Consultation on two proposals for registered nurse prescribing

New Zealand Medical Association

Submission to the Nursing Council of New Zealand

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"Correct is to recognize what diseases are and whence they come; which are long and which are short; which are mortal and which are not; which are in the process of changing into others; which are increasing and which are diminishing; which are major and which are minor; to treat the diseases that can be treated, but to recognize the ones that cannot be, and to know why they cannot be; by treating patients with the former, to give them the benefit of treatment as far as it is possible." — Hippocrates

About the NZMA

1. The NZMA is the country's largest pan-professional medical organisation with a membership of over 5,000 members. Our members come from all disciplines within the medical profession and include specialists, general practitioners, doctors-in-training and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values, and the health of New Zealanders.

2. The key roles of the NZMA are to:
   - provide advocacy on behalf of doctors and their patients;
   - provide support and services to members and their practices;
   - publish and maintain the Code of Ethics for the profession; and
   - publish the New Zealand Medical Journal.

Summary

3. The NZMA welcomes the opportunity to provide feedback on the Nursing Council's proposals for registered nurse prescribing. Our submission has been informed by consultations with our General Practice Advisory Council, Specialist Advisory Council, Doctors-in-Training Advisory Council, our members, and the NZMA Board.

4. The NZMA shares in the goals of improving the access, timeliness and convenience of healthcare services. However, we are unequivocally opposed to the proposals being advanced by the Nursing Council for independent designated community nurse prescribing and independent designated specialist nurse prescribing. We believe that these models of nurse prescribing could, if implemented, lead to serious adverse consequences for the health and safety of patients, undermine integrated collaborative healthcare teams, and have detrimental consequences for the wider health system in New Zealand. Our position should not be interpreted as one of blanket opposition to nurse prescribing. On the contrary, the NZMA has previously conveyed its support for non-medical prescribing that occurs within a delegated model. Our organisation would be supportive, in principle, with the extension of prescribing rights for suitably qualified nurses, provided that this occurs under a delegated model of prescribing.

Delegated prescribing and the Medicines Amendment Bill

5. The NZMA's view of a delegated prescribing model is one where a medical practitioner diagnoses and makes the initial treatment decision. Where clinically appropriate, prescribing is then delegated to a non-medical prescriber under parameters that are determined by the supervising doctor who will ultimately share responsibility for those decisions. The NZMA does not subscribe to the view that such a model is unduly onerous for medical practitioners. We consider that as a doctor's knowledge of, and confidence in, a delegated prescriber increases, they will delegate more autonomy to a non-medical prescriber under a pre-agreed framework.

6. We question the timing of the current proposals, given that the Medicines Amendment Bill (which contains provision for delegated prescribing) is currently before parliament. We do not believe it is appropriate to be consulting on these proposals when the Medicines Amendment Bill is before parliament. Our understanding is that if the Bill is passed, these provisions will come into effect in mid 2014. We have also received advice that delegated prescribing could be brought in even earlier via Order in Council. Given that the infrastructure for delegated prescribing will soon be in place, and given our major reservations surrounding independent designated non-medical prescribing, the NZMA urges the Nursing Council to reconsider its proposals for independent designated nurse prescribing.

Stakeholder acceptability and the quality of evidence

7. The NZMA notes that in developing the current proposals, "the Council consulted widely with a range of stakeholders….to ensure that the proposals that have been developed are broadly acceptable to the sector". We believe that the medical profession is a key stakeholder with respect to this initiative. Throughout the consultation, assumptions such as "freeing up doctors time" are repeatedly touted as a benefit of the proposals being advanced. Yet many doctors themselves do not identify this as a benefit; rather, many are actually concerned they could end up spending even more time as a result of what is being proposed, dealing with the consequences of inappropriate prescribing, for example.

