

Analysis of interviews to uncover the effects of nurse prescribing on the doctor-nurse relationship

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KEY WORDS

Nurse prescribing, professional relationship, doctor and nurse views

ABSTRACT

Objective

The introduction of nurse prescribing has had a profound effect on how patients obtain a prescription. Yet very little has been researched about the effects of nurse prescribing on the professional relationship between nurses and doctors since its introduction. It was this lack of enquiry that led to this research study to see if this relationship has changed since the introduction of the nurse prescriber.

Design methods

A purposeful sample approach was chosen, interviews were undertaken using a semi-structured method and interpretative phenomenological analysis was used to analyse the data.

Setting

A large teaching hospital in the north west of England.

Subjects

Four nurse prescribers and four doctors working in orthopaedics, breast surgery or urology looking after adult elective surgery patients.

Main outcomes

What emerged from this study is a complex pattern of readjustment within this relationship. The power once enjoyed by the medical profession is now challenged by the introduction of the nurse prescriber. A number of themes emerged around the topics of prescribing, relationship, educational and communication. Each help to focus how this change manifests itself in the relationship and how it needs to evolve if the maximum benefit from nurse prescribing is to be achieved.

Conclusions

What has emerged from this research is how complex the relationship between the nurse prescriber and doctor really is. The power to prescribe medication that was once the sole preserve of the medical profession is now shared with the nurse prescriber. But this shared authority remains unequal; the medical profession remains at least unwilling to give up its position of control just yet, but the dialogue has begun.

INTRODUCTION

A review of the literature on nurse prescribing would reveal a dichotomy of views, from support of nurse prescribing as a way to improve patients care to doctors viewing such a proposal as a step too far. Yet despite the medical professions opposition the UK government pushed forward with the proposals (DOH 2003; 2002; 2001; 2000; 1999a, 1999b). Having lost the initial argument the medical professions shifted its objections to questioning nurse prescribing in terms of its safety, its comparability and even if it was really necessary (Funnell et al 2014; Carey et al 2009, Watterson et al 2009; Bradley and Nolan 2007; Ladd 2005; Fisher and Vaughan-Cole 2003; Rodden 2001; Luker et al 1998). What has not been debated or discussed in any great depth is how the introduction of the nurse prescriber may affect the relationship between the nurse and the doctor.

METHODOLOGY

According to Dzurec and Abraham (1993) all forms of research develop from the human desire to understand and make sense of the world. In seeking the views of two professional groups (doctors and nurses) regarding the introduction of the nurse prescriber to elucidate this first-person experience, a phenomenological approach was chosen. Phenomenology is not only a philosophy, but also an approach and method for human science research (Heinonen 2015). Descriptive phenomenology by Husserl (1913/1983) emphasised the careful description of ordinary everyday life. While interpretive phenomenology by Heidegger (1927/1962) is about interpreting and understanding and not just describing the human experiences. Both approaches are concerned with the lived experience and the meaning of an experience through the identification of essential themes (Polit and Beck 2006).

The interpretative phenomenological analysis (IPA) approach by Smith et al (2009) was chosen. As Smith (2004) suggested the assumption of IPA is to learn something about the respondents' psychological world, such as the beliefs and constructs that have been manifested or suggested by what the respondents have said. IPA achieves this through purposive sampling, by finding a closely defined group for whom the posed research question will be significant. In this case the specificity of the sample group is doctors and nurses and the question is how the introduction of nurse prescribing has affected the relationship. According to Finlay and Ballinger (2006) IPA is a useful method when there is a need to obtain an in-depth appreciation of an issue, event or phenomenon of interest, in its natural real-life context. The level of detail undertaken by an IPA approach means very small numbers of cases can be used so the breadth of the study is sacrificed for a more in-depth one with the aim of revealing something of the experience of each of those individuals (Smith et al 2009).

A total of 10 participants (five nurses and five doctors) were identified and all worked within a hospital in the north west of England. All worked in surgery but within different speciality's and did not work directly with each other. According to Smith (2009) for an IPA study the maximum number of participants is 10, while the minimal number would be two participants. Due to clinical issues the number of participants eventually interviewed was eight – four nurses and four doctors. Analysis of the interviews revealed a number of themes such as, Prescribing, Relationship, Education and Communication.

