Extending prescribing: issues and opportunities

June Crown

Recently published reports from the 'Review of Prescribing, Supply & Administration of Medicines'\textsuperscript{1,2} put forward proposals that could have a considerable impact on current patterns of clinical practice.

Recommendations of the review

The key recommendations are that the authority to prescribe should be extended beyond current prescribers – doctors, dentists and some nurses – to a much wider range of health professionals; and that there should be two categories of prescriber, 'independent' and 'dependent'. The 'independent' prescriber would be allowed to take responsibility for the assessment of newly presenting patients, decide on the clinical management and initiate treatment, including prescribing. The 'dependent' prescribers would be allowed to take responsibility for the continuing care of patients who have been diagnosed or clinically assessed by an independent prescriber. Their care would include prescribing, usually within clinical guidelines. It is anticipated that each professional group of new prescribers would have access to medicines appropriate to its area of clinical practice.

Early applications to become independent prescribers are expected from, among others, family planning nurses, tissue viability nurses and optometrists. New dependent prescribers might include specialist nurses in the fields of diabetes, asthma and palliative care, and some groups of pharmacists.

Pressures for change

The pressures to undertake the review came from several areas. From the professional perspective, specialist training at the post-qualification level is now a feature of many disciplines. This has enabled health professionals such as nurses, physiotherapists and podiatrists to undertake more autonomous practice than in the past. In many instances, this leads to situations where a doctor signs a prescription, even though the clinical assessment and decisions on management have actually been taken by a non-medical colleague. This is not only unsatisfactory in terms of clarity of responsibility and accountability, but it is also likely to be illegal.

Similar situations arise with the development of multi-disciplinary clinical teams in both primary and hospital care. Such teams benefit patients and are welcomed by health professionals. Their effectiveness is likely to be improved if team members can sign the relevant prescriptions and take responsibility for their areas of care, rather than having to ask the doctor to sign the script.

Patient expectations have also changed, both in terms of the range of professionals they wish to consult and the improvements in access to care which they rightly expect.

Implications of extending prescribing

Quality of care

The key intention of the review is to improve the quality of care to patients. It is expected that this will be achieved by allowing more effective use of the full range of skills and experience available. Patients' access to care should be easier and better arrangements for the clinical oversight of patients with chronic conditions (including their medication) should be possible, with resulting improvements in health outcomes.

Professional relationships

Professional relationships and teamwork should benefit from greater clarity of roles and responsibilities. The removal of the need for one person to sanction the clinical decision which is quite appropriately, and with consent, taken by a professional colleague, should result in more mature relationships and improved recognition and respect for the contributions of each team member to the care of the patients.

Training

Members of professional groups who are newly authorised to prescribe will already be fully trained in their respective clinical disciplines. They will, however, require training programmes to prepare them for prescribing, though in due course this may be incorporated into specialist clinical training curricula. The demand for prescribing training will depend on the progress made in the designation of professional groups as prescribers. It could, however, be heavy at the outset. If this were the case, there would be great pressure on those who could provide such training – pharmacologists, clinicians and pharmacists. An unexpected benefit of such a situation might be the establishment of genuinely multidisciplinary learning programmes in which

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\textsuperscript{2} JR Coll Physicians Lond 1999;33:503–5
medical students and junior doctors, as well as new prescribers, might wish to participate.

Continuing education

The review suggests that the relevant professional regulatory bodies should ensure that authorised prescribers take part in programmes of continuing professional development related to prescribing. Although doctors have a professional obligation to participate in continuing education activities, they are not required to demonstrate that they are up-to-date in their prescribing practice. The medical Royal Colleges will doubtless wish to consider whether or not the expectations for new prescribers are also appropriate for doctors.

Costs to the NHS

There is understandable concern that increasing the number of authorised prescribers will result in an increase in drug costs in the NHS. There is, however, no significant evidence of unmet need for medicines in the NHS, so the assumption is that the transfer of prescribing responsibility between clinicians would have little effect on costs. This might not be the case if the new arrangements resulted in a major shift from privately purchased 'over the counter' medicines to NHS prescribed medicines.