8. The consultation states that the types of conditions specialist nurses might prescribe for have been developed from consulting with nurses and doctors. The NZMA would be keen to know more about the doctors that were consulted in the development of these conditions and whether they were selected as representatives of their wider professional organisations or were shoulder tapped for their individual views.

9. The NZMA believes that any health policy change of this magnitude should be informed by the evidence. Our organisation is concerned that many of the sweeping claims in the proposals to support designated nurse prescribing are unsubstantiated or reflect weak evidence (grey literature and unpublished research theses). On occasions, the literature appears to have been misinterpreted. For example, potential benefits of more nurses prescribing include the claims of "reduced hospital admissions" and "savings in time and money for health consumers" yet no data (New Zealand or international) are provided to substantiate these claims.

10. Other justifications being advanced for independent nurse prescribing include claims that "many patients are unable to enrol in general practices and others cannot make timely appointments to see a General Practitioner". Once again, no empirical data are provided to

support these statements. Later in the consultation document, it is stated that "the cost of preparing experienced nurses to expand their role is cost effective" but no supporting evidence is provided.

11. Although nurse practitioners are not the same as the proposed designated community nurse prescribers or the proposed designated specialist nurse prescribers, their success in New Zealand in reducing acute admissions in respiratory services is cited in the consultation document. Unfortunately, the citation in this instance is a PowerPoint presentation and not a peer-reviewed publication.[1]

12. While we agree that there is an increase in health needs as a result of an aging population and an increase in non-communicable diseases (identified on page seven in the consultation), it is not strictly correct to say that "two thirds of New Zealand adults **have** at least one diagnosed chronic disease or long term condition". The source for this statement, The Ministry of Health's 2006/07 New Zealand Health Survey, reports that "two out of every three adults (65.7%, 64.7–66.8) **had** been diagnosed by a doctor with a health condition that had lasted or was expected to last for six months or more".[2] Many of these conditions could have been historical or not currently active. The consultation appears to overstate existing health needs in an attempt to justify independent nurse prescribing.

13. The consultation document also makes the sweeping claim that "international evidence supports the safety of nurse prescribing". Yet both of the references that are cited in support of this statement highlight limitations in the data/methodology and urge caution when drawing conclusions.[3] A systematic review of the effects of nurse prescribing suggests that while the overall effects of nurse prescribing seem positive, a major limitation is the methodological quality of the studies.[4] With the exception of two studies with a moderate risk of bias, all of the included studies in this systematic review had a high risk of bias. Furthermore, the anticipated benefits for professionals, in the form of workload and time savings, or for the healthcare system with regard to accessibility and costs, could not be confirmed. Two studies in the systematic review actually showed that nurses prescribed medication for a higher percentage of patients than physicians. Consultation times were more commonly longer for prescribing nurses than doctors.

14. Also worth noting is that one of the key reports used to support the proposal for independent nurse prescribing alludes to the paucity of data on comparative models of prescribing.[5] In fact, this report goes on to explicitly state that "there is a lack of rigorous evaluation data published". The lack of 'hard' outcomes-based data to substantiate proposals

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[1] Hart, Diana. (2009) Making a Difference Nurse Practitioner Adult Respiratory 2009. Available from: www.healthpoint.co.nz/download,127431.do

[2] Ministry of Health. 2008. A Portrait of Health. Key Results of the 2006/07 New Zealand Health Survey. Wellington: Ministry of Health.

[3] Van Ruth LM, Mistiaen P, Francke AL. Effects of nurse prescribing of medication: a systematic review. The Internet Journal of Healthcare Administration 2008;5(2): DOI: 10.5580/11e; Latter S, Courtenay M. Effectiveness of nurse prescribing: a review of the literature. J Clin Nurs 2004;13(1):26-32

[4] Van Ruth et al 2008

[5] Nissen LM, Kyle G, Stowasser D, Lum P, Jones A, Gear C. (2010) Non-Medical Prescribing - An exploration of likely nature of, and contingencies for, developing a nationally consistent approach to prescribing by non-medical health professionals. Final Report. May 2010, Council of Australian Governments (COAG) / Australian Health Ministers' Advisory Council (AHMAC) - Health Workforce Planning Committee

for independent non-medical prescribing seems to be generally underplayed throughout the entire consultation document.