FINDINGS

Prescribing

The nurse prescribers' role has evolved in response to the reduction in the number of junior doctors and an ever increasing demand from patients for treatment on the National Health Service (NHS). This shift in emphases is illustrated by these quotes:

"I feel that you are offering a more complete service as an advanced nurse practitioner (ANP) and the patients are getting their drugs in a more timely manner...especially as doctors are limited." Nurse B.

"because of the way staffing levels..in..medical specialities is now..... if you got somebody on the ward all the time like you guys (ANP`s).....that can prescribe it is far better thing." Doctor 2.

"I see them working alongside the team... because nurse prescribers are more regularly working with the team it's a very positive role.... and a more safer way in terms of patient care." Doctor 3.

These quotes reveal the benefits of nurse prescribing in terms of flexibility and continuity of care. Yet despite what appears to be a harmonious relationship there remains areas of conflict. These points of conflict appear to revolve around prescribing issues, and involve more than just doctors as illustrated in the following quotes:

"There were certain ones that they (management) wanted us to have, but we...basically rebuked them and said no thank-you." Nurse A.

"We were.... pushed you might say to try and prescribe more than we wanted too... but.. we won." Nurse B.

These two quotes display a certain level of pressure felt by these nurses to prescribe more medication. Nurse prescribers are governed by a myriad of competing and sometimes opposing forces. Nationally there is the Nursing and Midwifery Council (NMC) which regulates all registered nurses, it outlines very clearly what the nurse prescribers' responsibilities are, in relation to prescribing. However as a nurse prescriber you are also bound by the overarching legal legislation that governs all practitioners detailing what drugs a practitioner can legally prescribe. In either case a nurse breaching these rules faces a number of sanctions. For breaches of NMC rules a nurse could face suspension or being struck off the NMC register, while a breach of drug legislation may warrant imprisonment. This is not unique to nurse prescribers. A similar arrangement also covers doctors with their governing body the General Medical Council (GMC). However nurse prescribers also have two further layers to navigate, within the hospital environment. The first is the individual directorates who each interpret nurse prescribing differently. While overseeing the nurse prescribers is the hospital's non-medical prescribers committee (made up of consultants and senior pharmacist) that has both an oversight role as well as an administrative role for granting or amending drugs the nurse prescriber has access too. While it is important to have a certain level of oversight, the level and complexity of this oversight has led to a wide variation in interpretation, even within this single hospital. as demonstrated by the following two quotes:

"I developed the formulary...its really to do with urology and all around our role as urology nurses." Nurse C.

"They have given me a surgical formulary which is even more limited than the generic formulary." Nurse D.

While Nurse C`s indicates that her formulary was a joint venture with her manager and so was considered fit for her role Nurse D`s formulary was imposed by management which did not take into account her clinical role and so in her opinion left her with an inferior formulary. This was not the only issue identified, Nurse C`s role incorporated both hospital and community settings. As a result Nurse C had numerous contact with doctors within the hospital as well as numerous general practitioners (GP). While Nurse C's working relationship in the hospital was deemed good, her relationship with the GPs was more difficult as seen in the following quote:

"one of our Consultants... as part of his practice includes prescribing initially Tadalafil 10mg twice weekly yet some GP`s have actually come back to us and complained that this is not recommended dose it should be PRN. However BAUS (British Association of Urological Surgeons) have recommended this treatment option as part of their post-operative recovery... but only for this procedure." Nurse C.

This raises an interesting point, as legally there is no difference between a nurse`s or doctor's prescription. So why does the GP reject the nurses prescription? Could it be an assumption from the GP that the nurse

prescriber has made an error in prescribing this drug, hence why the GP has queried the prescription? This would explain the initial enquires from the GP`s requesting clarification. However on further questioning Nurse C indicated that this happens a lot, which is both frustrating and annoying despite information being provided to the GPs in the discharge letter regarding the prescribing of this medication. It was also noted by Nurse C that when the prescription is re-presented with the consultants` signature the prescription is accepted by the GPs. Why this occurs is unclear, but it raises the possibility that it`s the signature on the prescription that determines whether the GP queries the prescription. This idea of a difference between a nurse`s and a doctor`s prescription was explored within the research study. While the nurses interviewed made no mention of any differences, the doctors in the study did express their views:

"I think there are certain groups of prescriptions which should be limited... certain cancer medication... should not automatically be given to all nurse prescribers unless they are working in such roles as oncology and have been specifically trained then that`s ok, but I think to give everyone all this training for all these specific needs may not be appropriate.. for the NHS." Doctor 1.

