

# Is it time to re-examine the doctor-nurse relationship since the introduction of the independent nurse prescriber?

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## KEY WORDS

Non-medical prescribing, power, professional relationship

## ABSTRACT

### Objective

The aim of this paper is to stimulate a debate and discussion into how the nurse-doctor relationship needs to change.

### Setting

The National Health Service, United Kingdom.

### Primary argument

The nurse-doctor relationship needs to be re-evaluated in light of the expanding role of nurse`s into areas that traditionally had been considered a doctor`s role. While the medical profession has been willing to relinquish some control to nurses in areas such as wound or incontinence care because these aspects do not threaten their authority, position or power. The issue of non-medical prescribing remains for some in the medical profession a topic of concern. Despite non-medical prescribing being discussed widely in the literature very little has been mentioned about how the introduction of the nurse prescriber has impacted the professional relationship between the nurse and the doctor.

### Conclusion

The blurring of the roles between nurses and doctors requires a re-evaluation of this relationship. As nurses take on more responsibility such as prescribing medication the old traditional view of this relationship is no-longer viable, if we are to maximise patient health care in the 21st century.

## INTRODUCTION

In order to explore the relationship it's important to understand the context of how this relationship has changed. The Introduction of nurse prescribing has had a profound effect on how a patient can obtain a prescription (Courtenay et al 2011; Jones et al 2011; Watterson et al 2009). This has resulted one might say in the inevitable blurring of the professional boundaries between the medical and nursing professions (Kroezen et al 2014; Kroezen et al 2013; Natan et al 2013; Bowskill et al 2012). What made doctors unique from other health professionals was the authority to prescribe medication and as a result the medical profession opposed granting prescribing rights to non-medical professionals. They had used similar tactics during the introduction of the National Health Service (NHS) to maintain a position of privilege and power. However by the 1990`s the political as well as medical landscape had changed. Politically the UK government faced numerous challenges on the public purse, cutting funding to the NHS would be seen as a vote loser. However making the resources already available to the NHS more accessible was something the public could understand. While secondly acknowledging that health care had become more technical and multifaceted requiring a much more co-ordinated approach. As a result, according to McCartney et al (1999), the UK government shifted its policy to reflect these views. A key component of this new policy was to extend prescribing rights to nurses and then use these nurses to make up the shortfall in doctors within the NHS. The government pushed through these plans despite the objections of the medical profession as a step too far and an attack on their authority (BBC 2005; Day 2005; Horton 2002).

The concept of the nurse prescriber is not unique to the UK but can be found worldwide from America, Australia, Europe and New Zealand. But what is unique is how extensive these rights are in the UK compared to other countries. In the UK a nurse can prescribe medication via two mechanisms. The first is as a supplementary prescriber (SP), under this method a tripartite agreement called a Clinical Management Plan (CMP) is drawn up between the doctor, the supplementary prescriber (a nurse or pharmacist) and the patient. This plan outlines the care and treatments that all parties agreed to with regard to the patients' illness and under what circumstances the SP could adjust or amend a patient's prescription without necessarily seeking the doctors' permission. It also outlined when the SP had to refer back to the doctor if the patient's condition fell outside of the parameters agreed.

Although the mechanism had many advantages (Carey et al 2014; Carey and Courtenay 2008; Morrison and Weston 2006; Hennell 2004), it allowed the SP to prescribe any drug as long as the drug or class of drug was mentioned in the CMP. Its main strength was that it worked well for patients with long standing health issues such as Diabetes, Asthma, Hypertension or COPD under the care of a dedicated doctor (Bissell et al 2008; Cooper et al 2008; Courtenay and Carey 2008; Courtenay et al 2007). However this mechanism had a number of weaknesses, it was cumbersome and time consuming because each patient needed to have a CMP before the SP could prescribe any drugs. If the patient presented with a new health problem not covered in the CMP the SP could not offer any treatment and would have to refer the patient back to the doctor. It was this inflexibility that eventually led to the UK government to introduce the independent non-medical prescriber in 2006. The key advantage of the Nurse Independent Prescriber (NIP) over the SP was the ability to prescribe drugs without the need of a CMP or requiring medical approval first. The success of NIP can be measured in terms of an improvement in the effectiveness of health care delivery, and being more responsive to the patients' needs (Jones et al 2011, Oldknow et al 2010).