15. Our organisation notes that the impetus for the proposals for independent nurse prescribing appears to stem from the success of the diabetes nurse prescribing project. We believe that it is inappropriate to extrapolate the (largely positive) findings from this project and use them as the basis for broader independent nurse prescribing. The diabetes prescribing project entailed a model of nurse prescribing that was more akin to delegated prescribing; nurses which prescribed did so under supervision and in partnership with medical practitioners.[6] Furthermore, the diabetes nurse specialists that participated in the project are not representative of other nursing groups.

Practising at the 'top of scope'

16. While the NZMA is supportive of encouraging all healthcare practitioners to practice at the 'top of scope', we do not believe that 'top of scope' should automatically be equated with the right to prescribe medications. Nurses play a vitally important role in the healthcare of New Zealanders and doctors place great value on their role as part of the collaborative multidisciplinary healthcare team. The NZMA fully supports measures to facilitate nurses to practice at the top of their scope but we believe that decisions relating to prescribing (including considerations of diagnosis) are clearly within the scope of medical, not nursing, practice. The corollary to this is that doctors must be held accountable for their prescribing, including when practising in a delegated prescribing relationship with a non-medical prescriber.

17. Good relationships between doctors, nurses and patients are at the centre of collaborative team-based healthcare. Confidence and trust between healthcare practitioners, each operating competently and at the top of their respective scopes of practice, are at the heart of this desired model of healthcare. For reasons that are elaborated on below, we believe that independent nurse prescribing would undermine the core dynamic of a successful collaborative healthcare team and potentially also increase the risk to public health and safety. In this regard, we note that the primary function of the Nursing Council is to protect the health and safety of members of the public. We find it somewhat unusual that the body entrusted with this primary function is leading the push to extend the scope of practice of its members to encompass the prescription of medicines.

Patient safety, inappropriate prescribing and cost considerations

18. The safety of patients should not be overlooked in the drive towards hypothetical improvements in efficiency. The decisions that underpin the prescription of medicines are complex and should not be underemphasised. Prescribing medicines is based on a detailed understanding of pharmacology (including pharmacokinetics and pharmacodynamics) as well as of pathophysiology. Yet despite years of formal and informal learning, harms from adverse drug reactions, drug interactions, and polypharmacy are still considerable. In the New Zealand

[6] Wilkinson JA, Carryer J, Adams J, Chaning-Pearce S (2011), Evaluation of the diabetes nurse specialist prescribing project [Report prepared for the New Zealand Society for the Study of Diabetes]. Wellington: Massey University. Available from: http://healthworkforce.govt.nz/sites/all/files/DNS%20Final%20evaluation%20report.pdf

Adverse Events study,[7] drug events made up 15.4% of all adverse events[8] and 9.3% of permanent disability or death adverse events.[9] It is likely that this is an underestimate. More recent research has found that adverse drug events occurred in nearly three out of every ten patients admitted to hospital.[10]

19. It is important to consider the impact of extending independent prescribing rights on adverse drug events as well as on pharmacovigilance. The NZMA believes that the proposed prescribing training for community nurses (up to six theory days with a mixture of on-line learning and workshop attendance) is woefully inadequate, with serious risks for patient safety. While the training proposed for specialist nurses (a postgraduate diploma in prescribing) is an improvement, the NZMA notes that this programme is intended to teach the pathophysiology of common conditions, skills in diagnosis, and a course in pharmacology. We believe this is an ambitious undertaking and have doubts it will impart potential nurse prescribers with sufficient depth of knowledge to enable safe independent prescribing, especially given the wide range of medications they will be able to prescribe.