"I have not had any problems with nurses prescribing drugs as long as they are within their limits and capabilities....I am sure that the drugs that are allowed for nurses to prescribe should not include the whole formulary... but a restricted one." Doctor 3.

The above quotes demonstrates quiet clearly the doctors dilemma of both acknowledging nurse prescribing merits, while still trying to control the nurse prescriber as articulated in these two quotes:

"supervised or at least been looked at by a senior medical person." Doctor 3.

"As long as it`s suitably monitored." Doctor 4.

The implication here is that nurse prescribing needs to be monitored (presumably for patient safety). While the point has some merit could not the same argument be made for all prescribers? Medical staff do have an important role to play with regard to reviewing medication, however the primary reviewer of all medication within the hospital setting is the ward pharmacist. They function as a resource for all prescribers, supporting and monitoring all prescriptions regardless of who the prescriber is. Interestingly while some of the doctors interviewed suggested medical staff could act as monitors of nurse prescribers, only Doctor 2 mentioned pharmacy`s role in this interesting quote:

"because everything is so heavily overseen by pharmacists its actual very rare that prescribers make.... that many mistakes." Doctor 2.

While this quote does not mention doctors for supervision, the implication is that pharmacists review all prescriptions. There is one further point to make about this quote by inference, Doctor 2 makes no distinction between the prescriptions of doctors and nurses. This led to the following quote from another doctor which also touched on parity between the two prescribers:

"We (doctors) prescribe an alpha blocker....if a nurse can prescribe an alpha blocker....then in the end who prescribes it...to me does not make a big deal of difference...as long as the protocols are followed." Doctor 4.

This quote offers a further dimension to the doctors views on nurse prescribers. In this doctors view who prescribers the medication is not important, it is how this decision is reached that is the important factor. While it is unclear if the protocol is to be used by either professionals or just the nurse prescriber, the prescribing decision is the primary concern. This concern regarding the correct decision was also mentioned by Doctor 2 in this quote:

“some..... junior doctors... tend to over prescribe antibiotics ... I think nurse prescribers are more willing to check about prescribing than the junior doctor and that makes it a safer practice.” Doctor 2.

This quote reveals two important points; the first is an acknowledgement that junior doctors tend to over prescribe antibiotics and secondly nurse prescribers do not over prescribe antibiotics. Doctor 2 offers a rather simplistic explanation for this discrepancy that a nurse prescriber is more willing to contact a senior doctor before prescribing an antibiotic than a junior doctor. What is not made clear by Doctor 2 is the reason why junior doctors are reluctant to seek senior advice before prescribing an antibiotic. One possible explanation is the dynamics of the junior-senior doctor relationship, they may not wish to appear unable to make a clinical decision in front of a senior doctor they may require a reference from at some point.

Relationship

What emerged from the interviews was a strong theme around the doctor-nurse prescriber relationship. A further theme revolved around the nurse prescriber and the ward nurses. What was also revealed from the analysis of the interviews and supported within the literature was how little mention was made of the patients' relationship with either prescriber except for passing references to improving patient flow or obtaining a prescription on time.

Doctor-nurse prescriber relationship

When discussing relationships the idea of an equitable division of labour was raised by Nurse A when she attempted to explain how this worked with the medical staff:

“I think they saw us taking the easy jobs leaving them more difficult prescribing issues.” Nurse A.

Nurse A's quote offers us the major objection from the medical profession that nurse prescribers take as quoted “the easy jobs” which by extension implies the doctors are left with the more complicated prescribing issues. This can be viewed negatively by the medical profession if it was wholly true. The reality however is much more complex and was highlighted by the following quote from nurse B as to a possible reason why the doctors get frustrated with nurse prescribers:

“I think the doctors are quite confused as to what we can and can't prescribe... because lots of ANP's ... have different formulary.” Nurse B.

While doctors maybe unfamiliar with the formularies a nurse prescriber may work from, this was not the only confusion to emerge from the transcripts as seen in this quote:

“their role is to principally ease the burden of the junior staff.” Doctor 4.

