controversy of too rapid a development of NMP. Perceptions of safety and competencies have been researched, though, revealing conservative, responsible attitudes among nurses (Bradley et al., 2007) and prescribing that was generally informed by accepted standards (Latter et al., 2007). One paradoxical finding is that despite the concerns emerging from sections of the medical profession about NMP, research suggests that doctors may lack awareness and understanding of NMP and supplementary prescribing in particular (Hughes & McCann, 2003; Weiss et al., 2006).

### Government

NMP represents part of the UK governments' plans to modernize the NHS and was intended to lead to explicit benefits in breaking down traditional hierarchies and so "shatter the old demarcations which have held back staff and slowed down care" (DoH, 2000a, p. 83; 2000b). Five key aims were identified (Table 2), including changes in the roles undertaken by healthcare professionals, but

**Table 2.** Government aims of nonmedical prescribing in the United Kingdom (DoH, 2006)

| |
|---|
| Improve patient care without compromising patient safety |
| Make it easier for patients to get the medicines they need |
| Increase patient choice in accessing medicines |
| Make better use of the skills of healthcare professional |
| Contribute to the introduction of more flexible team working across the National Health Service |

patient benefits were always a priority. It has also been argued that NMP would lead to several implicit benefits for the government, primarily in relation to economic cost savings, and these are apparent in some sections of the medical professions' critique of NMP (Keighley, 2006).

Furthermore, McCartney et al. (1999) argue that plans for nurse prescribing are wrong to be viewed in terms of increasing patients' access to medicines and professionalizing nursing. Instead, they claim NMP for nurses is an exercise in saving money by using cheaper staff to prescribe, disguising a shortage of doctors by transferring routine prescribing and, politically, sending a message to the medical profession that their power can be diminished, if necessary, by the government. However, it may also be argued that the pace of NMP development in the United Kingdom together with government funding of NMP training (at strategic healthcare authority level) indicates the government's commitment to this healthcare initiative. Therefore, the UK government represents a significant driver in spite of claims that NMP might have been introduced hastily in the last decade (Avery & Pringle, 2005; Horton, 2003; Mazhindu & Brownsell, 2003).

### Patients

As noted in the UK government's aims for NMP, patients are described as being central and the benefits that are claimed for patients include a reduction in waiting times for treatment, consultations, and obtaining medicines. NMP may also be congruent with recent government concerns about seeking greater patient involvement in their care given that supplementary prescribing, for example, requires the patient to agree to the development of a CMP, and indeed, the accreditation of NMP courses is contingent upon prescribers being able to demonstrate a commitment to patient involvement in the prescribing consultation. Unfortunately, little research has directly involved or engaged patients and the public in relation to NMP (Cooper et al., 2008), but what studies there are reveal that both nurse and pharmacist prescribing is valued by patients: in the primary care setting, nurses' prescribing was viewed positively because of claims that nurses knew the patient and their condition well (Luker et al., 1998), while also providing information, reassurance, and continuity of care (Brooks et al., 2001). Research indicates that pharmacist supplementary prescribing was valued by patients (Smalley, 2006) and resulted in more medicines information being provided and longer consultations than with their doctor (Weiss et al., 2006). Patients also recognized that NMP may reduce the workload of their doctor (Brooks et al., 2001; Weiss et al., 2006), and a random sample of the public was overall confident about nurse prescribing (Berry et al., 2006).

A point about which patients may be expected to be concerned is the safety of NMP. As noted, there is scant research to underpin doctors' claims that NMP may be detrimental to patient safety, but issues such as nurses' lack of pharmacologic knowledge (Offredy et al., 2007) may be significant and further research is needed to help inform such concerns.

## THE FUTURE OF NMP IN THE UNITED KINGDOM

NMP in the United Kingdom still represents a small percentage of the overall prescribing in community and primary care: in 2006 in England, nurses prescribed 6,307,506 items and pharmacists only 31,052 items, representing 0.8% and 0.004%, respectively, of the overall volume of some 751,954,100 items prescribed (Guillaume et al., in press; Horner, 2007). However, the trend overall is toward significant increases year on year for nurses and pharmacists, and, for independent nurse prescribing, this has increasingly included medicines, such as antibiotics, previously prescribed only by doctors (Prescribing Support Unit, 2007). As regards the future of NMP, it is anticipated that further increases in prescribing volume will occur as more pharmacists qualify independently, and there are proposals as well for optometrists to become independent prescribers. This also calls into question the education and training of those

hoping to undertake NMP and this may be a significant factor and require changes in the future for the success of NMP. As Avery and James (2007) note, enduring concerns about nurses' lack of pharmacologic knowledge and pharmacists' lack of diagnostic and examination skills may require the integration of NMP training into the undergraduate curricula of these professions instead of what they consider to be the inadequate present 26-day course and 12-day learning in practice. This may also address concerns about the number of NMP courses nationally that teach nurses, pharmacists, and allied healthcare professionals together despite each professions' potentially very different educational needs.

## CONCLUSIONS

The introduction of NMP in the United Kingdom has been relatively rapid and also ambitious in embracing not only nurses and pharmacists but also, more recently, other allied healthcare professionals while trying to balance a number of competing professional concerns. The question of whose interests NMP serves is not an easy one to answer because there appear to be conflicting arguments about benefits, even among individual stakeholder groups: for nurses, in particular, it would appear that their professional interests are served by greater clinical autonomy and better working practices with NMP, but may also be detrimentally affected if they are viewed as being merely exploited as a "cheaper" source of labor, who are being asked to move away from the traditional guiding principles of caring. For the medical profession, too, there is a tension between viewing NMP as a mechanism that will lead to improved working practice or a threat to professional dominance and power within the healthcare division of labor. The conflicting views expressed by doctors positively involved in NMP mentoring, and those who hold critical views about the entire NMP enterprise make it difficult to determine whether NMP is ultimately in the interests of the medical profession. It appears likely, however, that NMP in the United Kingdom will continue to expand and the issues and interests explored in this article—professional autonomy, boundary encroachment, patient-centered policy, and economic costs—will continue to not only drive these developments but also cause potential conflict.

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