As a result of the success of NIP the medical profession has shifted its argument away from the loss of medical authority. Instead they have moved to questioning non-medical prescribing in terms of its safety, its comparability to medical prescribing and even whether it is really necessary (Funnell et al 2014; Carey et

al 2009; Watterson et al 2009; Bradley and Nolan 2007; Ladd 2005; Latter et al 2005; Fisher et al 2003; Rodden 2001; Luker et al 1998). While these questions are legitimate concerns, it's surprising that the same arguments have not been used to highlight similar concerns about the prescribing habits of junior medical staff compared to more senior medical staff. Which raises the possibility the medical profession is using non-medical prescribing concerns to re-impose its medical domination. But what has not been debated or discussed to any great depth is the effect of the introduction of non-medical prescribing on the relationship between nurses and doctors. However before we can discuss this relationship we first need to understand the backgrounds of these two professions.

### **THE ORIGINS OF MEDICAL POWER**

Any attempt to analyse how the medical profession became so dominant in health care, must as a starting point understand that this dominance was not achieved overnight. It was in fact a long process. Michel Foucault one of the greatest philosophers and social theorists of the 20th century identified that the origins of medical power began to flourish from the 17th century onwards in what he called the "Disciplines". These disciplines began to develop alongside the developing institutions such as schools, hospitals and military organisations. The introduction of Disciplines not only standardised behaviour (Hardin 2001) but it was through this disciplinary power that one can meticulously control the body and use subtle coercions, to produce a docility-utility (Foucault 1995). This docility-utility is the means by which a person has hold over others so that they operate in a desired manner, with the techniques and efficiency that the person determines (Foucault 1995). This power was clearly identified in the seminal work of Freidson (1970) who argued that the medical profession had achieved this position of dominance by successfully negotiating considerable state sanctioned autonomy and self-regulation. In other words the medical profession over time began to slowly exert itself in areas over health and medicine. This control resulted firstly in dictating who should enter the profession to eventually who could legally treat a sick person. This dominance resulted in occupations such as Nursing and Pharmacist to fall under medical control.

However the very success with which the medical profession now controlled health care delivery, began to come under scrutiny from the government in the face of growing demands for improvements in health care delivery and a more efficient use of resources. This was most clearly indicated by the Wanless Review (Welsh Assembly Government, 2003) that assumed that 20% of work undertaken by medical staff will eventually be carried out by nurses. Some of these roles have been supported by the medical profession such as - wound care specialists, incontinence nurses; and diabetic nurses because they work within a framework of protocols and formularies, developed and approved by the medical profession that restricts and places the nurse in a subordinate position to the medical profession still (Creedon et al 2015). The government however was looking for a more radical solution to improve patients' access to timely treatments. What was highlighted was that patients at times faced delays in treatment, because doctors were not available to prescribe medication the patient needed. While experienced nurses who understood what was needed could not give that care. The government's response was to propose expanding prescribing rights to suitable qualified and experienced nurses, a response not universally supported by the medical profession.

### **ORIGINS OF THE NON-MEDICAL PRESCRIBER**

The attraction for the government of the introduction of the nurse prescribers' role was to make the NHS more responsive to the needs of the patient (NHS Plan 2000). However to implement this plan would require the government to undertake a complex legislative program of drafting new legislation and amending current legislation governing prescribing authority. The government also faced strong opposition from the medical

profession to the development of the non-medical prescriber (Keighley 2006; Avery and Pringle 2005; Horton 2002). The medical profession viewed the introduction of the nurse prescribers' role, as a direct challenge to both their authority and power (Elsom et al 2009; Waring 2007; Avery and Pringle 2005; Day 2005). This opposition to nurse prescribers should not be considered as unique to the United Kingdom; similar arguments were put forward in Australia (AMA 2005), New Zealand (Mackay 2003) and America (Hales 2002; Sharp 2000). The medical profession opposition to nurse prescribing in the UK however failed to appreciate that it was not solely about improving patient's access to timely health care. The UK government was in fact seeking ways to improve the efficiency of the NHS, in the face of an aging population with multiple complex health care needs that require multiple agency co-operation. It was an acknowledgement by the UK government that the medical profession could no-longer be the sole provider of health care. The solution to this problem according to the UK government was the nursing workforce. Nursing had become a graduate-entry profession and many nurses have undertaken a Master's degree giving them specialist qualifications. Coupled with the increasing technical skills required to perform many nursing tasks, expanding prescribing rights to suitably qualified and experienced nurses seemed a most logical solution to the UK government.

Having lost the argument the medical profession has seen an extensive legislative program put forward by the UK government. This initially gave prescribing rights to just nurses and pharmacists, but with this success it eventually saw it expand to include chiropodists/ podiatrists, physiotherapists, optometrists and radiographers. The nurse prescriber is now a vital part of delivering health care to-day. As the number of Nurse Prescriber`s have increased 43,000 in 2006 to 72,000 in 2015 (Merrifield 2015) many institutions such as hospitals, walk-in centres and GP practices routinely have nurse prescribers present. Despite the opposition of the medical profession to the concept of nurse prescribing, none of their dire predictions, such as patients coming to harm due to a non-medical prescriber over prescribing medication or inappropriate prescribing, have occurred. What has yet to be determined is how the introduction of the Nurse Prescriber has affected the professional relationship between the two health professionals.