Doctor 4's quote shows that at least some doctors view the nurse prescribers' role in terms of easing the burden of the junior staff and not improving patient care. This idea of reducing the burden was also identified by some nurse prescribers:

“they're quite happy (the doctors) for me to prescribe as long as it's in the p-formulary.” Nurse C.*

(*p-formulary is a list of drug, either by name or classification including routes, that a nurse prescriber has access to for any patient within an agreed speciality.)

“the workload has been reduced as ANP's take on more roles...so by taking on this role we allow the junior staff more time to go to theatre to gain experience.” Nurse D.

These statements clearly indicated that nurse prescribers do not pick the easy jobs but in fact work to their formulary. The desire of nurse prescribers to take on more prescribing (so reducing the doctors workload), is balanced against the need of the doctors to maintain control.

Nurse prescriber and ward relationship

The relationship between the nurse prescribers and the ward nurses was (like the doctors) a rather mixed picture of both positive and negative elements. The biggest negative issue was the perception of the ward staff regarding the nurse prescribers' refusal to prescribe certain drugs, as seen in these quotes:

"They still seem to ask for drugs that we are not able to prescribe." Nurse B.

"They (the ward staff) can't keep a track on what drugs I can and can't prescribe....they just ask me to prescribe a patients TTH`s." Nurse D.*

(*TTH- To Take Home medication on discharge).

The frequency with which this occurs suggest it cannot be down to just confusion alone, but a reflection of the wide variety of formularies this hospital has developed. But while this potentially could be a serious issue, the nurse prescribers also indicated the positive aspects of this relationship with the ward nurses, as seen in this quote:

"Nurse on the ward see us as a great help...someone who is there....to ask for...help." Nurse D.

Educational

Educational issues highlighted the mismatch between nurses and doctors when it comes to training. Nationally junior doctors have guaranteed time tabled educational sessions, and the nurse prescribers (who are undertaking a similar role) have not been offered similar opportunities as seen in this quote:

"Medical staff also have protected teaching time (when ward staff cannot bleep them)...we as nurse prescribers are not offered any such facilities yet we are carrying out tasks that were routinely the junior doctors jobs... without the necessary educational support. Even if we were offered say once a monththe opportunity to have some up-date on prescribing or pharmacology issues would be a good thing." Nurse D.

This clearly demonstrates that nurse education is neither guaranteed nor protected. This is despite the fact nurse prescribers have a national qualification and have the same responsibilities as their medical counterparts yet they are treated differently.

"We seem to have to jump through more hoops than medics do to prescribe certain drugs and whilst with some drugs I may understand that need. nurses have always been quite careful in how they prescribed maybe more so than medics." Nurse B.

Nurse B reveals an interesting point, that while she acknowledges a nurse prescriber may need further training to prescribe some medication, she wonders why this is not extended to the doctors as well. This idea of extra training was taken up by Doctor 2 in relation to previous comments regarding the prescribing antibiotics made this comment:

"Absolutely....I also think that some of the junior doctors...er, tend to over prescribe antibiotics." Doctor 2.

This idea of extra training for junior doctors was only supported by one of the doctors interviewed, but it did highlight again the gulf between the two professions. While the hospital made the nurse prescriber undergo compulsory training if they wanted to prescribe antibiotics, no such requirement was made of the junior doctors. Therefore it again reinforces the idea that the two professions prescribing are somehow different.

Communication issues

The analysis of the transcripts revealed a number of communication issues. Nurse A gives a great overview of the communication issue with this quote:

"There are a lot of variables, it depends on the person the lazy ones are quite happy for you to prescribe everything and then question why can't you prescribe more for them?... while the more efficient ones might like to prescribe their own medication so ask us not to prescribe anything for them." Nurse A.

Nurse A views on communication is very emotive, and somewhat simplistic but very revealing. Poor communication to her is a doctor who is not interested in what she can prescribe. As a result not only does she have to constantly justify her role she is also repeating what she can and cannot prescribe. Interestingly Nurse A also offers a view on what good communication looks like; it is a doctor that tells her directly that he will prescribe the medication. It is not clear if the medication prescribed by the doctor is medication Nurse A can or cannot prescribe but Nurse A certainly appreciates the doctor talking to her over prescribing matters. Interestingly Nurse B also had similar experience as seen in this quote:

"I think once you explain it to them some accept... what you are telling them. However....others are a bit... (sigh)...as if they don't really want to understand you." Nurse B.