The costs of the proposed changes are not, however, solely related to the drugs budget. There will inevitably be training and administrative costs if the review team's recommendations are accepted.

Economic appraisal in anticipation of the changes is difficult because extended prescribing is at present illegal. It is also much easier to assess the costs than to quantify financially the benefits of such changes. The review team proposes pilot studies in some areas, provided these do not result in excessive delays in implementing improvements in services.

Other recommendations of the review

The report contains 25 recommendations. Two areas are of particular interest to doctors:

Preregistration house officers and newly arrived overseas doctors and dentists

Preregistration house officers (PRHOs) and some newly arrived overseas doctors are not, at present, authorised to prescribe; though in a hospital setting, PRHOs can make entries on a medicine chart under the supervision of a fully registered doctor. This situation is likely to cause difficulties for PRHOs who spend part of their 12 month preregistration period in general practice. The review team proposes that PRHOs, and newly arrived overseas doctors and dentists who are required by the GMC to undertake training similar to that of a PRHO, should be able to prescribe medicines relevant to the duties of their posts, subject to close monitoring by their clinical supervisor. The GMC and postgraduate deans would have to agree a safe framework within which these changes could take place.

Repeatable prescriptions

At the present time, repeatable prescriptions are only available in the private sector, because of administrative problems in reimbursing a pharmacist more than once against the same NHS prescription. In addition, after the first dispensing, there is no limit on the duration of validity of a repeatable prescription, nor on the number of times that a product may be dispensed. The report recommends that the rules should be the same in the NHS and in the private sector; that repeatable prescriptions should be available on the NHS and that their duration and the number of times they can be dispensed should be limited.

The process of change

The review team's report is being considered by Department of Health ministers following a period of consultation. If the recommendations are accepted, implementation will require legislative change and educational and administrative action.

Extending the authority to prescribe to new professional groups will require changes to the Medicines Act. Allowing new prescribers' scripts to be dispensed at public expense will require changes to the NHS Act. The pressures on parliamentary time make it unlikely that these changes will be enacted rapidly.

If the government indicates that it will introduce these changes, professional bodies will have to prepare their cases for the acquisition of prescribing rights, and to develop training programmes for their eligible members. Professional regulatory bodies will have to introduce administrative arrangements to identify the trained prescribers on their registers.

Introduction of these changes will also require new administrative arrangements in the NHS, to match those which apply to prescribing by existing authorised practitioners.

Conclusion

The review team is convinced of the benefits of extending the authority to prescribe and hopes that its recommendations will be supported by professional colleagues. Implementation will lead to improved teamwork and greater clarity of clinical responsibilities, together with more appropriate use of the wide range of skills available to health care in the UK. It will legitimate clinical practices and care arrangements which will benefit patients and thus play its part in improving the quality of care in this country.
References

1 Department of Health. Review of prescribing, supply & administration of medicines. A report on the supply & administration of medicines under group protocols. London: DoH, 1998.
2 Review of prescribing, supply & administration of medicines. Final Report. London, DoH, 1999.

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CME Syllabus for 2000

The next volume of the JRCPL will cover the following subjects for CME:

Issues 182, January/February and March/April

- **ADOLESCENT MEDICINE**
  Edited by Dr T L Chambers, Consultant Physician, The Royal Hospital for Sick Children, Bristol

Issues 384, May/June and July/August

- **DIABETES**
  Edited by Professor J E Tooke, Professor of Vascular Medicine, University of Exeter

Issues 586, September/October and November/December

- **SEPTICAEMIA**
  Edited by Dr W A Lynn, Consultant in Infectious Diseases, Ealing Hospital, London

Erratum
College Commentary,
September/October 1999

MRCP(UK) Part 2 Oral and Clinical Examination

The dates given for these examinations were incorrect. They should read:

From Monday 28 February to Wednesday 1 March 2000

From Monday 19 June to Wednesday 21 June 2000

From Monday 23 October to Wednesday 25 October 2000