20. Many of the medications on the proposed list are associated with potentially serious adverse events, frequent drug interactions, a high risk of dependency and/or toxicity. Of particular concern is the finding in a UK study, reported in the consultation document, which showed that analgesics were prescribed more frequently by non-medical prescribers than doctors.[11] The dependency and misuse of opioid analgesics is already a well recognised problem,[12] and the propensity for independent non-medical prescribers to be more likely to prescribe analgesics than their medical counterparts is worrying.

21. Throughout the consultation, there appears to be an assumption that treatment equates to pharmacotherapy. Yet for many conditions, prescribing medication represents just a subset of available therapeutic options. For example, the consultation document states that medicines for some common mental health conditions have been included as 50 to 70% of mental health disorders are managed by general practice. Also mentioned is an expected doubling of demand for mental health services (although no evidence is provided to substantiate this claim). But many mental health conditions have effective non-pharmaceutical treatments (e.g. cognitive behavioural therapy for depression). Non-pharmacological strategies such as exercise and dietary modification are also often appropriate for many chronic diseases. Rather than focusing on obtaining designated prescribing rights, it may be worthwhile considering whether expanding nursing practice in other areas such as patient education, health promotion and preventative healthcare may represent a more appropriate, effective and safe way to address the growing healthcare needs of New Zealanders.

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[7] Davis P, Lay-Yee R, Briant R, Ali W, Scott A, Schug S. Adverse events in New Zealand public hospitals I: occurrence and impact. N Z Med J. 2002;115(1167):U271. Epub 2003/01/29

[8] Briant R, Ali W, Lay-Yee R, Davis P. Representative case series from public hospital admissions 1998 I: drug and related therapeutic adverse events. N Z Med J. 2004;117(1188):U747. Epub 2004/03/06

[9] Davis P, Lay-Yee R, Braint R, et al. Adverse Events in New Zealand Public Hospitals: Principle Findings From a National Survey. Wellington: Ministry of Health, 2001 December. Contract No.: ISBN 0-478-26268-X

[10] Mary E Seddon, Aaron Jackson, Chris Cameron, et al. The Adverse Drug Event Collaborative: a joint venture to measure medication-related patient harm. N Z Med J. 2013;126(1368)

[11] Hacking S & Taylor J (2010), An evaluation of the scope and practice of Medical Prescribing in the North West for NHS North West. Preston, United Kingdom: University of Central Lancashire, School of Nursing & Caring Sciences

[12] Ling W, Mooney L, Hillhouse M. Prescription opioid abuse, pain and addiction: clinical issues and implications. Drug Alcohol Rev. 2011 May;30(3):300-5

22. Inappropriate prescribing is also already a significant contributing factor in the development of antimicrobial resistance. The NZMA is concerned that extending independent prescribing rights to nurses may exacerbate, rather than mitigate, the overprescribing of antimicrobials and thus accelerate the development of resistance. We note that among the conditions being suggested as appropriate for community nurse prescribing are urinary infections and sore throats. For both these examples, diagnosis can represent a challenge and prescribing antibiotics is not always the appropriate course of action. Again, the Nursing Council appears to be aware of concerns relating to antimicrobial resistance, stating that "nurses can be educated to prescribe antibiotics appropriately", but it offers no support for this bold claim by way of evidence. This is a big assumption to make, given the frequent inappropriate prescribing of antibiotics by doctors despite major efforts in education about antimicrobial resistance.

23. The NZMA believes that cost considerations in terms of increased pressure on the pharmaceutical budget are also relevant and must be taken into account. The Nursing Council consultation document alludes to the fact that after workforce, medicines are the largest area of health spending. The number of prescriptions is growing each year because of increasing demand. PHARMAC reported a $777.4 million expenditure on pharmaceuticals for the year 2001-12, an increase of $60 million over the previous year's expenditure, and that 41.1 million funded prescriptions were written (a 3.5% increase).[13] The NZMA believes it is highly likely that the introduction of independent nurse prescribers will increase the demand for medicines and place additional pressure on the pharmaceutical budget. The Council appears to be aware of this and has attempted to allay concerns by citing evidence suggesting that nurses are conservative prescribers. Yet the supporting reference used in this instance is an unpublished health science thesis which looked at case studies in primary and secondary care in the UK.[14] Its validity in the New Zealand context is questionable.