## DISCUSSION

*"A nurse must begin her work with the idea firmly implanted in her mind that she is only the instrument by whom the doctor gets his instructions carried out: she occupies no independent position in the treatment of the sick person" McGregor-Robertson (1902).*

This statement, despite being over 115 years ago, demonstrates quite clearly the dominant position the medical profession had procured for its self with regard to health care delivery. Echoes of this dominance can still be found in the medical professions continued opposition to non-medical prescribing. However in the 115 years since this statement health care has undergone a dramatic change in terms of treatments and technology, but so too has societies views on gender stereotyping. Health care does not live in a vacuum and as society began to change so did health care, women were no-longer held back to being just nurses they were now physicians and surgeons. As a result from the late 1960`s through the 1970`s marked an important turning point in the field of social science research. This research was not solely related to society, health care also came under investigation. The work of Stein (1967) looked at the professional relationship between nurses and doctors in his article called "The doctor-nurse game". This article explored this relationship, starting from the superficial stereotypical idea dramatised in numerous novels and television series, to the game model, that demands participation. The attitudes created cause serious obstacles in the path of meaningful communication between physicians and nonmedical professional groups.

This idea of the nurse-doctor relationship has been further developed by numerous authors such as Freidson (1970), Abbott (1988) and Adamson et al (1995) who suggested that the relationship between the medical

and nursing profession display the classical case of a dominant profession (medicine) controlling a subordinate profession (nursing). The drive to maintain a dominant position continues to be the focus point of the nurse-doctor relationship (Apesoa-Varano et al 2011; Fisher 2009; Hirschhorn 2006; Fisher 2005). However despite this continuing need to impose themselves on other health professionals authors such as Copper et al (2008) and Kroezen et al (2013) have suggested that with the introduction of nurse prescribing the professional boundary between the medical and nursing professions need to be reassessed.

Prescribing had been traditionally an indication of the clinical autonomy and professional power of the medical profession within the wider structure of society (Weiss et al 2006). With the introduction of the nurse prescriber the medical profession has attempted to limit the sharing of knowledge with other health professionals, as well as making the medical profession the sole arbiter of health care management. The dichotomy between the perception (of what the medical profession believes is the extent of their power) and the reality (of how this power has been eroded) has become in effect what Fagin and Garelick (2004) described as the ongoing conflict around the doctor nurse working relationship. The medical profession has in response to nurse prescribing shifted its self from its prescribing role to one of a diagnostician in an attempt to re-impose its dominance over other health professionals. This action could be interpreted as the medical profession's failure to accept that it is no-longer in charge (Dent 2006, Willis 2006).

Health care is now viewed as a partnership between health professionals (a doctor or a nurse) and the patient. This change has also seen a shift in the relationship between health professionals. In part this is due to the blurring of roles between doctors and nurses. This has resulted in numerous authors suggesting that doctors should no longer be regarded as top of the health hierarchy nor thought of as indispensable to the delivery of healthcare (Crow and Smith 2003, Rosen and Dewar 2004, Barr and Ross 2006). This change in the professional relationship has also raised a question over power. Does the medical profession retain its power (over other health professionals still) or is this power now shared with the nurse prescriber.

## CONCLUSION

Despite overwhelming evidence of the benefits of nurse prescribing, the full potential of the role has yet to be attained. In part this is due to the continuing opposition of the medical profession to the idea of non-medical prescribers. This disparity not only strengthens the idea that medical prescribers are superior, but fosters the idea that the medical profession retain power over all health professionals. This opposition continues to hold back further development of nurse prescribing. Nurses need to take ownership of non-medical prescribing, by addressing the inequalities within the professional relationship. It is only by challenging this behaviour that will see nursing no-longer viewed as subservient to the whims of the medical profession. This will not be an easy task, challenging any behaviour is not easy however as more and more doctors become exposed to the work of non-medical prescribers, the concept of the nurse prescriber will no-longer be seen as an inferior to the medical prescriber and true equal partnership will develop between the two professions.

## RECOMMENDATIONS

- That nurse prescribers have the same educational opportunities as their medical counterparts' e.g in-house lectures, presentations from pharmaceutical companies.
- That nurse prescribers are given the opportunity to work with more experienced medical prescribers to develop not only their prescribing skill, but to foster a better understanding between the two professions.

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