

Should nurses prescribe?

Patricia Hewitt's announcement¹ that doctors' unique privilege to prescribe from the entire formulary will in future be usurped by nurses and pharmacists, subject to checks on professional competence, have understandably raised the hackles of doctors who see this as yet another attack on their professional status.

This, however, is more than a clinical version of a 1960-style demarcation dispute; it is a manifestation of a view prevailing among ministers and their advisers that GPs are intellectually inferior to their consultant colleagues and that their clinical and diagnostic skill can be fulfilled by other primary care team colleagues with less training, working to protocols. This is an attitude that forgets that the diagnostic process is often putative and uncertain and that any clinical algorithm involving the prescribing of powerful medication requires a reflective practitioner that will constantly revise and refine working diagnoses and, as a consequence, his or her prescribing decision. There is no clinical algorithm invented that can encompass that complexity or that can effectively substitute for skill in the art of diagnosis.

There is a dark irony in a government paying lip service to the academic work of Barbara Starfield, who shows that the most efficient health systems in the developed world are predicated upon a strong and well-resourced primary care system, then following an agenda increasingly hijacked by the financial black hole that is secondary care.

There can be no dispute that nurses can prescribe some antibiotics, many simple analgesics, and all dressings and lotions. Indeed, most doctors would instantly and willingly transfer tomorrow the prescribing of grocery lists for coeliac patients, a patently inappropriate duty for hard-pressed doctors. But to make the entire *British National Formulary* available to clinicians not trained in diagnosis, let alone therapeutics, is a potential disaster for the safety of patients and for the financial integrity of a health service constantly calling for more scarce resources.

Why is this attack aimed uniquely at doctors? We see no proposals for expert legal advice to be given by solicitors' clerks; there are no proposals for the core duties of teachers to be transferred to classroom assistants; and none of us would willingly risk handing over the preparation of our tax returns to unqualified accountants.

What, then, can be the reason for this radical departure in policy that would see nurses become surrogate doctors? The answer must lie in expediency; this is the latest Department(s) of Health solution to the problems of a health service with increasing demand and a limited human resource.

The four health ministers of the UK have a statutory duty under the NHS Acts to provide medical services to their populations. This duty cannot legitimately be fulfilled by the provision of alternative professionals and certainly not by nurses acting as quasi-doctors working to protocols, let alone by pharmacists with no pretensions to diagnostic skill. British GPs practise to the highest standards in the developed world, they are economic with medicines, they are trained in diagnosis and spend years honing their consulting skills. Every member of the public is statutorily entitled to those services.

GPs believe that no secretary of state should be allowed to dilute that level of care by inappropriately transferring core clinical duties to those not specifically and fully trained to perform them. If, and when, they do, they should be prepared to reap the electoral result from outraged patients and their families and carers when inevitable prescribing mistakes are made, or important diagnoses missed.

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REFERENCE

1. Department of Health. Nurse and pharmacist prescribing powers extended. (press release 10 Nov 2005). http://www.dh.gov.uk/PublicationsAndStatistics/PressReleases/PressReleasesNotices/fs/en?CONTENT_ID=4122999&chk=Mjc1MS (accessed 30 Nov 2005).



To find out more about this view see page 72