Diagnostic considerations

24. The NZMA does not believe that prescribing can be considered in isolation from diagnosis. We note that the consultation proposes to extend diagnosis to nurses, partly in an attempt to address this arbitrary distinction. However, the NZMA has major reservations about extending diagnosis to nurses, whether community or specialist. We believe that the consultation document fails to adequately reflect the complexity of the diagnostic process. Diagnosis and subsequent decisions about treatment are at the very core of the role of the doctor. These diagnostic skills are built on several years of study of anatomy, pathology and physiology, followed by years of training in clinical methods. As stipulated in the Consensus Statement on the Role of the Doctor, "Doctors regularly take ultimate responsibility for medical decisions and diagnoses in situations of complexity and uncertainty, drawing on scientific knowledge and principles, clinical experience, and well developed judgement." [15]

25. Doctors are trained in specific clinical skills such as the art of history taking and physical examination. They are also trained to request appropriate tests, interpret these in the context of other findings, and to generate a differential diagnosis. It is quite simply unrealistic

[13] PHARMAC Pharmaceutical Management Agency Annual Report For the year ended 30 June 2012. Available from:

[14] Bowskill, D. (2009), The Integration of Nurse Prescribing: Case Studies in Primary and Secondary Care (Doctor of Health Science Thesis). University of Nottingham, Nottingham, United Kingdom

[15] NZMA. Consensus Statement on the Role of the Doctor in New Zealand. November 2011. Available from: http://www.nzma.org.nz/sites/all/files/ps_RoD.pdf

to expect that a nurse with a minimum of three years of experience could develop these diagnostic skills in a six day course (in the case of proposed community nurse prescribers) or even in a postgraduate diploma (in the case of proposed specialist nurse prescribers). Interestingly, one of the references cited in the Council's own consultation document that evaluated independent nurse prescribing in the UK found there was potential for improvement in history taking, assessment and diagnosis skills.[16] This is hardly surprising, yet the failure to mention this finding in the consultation document is a matter of some concern.

26. Decisions regarding prescribing are often influenced by laboratory tests. We find it somewhat incongruous that the potential inappropriate ordering of laboratory testing by proposed designated nurse prescribers has not received due attention at the very same time as which measures to restrict the ordering of inappropriate testing by medical practitioners are being explored. The NZMA believes that enabling another category of health practitioners to request laboratory tests would almost certainly drive up the number of laboratory tests that are requested and push up associated costs.

27. The initial management of a patient with suspected hypertension provides a useful example to illustrate the complexity of the diagnostic process. The evaluation of such a patient requires a careful history including inquiry about alcohol, salt, liquorice and caffeine intake, smoking and exercise. Family history of cardiovascular disease is also important. Before initiating possible life long therapy, a comprehensive physical examination is required. Several blood pressure readings at different time points (in both arms) must be taken, the optic fundi must be examined, auscultation of the heart is necessary, and listening to the abdomen for renal bruits should also be undertaken. Urine testing for protein, renal function, and an ECG are also essential tests. Secondary causes of hypertension (and the appropriate laboratory tests to detect these) need to be considered and an absolute risk assessment has to be performed. For some patients, 24 hour ambulatory blood pressure monitoring may be indicated before commencing treatment. Furthermore, the management of patients under forty and over eighty years requires particular skills. The management of hypertension clearly involves much more than simply prescribing a particular medication according to a protocol based on a blood pressure reading.