Nurse B has made a similar distinction as Nurse A (without using lazy or efficient) regarding medical staff willingness to understand the nurse prescribers' role. How this affects the professional role between the two is only partially indicated by a further quote from Nurse B:

"I would not say have an unpleasant attitude towards you....there are limitations to our prescribing role." Nurse B.

It is unclear in these answers whether this reflects a true level of communication breakdown or personality clashes. What is clear however is the potential for a serious breakdown in team cohesion could impact patient care? Despite these negative comments, however Nurse D offers a good example of how this relationship should work as seen in this quote:

"During these ward rounds we would be discussing (within the team) patient's management." Nurse D.

Within this quote Nurse D outlines what she sees as good communication between herself and the doctors. They work as a team dividing up the jobs that the ward round produced which included prescribing issues. This inevitability then led onto communication issue with ward nurses.

"I get asked fairly regularly for different things that are not on our formulary.....had to tell them that no you can't prescribe." Nurse B.

The implication here is that some nurses on the wards (like some doctors) are also not aware of the limitations on a nurse prescriber. Whether this can lead to a poorer working relationship with the ward staff is not clear from Nurse B's response but it's a possibility. This was not the only example of poor communication as indicated in the following quote:

"they (the ward staff) will just bleep a doctor (not telling him everything) just that this patient needs their TTH's.. the doctor might complete the TTH'S not realising that he has double up on the patients TTH orders making more work that could be avoided so it can be very time consuming." Nurse D.

Two issues emerge from this quote; the first one (the obvious one) is a simple communication failure between the ward staff and the doctor. This failure to communicate however also raises a more serious problem for the nurse prescriber and the doctor. While it is not articulated in the answer, who contacts the doctor over this error in the TTH's? Is it the ward staff or is it left to the nurse prescriber to contact the doctor, and what effect does this have on the relationship between the two?

Interestingly the analysis of the transcripts from the medical participants was very revealing. They viewed communication in very specific terms as illustrated in the following quotes:

“As a nurse prescriber you are far more likely to check with me first (as opposed to a junior doctor).” Doctor 2.

“As long as they (nurse prescriber) takes advice of the Consultant or from a senior junior doctor it should not be a problem.” Doctor 3.

These two quotes offer a view of how the doctors view this communication, firstly that communication between the two is viewed at least by the doctors positively. However a more in depth exploration of these statements reveals the medical profession view this communication not so much as an equal two way process but as a way to control what the nurse can prescribe.

DISCUSSION

What this research has revealed is that despite a wealth of information around nurse prescribing, the medical profession remain unsure of the purpose of nurse prescribing. In part this confusion is due to a number of factors not least of which are the myriad of personal formularies within this single hospital trust. As a result two nurse prescribers working in the same surgical division can have very different prescribing formularies. Such anomalies only help foster within the medical profession a belief that medical prescribing is different (some doctors might call superior) to nurse prescribing. This belief is further enhanced if we look at antibiotic prescribing. Nurse prescribers wanting to prescribe antibiotics have to undergo a separate educational course run by the hospital (despite nurse prescribers having a national qualification). Junior medical staff do not require this course before they can prescribe antibiotics. Again this gives the impression that nurse prescribing is somehow different to medical prescribing.

CONCLUSION

What has emerged is despite both groups agreeing that nurse prescribing has improved patients access to medication and generally improved the patients' journey within the hospital environment, there remain some issues. The continuing confusion of the medical profession over what a nurse prescriber can and cannot prescribe needs to be addressed. While nurse prescribers have no objection to undertaking further training to prescribe antibiotics (despite having a national prescribing qualification), should junior doctors (as part of their foundation year program) also undergo this training? The advantage of such a proposal would be an improved working relationship between the two and it would help dispel the notion that medical prescribing is different to nurse prescribing. Finally as nurse prescribers become more common and more doctors become exposed to the nurse prescriber the working relationship can only improve and with it a new working relationship can develop.

RECOMMENDATIONS

- The myriad of personal formularies needs addressing, a generic formulary would eliminate discrepancies that have been highlighted in this study.
- Giving nurse prescribers the opportunity to attend educational sessions with junior doctors would help dispel the myth nurse prescribers are not the same as medical prescribers.
- As part of the hospital staffs mandatory training, all health professions should have a session on the role of the nurse prescriber, not only would this help foster a better understanding of the role but it would improve the communication failings highlighted in this study.

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