28. While the proposal posits that community nurses be able to diagnose and treat 'minor' ailments, differentiating minor from potentially serious ailments can be difficult. By way of an example, the list of minor ailments includes 'sore throats' – yet this could encompass a simple viral upper respiratory tract infection, tonsillitis or strep throat (with implications for the prophylaxis of rheumatic fever). Managing sore throat is as much a diagnostic skill as a prescribing skill. This example demonstrates the interlinked nature of decisions relating to diagnosis and prescribing. Furthermore, patients with otherwise 'minor' ailments may have underlying co-existing disease that also requires management. The NZMA believes that concerns relating to diagnosis stemming from the proposals being advanced would be obviated under a delegated model of prescribing in which a medical practitioner diagnoses and makes the initial treatment decision.

[16] Latter S, Smith A, Blenkinsopp A, et al. Are nurse and pharmacist independent prescribers making clinically appropriate prescribing decisions? An analysis of consultations. Journal of Health Services Research and Policy 2012;17:149-156

Impacts on integrated collaborative healthcare, accountability and employers

29. The NZMA shares the vision of a multidisciplinary collaborative healthcare system that is truly integrated (vertically and horizontally) and ensures continuity of care. While a delegated model of non-medical prescribing would support this objective, we believe that the designated model of nurse prescribing that is being proposed would undermine efforts to achieve a higher level of integration of our health services. The NZMA is concerned that independent nurse prescribing may well lead to greater fragmentation of care as it facilitates independent practice occurring outside the multidisciplinary team.

30. Many general practitioners have indicated that they already contend with less than ideal communication flows with hospital-based doctors. Medication regimens are often altered in hospital without adequate consideration of the patient's broader circumstances and with minimal consultation with the general practitioner. The addition of independent nurse prescribers in the absence of a shared electronic health record could exacerbate issues relating to communication and collaboration. Although the consultation document refers to designated nurse prescribers working "as part of a collaborative multidisciplinary team" the mechanics of how this collaboration would actually ensue, given their proposed independent designation, is unclear. We believe that a delegated model of nurse prescribing, based on a relationship with a specific doctor, would facilitate collaborative care and mitigate concerns about communication flows.

31. The NZMA is also concerned over issues relating to accountability with the designated prescribing model that is being proposed. For example, in a scenario where there is a serious drug interaction following the addition of a new nurse-prescribed medication to a patient's existing regimen, which prescriber will be held accountable, especially if there is disagreement between the prescribers on the appropriateness on any of the medications? It is also unclear where responsibility lies when an independent nurse prescriber initiates treatment in a patient who then develops complications or adverse events and is then referred to a doctor. A delegated model of prescribing would ensure clarity in such situations, with the doctor, as the authorised prescriber, having ultimate responsibility.

32. We note that the proposals for designated nurse prescribers would place significant responsibilities on the employer(s) of such nurse practitioners. The NZMA is particularly concerned at the implications of these proposals for private practice. Some General Practice owners are likely to face additional medico-legal issues and incur significant additional costs should they underwrite designated nurse prescribers. During a period when it is already difficult to make general practice attractive for new young General Practitioners, the consequences of the proposals on the General Practice workforce must be taken into consideration.

Conclusion and recommendations

33. In conclusion, the NZMA opposes the proposals by the Nursing Council to extend designated independent prescribing rights to community and specialist nurses. This stems primarily from our concerns that prescribing is inextricably linked to diagnosis. We believe that extending independent prescribing rights to nurses would undermine patient safety, exacerbate fragmentation and undermine the shared goal of a truly collaborative, integrated, multidisciplinary healthcare system. We are not convinced by the arguments advanced to address these concerns and believe the consultation document is light on evidence. Finally, we

wish to reiterate that the NZMA is not opposed to the concept of extending prescribing rights to nurses per se. We would, in principle, be supportive of this, providing it occurred within the context of a delegated model. Given that legislation to facilitate delegated prescribing is currently before parliament, we urge the Nursing Council to reconsider its application for independent designated prescribing.